



CHAPTER 30

Clinical Applications of Posttraumatic Growth

RICHARD G. TEDESCHI, LAWRENCE G. CALHOUN, and JESSICA M. GROLEAU

FOR ALMOST 30 YEARS, we have been examining a phenomenon that has been recognized since ancient times, that suffering sometimes yields strengthening and growth (Tedeschi & Calhoun, 1995). It is a theme found in literature, both ancient and modern, in religion and philosophy, and more recently it has been reported in the social and behavioral science literature. Pioneering thinkers such as Caplan (1964) and Frankl (1963) recognized the possibility that positive psychological change could occur in the context of highly stressful circumstances. In earlier empirical reports, growth associated with attempts to adapt to highly challenging events was examined as a peripheral factor (e.g., Andreasen & Norris, 1972; Lopata, 1973). More recently, we have considered how this process occurs in attempts to cope with bereavement (Calhoun & Tedeschi, 1989–1990; Calhoun, Tedeschi, Fulmer, & Harlan, 2000; Taku, Calhoun, Cann, & Tedeschi, 2008; Tedeschi & Calhoun, 2003; Tedeschi & Calhoun, 2007; Tedeschi, Calhoun, Morrell, & Johnson, 1984), physical disability (Tedeschi & Calhoun, 1988), and war (Powell, Rosner, Butollo, Tedeschi, & Calhoun, 2003; Tedeschi, Calhoun, & Engdahl, 2001; Tedeschi, 2011; Tedeschi & McNally, 2011), and looked at how this process may affect entire societies (Tedeschi, 1999). The available data suggest that at least a significant minority of individuals facing a wide array of traumas, including loss of a home in a fire, divorce, the birth of a medically vulnerable child, sexual assault, bone marrow transplantation, military combat and captivity, diagnosis with HIV, and others, report some aspect of personal growth, and we have reviewed these reports in other places (Calhoun & Tedeschi, 1999, 2006, 2013; Tedeschi & Calhoun, 1995, 2004; Tedeschi, Park, & Calhoun, 1998; see also Joseph, 2011, and Linley & Joseph, 2004).

In this chapter we briefly review the literature that shows that growth occurs in the aftermath of a variety of life crises, and summarize ways of understanding how this growth occurs. We then explore how the therapeutic relationship can be a vehicle for recognizing growth at a time of vulnerability. Finally, we encourage clinicians to utilize an existential-narrative-cognitive framework for approaching growth in clients.



THE CONCEPT OF POSTTRAUMATIC GROWTH

We coined the term *posttraumatic growth* (Calhoun & Tedeschi, 1999; Tedeschi & Calhoun, 1996) to describe the experience of positive changes that occur as the result of the struggle with major life crises. Other terms have been used for the phenomenon of posttraumatic growth, including "stren conversion" (Finkel, 1974, 1975), "positive psychological changes" (Yalom & Lieberman, 1991), "perceived benefits" or "constructing benefits" (Calhoun & Tedeschi, 1991; McMillen, Zuravin, & Rideout, 1995; Tennen, Affleck, Urrows, Higgins, & Mendola, 1992), "stress-related growth" (Park, Cohen, & Murch, 1996), discovery of meaning (Bower, Kemeny, Taylor, & Fahey, 1998), positive emotions (Folkman & Moskowitz, 2000), "flourishing" (Ryff & Singer, 1998) "thriving" (O'Leary & Ickovics, 1995), and adversarial growth (Linley & Joseph, 2004). Taylor and Brown (1988) have labeled similar outcomes "positive illusions." Coping mechanisms of "positive reinterpretation" (Scheier, Weintraub, & Carver, 1986) "drawing strength from adversity" (McCrae, 1984), and "transformational coping" (Aldwin, 1994; Pargament, 1996) have also been described. The term *posttraumatic growth* appears to capture the essentials of this phenomenon better than others since (a) it occurs most distinctively in conditions of severe crisis rather than lower-level stress; (b) it is often accompanied by transformative life changes that appear to go beyond illusion; (c) it therefore is experienced as an outcome rather than a coping mechanism; and (d) it often requires a challenging of basic assumptions about one's life that thriving or flourishing does not imply.

Our conceptualization of posttraumatic growth and of the inclusion of these elements into psychological intervention relies on two elements: the growing literature on this phenomenon and our combined clinical experiences as practicing clinical psychologists. The empirical literature focused specifically on posttraumatic growth is rather recent and still limited in some ways. And, when one relies on clinical experience, the possibility of inadvertent bias always exists. However, since our conceptualizations of posttraumatic growth have data to support them, this way of thinking appears to offer a helpful expansion of the way psychological interventions are done with persons struggling with trauma and its aftermath.

THE PARADOXICAL CHANGES OF POSTTRAUMATIC GROWTH

The kinds of positive changes people experience in their struggle with major stressors are reflected in the Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996): improved relationships, new possibilities for one's life, a greater appreciation for life, a greater sense of personal strength, and spiritual development. There appears to be a basic paradox that is apprehended by trauma survivors who report these aspects of posttraumatic growth, that *their losses have produced gains*.

We also find other paradoxes. For example, "I am more vulnerable, yet stronger." Individuals who experience negative life events not surprisingly tend to report an increased sense of vulnerability, congruent with the fact that they have suffered in ways they may not have been able to control or prevent (Janoff-Bulman, 1992). However, a common theme in the experience of persons who have faced major life challenges is *an increased sense of their own capacities to survive and prevail* (Calhoun & Tedeschi, 1999).

Another paradox often reported is that in the midst of suffering through the worst times in life, trauma survivors discover both the worst and best in others. People talk about finding out "who their real friends are" or "who you can really count on." People often find themselves disappointed in the responses of some of those persons with whom they may have been close, but on the other hand, pleasantly surprised by the



helpfulness of others they may not have been particularly close to. A need to talk about the traumatic events sets in motion tests of interpersonal relationships—some pass, others fail. Another aspect of this self-disclosure is that trauma survivors find themselves becoming *more comfortable with intimacy*. A further component of the interpersonal elements of posttraumatic growth is the experience of *greater sense of compassion* for others who experience life difficulties. Although this increased sense of compassion may extend to other persons generally, it seems to be particularly the case for others who experience similar life difficulties.

