

A person-centered perspective on working with people who have experienced psychological trauma and helping them move forward to posttraumatic growth

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## Abstract

Over the past decade posttraumatic growth has emerged to become a major topic for theory, research and practice in mainstream trauma psychology. The aim of this paper is to discuss the implications of posttraumatic growth for the person-centered approach. It is argued that posttraumatic growth provides a new non-medical language for understanding psychological trauma that is consistent with the person-centered approach. Person-centered personality theory provides an explanation for how posttraumatic growth arises and leads to new testable predictions for research into how person-centered therapy may be able to facilitate posttraumatic growth.

## **Introduction**

Throughout human history, literatures, religions, and philosophies have conveyed the notion that there are gains to be found following trauma. Most notable is Nietzsche's famous dictum 'What doesn't kill me makes me stronger' (Nietzsche, 1889). It was also an idea familiar to the existential and humanistic psychologists of the mid twentieth century. Viktor Frankl (1963) wrote about the will to meaning following his experiences in Auschwitz. Abraham Maslow (1955) noted that confrontations with tragedy were often a precursor to self-actualization. Although these ideas are widely recognised within existential and humanistic psychology, until recently they were overshadowed in the mainstream psychological trauma literature by the medical model concept of posttraumatic stress disorder (PTSD) (American Psychiatric Association, 2013). However, interest in how there can be gains following trauma has begun to attract mainstream attention following the emergence of the new concept of posttraumatic growth (PTG).

PTG is a term introduced by Richard Tedeschi and Lawrence Calhoun in 1995 to refer to the positive changes that people often report following adversity (Tedeschi & Calhoun, 1995). PTG is now a topic within mainstream trauma psychology and has become one of the flagship topics for the new science of positive psychology (Joseph, 2011). Despite the fact that the idea of PTG has much in common with many of the earlier ideas of existential and humanistic psychology it is a topic that remains relatively unknown to therapeutic practitioners in the person-centered approach (PCA).

The aim of this paper is to provide an overview of the field of PTG and how it relates both theoretically and practically to the person-centered approach (PCA). There

are two reasons to wish to build bridges between PTG and the PCA. First, the PCA is rarely included in mainstream texts on psychological trauma. Practitioners of the PCA are marginalised in clinical practice because of the perception that they lack the knowledge or skills to work with traumatized individuals. As such, by showing the conceptual similarity of PTG and the PCA practitioners will see that the work that they already do is relevant to trauma survivors. By engaging with the language of PTG practitioners will be able to communicate to others who are less familiar with the PCA how what they do is helpful to trauma survivors. Second, for researchers in mainstream trauma and positive psychology it will be helpful to understand how the PCA provides a theoretical understanding and a therapeutic method for the facilitation of PTG.

The paper is divided into three sections. Following a brief overview of the field of PTG, I will discuss the PCA to PTG, and finally the implications for person-centered practice and research.

### **Posttraumatic growth (PTG)**

Three broad related dimensions of positive change have been discussed: First, relationships are enhanced in some way, for example, that people now value their friends and family more, and feel an increased compassion, and kindness toward others. Secondly, people change their views of themselves in some way, for example, that they have a greater sense of personal resiliency, wisdom, and strength, perhaps coupled with a greater acceptance of their vulnerabilities and limitations. Third, there are reports of changes in life philosophy, for example, finding a fresh appreciation for each new day,

shifts in understanding of what really matters in life (see also, Tedeschi & Calhoun, 2004).

Since the development of PTG as an area of scholarly interest, researchers have explored experiences of PTG in a variety of contexts, for example, in survivors of childhood abuse (Woodward & Joseph, 2003), in people who have been bereaved by suicide (Smith, Joseph, & Das Nair, 2011), or suffered a life-threatening illness (Hefferon, Grealy, & Mutrie, 2009) to mention but a few of the many studies that have now documented this phenomenon.

Several psychometric tools have been developed with the purpose of assessing individual differences in positive changes following adversity: the Changes in Outlook Questionnaire (CiOQ: Joseph, Williams, & Yule, 1993); the Posttraumatic Growth Inventory (PTGI: Tedeschi & Calhoun, 1996), the Psychological Well-Being Posttraumatic Changes Questionnaire (PWB-PTCQ: Joseph, Maltby, Wood, Stockton, Hunt & Regel, 2012), the Stress-Related Growth Scale (SRGS: Park, Cohen, & Murch, 1996); the Perceived Benefit Scales (PBS: McMillen & Fisher, 1998); and the Thriving Scale (TS: Abraido-Lanza et al., 1998).

