

# **Post-Traumatic Growth: Understanding a New Field of Research**

**An interview with Dr. Mark Chesler by Steven Ungerleider, Ph.D. (editor of the Prevention Researcher), 2004**

**Post-traumatic growth is an emerging and rapidly growing field of interest. Dr. Mark Chesler of the University of Michigan, along with his colleagues, Dr. Bradley Zebrack of the University of Southern California, and Dr. Carla Parry of the University of Colorado Health Sciences Center, have been examining the emergence of post-traumatic growth in long-term survivors of childhood cancer. In an effort to understand the concept of post-traumatic growth better, Dr. Chesler has agreed to answer our questions about his exciting new concept.**

## **Dr. Ungerleider: What is Post-Traumatic-Growth?**

**Dr. Chesler:** Most people are familiar with the concept of post-traumatic stress (PTS). PTS is the recurrent experience of psychological, psychophysical, and/or social symptoms as a result of trauma or crisis. Psychological symptoms can include anxiety, fear, nightmares or hypochondria. Psychophysical symptoms can include sweating upon reminders and faintness upon certain smells associated with the crisis. Social symptoms can include lowered aspirations and school dropout. Post-traumatic stress disorder (PTSD) is a formal psychiatric diagnosis associated with the extreme form of PTS: PTSD and PTS are not interchangeable terms. Post-traumatic growth (PTG), on the other hand, is the experience of expression of positive life change as an outcome of a trauma or life crisis. This does not mean that anyone is "glad that they had cancer", but that they report "having experienced benefits" or "having made something positive out of it."

I highlight "outcome" for two reasons. First, since it is unusual to have before-after measures of people experiencing traumatic events or illnesses, the report of PTG is dependent upon post-hoc reflections by informants. Second, it is dependent upon informants' attributions of growth or change in their life due to the trauma. On both counts, without pre- and post-measures, one must be cautious about whether real change has occurred. As a result, questions about the accuracy or validity of post-hoc reflections of positive change are common.

We sought to assess the validity of our research results regarding PTG in two ways. First, we submitted the tape transcripts of in-depth interviews with survivors of childhood cancer to a panel of pediatric oncology social workers, asking them to categorize informants regarding their post-traumatic psychosocial status: positive growth, return to normal, continued stress/struggle, or serious disability/dysfunction. Second, we submitted a summary of the informants' report of positive growth to an independent panel of survivors of childhood cancer, asking them whether or not they had similar experiences and whether these results were believable.

## **Dr. Ungerleider: What is the difference between Post-Traumatic growth and resilience?**

**Dr. Chesler:** At the present time, a variety of terms are being introduced to describe the phenomenon of positive coping subsequent to a life crisis or trauma. Given the emerging state of the research in this area, meaningful, agreed-upon, empirically sound distinctions do not yet exist between terms such as PTG, Resilience, Thriving, Benefit Finding, and others. Different scholars use different terms. Several (although not by any means universal) suggest that "resilience" describes a "bounce back" or return to prior/normal functioning, while both "thriving" and PTG suggest something gained or a higher level of coping or psychosocial quality of life. One important distinction in this literature is between a threshold or level of coping measure and a measure of growth or positive change.

***Post-traumatic growth is the experience or expression of positive life change as an outcome of a trauma or life crisis.***

## **Editor: can Post-Traumatic Growth and Post-Traumatic stress occur in the same person, tied to the same event?**

**Dr. Chesler:** Yes, at least according to the theoretical frames and measures currently in use. Post-traumatic growth requires people to be able to remember the struggle associated with the trauma or life crisis, not to deny or ignore it. To remember this pain and uncertainty, to articulate it, and integrate it into one's life, is an essential element in attaining PTG.

The report of such painful memories (and associated psychological, psychophysical and social symptoms) is included in some measures of PTS and may also be taken as a sign of continuing stress.

PTG and PTS are not the same, but some elements of each of them may appear in the same person. My colleagues and I are hoping to test this possibility in the near future.

**Dr. Ungerleider: What are some of the experiences a youth might have when experiencing PTG?**

**Dr. Chesler:** It is important to remember here that I am not suggesting that most survivors of childhood cancer experience PTG, but some do. Those who do report growth do so in some of the following terms, and this is some of the evidence of PTG:

- \* New and greater strength (psychological toughness/resilience)
- \* Greater compassion and empathy for others (for those who have illness/disabilities, for one's parents/siblings)
- \* Greater psychological/emotional maturity (and greater than their age-peers)
- \* A recognition of vulnerability and struggle, and a deeper appreciation of life.
- \* New values and life priorities (often not so materialistic, heightened intimacy in relationships)
- \* Greater existential or psychospiritual clarity (who am I, what is my purpose in life)

**Dr. Ungerleider: What capacities or experiences characterize youths who experience Post-Traumatic Growth? Is there a difference between those who develop PTG and PTS, does resiliency play a role, or wealth or other social status factors?**