People who face traumatic events, particularly those that make human mortality salient, may be more likely to become cognitively engaged with fundamental existential questions about death and the purpose of life. A commonly reported change is for the individual to *value the smaller things in life more*, and the apparently more important things less. For example, one's family, friends and small daily pleasures can be viewed as more important than before, and perhaps are now seen as more important than others, such as working long hours at one's occupation.

Facing mortality can produce important changes in the *religious, spiritual, and existential* components of philosophies of life. The specific content varies, of course, contingent on the individual's initial belief system and the cultural contexts within which the struggle with a life crises occurs. A common theme, however, is that after a period of spiritual or existential quest, individuals often report that *their philosophies of life are more fully developed, satisfying, and meaningful* to them. It appears that for many trauma survivors, a period of questioning their beliefs is ushered in because existential or spiritual issues have become more salient and less abstract. Although firm answers to the questions raised by trauma—why do traumatic events happen, what is the point to my life now that this trauma has occurred, why should I continue to struggle—are not necessarily found, grappling with these issues often produces a satisfaction in trauma survivors that they are experiencing life at a deeper level of awareness. This may be part of a developing life wisdom (see Linley, 2003), particularly in terms of the "fundamental pragmatics of life" (Baltes & Freund, 2003; Baltes & Smith, 1990) and the further development of the individual's own life narrative (McAdams, 1993; Tedeschi & Calhoun, 1995). It should be clear by now that the reflections on one's traumas and their aftermath are often unpleasant, although necessary in reconstructing the life narrative and establishing a wiser perspective on living that accommodates these difficult circumstances. Therefore, posttraumatic growth does not *necessarily* yield less emotional distress.

POSTTRAUMATIC GROWTH, PSYCHOLOGICAL COMFORT, AND SELF-ENHANCEMENT

One of the areas in which there is some inconsistency in the empirical data is on the relationship between posttraumatic growth and the sense of psychological comfort (Park, 1998). Although some studies find some relationship between measures of distress and measures of growth, others do not. It appears that the experience of posttraumatic growth, and psychological distress and comfort, may be essentially separate dimensions. This is relevant to the clinical context, because *people who experience significant levels of posttraumatic growth will not necessarily experience a commensurate decrease in their levels of distress nor an increase in their levels of happiness*. Furthermore, the maintenance of the growth experienced may require periodic cognitive reminders, that are not pleasant, of what has been lost, so that in an apparently paradoxical way, what has been gained remains in focus as well. Posttraumatic growth may lead to a more fulfilling and meaningful life, but it seems not to be the same as simply being carefree, happy, or feeling good. Living a life at a deeper level



of personal, interpersonal, and spiritual awareness is not necessarily the same as feeling good.

Given that survivors of major life crises may reflect on any of these aspects of post-traumatic growth, clinicians need to be prepared to grapple together with their clients as they address these issues. Clinicians need to appreciate paradox and ambiguity, the usefulness of thinking dialectically, and the patience necessary to process these concerns. Clinicians may also recognize some elements of self-enhancing bias at work in the experience of posttraumatic growth (McFarland & Alvaro, 2000). Our view, however, is that the clinician should approach such experiences on the part of their patients by accepting the reality of the experience for the individual. In addition, the available empirical evidence suggests that the self-ratings of growth on the part of individuals facing significant life challenges tend to be correlated with the ratings given to them by others (Moore et al., 2011; Park et al., 1996; Shakespeare-Finch & Enders, 2008; Weiss, 2002), indicating that the experience of posttraumatic growth is more than the mere manifestation of a self-enhancing cognitive bias.

Q1

A Clarification About Viewing Trauma as Beneficial We interrupt our discussion with a perhaps unnecessary reminder that these traumatic events tend to produce a variety of distressing responses in the persons who experience them. These responses are almost always unpleasant, sometimes long lasting, and for some people the traumatic sets of circumstances may lead to the development of identifiable psychiatric disorders. It would be a misunderstanding to think that trauma is good—we most certainly are not saying that. What we are saying is that despite these distressing experiences people often report positive transformations, what we have called posttraumatic growth. An important way to think about this, which has implications for clinical practice, is that the traumatic events set in motion attempts to cope and that *the struggle in the aftermath of the crisis, not the event itself*, produces the posttraumatic growth. We also wish to make clear that the empirical evidence indicates that *posttraumatic growth is common but certainly not universal*, and as clinicians, we should never have the expectation that every survivor will experience growth, or that it is a necessary outcome for full trauma recovery.

THE PROCESS OF POSTTRAUMATIC GROWTH

A central theme of the life challenges that are the focus here is their *seismic* nature (Calhoun & Tedeschi, 1998). Much like earthquakes can impact the physical environment, the events that represent major life crises are those that severely shake, challenge, or sometimes shatter the individual's way of understanding the world and her place in it (Janoff-Bulman, 1992). These seismic circumstances, characterized by their unusual, uncontrollable, potentially irreversible and threatening qualities, can produce a severe upheaval in the individuals' major assumptions about the world, their place in it, and how they make sense of their daily lives. When this shaking of the foundations of the individual's assumptive world (Parkes, 1970) reaches a sufficient catastrophic threshold, then the individual can be thought of as experiencing a traumatic event. In our model of posttraumatic growth (Calhoun, Cann, & Tedeschi, 2010; Calhoun & Tedeschi, 1998; Tedeschi & Calhoun, 1995), we emphasize that events must be of great enough impact to force individuals to reconsider the basic assumptions about who they are, what people around them are like, what kind of world they live in, or what the future may hold. In this reconsideration, there are the seeds for new perspectives on all these matters, and a sense that valuable, though painful, lessons have been learned. From a narrative perspective, the story of one's life has



been divided into before and after the traumatic event, and the person after is quite different from the person before (McAdams, 1993; Tedeschi & Calhoun, 1995). This is particularly so when trauma has produced a very strong challenge to, or has invalidated, higher order goals or schemas (Carver, 1998).

COGNITIVE ENGAGEMENT AND COGNITIVE PROCESSING

Challenged or shattered assumptive worlds, or schemas, must be revised or reconstructed. The necessity of rebuilding a more resilient set of schemas leads people who have experienced trauma to think repeatedly about their circumstances, a form of cognitive processing that is characterized by "making sense, problem solving, reminiscence, and anticipation" (Martin & Tesser, 1996, p. 192). In the encounter with a traumatic event, the individual's *cognitive engagement*, recurring ruminative thought, tends to reflect the lack of fit between what has happened and the individual's reaction on the one hand, and the organizing schemas, beliefs, and life goals, on the other hand. This repeated cognitive engagement with the elements that have been made salient by the crisis, can lead to the recognition that certain life goals are no longer attainable, that certain schemas no longer accurately reflect what is, and that certain beliefs (e.g., *my world is safe*) are no longer valid.