Each of the above measures asks respondents to reflect on an event that has occurred in their lives and then to rate items that describe ways in which they may have changed in more fully functioning ways. For example, the most widely used of the measures is the Posttraumatic Growth Inventory (PTGI) which assesses five domains: (1) perceived changes in self (becoming stronger, more confident); (2) developing closer relationships with family, friends, neighbours, fellow trauma survivors and even strangers; (3) changing life philosophy/increased existential awareness; (4) changed

priorities and (5) enhanced spiritual beliefs. Another measure, the PWB-PTCQ, describes six dimensions of change: (1) self-acceptance, (2) autonomy, (3) purpose in life, (4) relationships, (5) sense of mastery and (6) openness to personal growth.

Research into PTG within mainstream psychology has progressed considerably with the introduction of these standardised self-report instruments (see Joseph & Linley, 2008 for a review on measurement). Indeed, some degree of posttraumatic growth is commonly reported in around 30-70% of survivors of various events (including transportation accidents (shipping disasters, plane crashes, car accidents), natural disasters (hurricanes, earthquakes), interpersonal experiences (combat, rape, sexual assault, child abuse), medical problems (cancer, heart attack, brain injury, spinal cord injury, HIV / AIDS, leukaemia, rheumatoid arthritis, multiple sclerosis, illness) and other life experiences (relationship breakdown, parental divorce, bereavement, immigration) (Linley & Joseph, 2004).

One of the main criticisms of the field of PTG has been its reliance to date on measures of PTG that rely on people making retrospective self-reports on how they perceive themselves to have changed as a result of an event. This is problematic for a number of reasons. Ford, Tennen, and Albert (2008) describe the complex cognitive operations required on the part of respondents which can be subject to bias, such that it is simply hard for people to be accurate in recalling how they have changed over a period of time. This represents a concern for researchers insofar as perception of growth may not always reflect actual change (Frazier et al, 2009). For this reason, researchers now distinguish between perceptions of growth which refer to the ways in which people think that they have changed, and actual growth which refers to more objective forms of

assessment such as those obtained using other more objective forms of assessment such as reports by others or ideally in which people are tracked over time in order to document the ways in which they actually change (Joseph & Linley, 2008). Assessment of actual growth is ideal but of course harder to implement in research studies as it requires several time points of study, but this is one of the cutting edge issues for future research.

Turning to psychotherapeutic applications, the facilitation of PTG as a focus for therapeutic activity has begun to receive attention. PTG theorists argue that such positive changes are of value in themselves and that facilitation of growth is a worthwhile clinical outcome in its own right. However, for those unused to thinking in such terms, there is a need to demonstrate the benefits of PTG against other more established criteria such as PTSD. This has proven problematic as the relationship between PTSD and PTG appears complex.

It has been suggested that the intrusive experiences characteristic of posttraumatic stress are actually necessary for the development of PTG. In support of this, Helgeson et al (2006) conducted a meta-analytic review showing that posttraumatic growth was related to more intrusive posttraumatic experiences. In this sense, it needs to be emphasised that posttraumatic stress and PTG are not mutually exclusive but often seem to co-exist.

However, studies which adopt a longitudinal focus tend to show that PTG does seem to be predictive of lower PTSD subsequently. Linley, Joseph & Goodfellow (2008) found that people who report growth are less likely to experience problems of posttraumatic stress six months later. Frazier et al. (2001) asked 171 rape survivors to complete a specially designed questionnaire to measure positive changes at 2 weeks

following the assault, and then again at 2, 6, and 12 months later. This was a well designed study which allowed the investigators to see how positive changes related to well being over time. First, she created four groups. (1) Those who reported low levels of positive change at 2 weeks and high levels at 12 months (gained positive change group). (2) Those who reported high levels of positive change at 2 weeks and low levels at 12 months (lost positive change group). (3) Those who reported low levels at both time points (never had positive change group). (4) Those who reported high levels at both time points (always had positive change group). What was found was that those in the always had positive changes group did the best showing lowest levels of depression and posttraumatic stress. Posttraumatic growth appears beneficial in other ways. Affleck, Tennen, Croog & Levine (1987) reported that heart attack patients who found benefits immediately after their first attack had reduced re-occurrence and morbidity statistics eight years after the attack.

