Post-Traumatic Growth Resilience Factors During Adolescence

A Literature Review

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Abstract

Although it is widely known that posttraumatic stress disorder (PTSD) is a possible negative outcome of trauma, the mental health community has just begun to recognize the possibility of post-traumatic growth (PTG) or positive psychological change following a trauma. Research has demonstrated that possessing certain resilience factors, such as a sense of belonging, high levels of social interest, and a secure attachment, can help ease the path to PTG; however, there appears to be a gap in the literature regarding adolescents who do not possess these resilience factors prior to a trauma experience. The purpose of this literature review is to examine the risk factors adolescents may experience after trauma. Concrete steps are provided to build social interest, a sense of belonging, and a secure attachment style, which will promote PTG after a trauma has occurred.

*Keywords:* posttraumatic stress disorder, PTSD, post-traumatic growth, PTG, adolescence, attachment, Individual Psychology
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Dedication

This literature review is dedicated to anyone who has been hurt and feels like healing will never come. My therapist said to me recently that you do not need hope to heal. I believe that is true. Even if you feel hopeless, powerless, and full of despair because of what has happened to you, what has been done to you, or what has not been done for you, that does not mean you cannot heal and grow. There are people out there who will hold hope for you until you can see it yourself. This is dedicated to anyone who feels unseen, unheard, or invalidated after a traumatic experience. I see you, and I hear you.
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Post-Traumatic Growth Resilience Factors During Adolescence

By age 16, over two-thirds of adolescents living in the United States have experienced a traumatic event (Espil, Viana, & Dixon, 2016). Trauma can yield many negative physical and mental results for adolescents including posttraumatic stress disorder (PTSD; Nugent & Brier, 2016). According to the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM – 5)*, PTSD is diagnosed when adolescents experience a persistent long-term reexperiencing of the trauma as well as hyperarousal, hyperavoidance, and dissociation (American Psychiatric Association [APA], 2013). De Bellis, Spratt and Hooper (2011) reported that adolescents with PTSD are associated with higher rates of psychiatric impairment, developmental disorders, and comorbid mental diagnosis.

Trauma may lead to positive changes and opportunities for growth in an adolescent’s life (Albuquerque, Narciso, & Pereira, 2018). This phenomenon is coined *post-traumatic growth* (PTG) and is a process that develops as a cognitive response used to cope with trauma. The outcome of PTG is positive personal changes among a variety of areas while the adolescent continues to struggle with the effects of their trauma. Post-traumatic growth is measured by a PTG inventory used to assess personal strength, spiritual change, the ability to relate to others, appreciation of life, and new possibilities after trauma (Albuquerque et al., 2018).

Researchers have demonstrated that possessing certain resilience factors can ease the path to PTG. Individual Psychology, founded by Alfred Adler, accounts for two of these resilience factors after a trauma: a sense of belonging and social interest. The third resilience factor to aid in moving toward PTG that will be discussed in this paper is secure attachment (Grad & Zeligman, 2017). Some adolescents do not possess these resilience factors before they experience a trauma to help protect them from the effects of PTSD; however, there are concrete
steps mental health professionals can take to help adolescents increase a sense of belonging, social interest, and secure attachment after a trauma.

Adolescents with secure attachment are more likely to demonstrate posttraumatic growth than those with insecure attachment (Albuquerque et al., 2018). Securely attached individuals often have positive interpersonal skills and positive working models of the self and others when compared to adolescents with insecure attachment who are at risk for depression, suicide attempts, and anxiety (Košutić et al., 2019; Sheftall, Schoppe-Sullivan, & Bridge, 2014). Adolescents with secure attachment use their resiliency to find meaning in their traumatic experiences (Albuquerque et al., 2018). By encouraging emotional attunement, adolescent autonomy, and therapeutic relationships, mental health professionals can help adolescents and their families repair deviations from secure attachments and work toward PTG (Allen et al., 2003).

Through an optimistic Individual Psychology view, mental health professionals work with the assumption that every adolescent has the potential to build social interest and a sense of belonging after experiencing trauma (Millar, 2013). After a traumatic experience, many adolescents withdraw from others and have emotional distress that can be overcome by increasing social interest (Grad & Zeligman, 2017). Mental health professionals can encourage adolescents to increase their social interest by getting involved in their communities and shifting their perspectives that were shaped during the trauma. Through the use of democratic methods of positive discipline and increased social support, adolescents can develop a perceived sense of belonging and connection to others that was lost during trauma (Gfroerer, Nelsen, & Kern 2013). Increased awareness of PTG can help mental health providers determine effective treatment strategies for
adolescents who have yet to establish resilience factors against PTSD and provide a sense of hope after trauma.

Posttraumatic Stress Disorder

Before a mental health provider can create a treatment plan to help an adolescent who has experienced trauma, both the provider and the adolescent need to understand the definition of trauma and PTSD. After an adolescent can subjectively conceptualize the trauma, and a mental health provider can objectively define the trauma, the therapeutic healing process can begin (Boals, 2018).

Trauma

In the DSM – 5, APA defines a traumatic event as an “exposure to actual or threatened death, serious injury, or sexual violence” (APA, 2013, p. 271). Under the criterion for posttraumatic stress disorder, it states that individuals can be exposed to a traumatic event in one of four ways to qualify for the PTSD diagnosis. People may either (a) directly experience the traumatic event, (b) witness it happening to someone else, (c) learn that it happened to a loved one, or (d) “experience repeated or extreme exposure to aversive details of the traumatic events” (APA, 2013, p. 271). The DSM – 5 states the traumatic event must be violent or accidental in cases of actual or threatened death and does not apply to exposure through media, television, or pictures (APA, 2013).

Although the DSM – 5 definition of a traumatic event is used by mental health providers, there are some who argue that the definition is too narrow. After conducting a research study, Boals (2018) stated that when an individual is exposed to an event that is objectively defined as trauma per the DSM – 5 definition, it does not predict whether or not the individual will develop PTSD symptoms. Additionally, Boals and Schuettler (2009) reported that individuals
experienced PTSD symptoms even if the experience did not fall under the objective definition of trauma (e.g., bullying or a failed marriage).

Boals (2018) suggested an individual’s subjective experience of a potentially traumatic event was equally important as the objective definition based on the person’s event centrality (i.e., the extent to which someone perceives an event as a part of their identity). Boals (2014) reported that high rates of PTSD are correlated with event centrality. Boals (2018) explained that event centrality is a significant predictor of PTSD symptoms because a stressful event can lead to a disruption in an individual’s core beliefs, which is a DSM – 5 (APA, 2013) criterion for PTSD.

Boals (2018) recommended that clinicians consider the results of the study and suggested individuals can experience clinically significant rates of PTSD and depression stemming from events that are not objectively defined as traumatic in the DSM – 5. Measures of event centrality can be used to understand how an individual perceived an event, and mental health providers can be more sensitive to an individual’s subjective experiences after stressful life events (Boals, 2018).