As the person comes to recognize some goals as no longer attainable and that some components of the assumptive world cannot assimilate the reality of the aftermath of the trauma, then it is possible for the individual to begin to formulate new goals and to revise major components of the assumptive world in ways that acknowledge his changed life circumstances. To the extent that cognitive engagement produces these kinds of changes, and the individual begins to experience a movement toward the achievement of new life goals, then increased life satisfaction might be expected as a result (Little, 1998).

People who face major stressors often experience high levels of emotional distress that, for some persons, can be debilitating. Our assumption is that for many persons the level of emotional distress, which tends to be higher in the time following a traumatic event, tends also to be accompanied by cognitive engagement that may be more automatic than deliberate. These are automatic processes of coping with negative emotional states that at the earlier stages are more likely to include intrusive thoughts and intrusive images. As the individual's adaptive mechanisms become more effective at managing the high levels of emotional distress, eventually the reduction of distress and the process of ongoing cognitive engagement with trauma can lead to the adaptive disengagement from the goals and fundamental beliefs and assumptions that are no longer tenable. It is important, however, to keep in mind that for some persons this process will take a long time, perhaps months or years. And it is also possible that for some persons the attempt at adaptation to loss or trauma will never achieve a fully satisfactory psychological outcome (Wortman & Silver, 2001).

For many people faced with major crises and losses, their circumstances tend to lead them to become cognitively engaged in two general domains: making sense out of the immediate circumstances and making sense of the more fundamental elements of significance raised by the circumstances (Calhoun, Selby, & Selby, 1982; Davis, Nolen-Hoeksema, & Larson, 1998). The first domain reflects the process of attempting to understand the particular sequence of events that produced the set of circumstances with which the person must now cope. For example, what led a loved one to commit suicide, or what sequence of events produced a transportation accident? The second general domain reflects broader and more abstract concerns, often existential or spiritual in nature, about the fundamental meaning of circumstances of one's life as



it exists in the aftermath of a trauma. These two domains of making sense of trauma are interwoven to some degree, although the dealing successfully with the first probably allows the trauma survivor to focus more on the second. Cognitive processing of trauma is not a neat process that can be easily reduced to a formula. There are many recursive and iterative aspects to it.

We are following the model of Martin and Tesser (1996), who describe this cognitive processing as conscious, which is easily cued, but also as occurring without direct cueing and involving attempts to make sense, problem solve, reminisce, or anticipate. There is some empirical suggestion that this kind of cognitive processing can be related to higher levels of posttraumatic growth. In one study, for example, young adults who had experienced major life stressors tended to report greater levels of posttraumatic growth when also reporting higher levels of cognitive engagement and processing recalled as occurring soon after crisis events (Calhoun, Cann, Tedeschi, & McMillan, 2000). In a study of the effects of journaling (Ullrich & Lutgendorf, 2002), university students who had been instructed to cognitively process their emotional responses, as compared to those instructed to focus on the facts or the associated emotions alone, reported higher levels of posttraumatic growth after four weeks. As such, cognitive engagement has become an integral component of the posttraumatic growth model (Calhoun, Cann, & Tedeschi, 2010; Calhoun & Tedeschi, 2013).

We have made a distinction in our model between the cognitive engagement of “deliberate rumination” and intrusive or automatic rumination. This distinction has also been described as reflective rumination versus brooding (Treynor, Gonzalez, & Nolen-Hoeksema, 2003). It appears that deliberate rumination about changes in core beliefs may be a strong predictor of posttraumatic growth (Triplett, Tedeschi, Cann, Calhoun, & Reeve, 2012).

DISCLOSURE, SUPPORT, AND NARRATIVE

The individual’s cognitive engagement with, and cognitive processing of, crisis events may be assisted by the disclosure of that internal process to others in socially supportive environments. The available evidence suggests that such disclosure, in the form of written communications, can have useful health benefits (Pennebaker, 1997). Written disclosure of trauma-related material can also have an impact on the extent of posttraumatic growth experienced (Slavin-Spenny, Cohen, Oberleitner, & Lumley, 2011; Smyth, Hockemeyer, & Tulloch, 2008; Ullrich & Lutgendorf, 2002), particularly when the focus is on the processing of cognitive and emotional elements. The degree to which individuals perceive their social contexts to either encouraging and accepting, or inhibiting and sanctioning, their disclosure of trauma-related thoughts and feelings may play an important role in the process of posttraumatic growth. When people affected by trauma perceive their significant others as not wanting to hear about their difficulties, cognitive processing may be inhibited. And, to the extent that cognitive engagement with crisis related material is limited, it might be expected that crisis related growth is less likely (Cordova, Cunningham, Carlson, & Andrykowski, 2001).

The experience of social constraints that inhibit the disclosure of trauma-related thoughts, particularly those thoughts that are troubling and intrusive, produces a reliable relationship between the occurrence of those thoughts and depression (Lepore & Helgeson, 1998; Lepore, Silver, Wortman, & Wayment, 1996). Persons who are engaging in significant levels of trauma-related cognitive processing, but who experience social constraints limiting or prohibiting such disclosure, appear to be at higher risk for dysphoric emotions in the aftermath of a major life crisis. Conversely, trauma



survivors who are supported when they engage in the disclosure of their cognitive processing may not only be less likely to experience depression, but may experience somewhat higher levels of posttraumatic growth as well (Nolen-Hoeksema & Larson, 1999). This assumption has also been empirically confirmed in a sample of cancer survivors who had undergone hematopoietic stem cell transplant. The results of this study indicate that social support is positively associated with self-reported posttraumatic growth (Nenova, DuHamel, Zemon, Rini, & Redd, 2013). In addition, it may be the case that *the presence of a social environment that explicitly addresses and encourages growth* may be an important factor in promoting posttraumatic growth. The availability of examples of growth narratives in the immediate social environment, perhaps in stories about how others have been changed positively by their encounters with trauma, or by exposure to others who have experienced similar difficulties and exhibit or describe ways in which their struggles have changed them, may enhance the likelihood that the individual will experience posttraumatic growth (Calhoun & Tedeschi, 2000).