**Dr. Chesler:** Remember that we are talking about growth or change, not a threshold level of coping or functioning, per se. So it is possible for someone who was at a high level of coping/functioning prior to diagnosis and treatment to still be at a high level of functioning/coping and yet not evidence PTG. And it is possible for someone who was previously at a low level of coping/functioning to show evidence of PTG but still not achieve the same level of functioning/coping as the former person. Consider the somewhat hypothetical case of a young man from an alcoholic and broken/abusive family, with a brother in prison. Prior to being diagnosed with cancer, this young man was ready to drop out of high school and had a poor future trajectory. He reports that during his extended and repeated stays in the hospital he found in the hospital staff the "only loving family I ever had", and from their modelling and support decided to get counselling, gained a GED, is now attending a community college, and has significant professional aspirations. He has grown and attributes his growth in large part to the childhood cancer experience. At the same time, he is still not headed to the elite colleges and the kind of socio-economic status as some other young survivors (who may achieve well but may or may not have experienced growth).

It makes sense to theorize that some pre-existing psychological coping capacity (such as resiliency) is involved in experiencing PTG. We have not assessed such internal psychological states, and how to assess their pre-existing natures and roles presents a substantial research dilemma. This would be a good future research agenda.

It also makes sense to theorize the involvement of certain social status characteristics such as wealth, race/ethnicity, coming from a nuclear family, or having loving family and friends. Our sample was not large enough to provide more than guesses about this. But remember that we are talking about growth, not level, and growth can happen at any level of social status ... although we can assume that higher status families can find more resources to promote growth than can lower status families. Or as a corollary, medical and social service institutions in higher status communities can provide more growth productive resources and support than can institutions in lower status communities.

On the basis of our data, what do we know or suspect that makes a difference? Note that all the following are as much propositions as results; they should be explored and tested further.

Disease/treatment outcome that do not include major physical after-effects (as experienced and reported by the survivors themselves.) For some, an amputation is not major while for others it is. Many survivors of brain tumors do report major treatment after-effects, especially in the cognitive and motoric realm. Thus, both their more serious after-effects and potentially compromised cognitive capacity may affect their ability to experience, integrate and articulate a coherent growth narrative.

The cognitive or developmental capacity to make sense out of the experience and to integrate it into one's life story, essentially the ability to construct and articulate a growth narrative. Thus, being diagnosed/ treated at an age when one could understand and make sense of (or have others explain to them) what was happening is essential.

The age of diagnosis and treatment. Some very young survivors have little memory of the trauma or crisis of childhood cancer. If they also have no or minimal after-effects they may have had no

subjective crisis to struggle with (or no conscious memory of a struggle) and no story to narrate. Further, survivors who were diagnosed after the age of 20 or so may have already developed a fairly clear identity in their life story, making it more difficult to see major changes or to integrate the cancer experience as a central growth feature of their perhaps well-formed lives. Youngsters and teenagers diagnosed and treated at an age of developmental stage where their identities and life stories are just beginning to be formed may find it more necessary and easier to integrate the cancer experience into this story.

Support from significant others who can provide love, a hopeful message, and a supportive story of the illness experience. This may include parents, medical personnel, friends, and other survivors, among others. Certainly, wise and skilful medical and social service practitioners can make a difference as well – if they are prepared to focus appropriately on growth and not just survival of recovery.

An understanding (provided by others) that the child or young person him/herself was not to blame for the illness nor responsible for the recovery. In the vast majority of cases of childhood cancer we do not know the cause of the disease; it is an accident or act of fate and not a product of personal or familial behavior. Thus, self-blame is irrelevant and does not have to be wrestled with or overcome, as is the case with many adult cancers or other illnesses/conditions or traumatic events.

**Dr. Ungerleider: Is there any evidence that PTG occurs for survivors of other traumatic experiences?**

**Dr. Chesler:** Yes. The concept was developed earlier out of research into the experience of survivors of these conditions, especially those that had considerable support (professional and lay/familial) and who saw, or could be helped to see, that they were not responsible for what had befallen them, reported major growth in their lives.

**Dr. Ungerleider: How extensive is the literature in PTG? And how does one learn how to intervene in ways that promote it?**

**Dr. Chesler:** The literature is sparse but growing rapidly, with investigations into a variety of traumatic situations and practice arenas, sustained in part by the merging tradition of positive psychology. It makes sense that some of the service programs or interventions that are proposed to reduce post-traumatic stress should promote PTG (e.g. family stems approached to coping, support from significant others). But reducing the threat of dysfunction or ameliorating stress is not the same as promoting growth, and other nets of interventions need to be developed. Chief among them may be the effort, early on in treatment, to help survivors develop an understanding of their situation and to integrate their cancer experience in their lives. The development of a coherent narrative, as suggested above, is critical. One often underused resource in this regard is the wisdom and comradery of other survivors of childhood cancer. Not only can these "veterans" share a story and help new survivors piece together their own, but by working together as a group they may create a "narrative community" that can enter the public arena, helping to establish a new culture around childhood cancer.

*Mark Chesler, Ph.D.*

*Professor of Sociology. University of Michigan, Ann Arbor (USA)*

*This text was first printed in The Prevention Researcher Vol. 10, Suppl. December 2003. Reprinted here with the kind permission of the author and the journal.*