Boals (2018) found that regardless of whether the trauma was objectively or subjectively defined, individuals who experienced trauma reported lower quality of life, and higher rates of depression. Additionally, an individual who experienced an event that meets the DSM – 5 criteria for an objective definition of trauma, as well as subjectively defined their experience as a traumatic event, were at the highest risk for developing PTSD symptoms (Boals, 2018).
Posttraumatic Stress Disorder

The DSM – 5 outlines symptom criteria an individual must meet to receive a diagnosis of PTSD (APA, 2013). The DSM – 5 provides the requirements of symptoms, duration, and intensity of impairment so that mental health providers can differentiate between a client’s typical reaction to a traumatic event and an individual experiencing PTSD (Stein et al., 2014).

There are five main criteria that a mental health professional must observe before they diagnose PTSD (APA, 2013). The DSM – 5 requires that the symptoms continue for at least one month before a PTSD diagnosis. The first criterion for a PTSD diagnosis is the client has been exposed to a trauma, which includes actual or threatened death, sexual violence, or serious injury. To meet the second criterion for a PTSD diagnosis, an individual must have at least one intrusive symptom. Intrusive symptoms could include involuntary memories, distressing dreams, flashbacks, or intense psychological distress when exposed to a reminder of the trauma. To meet the third criterion for PTSD, the individual must persistently avoid any stimuli that triggers memories of the event, which includes people, places, thoughts, and feelings. The fourth criterion is that the individual must experience a negative shift in mood. For example, the person could believe he or she is to blame for the trauma or experience dissociative amnesia or an inability to feel pleasurable emotions. The last criterion for PTSD is the individual must display a change in their arousal or reactivity. They may be hypervigilant, have difficulty sleeping, or show signs of aggression (APA, 2013).

Adolescents and Trauma

Developmentally, adolescents are at higher risk for trauma when compared to the rest of the population (Nugent & Brier, 2016). By age 16, over two-thirds of American adolescents experience a traumatic event (Espil et al., 2016). Lang, Ford, and Fitzgerald (2010) reported
over 60% of adolescents receiving outpatient mental health services have experienced trauma. Adolescents who go on to receive a PTSD diagnosis experience a significant negative impact on their social, academic, and mental functioning (Meiser et al., 2017). De Bellis et al. (2011) reported that adolescents with PTSD are associated with higher rates of psychiatric impairment, developmental disorders, and comorbid mental diagnosis.

As children, the most common types of traumatic events are physical and emotional bullying and assault by siblings or others. When children reach late adolescence, the most common traumatic experiences are sexual assault, dating violence, and physical, emotional, or psychological abuse. Gilbert et al. (2009) reported that if a child or adolescent experiences one type of abuse, they have an increased risk of experiencing multiple types of abuse. Additionally, Wrenn et al. (2011) stated children who experience trauma have a higher chance of developing PTSD than when trauma is experienced as adults.

**Development of Posttraumatic Stress Disorder**

Nugent and Brier (2016) suggested that biological and social factors can play a role in the development of PTSD among adolescents. Delahanty and Nugent (2006) reported that the sympathetic nervous system is central in the development of PTSD. For instance, during and immediately after a trauma, catecholamine hormones are elevated in the adrenal glands, which may cause hyperarousal of memories. As a result of this process, an individual will experience intrusive memories and flashbacks of the traumatic memory, which are common symptoms of PTSD. As individuals experience intrusive memories, their bodies react with physiological arousal. This combination of re-
experiencing the memories and physiological distress may prompt individuals to avoid any stimuli associated with the trauma, which is another symptom of PTSD. Maccani, Delahanty, Nugent, and Berkowitz (2012) recommended that the focus of additional research should include early biological processes to help professionals understand biological models of PTSD and provide relief to individuals in the early stages of trauma.

Researchers have long been interested in the social aspect associated with the development of PTSD; however, Nugent and Brier (2016) stated that adolescents provide their own unique set of interpersonal interactions after a trauma that may contribute to an increased risk for developing PTSD. Based on self-reported data, it is difficult for researchers to decipher whether individuals report more PTSD symptoms because of a non-supportive social environment or if poor social support contributed to the development of the individual’s PTSD symptoms. As time goes on, the function and nature of social interactions quickly changes due to technology and social media. Adolescents now use social media for many social interactions, which has the potential to change the social models of PTSD. Implications of social media and its potential impact on PTSD risk factors for adolescents still requires further research (Nugent & Brier, 2016).

**Effects of Posttraumatic Stress Disorder**

When adolescents experience PTSD symptoms, they may suffer impairment in many life domains “behavioral-emotional problems, social/interactional problems, academic failure, health problems, cognitive deficits, comorbid psychological disorders, and suicidal thoughts and behaviors” (Nugent & Brier, 2016, p. 1). Finkelhor, Turner, Ormond, and Hamby (2009) stated that regardless of a PTSD diagnosis, when adolescents experience trauma, they are at an increased risk of health problems later in life.
As adolescents continue to develop, traumatic experiences can affect brain development, which makes obtaining and retaining information difficult (Lucio & Nelson 2016). Additionally, Dannlowski et al. (2012) reported a higher risk of heart disease, alcohol abuse, mood disorders, and suicide in children and adolescents with adverse childhood experiences (ACEs). Those individuals with multiple ACEs or traumas have a higher risk of developing PTSD symptoms. Pine and Cohen (2002) reported that other risk factors for a PTSD diagnosis include a history of other mental health disorders, parental psychopathology, family hardship, and a poor social support network.

Among the adolescent population, depression is one of the most common mental health disorders correlated with PTSD (Espil et al., 2016). Linning and Kearney (2004) reported that when adolescents lived in shelters and had a diagnosis of PTSD, they had a significantly higher chance of a comorbid diagnosis of major depressive disorder when compared to adolescents in the shelter without a PTSD diagnosis. Additionally, Kilic, Ozguven and Sayil (2003) reported depression rates among adolescents were positively correlated with PTSD rates after exposure to natural disasters. Similarly, Lengua, Long, Smith, and Meltzoff (2005) confirmed this positive correlation between depression and PTSD in youth who experienced the September 11, 2001 terrorist attacks.

Espil et al. (2016) suggested that an adolescent’s difficulty with emotional regulation may be one reason that adolescents diagnosed with PTSD experience increased impairment in functioning levels and a comorbid mental health diagnosis (e.g., depression). Ford, Fraleigh, Albert, and Connor (2010) reported that exposure to childhood and adolescent trauma is associated with a greater difficulty regulating negative emotions.
Current Treatments for Posttraumatic Stress Disorder

Treatment for PTSD can be a complicated and intense process for adolescents (Lucio & Nelson, 2016). Depending on how much time has passed since the trauma, the adolescent’s support systems, and willingness to engage in therapeutic process, treatment plans can vary. It is up to the mental health professional and client to find a treatment plan that works best for each client (Lucio & Nelson, 2016). For the purpose of this literature review, the focus will be on trauma focused cognitive behavioral therapy (TF-CBT) and eye movement desensitization and reprocessing (EMDR; Diehle, Opmeer, Boer, Mannarino, & Lindauer, 2015; Lucio & Nelson, 2016).