COGNITIVE PROCESSING, THE LIFE NARRATIVE, AND WISDOM

As individuals weave the experience of posttraumatic growth into the fabric of their life narratives (McAdams, 1993), the way they understand themselves and their lives can change. Trauma can become incorporated in the individual's own life story as a "reckoning time" that sets the stage for some fundamental changes in outlook (Tedeschi & Calhoun, 1995) or at least as "redemption sequences" (McAdams, Reynolds, Lewis, Patten, & Bowman, 2001) that are incorporated into life narratives. At some point, trauma survivors may be able to engage in a sort of metacognition or reflection on their own processing of their life events, seeing themselves as having spent time making a major alteration of their understanding of themselves and their lives. This becomes part of the life narrative and includes an appreciation for new, more sophisticated ways of grappling with life events. This is part of how posttraumatic growth develops dynamically over time, and the processes that lead to its maintenance—and, for some, perhaps its abatement over time—are dynamic also.

WAYS CLINICIANS CAN FACILITATE THE PROCESS OF POSTTRAUMATIC GROWTH

With a basic understanding of the variables involved in the process of posttraumatic growth, we can consider how a clinician can affect this process in useful ways. We have talked about clinicians playing roles as facilitators of this process, because posttraumatic growth is likely to be inhibited by heavy-handed attempts to move trauma survivors toward understandings they have not yet directly experienced (Calhoun & Tedeschi, 1999, 2013). The changes that life crises produce are experiential, not merely intellectual, and that is what can make them so powerful. This is the same for posttraumatic growth—there is a compelling affective or experiential flavor to it that is important for the clinician to honor. Therefore, we see the clinician's role as often subtle in this facilitation. The clinician must be well attuned to the client when the client may be in the process of reconstructing schemas, thinking dialectically, recognizing paradox, and generating a revised life narrative. What follows here are some general guidelines to follow in this process. We refer the reader to Calhoun and Tedeschi (2013) for more extensive discussion and case examples.

We also wish to emphasize that the clinical activity we recommend does not constitute a technique to be employed, nor is this a proposal for a new therapy school.



The recommendation is that clinicians broaden their clinical perspectives so that elements of posttraumatic growth, and the possibility of helping clients further develop it, are part of the general clinical perspective they employ when trying to understand and assist persons who have been psychologically affected by a variety of events that might be considered traumatic for particular clients. Attention to elements of posttraumatic growth is compatible with a wide variety of the approaches that are currently utilized to provide help to persons dealing with trauma. Initially, clinicians should address high levels of emotional distress, providing the kind of support that can help make this manageable (Tedeschi & Calhoun, 1995). Allowing a distressed client to regain the ability to cognitively engage the aftermath of the trauma in a rather deliberate fashion will promote the possibility for posttraumatic growth. Then, it is likely that the domain the clinician may find to be the most productive for a possible focus on elements of posttraumatic growth is the process of cognitive engagement, cognitive processing, and cognitive change, including narrative reconstruction.

THE EXPERT COMPANION

When working with people who come to us for assistance in coping with trauma and its aftermath, we refer to the stance we take as professionals as *expert companionship* (Calhoun & Tedeschi, 2013; Tedeschi & Calhoun, 2006). This term emphasizes the view that both professional expertise as well as human companionship are crucial for the people seeking our help. We chose these words carefully; we view ourselves as *facilitators* rather than creators of growth, and *companions* who offer some *expertise* in nurturing naturally occurring processes of healing and growth. Just as many of the procedures that physicians perform on the body facilitate a healing process that the body must ultimately do for itself, we see ourselves as likewise facilitating the natural process of psychological healing, which may not be able to function smoothly on its own in the aftermath of trauma. In the remainder of this chapter, we will review various aspects of the facilitation that the expert companion provides. We will also describe the kind of companionship we seek to give to trauma survivors, and the various aspects of expertise that are necessary to address the tasks that appear to be important in moving toward a growth outcome.

General Considerations in Facilitating Posttraumatic Growth Particularly when working with survivors of traumatic events, who may be very distressed and vulnerable, it is important to utilize the best clinical practices. We also believe that these practices are critical to the facilitation of posttraumatic growth. We will highlight the relationship between these practices and how the clinician can act as a facilitator.

The Framework of the Trauma Survivor Although for most clinicians the reminder is unnecessary, it is probably useful to repeat a general recommendation to make a good effort to understand the client's way of thinking about the situation. We emphasize three aspects of the client's perspective that need to concern clinicians. First, it is imperative that *clinicians listen carefully to the language of crisis and psychological response that clients use, and that they judiciously join clients in this form of communication*. Second, it is useful for clinicians to feel comfortable and willing to help their clients process their cognitive engagement with existential or spiritual matters. It is important for *clinicians to respect and work within the existential framework that clients have developed or are trying to rebuild in the aftermath of a trauma*. Another way in which the clinician should respect the client's framework, particularly when issues of posttraumatic growth are the focus, regards the acceptance of what the clinician may



view as positive illusions (Taylor & Brown, 1988). Human beings generally tend to operate with certain benign cognitive distortions and persons facing major crises are probably not an exception. When working with clients dealing with traumatic circumstances, *clinicians may need to have some degree of tolerance and respect for the use of some benign cognitive biases*. Although the evidence tends to support the veracity of reports of posttraumatic growth, some clinicians may still be somewhat skeptical about the realistic foundations of the client's experience of growth. Although there certainly can be exceptions, our assumption is that clinical attempts to directly modify cognitions so that the benign illusory elements are corrected are likely to do psychological harm rather than to produce psychological benefit.

The Value of Effective Listening As we have suggested, individuals in the aftermath of trauma exhibit a high level of cognitive engagement with and cognitive processing of their life situation. Such cognitive processes can lay the foundation for the development of the elements of posttraumatic growth. The availability of a skilled listener, who can encourage the individual to disclose the cognitive processing related to the crisis event, can encourage the kinds of cognitive changes that not only enhance coping generally, but also may promote posttraumatic growth. Although individual clients may need additional specific interventions designed to alleviate crisis related psychological symptoms, we think that the clinical guideline of *listen without necessarily trying to solve* (Calhoun & Tedeschi, 1999, 2013) can be a helpful one. One way of ensuring that clinicians practice this approach is to relate to survivors in such a way that their story affects the clinician personally. Being open to the possibility of being changed oneself, as a result of listening to the story of the trauma and its aftermath, communicates the highest degree of respect for clients, and encourages them to see the value in their own experience. This acknowledged value is a short step away from posttraumatic growth.