Other research has investigated the development of PTG, suggesting for example, the beneficial role of social support processes. Schroevers, Helgeson, Sanderman, & Ranchor (2010) conducted a study of 206 long-term cancer survivors. Emotional support at 3 months after diagnosis significantly predicted a greater experience of positive consequences of the illness at 8 years after diagnosis. This association remained significant, when controlling for concurrent levels of emotional support at 8 years after diagnosis.

In summary, one of the most remarkable advances in our knowledge of trauma in recent years is that in the aftermath of the struggle with adversity it is common to find benefits. The perception of benefits, in turn, may lead to higher levels of psychological



functioning and improved health. This is not to overlook the personal devastation of psychological trauma, but equally we must not overlook the fact that psychological trauma does not necessarily lead to a damaged life. Simply being aware of the possibility of benefits can offer hope to people. There is much basic science yet needed to further our understanding of the architecture of growth, its predictors, and there are novel emerging applications within the health and clinical domains to help foster growth as well as interventions to use growth to improve health and psychological functioning. One of those emerging applications is the PCA.

### **Person-centered approach (PCA) to posttraumatic growth (PTG)**

As already noted, PTG presents a new approach for many in mainstream trauma psychology which for the past three decades has focused on understanding the nature of posttraumatic stress disorder (PTSD) and its treatment (see Regel & Joseph, 2010). However, although PTG is a novel idea for many trauma psychologists it is an idea that is consistent with the ambition of person-centred psychology to offer a non-medical positive psychological view of mental health (See Joseph & Worsley, 2005). However, it has been argued that the PCA has for so long been subject to evaluation by the standards of the medical model and so caught up in the language of disorder and deficit that its practitioners have forgotten that they were working within a potentiality model (Joseph, 2006). The concept of PTG provides a new language for person-centered therapists to describe what in their terms would be called a movement towards more fully functioning.

*Posttraumatic growth and the fully functioning person*

For person-centered therapists the idea of PTG offers a way of thinking which is theoretically compatible with the potentiality model of the PCA. The PCA was originally developed to be concerned with the facilitation of people towards becoming more fully functioning (Joseph & Murphy, 2012). By fully functioning Rogers meant more than the absence of distress and dysfunction:

“The fully functioning person” is synonymous with optimal psychological adjustment, optimal psychological maturity, complete congruence, complete openness to experience....Since some of these terms sound somewhat static, as though such a person “had arrived” it should be pointed out that all the characteristics of such a person are *process* characteristics. The fully functioning person would be a person-in-process, a person continually changing” (Rogers, 1959, p. 235).

The fully functioning person is someone who is accepting of themselves, values all aspects of themselves - their strengths and their weaknesses, is able to live fully in the present, experiences life as a process, finds purpose and meaning in life, desires authenticity in themselves, others, and societal organizations, values deep trusting relationships and is compassionate toward others, and able to receive compassion from others, and is acceptant that change is necessary and inevitable (Rogers, 1959).

However, in recent years debate about the effectiveness of the PCA has become dominated by whether it is an effective approach for the various psychiatric categories of depression, anxiety, and PTSD, for example, rather than whether it facilitates more fully functioning behaviour. Clearly those who are experiencing the problems associated with these diagnostic categories are less than fully functioning, and as such person-centered

therapy should be helpful in becoming more fully functioning, but the point is that the alleviation of these states can only ever be part of what it means to become fully functioning. Put another way, if the traditional goal of therapy based in the medical model has been to help people move from -5 to 0 the person-centered therapist is interested in how to help them move from -5 to +5. Changing the terms of therapy in this way has significant implications. It alters how we think about what we are doing. We begin to have different conversations with our clients. We listen to our clients in new ways (see, Joseph, 2015).

PTG is a term developed within mainstream psychology, but seen from the person-centred frame of reference, it describes the specific movement towards fully functioning that can occur in survivors of trauma (Joseph, 2004). As such, for person-centred practitioners the introduction of PTG provides a means of engaging anew with mainstream psychology from an epistemological position consistent with the PCA. To put it another way, in contrast to other therapies based on the medical notion of symptom reduction, person-centered therapy is based on humanistic growth-oriented views of human nature. In this way, the concept of PTG can reinvigorate the PCA to challenge the dominance of the medical model and help practitioners to reengage with the original ideas of helping people to become more fully functioning.