Trauma Focused Cognitive Behavioral Therapy

Trauma focused cognitive behavioral therapy (TF-CBT) is an empirically supported therapy used to reduce trauma symptoms in youth (Lucio & Nelson, 2016). Cohen, Mannarino, and Iyengar (2011) reported that TF-CBT had positive outcomes with adolescents who have been exposed to a variety of traumatic experiences including natural disasters, witnessing domestic violence, and sexual abuse.

Trauma focused cognitive behavioral therapy is used to help clients manage the entire spectrum of trauma effects by incorporating (a) skill building, (b) trauma centered exposure, and (c) managing reactions to trauma (Lucio & Nelson, 2016). There are nine primary steps involved in TF-CBT (Lucio & Nelson, 2016). The nine steps can be understood by using the acronym practice. The “p” stands for psychoeducation, where information about trauma and trauma reactions is given to the youths and their parents. Additionally, the “p” includes parenting skills, and parents are asked to apply their understanding of trauma in order to
understand the impact of trauma on their children. During the “r” step, clients learn relaxation skills to help manage physiological reactions to trauma (Lucio & Nelson, 2016).

In the practice acronym, the “a” refers to how clients acquire knowledge about their affective reactions to trauma (Lucio & Nelson, 2016). The “c” stands for cognitive coping skills, including teaching clients how to understand the correlation between their thoughts, feelings, and behaviors. The “t” stands for trauma narrative processing, and mental health providers bring cognitive distortions about the trauma to the client’s awareness. To accomplish the “i” step, clients will complete in vivo exposure of trauma triggers to aid in the process of overcoming fears. Conjoint sessions with parents and children will be held to complete step “c.” Parents are used as a resource to help their children practice TF-CBT skills, which increases the likelihood that the youth will continue to improve in between therapy sessions. Lastly, the “e” stands for enhancing safety, because in TC-CBT, it is essential to plan for the future and create a safety plan (Lucio & Nelson, 2016).

According to Cohen (2010), TC-CBT has been an effective form of trauma therapy for children and adolescents, including minority populations such as Latino, Native American, and African American youth. Cohen and Mannarino (2010) reported that over three-fourths of the youth participants found significant improvement in trauma symptoms after participating in 12 sessions of TC-CBT.

**Eye Movement Desensitization and Reprocessing**

Trauma focused cognitive behavioral therapy is the most researched therapy for adolescents with a trauma background (Diehle et al., 2015). A newer, alternative treatment
option for healing traumatic experiences is eye movement desensitization and reprocessing (EMDR). Eye movement desensitization and reprocessing was originally titled *eye movement desensitization* and was developed for adult populations by Francine Shapiro (Greyber, Dulmus, & Cristalli, 2012). According to Shapiro (2001), EMDR involves saccadic eye movements to tap into a client’s emotions, physical responses, and beliefs. This eye movement process is used with clients who have experienced trauma to reduce negative experiences, so thought processes can be restored and converted to positive experiences. Shapiro (2001) believed that memories could be stored in dysfunctional ways, and through information processing via eye stimulation, memories could be reexperienced until they were no longer distressing.

Although researchers have studied the effectiveness of EMDR with youth who have experienced trauma, a large number of research studies do not yet exist, and sample sizes have been smaller with existing research; therefore, EMDR is not yet considered evidence-based like TF-CBT (Diehle et al., 2015). Diehle et al. (2015) compared TF-CBT and EMDR with youth identified with posttraumatic stress syndrome (PTSS) and found usefulness in both treatment approaches. Diehle et al. (2015) conducted the study in a Dutch outpatient facility with 75 individuals in each treatment group. Participants were between the ages of 8 and 18. The participants were interviewed using the Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA) and their parents participated in a structured interview about the child’s PTSD diagnosis. The EMDR therapy group received psychoeducation about trauma and completed the process of preparing and desensitizing the traumatic memory. The desensitization of the memory included asking the participants to keep their distressing memories in mind while simultaneously focusing on a distracting stimulus. The participants were asked to reflect on their
experiences and bodily sensations. This procedure was repeated until participants no longer felt distress (Diehle et al., 2015).

Through their randomized control trial, Diehle et al. (2015) concluded that both TF-CBT and EMDR were effective treatments for children and adolescents with PTSS in outpatient settings. In addition, statistically significant differences did not exist between the two CAPS-CA; however, the parents of the TF-CBT group reported more favorable outcomes in regard to comorbid symptoms such as anxiety and depression. Diehle et al. (2015) suggested the favorable outcomes may be due to the heavy parental involvement in TF-CBT. As a result of the newly acquired skills, the parents in the TF-CBT group became better equipped to cope with their child’s behaviors and emotions when compared with the parents in the EMDR group (Diehle et al., 2015).

Post-Traumatic Growth

Although it is widely known that PTSD is a possible negative outcome associated with trauma, the mental health community has only recently recognized the possibility of positive effects following a trauma. Post-traumatic growth is a term proposed by Tedeschi and Calhoun (2004) that refers to self-reported positive psychological changes following a trauma. Post traumatic-growth emerges as an adaptive response to coping after surviving a distressing life event and its aftermath (Leiva-Bianchi & Araneda, 2015). According to Tedeschi and Calhoun (2004), PTG is a multifactorial construct that leads to changes in an individual’s interpersonal relationships, self-perception, and life philosophy.

By definition, PTG is a list of positive qualities, but PTG is not defined by the absence of psychological distress. Joseph, Murphy, and Regel (2012) reported that a
certain amount of psychological distress is necessary for PTG to develop, and stress will coexist with PTG. Tedeschi and Calhoun (2004) supported this idea and believed that for PTG to occur, a distressing event must be perceived as sufficiently traumatic by the individual. When individuals experience a traumatic event, it will hold high levels of event centrality for them and shift their fundamental view of the self and their place in the world (Albuquerque et al., 2018; Boals 2018).

Although a certain amount of emotional distress is necessary for PTG, Mack et al., (2015) reported that measures of PTG should correlate moderately to weakly with depression. Silva Ownsworth, Shields, and Fleming (2011) supported this claim by conducting a study with participants who suffered brain trauma, and moderately positive or negative correlations between PTG and depressive symptoms were reported.

**Post-Traumatic Growth Inventory**

To measure an individual’s level of PTG, Tedeschi and Calhoun (2004) created a post-traumatic growth inventory (PTGI) used to assess perceived positive outcomes from a traumatic or distressing event (Albuquerque et al., 2018). The PTGI measures growth across five subscales: (a) personal strength, (b) spiritual change, (c) ability to relate to others, (d) appreciation of life, and (e) new possibilities after trauma (Albuquerque et al., 2018). The PTGI has satisfactory construct validity, internal consistency, and test-retest reliability over a two-month period. There are 21 items on the inventory that individuals rate from zero (i.e., I did not experience this change as a result of trauma) to five (i.e., I experienced this change to a very great extent; Arikan, Stopa, Carnelley, & Karl, 2016).