People who have been exposed to trauma may find it useful to tell their story repeatedly, and the clinician may need to listen patiently as the client repeats the story of what has happened. The individual's repetition of the account of the difficult experience can serve a safe exposure function when the difficulty is associated with an identifiable stimulus array, and this alone can have therapeutic value. The retelling of the account can also help the person engage in the kinds of cognitive activity that can help the individual accommodate cognitive structure to the undeniable events, and in this process the possibility of discovering posttraumatic growth exists.

Although we are encouraging what may seem to be a rather passive clinical stance, the way the clinician listens and what the clinician listens and attends to can have significant therapeutic consequences. As is apparent, our assumption is that clinicians will need to be skilled at deciding the types of responses to make and what to encourage the client to say and do. For example, in listening to the repeated telling of stories, clinicians may highlight the subtle changes in the tellings—details never included before, differences in the descriptors used, changes in the perspective taken, shifts in the affect displayed. Any such elements can be pointed out, especially when there is a hint of an emerging aspect of posttraumatic growth. Although compared to more structured approaches, what is suggested here does lack a certain degree of prescriptiveness, this general framework can certainly be woven into even rather prescriptive, manual driven psychological interventions designed to help persons coping with the aftermath of trauma.

Listen For and Label Posttraumatic Growth Clients will routinely and spontaneously articulate ways in which their struggle has produced highly meaningful changes in



them, without clinicians prompting them. However, our experience has been that only rarely will clients actually identify such changes as a representation of posttraumatic growth. A small but very useful change that clinicians can make in their work with persons who are dealing trauma, then, is simply to *listen for themes of posttraumatic growth* in what their clients say. When clinicians notice and label as positive the positive changes that clients relate, this can be a therapeutic cognitive experience for the client. The clinician must have good knowledge of the domains and elements of posttraumatic growth, listen for and attend to the client's account of the experience of growth, and label the experience in a way that makes the growth experience cognitively salient for the client. However, *the clinician must guard against the mechanistic offering of empty platitudes* that tell the client, for example, what wonderful opportunities for growth are offered by the experience of trauma. If the clinician has listened well to the client's account of the circumstances and of the client's personal reactions, including affective, cognitive, and behavioral components, the insensitive and inappropriate offering of platitudes becomes extremely unlikely. What we are suggesting is that the clinician should respond in ways that reflect discoveries that their clients themselves are making. As we have implied, however, the way in which the client has cognitively constructed the posttraumatic experience may only implicitly reflect the experience of growth, and the clinician can highlight these statements that imply growth.

How and When a Clinician Chooses to Highlight The posttraumatic growth that is emerging in a client is an important consideration. Just as a clinician could make insensitive remarks that come across as platitudes, getting the timing of posttraumatic growth remarks wrong can also have a counterproductive effect. Our experience suggests to us that *very early in the posttrauma process is usually not a good time* for attention to be directed toward the possibility of posttraumatic growth. The immediate aftermath of tragedy is a time during which clinicians must be particularly sensitive to the psychological needs of the patient, and never engage in the insensitive introduction of didactic information or trite comments about growth coming from suffering. This is not to say that systematic treatment programs designed for trauma survivors should not include growth-related components, since these may indeed be helpful (Antoni et al., 2001). But we tend to think that even as part of a systematic intervention program, matters related to growth are best addressed only after the client has had a sufficient time to achieve at least some degree of equilibrium.

Focus on the Struggle, Rather Than the Event For some trauma survivors, what has happened to them may have been so horrible, and the aftermath may be so devastating, that the very concept of posttraumatic growth may be repellent. Clinicians should respect that perspective. The available data, however, indicate that some people coping with even the most horrible events can experience some degree of posttraumatic growth (Tedeschi & Calhoun, 1995). The clinician who is interested in the encouragement of growth that some clients may experience, then, must perform what on the surface may be a paradoxical task—to acknowledge the reality that for some persons the very discussion of growth coming from the struggle may be unacceptable given the horrific nature of what they have undergone, but at the same time the clinician should be open to the possibility that clients themselves may experience growth from their struggle with even the most tragic and traumatic sets of circumstances. To try to address this issue, a clinician may say, "You may have heard people say that they have found some benefit in their struggle with trauma. Given what has happened to you,



do you think that is possible?" Also notice that in this question, the clinician makes a clear distinction between the events that have happened and the individual's *struggle* to survive psychologically and adapt to their painful circumstances. A useful way to speak of the possibility of growth is to use words that indicate that the experience of growth the patient may have undergone is a result of *the struggle* to adapt to the trauma and not to the situation itself.

Clinicians who work with survivors of highly stressful events often find themselves using metaphors in their conversations with clients, because description of the traumatic events and their effects may be difficult to achieve in more straightforward language. Listening for metaphors a client uses, or introducing metaphors that might be particularly salient for an individual, allows for discussions of posttraumatic growth in these more indirect ways, allowing trauma survivors to acknowledge things that otherwise would be difficult. For example, we have described a case where a photographer whose son died could recognize changes in himself as photos emerging from developing fluid (Calhoun & Tedeschi, 1999, 2013).

Exposure to Models of Posttraumatic Growth Trauma survivors may be better able to develop an ability to recognize, or even aspire to, posttraumatic growth if they are exposed to other survivors who have responded in this way. For this reason we have favored the use of group treatments for many trauma survivors (Tedeschi & Calhoun, 1995, 2003), with the expectation that the mutual help exchanged in such groups may also give trauma survivors an opportunity to experience the power of their own gifts of empathy and compassion, learned from their trauma. We also have recommended a number of books and other resources that include growth themes in trauma survival (Calhoun & Tedeschi, 1999, 2013; Tedeschi & Calhoun, 1995, 2003).

A Little Push Toward Growth Without announcing to clients that we have any expectations for them to experience posttraumatic growth, we sometimes offer assignments that may allow them to begin to notice aspects of growth in their struggles. Writing assignments that encourage narrative development are often useful for trauma survivors (Resick & Calhoun, 2001), and in these narratives growth can emerge. We also have suggestions for assignments that involve self-monitoring of changing beliefs in the aftermath of trauma (Calhoun & Tedeschi, 1999). Focus on these assignments in subsequent therapy sessions can allow clinicians an opportunity to highlight emerging growth perspectives.