#### *Measurement of PTG from the PCA*

As already noted, several psychometric tools have been developed with the purpose of assessing PTG. The use of measurement tools within the PCA has, however, been controversial as their use may represent assessment from the frame of reference of the researcher or practitioner rather than the client (Wilkins, 2005). Understandably,

practitioners in the PCA may have objections to the use of psychometric tools generally and to the use of measures developed on the basis of a pre-existing frame of reference. However, given that in many contexts the use of psychometric tools is a necessary requirement for a research project or for service evaluation I would argue that it is important to choose measures mindfully so that if they must be used then they are consistent with the theoretical frame of reference of the PCA (Joseph, 2015). It is in this sense that it would seem preferable to use measures of PTG instead of, or at least alongside, measures of PTSD, where such measures must be used. Those who work in such services should make the case to their managers that there is a need for theoretically consistent measurement.

Typically, quantitative research relevant to the PCA has called for evaluation of the PCA in relation to its effectiveness with patients suffering from psychiatric conditions of depression, anxiety, posttraumatic stress, and so on. While this can be helpful in building support for the PCA as a form of therapy suitable for these psychiatric categories, psychiatric categories represent ways of thinking about human suffering that are at odds epistemologically with the PCA. As already mentioned, the PCA stems from the notion of potentiality, as opposed to deficit; that is to say a growth model as opposed to a medical model. In this regard, the concept of PTG provides the PCA with a more epistemologically congruent view of an outcome following trauma than other more traditionally used measures of posttraumatic stress. Those conducting research into the effectiveness of the PCA should themselves be turning to theoretically consistent measurement.

*Posttraumatic growth theory and the PCA*

Researchers have sought to understand the processes through which posttraumatic growth arises. Over ten years ago I described how the PCA was able to provide a theoretical understanding of PTSD and PTG (see, Joseph, 2003, 2004, 2005). It was argued that Rogers (1959) explanation of the process of breakdown and disorganisation of the self-structure could be applied to traumatic stress. In brief, traumatic events are thought to demonstrate incongruence between self and experience, leading to the process of breakdown and disorganization, and the need to accurately symbolise the new experience in awareness. Rogers described the anxiety that is experienced as incongruence is subceived and how as the self-structure breaks down the person attempts to deny their experiences and hold onto their pre-existing self-structure, and on the other hand, to accurately symbolize in awareness their experience. This explanation accounts for the avoidant and intrusive features of PTSD.

Rogers was writing over two decades before the introduction of the diagnostic term PTSD but his description of breakdown and disorganization is remarkably similar to more contemporary theories of psychological trauma which emphasise the need people have to rebuild their shattered assumptions (Janoff-Bulman, 1992) and to process experience through alternating cycles of intrusion and avoidance (Horowitz, 1986).

But what was unique about Rogers' (1959) approach was that he was attempting to not only explain the development of distress and dysfunction, but how this was also an intrinsically motivated process towards congruence between self and experience, which in this context can be described as PTG. PTG, as understood from the PCA, is a way of describing the psychological functioning that arises when there is increased congruence between self and experience (see Joseph, 2003, 2004, 2005).

Building on the above work the Organismic Valuing Process (OVP) theory of growth following adversity accommodates mainstream theories of trauma but which is grounded in Rogers' (1959) potentiality model OVP theory is a person-centered theory of growth following adversity that posits: 1. that people are intrinsically motivated towards posttraumatic growth; 2. that posttraumatic stress is a normal and natural processes that triggers growth; and 3 that growth is not inevitable but a process which is influenced by the social world and the support that is available that can help or hinder affective-cognitive processing (Joseph & Linley, 2005; 2006).

OVP theory also leads to new testable predictions. Rogers (1959) held that in a social environment characterised by unconditional positive regard, people will develop unconditional positive self-regard, and thus unhindered by defences and distortions, will self-actualise in a direction consistent with their actualising tendency toward becoming what he referred to as fully functioning human beings. As such, OVP theory predicts that unconditional self acceptance allows people to accommodate their trauma-related experiences. Trauma presents people with new information about themselves and the world that may be incongruent with their self-structure. For example, trauma-related information may be that events in the world can happen randomly and outside one's control which is challenging for a person with unrealistically strong beliefs in the justice and controllability of the world. It is this incongruence that gives rise to posttraumatic stress, which is characterised by the presence of intrusive thoughts and attempts at avoidance. These are seen as normal and natural reactions that signify that the person is engaged in affective-cognitive processing in an attempt to resolve their incongruence (see, Joseph & Linley, 2005, 2006).