Palmer, Graca, and Occhietti (2012) reported the PTGI is a valid and reliable way to measure growth in samples of individuals across many cultural backgrounds and ages who have
been exposed to a variety of different traumatic events. For example, the PTGI has been adapted to conduct research for individuals who have experienced the loss of a child, survived an earthquake, experienced a stroke, and experienced violent and abusive crimes across countries such as Germany, Turkey, India, and Chile (Albuquerque et al., 2018; Kumari & Singh, 2016; Leiva-Bianchi & Araneda, 2015; Mack et al., 2015).

Additionally, there are variations of the original PTGI tailored to the studied population including the Post-Traumatic Growth Inventory-Short Form (PTGI-SF), which consists of 10 items (Albuquerque et al., 2018).

**Relationship with others.** In the first category of the PTGI, Tedeschi and Calhoun (2004) asked individuals to reflect on their relationships with others. Individuals responded to questions about the importance of relationships and if they felt they could accept the fact that they need others in their lives. When participants had a high score in this category, they reported satisfaction with their social support system, which included family and friends. Participants reported they were happy living with other individuals after they may have previously lived alone. Additionally, participants responded that they felt compassionate toward others and mirrored other’s emotions. Additionally, individuals who had experienced trauma reported that they are now more easily able to relate to others who have faced challenges in their lives (Kumari & Singh, 2016).

**New possibilities.** In the second category of the PTGI, Tedeschi and Calhoun (2004) asked individuals to rate how open they are to new possibilities. Individuals reflected on any opportunities they had taken to change their lives or any new areas of interest they had (Mack et al., 2015). People who scored high in this category reported
that they choose to live their lives in a more deliberate way according to plans they had formed. Kumari and Singh, (2016) stated that women who responded positively to this category reported they were now working on their own and making their own decisions. After facing a trauma, these women decided they wanted to create a new sense of purpose and earn a living for their families (Kumari & Singh, 2016).

**Personal strengths.** Tedeschi and Calhoun (2004) decided personal strengths should be the third factor assessed by the PTGI. This category was used to measure an individual’s perception of self-reliance and potential (Mack et al., 2015). When participants had a positive response in this category, they stated they have greater acceptance of difficulties that arouse in life. Women in this category felt they were no longer solely dependent on the men in their lives. Because of the trauma and hardship these women experienced, they reported they had more faith in themselves. After the women ranked themselves high on self-reliance, they believed they could care for their children and their families without struggle (Kumari & Singh, 2016).

**Spiritual change.** The fourth factor in the PTGI Tedeschi and Calhoun (2004) created was spiritual change. Spiritual change was defined by a strengthening of existing spiritual or religious beliefs or the development of new beliefs. Individuals who scored high in this category reported that they had recently reconnected to a community of similar believers or rejoined with their spiritual roots. Many individuals reported a strong belief in God after a trauma; however, some women in India believed that the trauma was a punishment from God because of sins from a previous life (Kumari & Singh, 2016).

**Appreciation of life.** The last factor in the PTGI that Tedeschi and Calhoun (2004) decided to measure was an individual’s appreciation of life. This fourth category included shifts in life priorities as a result of their trauma. Often, people reevaluated their values after a trauma
and became more optimistic about their future. Those who responded positively in this category of the PTGI reported they were more social and talkative and focused on being present in daily life. This sense of mindfulness was reflected in responses that included taking life each day at a time and appreciating every day (Kumari & Singh, 2016).

**Marriage and Family Therapy and Post-Traumatic Growth Inventory**

A mental health provider can use the PTGI to measure an individual’s psychological growth over time following a trauma. Marriage and family therapists may use the PTGI to examine the systematic effects of trauma. Most of the research on PTG includes a sole focus on an individual’s experience of trauma, but recently it has become clear that the trauma effects extend to an individual’s support system and relationships (López & Blow, 2017).

Frequently, survivors of a trauma are left with feelings of fear or helplessness after a trauma experience (López & Blow, 2017), and many times the fear or helplessness shatters the perception of the world as a safe place. According to van der Kolk (2003), survivors may question their safety around others, and this fear may lead them to isolate from their families and social circles. As survivors heal and grow after a trauma, positive relationships are central to their recovery environment (López & Blow, 2017).

Kunzler, Nussbeck, Moser, Bodenmann, and Kayser (2014) studied couples coping with cancer and found that support from a partner plays a critical role in an individual’s PTG process. Kunzer et al. (2014) found that although couples experienced the hardship of a cancer diagnosis together, they also shared the positive benefits of recovery and growth. Similarly, Buchi et al. (2009) researched couples experiencing grief after the death of a premature baby and found that couples who shared a concordant
grief process also shared a process of growth. The implications of these studies suggest that PTG occurs on an individual level, and the negative and positive psychological consequences of a trauma have a relational aspect as well (López & Blow, 2017). The PTGI can provide systemic therapists an overview of how individuals heal and grow from trauma over a variety of domains including relationships with others.

Attachment Theory and Adolescents

British psychologist John Bowlby was one of the first people to study attachment relationships between children and their caregivers (Bifulco, Jacobs, Ilan-Clarke, Spence, & Oskis, 2017). As a result of Bowlby’s work, attachment theory was formed. Researchers examined long-term relationship dynamics through the lens of early childhood interactions, particularly between children and their caregivers. Bowlby proposed that children have a biologically based attachment system that is wired to keep them in close proximity to their caregivers during times of distress (Gross, Stern, Brett, & Cassidy, 2017). Bowlby also believed that caregivers have an attachment system that allows them to respond to a child’s distress. The rate, consistency, and care in which caregivers respond to a child’s needs determines the quality of the child’s attachment. This can be reflected in one of four attachment patterns: secure, anxious, avoidant, or disorganized (Gross et al., 2017).

Secure Attachment

Secure attachment exists when children feel secure and safe in the presence of their caregivers (Bifulco et al., 2017). Securely attached children understand they can depend on their adult caregivers to fulfil their basic needs. Securely attached children become distressed when they are separated from a caregiver and demonstrate happiness when reunited. When separated from their caregivers, distress does not last long because children feel confident the caregiver
will return. Another marker of secure attachment is that children seek out caregivers when they are frightened, distressed, or have a need they cannot meet (Bifulco et al., 2017).

Secure attachment provides many beneficial outcomes for children; however, there are many instances where children do not develop a secure bond with their caregivers (Bifulco et al., 2017). If an attachment pattern is not secure, the patterns falls under the category of insecure attachment.

**Insecure Attachment**

Insecure attachment is divided into three patterns: ambivalent attachment, avoidant attachment, and disorganized attachment (Bifulco et al., 2017). When children are *ambivalently attached*, they learn that they are unable to depend on their caregivers when they are in need. When their caregivers leave, ambivalently attached children become extremely distressed and are difficult to console (Bifulco et al., 2017). Children with *avoidant attachment* pattern often show no preference between caregivers and strangers (Bifulco et al., 2017). Typically, children with an avoidant attachment pattern will avoid caregivers due to abuse or neglect. When children develop avoidant attachment pattern, they learn that relying on someone results in punishment, so they avoid seeking help from anyone in the future (Bifulco et al., 2017).