UTILIZING A MODEL OF POSTTRAUMATIC GROWTH INTEGRATED WITH TRAUMA TREATMENT

Effective clinicians treating trauma survivors should maintain a focus on the possibility of posttraumatic growth from the start of treatment as they use empirically supported trauma treatment approaches together with empirically based growth facilitation. Calhoun and Tedeschi (2013) offer a description of five elements of growth-oriented trauma therapy that expert companions can use: a psychoeducational component that emphasizes normal trauma responses that act as precursors to growth; the development of emotion-regulation strategies to allow for effective deliberate rumination; methods of constructive self-disclosure within relationships; the creation of a new life narrative with posttraumatic growth elements; and the development of life principles and core beliefs that are robust to future traumas and promote resilience.



CAVEATS AND REMINDERS

Posttraumatic growth occurs in the context of suffering and significant psychological struggle, and a focus on growth should not come at the expense of empathy for the pain and suffering of trauma survivors. For most, posttraumatic growth and distress will coexist. It is also important to remember that trauma is not necessary for growth. People can mature and develop in meaningful ways without experiencing tragedy or trauma. In no way are we suggesting that trauma is good. We regard life crises, loss, and trauma as undesirable, and our wish would be that nobody would have to experience such life events. We regard traumatic events as indeed negative, but the evidence suggests that those who are forced to struggle with them can experience highly meaningful personal changes. To repeat what we have previously said—posttraumatic growth is neither universal nor inevitable. Although a majority of people experiencing a wide array of highly of challenging life circumstances experience posttraumatic growth, there are also a significant number of persons who experience little or no growth in their struggle with trauma. This sort of outcome is quite acceptable; we are not raising the bar on trauma survivors—they should not be expected to show posttraumatic growth before being considered recovered.

THE CLINICIAN'S GAIN

Work with survivors of traumatic events from the growth perspective we have outlined can be highly rewarding for clinicians. In listening to clients with respect for their strength and ability to change, we find ourselves changed for the better. We learn lessons along with our clients and find that many of our colleagues can also identify this vicarious posttraumatic growth (Arnold, Calhoun, Tedeschi, & Cann, 2000; Horrell, Holohan, Didion, & Vance, 2011; Linley, Joseph, & Loumidis, 2005; Profit, Calhoun, Tedeschi, & Cann, 2002). The model we have outlined allows us to share both the suffering and the possibilities with those who are being tempered by the fire.

SUMMARY POINTS

- Be aware of the possibility of posttraumatic growth (PTG) from the beginning of trauma treatment.
- Highlight and explore PTG indications when they begin to appear in the client's story.
- PTG is not a way to eliminate the distress of trauma.
- A focus primarily of symptom reduction will tend to retard the process of growth.
- To be an expert companion for trauma survivors, focus on learning from them and let this be the conversation you have, rather than being intent on changing them.

REFERENCES

- Aldwin, C. M. (1994). *Stress, coping, and development*. New York, NY: Guilford Press.
- Andreasen, N. L., & Norris, A. S. (1972). Long-term adjustment and adaptation mechanisms in severely burned adults. *Journal of Nervous and Mental Disease*, 154, 352–362.
- Antoni, M. H., Lehman, J. M., Kilbourn, K. M., Boyers, A. E., Yount, S. E., Culver, J. L., ... Carver, C. S. (2001). Cognitive-behavioral stress management intervention decreases the prevalence of depression and enhances the sense of benefit among women under treatment for early-stage breast cancer. *Health Psychology*, 20, 20–32.

*Clinical Applications of Posttraumatic Growth* 515

- Arnold, D., Calhoun, L. G., Tedeschi, R. G., & Cann, A. (2000, August). *Vicarious transformation in psychotherapy with trauma survivors*. Poster presented at the Annual Convention of the American Psychological Association, Washington, DC.
- Baltes, P. B., & Freund, A. M. (2003). Human strengths as the orchestration of wisdom and selective optimization with compensation. In L. G. Aspinwall & U. M. Staudinger (Eds.), *A psychology of human strengths* (pp. 23–35). Washington, DC: American Psychological Association.
- Baltes, P. B., & Smith, J. (1990). Toward a psychology of wisdom and its ontogenesis. In R. J. Sternberg (Ed.), *Wisdom: Its nature, origins, and development* (pp. 87–120). New York, NY: Cambridge University Press
- Bower, J. E., Kemeny, M. E., Taylor, S. E., & Fahey, J. L. (1998). Cognitive processing, discovery of meaning, CD 4 decline, and AIDS-related mortality among bereaved HIV-seropositive men. *Journal of Consulting and Clinical Psychology, 66*, 979–986.
- Calhoun, L. G., Cann, A., & Tedeschi, R. G. (2010). The posttraumatic growth model: Sociocultural considerations. In T. Weiss & R. Berger (Eds.), *Posttraumatic growth and culturally competent practice* (pp. 1–14). Hoboken, NJ: Wiley.
- Calhoun, L. G., Cann, A., Tedeschi, R. G., & McMillan, J. (2000). A correlational test of the relationship between posttraumatic growth, religion, and cognitive processing. *Journal of Traumatic Stress, 13*, 521–527.
- Calhoun, L. G., Selby, J. W., & Selby, L. E. (1982). The psychological aftermath of suicide: An analysis of current evidence. *Clinical Psychology Review, 2*, 409–420.
- Calhoun, L. G., & Tedeschi, R. G. (1989–1990). Positive aspects of critical life problems: Recollections of grief. *Omega, 20*, 265–272.
- Calhoun, L. G., & Tedeschi, R. G. (1991). Perceiving benefits in traumatic events: Some issues for practicing psychologists. *Journal of Training & Practice in Professional Psychology, 5*, 45–52.
- Calhoun, L. G., & Tedeschi, R. G. (1998). Posttraumatic growth: Future directions. In R. G. Tedeschi, C. L. Park, & L. G. Calhoun, (Eds.), *Posttraumatic growth: Positive change in the aftermath of crisis* (pp. 215–238). Mahwah, NJ: Erlbaum.
- Calhoun, L. G., & Tedeschi, R. G. (1999). *Facilitating posttraumatic growth: A clinician's guide*. Mahwah, NJ: Erlbaum.
- Calhoun, L. G., & Tedeschi, R. G. (2000). Early posttraumatic interventions: Facilitating possibilities for growth. In J. M. Volanti, D. Paton, & C. Dunning (Eds.), *Posttraumatic stress intervention: Challenges, issues and perspectives* (pp. 135–152). Springfield, IL: Charles C. Thomas.
- Calhoun, L. G., & Tedeschi, R. G. (2006). *Handbook of posttraumatic growth*. Mahwah, NJ: Erlbaum.
- Calhoun, L. G., & Tedeschi, R. G. (2013). *Posttraumatic growth in clinical practice*. New York, NY: Routledge.
- Calhoun, L. G., Tedeschi, R. G., Fulmer, D., & Harlan, D. (2000, August). *Parental grief: The relation of rumination, distress, and posttraumatic growth*. Poster presented at the Annual Convention of the American Psychological Association, Washington, DC.
- Caplan, G. (1964). *Principles of preventive psychiatry*. New York, NY: Basic Books.
- Carver, C. S. (1998). Resilience and thriving: Issues, models, and linkages. *Journal of Social Issues, 54*, 245–266.
- Cordova, M. J., Cunningham, L. L. C., Carlson, C. R., & Andrykowski, M. A. (2001). Posttraumatic growth following breast cancer: A controlled comparison study. *Health Psychology, 20*, 176–185.
- Davis, C. G., Nolen-Hoeksema, S., & Larson, J. (1998). Making sense of loss and benefiting from the experience: Two construals of meaning. *Journal of Personality and Social Psychology, 75*, 561–574.
- Finkel, N. J. (1974). Strens and traumas: An attempt at categorization. *American Journal of Community Psychology, 2*, 265–273.