In the above case, the new assumptive world would be characterized by a more realistic view of the world that recognises that random events outside one's control may happen. Depending on how these new assumptions are appraised, the person may be said to experience PTG (for example, if the implication of the appraisal is to reorder one's priorities in life so as to spend more valuable time with family and friends). Here, PTG refers to the accommodation of the new trauma-related information within the self-structure which by definition must now change.

### **Implications for practice and research**

The idea of PTG as a goal for therapy resonates with the PCA which has always been concerned with the development of personal growth as a focus. However, researchers and theorists in the field of PTG do not necessarily adopt a person-centered viewpoint. PTG is a broad field of study that has brought together researchers and practitioners from a range of theoretical backgrounds.

#### *Practice*

Many commentators discuss the facilitation of PTG in a way that would not be considered person-centered. Calhoun and Tedeschi (2008) provide advice on working with patients in a clinical setting. They advise practitioners to learn about the phenomenon themselves, and then 'become the expert companion' on the patient's potential journey to growth. What is important they emphasise is that the practitioner must not push the idea of posttraumatic growth as this might lead to pressure and anxiety on the client as well as disappointment if they do not experience posttraumatic growth.

The use of the phrase 'expert companion' might be seen as problematic insofar as it might obfuscate the notion that the client is their own best expert.

The main issue for person-centered practitioners with the expert companion approach is that although it may not explicitly push the client towards growth, it is nonetheless an instrumental approach insofar as the aim of the therapy is to produce growth. Calhoun and Tedeschi's (2008) approach is nonetheless more client-led than some other programmes that have been developed to facilitate growth which contain strong instructional and directive components. For traditional cognitive-behaviorally trained therapists the PCA to PTG might seem challenging (Payne, Liebling-Kalifani, & Joseph, 2007), particularly in the context of trauma where various techniques for intervention are recommended for the treatment of posttraumatic stress.

The term PCA is used deliberately to signify that this is an *approach*, not a set of techniques. The practitioner adheres to the philosophical principle of respecting the self-determination of the client. The aim of the client-centred therapist is to create facilitative social-environmental conditions that will enable the client to evaluate experiences for themselves and to find their own directions in life. However, the non-directive approach does not exclude the therapist from understanding general psychological processes involved in adjustment to psychological trauma. It may also be appropriate in some cases to incorporate what might otherwise be seen as the use of techniques.

Non-directive approaches respond to individual client needs, and as such have the flexibility to incorporate techniques during the sessions or the use of psychometric measures, however, each would be provided by the therapist in their attempt to understand and communicate their acceptance of the client rather than the attempt to



reduce or treat symptoms. Non-directive therapy implies the idea of going with the client's direction and in this way there are ways in which the therapist is able to offer advice, suggestions, or the use of techniques that can facilitate their affective-cognitive processing – when these are clearly in line with the client's direction (Joseph, Murphy & Regel, 2012). The client's direction will be to make sense of their experience, find ways to deal with their feelings, seek solutions, set new goals, or whatever – the task of the therapist is to be attuned to the client's direction rather than to impose the direction they think the client needs to go in.

As discussed above, clients' will move between states of denial and needing to accurately symbolize in awareness their experience, so it is likely that in some way or another that therapists will be asked to support clients needs. As such it may be appropriate to advise the client on social support seeking, help them engage in exposure related activities, to facilitate reappraisal processes, promote helpful coping, or to offer ways to reduce negative emotional states (see Joseph, Murphy, & Regel, 2012). We know from the wider trauma literature that such activities can be helpful to people. It is not the use of such activities per se that is in question, but how they are introduced and used, and most importantly, why. There are many activities that traumatized clients will find helpful but rarely does the therapist need to introduce them as they will arise from the client.

For example, clients may benefit from exposure related activities and will move towards doing these at their own pace. Initially a client may be avoidant of their traumatic experience but over time will begin talking about what happened to them. This may be

gradual but even so it is not necessary to push the client towards this any faster than they are going. To do so is likely to be counter-productive.