*Disorganized attachment* occurs when there are mixed signals from a caregiver, which leaves children confused and disoriented (Bifulco et al., 2017). In disorganized attachment, caregivers may provide comfort to their children at times, but they also serve as a source of fear. Due to this inconsistency, children avoid their caregivers and find it difficult to trust anyone (Bifulco et al., 2017).
Attachment and Adolescents

Adolescent attachment patterns can be played out through their relationships with their caregivers and their peers (Košutić et al., 2019). Parents and caregivers play a crucial role in adolescent development because they have the strongest social impact on their children. The attachment bond between children and caregivers is one aspect of the relationship, and safety and security are elements necessary in a securely attached relationship. Secure relationships with peers are salient components in the development of adolescent mental health. Securely attached relationships with peers can decrease the negative influence of insecure caregiver attachment in adolescent development (Košutić et al., 2019).

Insecure Attachment and Depression

The way adolescents relate to their parents can set the tone for interpersonal relationships later in life (Košutić et al., 2019). For example, adolescents with secure attachment styles display adaptability and positive emotional regulation skills. Insecurely attached adolescents have an increased risk of depressive disorders (Košutić et al., 2019). Additionally, adolescent attachment patterns may be closely related to other common mental health struggles such as anxiety disorders, substance abuse, conduct disorders, and personality disorders (Košutić et al., 2019).

Košutić et al. (2019) compared two groups of adolescents, one with depressive disorder diagnoses and one without. The groups self-reported depression rates, emotional regulation skill, and attachment patterns using The Beck Depression Inventory, the Emotional Regulation Questionnaire, and the Inventory of Parent and Peer Attachment. Košutić et al. (2019) found that when adolescents were diagnosed with depressive disorders, they had fewer secure attachments to parents and peers when compared to those in the control group. Additionally, the group of
adolescents with the depressive disorder diagnoses were unable to regulate their emotions as well as those in the control group were able to (Košutić et al., 2019).

**Insecure Attachment and Suicidal Behavior**

Sheftall et al. (2014) examined the relationship between insecure attachment and suicidal behaviors in adolescents. A sample of 40 adolescents who had attempted suicide and 40 adolescents who had never been suicidal completed self-reported measures of depressive symptoms, family alliance, and attachment styles. The adolescents ranked these factors using the Experiences in Close Relationships Scale, the Family Alliance Scale, and the Beck Depression Inventory (Sheftall et al., 2014).

Sheftall et al., (2004) believed that insecure attachment patterns in adolescents are important to examine in regard to suicidal behavior. For instance, insecure attachment is connected to relationship dysfunction, which often precedes adolescent suicide attempts. Additionally, familial discord and low support are both risk factors associated with adolescent suicidal behavior (Sheftall et al., 2014).

Sheftall et al. (2014) found that when adolescents attempted suicide, they reported significantly higher insecure attachment styles, particularly avoidant attachment. Brennan, Clark, and Shaver (1998) explained that those who ranked high on the avoidance dimension tend to have a negative view of others, do not pursue support when they are distressed, and do not disclose their thoughts and emotions.

Mental health providers who work with suicidal adolescents make safety plans with their clients a top priority (Sheftall et al., 2014). According to Stanley and Brown (2012), socializing with family and friends and identifying social contacts adolescents can turn to during a crisis are strategies within a safety plan. Although these strategies may come easy to an adolescent with
securely formed relationships, adolescents with insecure attachment often experience interpersonal struggles; therefore, Allen and Land (1999) suggested that these strategies alone may not be sufficient for the prevention of suicidal behavior.

**Insecure Attachment and Residential Care**

Bifulco et al. (2017) examined 118 adolescents’ attachment styles in residential care in the UK and Isle of Man. The Attachment Style Interview and the Vulnerable Attachment Style Questionnaire were used as self-reporting measures to determine the attachment styles of the adolescents. The researchers reported that all but one participant had an insecure attachment style. Approximately half the adolescents identified as a disorganized attachment style. Conversely, more than half of the control group participants reported as securely attached (Bifulco et al., 2017).

Adolescents placed in residential care typically have a set of complex needs and have often exhausted all other modes of treatment. Bifulco et al. (2017) believed insecure attachment is so common in residential treatment because of high rates of interpersonal difficulties and early life experiences that included neglect and abuse. Mental health providers now understand that an attachment lens may be necessary to examine an adolescent’s distrust or difficulty in forming relationships. Because residential treatment is often considered a last resort of healing, creating a safe, caring, and stable environment for adolescents with insecure attachment can strengthen attachment resiliency (Bifulco et al., 2017).

**Attachment and Trauma**

Researchers Gross et al. (2017) found that both anxious and avoidant attachment pattern are predictors of PTSD and other trauma related mental health disorders. In contrast, Benoit, Bouthillier, Moss, Rousseau, and Brunet (2010) discovered secure attachment was linked to
reduced severity of PTSD three months post trauma. Albuquerque et al., (2018) highlighted how attachment styles influence emotion regulation and cognitive processing after a trauma. Albuquerque et al. (2018) concluded that negative posttraumatic appraisals (e.g., “I am weak”) are related to posttraumatic symptom severity.

Albuquerque et al. (2018) stated participants who had experienced at least one traumatic event self-reported negative posttraumatic self-appraisals, attachment patterns, PTSD symptoms, and PTG process. The researchers concluded that anxious attachment and negative posttraumatic self-cognitions are positively correlated. Albuquerque et al. (2018) based their study on the Ehlers and Clark model of PTSD, which stated that negative appraisals of the self after a trauma determine posttraumatic mental health.

Albuquerque et al. (2018) acknowledged that there are preexisting factors that may lessen or intensify the strength of negative self-appraisals. One of these preexisting factors is an individual’s attachment pattern. The attachment pattern determines the individual’s perception of the self and others. In accordance with the DSM – 5 criteria, after a trauma, an individual’s view of the self, others, or the world will change (APA, 2013). Individuals with working models developed through secure early attachment experiences are more protected from posttraumatic stress symptoms (Albuquerque et al., 2018).

**Individual Psychology**

Alfred Adler, an Austrian psychologist, was the founder of Individual Psychology (Sperry & Binensztok, 2018). Therapists who practice Individual Psychology are referred to as Adlerian therapists, and they stick to the guiding principles Adler created. Adler devoted much of his research to what makes an individual feel inferior to others, which he defined as an inferiority complex (Sperry & Binensztok, 2018). Adler did not believe psychopathology
developed through a biological defect, but rather through discouragement (Sperry & Binensztok, 2018). Additionally, Adler believed an individual’s mental health could be measured by the level of *social interest*, or interest in the interest of others, and a perceived sense of belonging (Sperry & Binensztok, 2018). Although Individual Psychology includes a focus on the development on the individual’s personality and thought processes, Adlerian therapists emphasize the importance of *holism*. *Holism* is a concept meaning an individual and all their complexities cannot be fully understood without looking at them through the context of their environment (Sperry & Binensztok, 2018).