- Finkel, N. J. (1975). Strens, traumas and trauma resolution. *American Journal of Community Psychology*, 3, 173–178.
- Folkman, S., & Moskowitz, J. T. (2000). Stress, positive emotion, and coping. *Current Directions in Psychological Science*, 9, 115–118.
- Frankl, V. E. (1963). *Man's search for meaning*. New York, NY: Pocket Books.
- Horrell, S. C. V., Holohan, D. R., Didion, L. M., & Vance, G. T. (2011). Treating traumatized OEF/OIF veterans: How does trauma treatment affect the clinician? *Professional Psychology: Research and Practice*, 42, 79–86.
- Janoff-Bulman, R. (1992). *Shattered assumptions*. New York, NY: The Free Press.
- Joseph, S. (2011). *What doesn't kill us: The new science of posttraumatic growth*. New York, NY: Basic Books.
- Lepore, S. J., & Helgeson, V. S. (1998). Social constraints, intrusive thoughts, and mental health after prostate cancer. *Journal of Social and Clinical Psychology*, 17, 89–106.
- Lepore, S. J., Silver, R. C., Wortman, C. B., & Waymant, H. A. (1996). Social constraints, intrusive thoughts, and depressive symptoms among bereaved mothers. *Journal of Personality and Social Psychology*, 70, 271–282.
- Linley, P. A. (2003). Positive adaptation to trauma: Wisdom as both process and outcome. *Journal of Traumatic Stress*, 16(6), 601–610.
- Linley, P. A., & Joseph, S. (2004). Positive change following trauma and adversity: A review. *Journal of Traumatic Stress*, 17(1), 11–21.
- Linley, P. A., Joseph, S., & Loumidis, K. (2005). Trauma work, sense of coherence, and positive and negative changes in therapists. *Psychotherapy and Psychosomatics*, 74(3), 185–188.
- Little, B. R. (1998). Personal project pursuit: Dimensions and dynamics of personal meaning. In P. T. P. Wong & P. S. Fry (Eds.), *The human quest for meaning: A handbook of psychological research and clinical applications* (pp. 193–212). Mahwah, NJ: Erlbaum.
- Lopata, H. Z. (1973). Self-identity in marriage and widowhood. *Sociological Quarterly*, 14, 407–418.
- Martin, L. L., & Tesser, A. (1996). Clarifying our thoughts. In R. S. Wyer (Ed.), *Advances in social cognition: Vol. 9. Ruminative thoughts* (pp. 189–209). Mahwah, NJ: Erlbaum.
- McAdams, D. P. (1993). *The stories we live by: Personal myths and the making of the self*. New York, NY: Morrow.
- McAdams, D. P., Reynolds, J., Lewis, M., Patten, A. H., & Bowman, P. J. (2001). When bad things turn good and good things turn bad: Sequences of redemption and contamination in life narrative and their relations to psychosocial adaptation in midlife adults and in students. *Personality and Social Psychology Bulletin*, 27, 474–485.
- McCrae, R. R. (1984). Situational determinants of coping responses: Loss, threat, and challenge. *Journal of Personality and Social Psychology*, 46, 919–928.
- McFarland, 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.
- McMillen, C., Zuravin, S., & Rideout, G. (1995). Perceived benefits from child sexual abuse. *Journal of Consulting and Clinical Psychology*, 63, 1037–1043.
- Nenova, M., DuHamel, K., Zemon, V., Rini, C., & Redd, W. H. (2013). Posttraumatic growth, social support, and social constraint in hematopoietic stem cell transplant survivors. *Psycho-Oncology*, 22(1), 195–202. doi: 10.1002/pon.2073
- Nolen-Hoeksema, S., & Larson, J. (1999). *Coping with loss*. Mahwah, NJ: Erlbaum.
- O'Leary, V. E., & Ickovics, J. R. (1995). Resilience and thriving in response to challenge: An opportunity for a paradigm shift in women's health. *Women's Health: Research on Gender, Behavior, and Policy*, 1, 121–142.
- Pargament, K. I. (1996). Religious methods of coping: Resources for the conservation and transformation of significance. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 215–240). Washington, DC: American Psychological Association.