One client who was extremely distressed at her recollection of a terrorist attack began after the first session to say a little about what had happened. Then over several further sessions she began to recount her story in more detail. In doing so she was distressed and would stop short having told only so much. After several sessions she had told her story in full although the sessions had been distressing for her. In subsequent sessions she retold the story in full again and again, each time with diminishing distress and also beginning to introduce new material without my prompting about how the event has changed her life in more meaningful ways. I did not need to direct the client to tell her story, but I understood that it was necessary for her to do so as a form of exposure.

Another client brought in photographs of a deceased relative which he would lay out on the floor and talk about. At first it was one photograph for a short period of time, but after some sessions it was several photographs for the entire session. Again, I did not need to direct the client toward doing this but in both cases understood their need for exposure to the traumatic memories. When levels of posttraumatic stress are sufficiently diminished and the event has been comprehended the client is more able to engage with actively processing the significance of their experience.

There is a misapprehension that person-centered therapy needs to be long-term. It is often the case that clients' willingly seeking greater personal growth will embark on longer term therapeutic relationships, but for many seeking help following trauma theirs is a wish for quick reduction from their distress. Indeed, the client's own frame of reference for understanding their problems may be a medicalized one that is inconsistent

with the notion of growth-oriented therapies, but, as in the ways discussed above, for the person-centered therapist who is carefully, closely and creatively tracking the clients' pace and direction it will be possible to engage the client in a way that is meaningful to that client.

It has been argued above that activities brought into the session by the therapist can sometimes be part of a client-led process where it is clearly the desire or request of the client to receive such advice. To deny this to the client, when the therapist has something to offer would not be consistent with the client-centered philosophy. However, it may be unclear to some readers what distinguishes between the person-centered therapist who offers activities from a cognitive behavioral therapist. The answer is that the cognitive-behavioral therapist offers these techniques and advice because they believe they will alleviate the client's distress in a certain direction, whereas the person-centred therapist offers such activities only as an expression of the therapeutic conditions, not because they are seeking to change the client. In this way, it is not being suggested that person-centered therapists do anything differently to what they already do, but rather that they recognise PTG as a way of describing what they do that engages with contemporary theory and practice in mainstream psychology.

### *Research directions*

There are several lines of research to be pursued. There is a need to establish the effectiveness of the PCA as a way to promote PTG. Although it seems likely that the PCA will be able to facilitate PTG, evidence is lacking. Case study evidence can provide insight into the contexts and challenges of working in the PCA with traumatized clients (Murphy, 2009). Further case study research which is called for. However, case study

research is limited in its ability to establish that therapy has a causal effect. As such, if we are to establish the effectiveness of the PCA there is now a need for new research using experimental methods that can establish that person-centered therapy is effective for promoting PTG. Even if person-centered therapy is effective that does not confirm why it is effective. We know that relationship factors are common to all trauma therapies (Meichenbaum, 2013). What is needed is an understanding of the underlying processes that lead to PTG. OVP theory offers several hypotheses, notably that unconditional positive self-regard allows people to more flexibly accommodate new and threatening trauma-related information. Mainstream psychology may benefit from a deeper understanding of person-centered theory and how it provides an alternative to the medical model for understanding psychological trauma and specifically the facilitation of PTG.

## **Conclusions**

Therapists should be aware of the potential for positive change in their clients following trauma. Personal growth after trauma should be viewed as originating not from the event, but from within the person themselves through the process of their cognitive struggle with the event and its aftermath. The topic of PTG has opened up debate on the ethics of the therapeutic process. Researchers and clinicians are urged to be wary of the prison of positive thinking and to consider carefully the moral issues associated with interventions deliberately aimed at helping patients find benefits. But while the topic of PTG has raised these issues for mainstream psychologists, non-directivity is fundamental to person-centred practitioners who will be readily familiar with the notion to work only with clients' growth when it spontaneously occurs. Person-centered theory suggests that the

non-directive approach should facilitate PTG; but this does not imply that therapists have any intention to direct their clients towards PTG. Adversity does not lead to positive change for everyone. Therefore therapists need to be careful not to inadvertently imply that the person has in some way failed by not making more of their experience, or that there is anything inherently positive in the person's experience. For therapists within the PCA such advice is consistent with their existing approach to have an attitude of unconditional positive regard towards the client.

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