Adler believed in a systemic thinking pattern and that no individual exists in isolation (Sperry & Binensztok, 2018). To minimize shame and blame, Adlerian therapists view family as mutually influential relationships. Adlerian therapists typically use a *lifestyle assessment* to assist their clients in correcting flawed *private logic* created in childhood. Lifestyle assessments consist of a personal history with an emphasis on *early recollections* and *birth order* (Sperry & Binensztok, 2018). Within Individual Psychology, the perception is that development can become either maladaptive or psychologically healthy, and it depends on the connection with others and the level of social interest. That is, psychopathology develops when people become discouraged, do not feel a sense of belonging, and do not act with social interest (Sperry & Binensztok, 2018). Sperry and Binensztok (2018) stated Adler believed social interest could be a motivating factor when striving for success because he believed every human had the capacity to develop social interest and feel connected to others (Sperry & Binensztok, 2018).

**Social Interest**

Adler believed social interest helped individuals live a healthy, meaningful life (Sperry & Binensztok, 2018). Social interest is a term Adler used to define a person’s sense of belonging
and community feeling. Social interest, or the interest in the interest of others, is necessary for individuals to feel a sense of belonging to a community. When social interest is high, people feel more compassion, a sense of identity, and less isolation. Adler believed every person could develop social interest; however, social interest takes a conscious effort (Sperry & Binensztok, 2018).

Many researchers demonstrated that social interest is positively correlated with an individual’s mental health. For example, Millar (2013) found that those who have low levels of social interest have higher levels of depression, anxiety, hostility, substance abuse, and feelings of hopelessness. Schwartz, Meisenhelder, Ma, and Reed (2003) researched the phenomenon of finding joy in helping others, which is a characteristic of social interest. In a two-year follow-up, when participants voluntarily provided support to others, they reported higher levels of coping skills, self-efficacy, and general well-being compared to those individuals who just received help from others (Tsz Yin Fung & Webster, 2018).

**Social interest and adolescents.** Adlerian therapists believe that discouragement plays a large role in adolescent mental health (Ostrovsky, Parr, & Gradel, 1992). During adolescence, there are unique life tasks that must be addressed. For example, adolescents must address a blossoming independence and begin to accept adult responsibilities. If adolescents are unsuccessful in managing the life tasks, they become discouraged and believe they are inadequate (Ostrovsky et al., 1992). If adolescents lack a positive social support system to convince them they are capable, adolescents might accept the worldview that they will never be good enough. Adolescents who have a high degree of social interest, on the other hand, have lower degrees of discouragement and believe they
can more successfully manage life tasks, even when difficulties come their way (Ostrovsky et al., 1992).

**Belonging**

According to Ferguson (1989), Adler believed a sense of belonging is necessary for individuals to thrive and that one of the basic motivations in life is to have a sense of social belonging or social feeling. Adler described *social feeling* as the tendency for people “to unite themselves with other human beings to accomplish their tasks in cooperation with others and be socially useful” (Ferguson, 1989, p. 356). Ferguson (1989) stated Adler believed that humans needs the strength of a group to survive. If individuals are not a part of a group and withdraw from others due to trauma, it could prevent them from accessing the social support that Adler deemed necessary for survival.

**Belonging and adolescents.** Adlerian therapists believe children and adolescents all have a universal need to belong (Dreikurs, 1947). When children and adolescents perceive a lack of belonging, there are several ways they act to achieve a sense of belonging. Dreikurs (1947) believed children and adolescents feel discouraged when they do not feel like they belong. To remedy this feeling, Dreikurs (1947) recognized children and adolescents typically act in ways that achieve one of four goals: attention, power, revenge, and avoidance. Since these four goals do not include a sense of belonging, they are referred to as *mistaken goals* (Dreikurs, 1947).

- Mistaken goal for attention: Adolescents believe that they belong if they are the center of attention, so they often develop many attention-getting skills (Dreikurs, 1947). These adolescents often feel insignificant if they do not receive attention.
• Mistaken goal of power: Adolescents who demonstrate the goal of power feel they belong if they are in complete control. In addition, if adolescents believe they lose power, they act out in unfavorable ways (Dreikurs, 1947).

• Mistaken goal of revenge: When adolescents feel inferior to others, they often seek revenge (Dreikurs, 1947). As a result of this mistaken goal, adolescents believe they belong only when they make others feel as hurt as they are.

• Mistaken goal of avoidance: Typically, when adolescents engage in the goal of avoidance, they are discouraged. That is, they believe they will fail at everything they do, so there is no point in trying. Adolescents may have learned this avoidance through punishment from others or through negative self-appraisals (Dreikurs, 1947).

**Discussion**

Grad and Zeligman (2017) reported that by the time adolescents reach college age, 66% to 85% will report at least one traumatic event in their lifetime. Researchers have demonstrated that secure attachment, high levels of social interest, and a sense of belonging are protective factors for adolescents in their journey towards PTG (Allen et al, 2003; Grad & Zeligman, 2017; Hjertaas, 2013). Some adolescents do not have this set of protective factors to foster their success. Mental health providers need to be properly equipped with knowledge and tools to guide at-risk adolescents toward PTG and the healing of trauma (Grad & Zeligman, 2017).

**Implication for Practice**

Due to the high level of trauma experienced by adolescents, it is important mental health professionals understand the protective factors for adolescents against PTSD (Grad & Zeligman, 2017). More importantly, it is essential that both the mental health provider and the client
understand the concrete steps that need to be taken to work towards these protective factors if they do not already exist in an adolescent’s life. Helping adolescent’s take realistic and manageable steps towards building secure attachments, social interest, and a sense of belonging will set the client up for PTG (Grad & Zeligman, 2017).

**Building secure attachment.** Exploring an individual’s attachment style can help provide mental health professionals with a better understanding of how preexisting factors influence the development of either PTG or PTSD after a trauma (Albuquerque et al., 2018). Insecure attachment can lead to a variety of unfavorable outcomes during adolescence (e.g., depression, anxiety, and higher suicide rates; Košutić et al., 2019; Sheftall et al., 2014). In contrast, secure attachment is considered a protective factor that helps adolescents move toward PTG (Albuquerque et al., 2018). By repairing any deviations from secure attachments, mental health providers can help adolescents and families heal attachment wounds and work toward PTG (Kobak, Zajac, Herres, & Krauthamer Ewing, 2015).

**Attachment with caregivers.** One way to build a secure attachment between adolescents and their caregivers is to strive toward emotional attunement (Allen et al., 2003). Allen et al. (2003) conducted a study measuring the factors that influenced adolescent attachment to caregivers. In the study, 126 adolescents were asked to complete an adolescent self-perception questionnaire to evaluate the following categories: scholastic and athletic competence, social acceptance, romantic appeal, behavioral conduct, physical appearance, close friendship competence, and overall self-worth. The mothers were instructed to complete the same questionnaire about how they thought their adolescents would answer the questions. The mother’s questionnaire results were an accurate marker regarding her attunement to the child’s
self-perception. Allen et al. (2003) reported that when mothers and adolescents answered more questions with a similar response, they were more securely attached (Allen et al., 2003).