*Clinical Applications of Posttraumatic Growth* 517

- Park, C. L. (1998). Implications of posttraumatic growth for individuals. In R. G. Tedeschi, C. L. Park, & L. G. Calhoun (Eds.), *Posttraumatic growth: Positive change in the aftermath of crisis* (pp. 153–177). Mahwah, NJ: Erlbaum.
- Park, C. L., Cohen, L., & Murch, R. (1996). Assessment and prediction of stress-related growth. *Journal of Personality, 64*, 71–105.
- Parke, C. M. (1970). Psycho-social transitions: A field for study. *Social Science and Medicine, 5*, 101–115.
- Pennebaker, J. W. (1997). *Opening up: The healing power of expressing emotions*. New York, NY: Guilford Press.
- Powell, S., Rosner, R., Butollo, W., Tedeschi, R. G., & Calhoun, L. G. (2003). Posttraumatic growth after war: A study with former refugees and displaced people in Sarajevo. *Journal of Clinical Psychology, 59*, 71–83.
- Profitt, D. H., Calhoun, L. G., Tedeschi, R. G., & Cann, A. (2002, August). *Clergy and crisis: Correlates of posttraumatic growth and well-being*. Poster presented at the Annual Convention of the American Psychological Association, Chicago, IL.
- Resick, P. A., & Calhoun, K. S. (2001). Posttraumatic stress disorder. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders* (3rd ed., pp. 60–113). New York, NY: Guilford Press.
- Ryff, C. D., & Singer, B. S. (1998). The role of purpose in life and personal growth in positive human health. In P. T. P. Wong & P. S. Fry (Eds.), *The human quest for meaning: A handbook of psychological research and clinical applications* (pp. 213–235). Mahwah, NJ: Erlbaum.
- Scheier, M. F., Weintraub, J. K., & Carver, C. S. (1986). Coping with stress: Divergent strategies of optimists and pessimists. *Journal of Personality and Social Psychology, 51*, 1257–1264.
- Shakespeare-Finch, J., & Enders, T. (2008). Corroborating evidence of posttraumatic growth. *Journal of Traumatic Stress, 21*, 421–424.
- Slavin-Spenny, O. M., Cohen, J. L., Oberleitner, L. M., & Lumley, M. A. (2011). The effects of different methods of emotional disclosure: Differentiating post-traumatic growth from stress symptoms. *Journal of Clinical Psychology, 67*, 993–1007.
- Smyth, J. M., Hockemeyer, J. R., & Tulloch, H. (2008). Expressive writing and post-traumatic stress disorder: Effects on trauma symptoms, mood states, and cortisol reactivity. *British Journal of Health Psychology, 13*, 85–93.
- Taku, K., Calhoun, L. G., Cann, A., & Tedeschi, R. G. (2008). The role of rumination in the coexistence of distress and posttraumatic growth among bereaved Japanese university students. *Death Studies, 32*(5), 428–444.
- Taylor, S. E., & Brown, J. D. (1988). Illusion and well-being: A social psychological perspective on mental health. *Psychological Bulletin, 103*, 193–210.
- Tedeschi, R. G. (1999). Violence transformed: Posttraumatic growth in survivors and their societies. *Aggression and Violent Behavior, 4*, 319–341.
- Tedeschi, R. G. (2011). Posttraumatic growth in combat veterans. *Journal of clinical psychology in medical settings, 18*(2), 137–144.
- Tedeschi, R. G., & Calhoun, L. G. (1988, August). *Perceived benefits in coping with physical handicaps*. Paper presented at the Annual Meeting of the American Psychological Association, Atlanta, GA.
- Tedeschi, R. G., & Calhoun, L. G. (1995). *Trauma and transformation: Growing in the aftermath of suffering*. Thousand Oaks, CA: Sage.
- Tedeschi, R. G., & Calhoun, L. G. (1996). The Posttraumatic Growth Inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9*, 455–471.
- Tedeschi, R. G., & Calhoun, L. G. (2003). *Helping the bereaved parent: A clinician's guide*. New York, NY: Brunner-Routledge.
- Tedeschi, R. G. & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15*(1), 1–18.





- Tedeschi, R. G., & Calhoun, L. G. (2006). Expert Companion: Posttraumatic growth in clinical practice. In L. G. Calhoun & R. G. Tedeschi (Eds.), *Handbook of posttraumatic growth: Research and practice* (pp. 291–310). Mahwah, NJ: Erlbaum.
- Tedeschi, R. G., & Calhoun, L. G. (2007). Beyond the concept of recovery: Growth and the experience of loss. *Death Studies, 32*(1), 27–39.
- Tedeschi, R. G., Calhoun, L. G., & Engdahl, B. E. (2001). Opportunities for growth in survivors of trauma. *National Center for PTSD Clinical Quarterly, 10*, 23–25.
- Tedeschi, R. G., Calhoun, L. G., Morrell, R. W., & Johnson, K. A. (1984, August). *Bereavement: From grief to psychological development*. Paper presented at the Annual Meeting of the American Psychological Association, Toronto, ON.
- Tedeschi, R. G., & McNally, R. J. (2011). Can we facilitate posttraumatic growth in combat veterans? *American Psychologist, 66*(1), 19.
- Tedeschi, R. G., Park, C. L., & Calhoun, L. G. (Eds.). (1998). *Posttraumatic growth: Positive change in the aftermath of crisis*. Mahwah, NJ: Erlbaum.
- Tennen, H., Affleck, G., Urrows, S., Higgins, P., & Mendola, R. (1992). Perceiving control, construing benefits, and daily processes in rheumatoid arthritis. *Canadian Journal of Behavioral Science, 24*, 186–203.
- Treynor, W., Gonzalez, R., & Nolen-Hoeksema, S. (2003). Rumination reconsidered: A psychometric analysis. *Cognitive Therapy and Research, 27*, 247–259.
- Triplett, K. N., Tedeschi, R. G., Cann, A., Calhoun, L. G., & Reeve, C. L. (2012). Posttraumatic growth, meaning in life, and life satisfaction in response to trauma. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*, 400–410.
- Ullrich, P. M., & Lutgendorf, A. K. (2002). Journaling about stressful events: Effects of cognitive processing and emotional expression. *Annals of Behavioral Medicine, 24*, 244–250.
- Weiss, T. (2002). Posttraumatic growth in women with breast cancer and their husbands: An intersubjective validation study. *Journal of Psychosocial Oncology, 20*, 65–80.
- Wortman, C. B., & Silver, R. C. (2001). The myths of coping with loss revisited. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping and care* (pp. 405–429). Washington, DC: American Psychological Association.
- Yalom, I. D., & Lieberman, M. A. (1991). Bereavement and heightened existential awareness. *Psychiatry, 54*, 334–345.





Queries in Chapter 30

Q1. Please add reference entry for Moore et al., 2011