Through an attachment lens, the content of the adolescent’s self-perception was far less important than whether the adolescent’s mother was aware of the adolescent’s self-perception (Allen et al., 2003). Allen et al. (2003) stated it was important to the adolescents that they felt secure enough with their mothers to communicate their strengths or shortcomings. Mental health professionals should encourage this emotional attunement between caregivers and adolescents. If caregivers are well attuned to their adolescents, the likelihood of healing an insecure attachment rupture will increase. A caregiver who is trusted and attuned to the adolescent’s strengths and weaknesses is more likely to be prepared to handle any distressing topics that arise during the adolescent’s developmental period (Allen et al., 2003).

*Idealization of caregiver.* A second method to increase secure attachment between caregivers and adolescents is to explore the adolescent’s idealization of the caregiver (Allen et al., 2003). Young children often have an idealized, simplistic view of their caregivers; however, as they become adolescents and are capable of more critical thinking, adolescents are capable of recognizing their autonomy. Allen et al. (2003) found that this gradual deidealization of caregivers is necessary for adolescents to start to develop their emotional and cognitive independence. Allen and Land (1999) suggested that viewing caregivers as fallible humans helped adolescents explore their own thoughts and views that may differ from their caregivers’ thoughts and views. To increase secure attachment, mental health providers can encourage caregivers to give their adolescents the freedom to explore their autonomy and reassure them that deidealization of caregivers is not parallel to the rejection of their relationship. Adolescents who were too afraid to disagree with parents when they were growing up or were never given the
chance to speak up due to trauma will feel empowered by the option for autonomy. By allowing adolescents this freedom, insecure attachment can slowly heal, and adolescents will continue to return to a secure base (Allen et al., 2003).

**Respectful disagreements.** A third way to work toward secure attachment between caregivers and their adolescents is to have respectful, goal-oriented disagreements (Allen et al., 2003). A lack of arguments would be out of the ordinary for caregivers and their adolescents, particularly for vulnerable adolescents who have gone through trauma and do not feel securely attached to their caregivers. Mental health professionals can normalize family disagreements and help families understand that disagreements are a necessary component in the healing process; however, the manner in which disagreements are expressed is what determines the healing potential in the relationship (Allen et al., 2003).

Allen et al. (2003) observed 126 adolescents and their caregivers having disagreements about a variety of common adolescent topics such as money, household rules, friends, siblings, communication, the future, alcohol, drugs, religion, and dating. The discussions were videotaped and transcribed. Using the Displaying Relatedness Scale, Allen et al. (2003) documented validating statements, empathy with the other party, and active engagement. The Displaying Autonomy Scale revealed instances where both parties presented their side of the discussion with confidence instead of with harshness. Based on these results, both the adolescent and the caregiver must work together to create a secure base. Kobak et al. (2015) confirmed that discussions where both parties respectfully acknowledged each other’s perspective promoted secure attachment.

**Attachment with therapists.** Although the ideal situation is to repair or build secure attachments between caregivers and adolescents, sometimes this is not possible. Often,
adolescents go through a period of independence and choose not to disclose with their parents (Kobak et al., 2015). Biologically, attachment needs are less frequently activated during the adolescent period, and peer relationships become more important. During this time, adolescents still need someone they can confide in and feel securely attached to (Kobak et al., 2015).

In other cases, caregivers may be the ones who have hurt or traumatized the adolescents; therefore, attempting to repair attachment wounds with caregivers may feel out of reach. During this time, seeing a therapist can be beneficial for the adolescent and offer a safe space to heal and practice forming secure attachments (Kobak et al., 2015). Therapists who do attachment work should work to identify any breaks in a family attachment system and link those breaks to the adolescent’s symptoms. Therapists can listen to adolescents describe their caregiver dynamics and raise awareness to any negative systemic patterns that deviate from secure attachment. Helping the adolescent identify insecure attachment patterns is the first step toward a secure relationship between the therapist and the adolescent. Once the client can verbalize painful memories when caregivers were neglectful, unavailable, or unresponsive, they will begin to feel safe in a nonjudgmental space (Kobak et al., 2015).

Establishing a secure client-therapist relationship is necessary before the work of family attachment behavior therapy can begin (Kobak et al., 2015). The relationship is made secure when the therapist encourages the client in times of distress, allows the client autonomy to explore, and provides an empathetic secure base. Once clients feel safe with the therapist, they can begin to reassess the adolescent internal working models of the self and others that were developed at a young age (Kobak et al., 2015).

Therapeutic conversations should revolve around alternative views of the client and others and challenge preexisting beliefs based on insecure attachment patterns and trauma.
Therapists can gently challenge adolescents to test the validity of their existing internal working models through supportive friends or family members. After recognizing that the negative views of the self and others must be reevaluated, adolescent clients can begin to feel more secure and acknowledge that their negative expectations contribute to interpersonal difficulties throughout life (Kobak et al., 2015).

**Building social interest.** Grad and Zeligman (2017) reported that increasing social interest in adolescents can be a powerful resilience factor for adolescents who have gone through a traumatic event. Mental health providers are encouraged to use the optimistic Individual Psychology mindset that any individual is capable of building social interest after a trauma has occurred (Millar, 2013). By helping adolescents shift their private logic and become more involved in the community, mental health providers can help clients build their social interest and promote PTG after a trauma (Grad & Zeligman, 2017).

**Community involvement.** Grad and Zeligman (2017) recommended specific methods of building social interest in traumatized clients, which included increasing the social activity of the client. Specifically, Fung and Webster (2018) found that participants who voluntarily provided help and befriended individuals with dementia gained significant benefits from the interactions. By providing social and emotional support to others, the volunteers were able to strengthen their own personal coping abilities. The volunteers reflected that the opportunity to see positive change in others’ lives improved their enjoyment and overall well-being. Fung and Webster (2018) illustrated how increasing social interest behaviors in adolescents (e.g., caring for mental health patients) can improve the mental health of those performing the service (Tsz Yin Fung & Webster, 2018).
Additionally, Gfroerer et al. (2013) agreed that adolescents can build social interest by contributing to others. Adolescents who involve themselves in an age appropriate job that contributes to the larger community reported feeling a sense of purpose. Dreikurs (1964) recognized that adolescents who are unable to find significance through contribution often misbehave in a variety of ways; therefore, if mental health providers can guide adolescents toward responsibilities that make them feel valued, they will find their significance in a healthy manner (Gfroerer et al., 2013).

**Shifting perspective.** When adolescents have low social interest, mental health professionals could help them identify their non-useful attempts to solve life problems (Grad & Zeligman, 2017). From there, mental health providers can assist clients in substituting more useful problem-solving methods. Grad and Zeligman (2017) researched the role of social interest in college students who had experienced at least one traumatic experience in their life, and 531 students self-reported their level of social interest, post traumatic growth, and meaning in life. Grad and Zeligman (2017) found that social interest is a significant factor of PTG. Additionally, social interest is positively related to the presence of meaning in life. According to Grad and Zeligman (2017), social interest relates to PTG because when individuals are healing from trauma, they may find meaning from their suffering and improved life satisfaction post trauma.

Traumatic events often shift a client’s perspective or meaning of life, so it can be helpful for mental health providers to help adolescents find meaning in trauma (Grad & Zeligman, 2017). It is through meaning that clients start to live in the present instead of ruminating on their past. Finding the meaning in trauma can occur over time where mental health providers “empower clients to see themselves as cocreators of their own
lives while acknowledging their pain and struggle” (Grad & Zeligman, 2017, p. 201). According to Tedeschi and Calhoun (2004), this helps clients rely on the strengths they identified throughout their struggles and place their trauma in the past.

Grad and Zeligman (2017) found a positive relationship between meaning in life, PTG, and social interest, so mental health providers should continue to place an emphasis on exploring the meaning clients give to their trauma and how it affects their level of social interest (Grad & Zeligman, 2017). Mental health providers should help clients understand how trauma connects them to others. As clients begin to shift their flawed private logic and become empowered through healing, they will begin to feel less isolated and more connected to their support systems (Grad & Zeligman, 2017).

Building a sense of belonging. Ansbacher and Ansbacher (1956) believed that a sense of belonging was essential to an individual’s well-being, and they understood the dangers of isolation due to trauma. After a traumatizing experience, adolescents often perceive the world as a threatening place and others as dangerous or uncaring. There are many ways providers can help adolescents increase their sense of belonging and realize they can still enjoy and participate in life even after a traumatic experience (Hjertaas, 2013).

Social support. Trauma based on violence can have a negative effect on an adolescent’s sense of belonging (Hjertaas, 2013). When individuals experience or witness intense violence by another human being, it can disrupt their conviction that most people are inherently kind. This disruption causes a lack of safety in their world, and they will go to great lengths to avoid any stimuli associated with the trauma. Van der Kolk, Hostetler, Herron, and Fister (1994) stated this avoidance can lead to total withdrawal from people, places, situations, and events out of fear of trauma flashbacks. People become stuck in fear and feel unable to reach out to a support
system. It is the job of mental health providers to help clients expand their narrowed view of the world and challenge generalizations (Hjertaas, 2013).

A key factor for reducing posttraumatic stress in adolescents involves the subjective experience of support and one’s sense of belonging (Hjertaas, 2013); therefore, it is important for mental health providers to focus on the rebuilding of social connections during the aftermath of a trauma (Millar, 2013). If adolescents are surrounded by a support system filled with love and support, they will be more able to understand that their traumatic experience was the exception to the rule and not all people will become generalized as negative people (Hjertaas, 2013).

A sense of belonging can improve through secure attachment to significant people in the adolescent’s life (Hjertaas, 2013). Through these healthy relationships, the adolescent can regain courage to face life, even during difficult times. Additionally, a sense of belonging can be built for adolescents (after trauma) within the therapeutic process. Yalom (1985) believed that the client-therapist relationship can help the client feel a sense of belonging they may not have experienced before therapy. Yalom (1985) also believed that clients can feel social connectedness to others during group therapy due to shared distress; social connectedness could be an important protective factor against the risks of trauma.

Gfroerer et al. (2013) agreed with Adler and stated an individual’s perceived sense of belonging and social support are vital to mental well-being. Gfroerer et al.’s (2013) research supports the belief in Individual Psychology that an individual’s sense of belonging influences personality development and the way in which one views the self. Kern, Gfroerer, Summers, Curlette, and Matheny (1996) established that it is the
"perception" of social support that seems to be a stronger resilience factor for mental health than actual social support. Adler would agree that it is an individual’s perception, or private logic, about a situation that has an impact on mental functioning, rather than the actual situation (Ansbacher & Ansbacher 1956).

**Positive discipline.** Through their research, Gfroerer et al. (2013) explored positive discipline, which is based on the theories of Alfred Adler and Rudolph Dreikurs. Positive discipline includes the principles of Individual Psychology used to teach caregivers and educators effective strategies for building positive relationships with children and adolescents. One of the main principles of positive discipline is to help adolescents feel a secure sense of belonging at home or school (Gfroerer et al., 2013).

Gfroerer et al. (2013) explored several concrete ways to help adolescents perceive a secure sense of belonging and social support, which are important protective factors in developing coping resources after a trauma. One recommended strategy to build a sense of belonging is encouraging adults and adolescents to use positive time-outs. Taking time to use the rational brain, calm down, and think clearly during high stress situations teaches adolescents an important conflict-resolution coping skill. Adults should model positive time-outs during times of conflict as a way to demonstrate a democratic, nonpunitive discipline strategy. Positive timeouts encourage adolescent belonging because timeouts foster the development of the adolescent’s private logic, or internal message, and ideas are valued during times of conflict. Adolescents who have experienced trauma may need consistent reminders that they are valued and wanted (Gfroerer et al., 2013).

A second strategy Gfroerer et al. (2013) recommended was to increase adolescent belonging through encouraging the adolescent to build an internal sense of control and self-
respect. Encouragement improves adolescent private logic about the self through positive self-talk. When a caregiver or educator uses encouragement with an adolescent, the focus of the conversation is on determination and effort rather than outcomes. Consistent use of encouragement will help adolescents feel an authentic sense of social support rather than simply being praised for the outcome of their work (Gfroerer et al., 2013). This matters for adolescents who have experienced trauma because they often hold negative assumptions about themselves (APA, 2013).

Lastly, family and class meetings build a perceived sense of belonging in adolescents. Gfroerer et al. (2013) recommended using meetings to resolve conflicts within the classroom or the family. Within this group structure, everyone works together to solve problems and this helps adolescents learn important coping skills (e.g., problem solving, effective communication, and conflict resolution). These skills contribute to an environment where adolescents feel valued, encouraged, and supported, which builds a sense of belonging and social support (Gfroerer et al., 2013). Adolescents who have experienced trauma often feel isolated and trapped in a world of trauma triggers (APA, 2013). Creating a sense of community support and a sense of belonging will pave the way toward healing and PTG.

**Recommendations for Future Research**

This purpose of this literature review was to examine how trauma affects the adolescent. It may be beneficial for researchers to separate adolescents into smaller demographics based on gender, age groups, race, socioeconomic status, or family constellation. Through the study of specific adolescent subgroups who have experienced trauma, mental health professionals could more easily tailor therapeutic treatment to best assist in the healing process. Additionally, as PTG continues to gain popularity in the
mental health community, conducting longitudinal studies to examine the long-term effects of PTG could aid in the understanding of the role PTG in adolescent and future adult life.

**Conclusion**

Initially, the outlook may look grim for adolescents who have experienced trauma. Posttraumatic symptoms in adolescents include a wide variety of unfavorable physical and mental outcomes (Albuquerque et al., 2018); however, increased awareness of PTG reveals that adolescents can experience positive life changes and growth despite the pain that accompanies a trauma (Albuquerque et al., 2018). Positive changes in personal strength, spiritual change, ability to relate to others, appreciation of life, and new possibilities after trauma have been reported by those experiencing PTG. Helping at-risk adolescents build resilience factors for PTG that includes secure attachment, a sense of belonging, and social interest can promote hope, healing, and the ability to thrive after a trauma (Albuquerque et al., 2018; Hjertaas, 2013).
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