

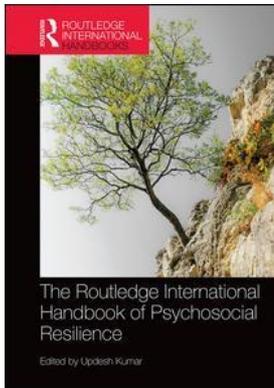
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Katrina Sims, Julie Ann Pooley

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Posttraumatic growth amongst refugee populations

A systematic review

Katrina Sims and Julie Ann Pooley

Personal growth following adversity is an age-old concept that can be observed in literature drawn from the fields of religion, philosophy and psychology. Fredrick Nietzsche's famous quote "That which does not kill us makes us stronger" is an often cited example of the notion that people can change in beneficial ways following adversity. Scientific interest in growth following adversity commenced in the late 1980s with studies reporting positive changes after traumatic experiences such as combat, cardiac arrest and rape (Joseph & Butler, 2010). Research and interest in this field has grown steadily over the past two decades. Development in posttraumatic growth research has been linked to the expansion of the positive psychology movement. This movement has seen a paradigm shift that has encouraged facilitation of positive emotional states rather than a singular focus on relieving negative symptoms (Joseph & Linley, 2005; Seligman & Csikzentmihalyi, 2000).

Different terms such as benefit finding (Lechner & Weaver, 2009), stress-related growth (Park, 2004) and perceived benefits (McMillen & Fisher, 1998) have been used in literature to refer to similar concepts. Posttraumatic growth (PTG), as proposed by Tedeschi and Calhoun (1996), has become the most commonly used term in current literature to describe positive change following adversity (Joseph & Butler, 2010). Tedeschi and Calhoun (1996) use the term to refer to the experience of positive psychological change following trauma.

It is proposed that after a traumatic event some survivors through their struggle to make sense of their experience perceive psychological development beyond that reported prior to the life-threatening event. Reported positives changes include a greater appreciation of life, enriched intimate relationships, awareness of personal strength, revaluation of priorities and possibilities and positive spiritual change (Tedeschi & Calhoun, 2004). Drawing on the "shattered assumptions" work of Janoff-Bulman (1992), Tedeschi and Calhoun suggest that traumatic events shatter basic world assumptions of benevolence, meaningfulness and self-worth. PTG is assumed to be derived through rebuilding assumptions using processes such as effortful rumination. PTG can therefore be considered a process or an outcome. PTG is not an automatic process that occurs for all people nor is it considered to replace distress. For those who experience PTG, this often occurs alongside ongoing distress.

Within the posttraumatic growth field researchers have reached consensus that PTG occurs following a diverse range of traumatic events and in a range of different populations. PTG has been reported amongst children (Meyerson, Grant, Carter, & Kilmer, 2011), adolescents and adults from different cultures (Splevins, Cohen, Bowley, & Joseph, 2010). Posttraumatic growth has been identified following diverse experiences that include life-threatening illnesses (Hefferon, Grealy, & Mutrie, 2009), survivors of bone marrow transplants (Tallman, Shaw, Schultz, & Altmaier, 2010), bereavement (Cadell & Sullivan, 2006), sexual assault (Frazier, Conlon, & Glaser, 2001), earthquake survivors (Karanci & Acaturk, 2005), terrorist attacks (Peterson & Seligman, 2003) and war (Powell, Rosner, Butollo, Tedeschi, & Calhoun, 2003). A review conducted by Linley and Joseph (2004) indicated that 30–70% of survivors of a range of traumatic events including accidents, medical problems, assaults and natural disasters experienced positive change following a traumatic event. The review found that people who maintained PTG over time were also less distressed. PTG was found to be related to positive well-being and lower rates of depression in a meta-analytic review of seventy-seven studies (Helgeson, Reynolds, & Tomich, 2006). Current research provides evidence to support that posttraumatic growth can occur across different age groups following a diverse range of traumatic events and is related to positive outcomes.

While the body of research into PTG has grown steadily, particularly among Western samples, posttraumatic growth in refugee populations has received much less attention. Given the high incidence of trauma and trauma-related problems reported among many refugee populations and the growing number of refugees settling in Western countries, treatment of refugee trauma-related problems has become an area of importance to health professionals working with refugee populations. The current chapter will review the body of research that has explored posttraumatic growth amongst refugee populations. The United Nations High Commissioner for Refugees (UNHCR, 2012) defines refugees as those who have been forced to relocate for humanitarian reasons including armed conflict, violence, persecution or violation of human rights and natural or manmade disasters. The UNHCR estimate that in 2011 there were 42.5 million refugees globally. Of these, 15.42 million have sought refuge in countries other than their own while 26.4 million were displaced but remain within their own country. Current figures indicate a growth trend in the number of new refugees each year. It was estimated in 2011 there were 800,000 new refugees, the highest number recorded in the past decade. Increase in the number of refugees globally has widespread implications for the displaced individuals and the countries hosting them.

Increase in the number of refugees settling in other countries along with higher incidence mental health problems has stimulated interest in refugee mental health. Estimates of PTSD alone in refugee samples have ranged from 12% to 91% (Johnson & Thompson, 2006). While forced relocation in itself can be considered a traumatic event (Ryff & Essex, 1992), many refugees have been exposed to or have witnessed prolonged and repeated trauma and life-threatening events including starvation, disease, torture, rape, extensive violence and injury or murder of family and friends. Research has identified a link between pre-migration trauma and mental health problems including PTSD, depression, anxiety and substance misuse (Steel, Silove, Phan, & Bauman, 2002). In addition postmigration factors such as loss of identity, acculturation, social isolation, unemployment and discrimination have been found to contribute to the development and maintenance of PTSD (Carlsson, Mortensen, & Kastrup, 2006; Kinzie, 2006).

Recent reviews of interventions to treat refugee mental health have found limited available research but also found some evidence for conventional therapies such as cognitive behaviour therapy and some promising therapies such as narrative exposure therapy (Crumlish & O'Rourke,

2010; Palic & Elklit, 2010). For mental health practitioners in developed countries, there has been a push to respond to refugee mental health in a culturally sensitive manner (Murray, Davidson, & Schweitzer, 2008). While research into effective culturally sensitive therapies to treat refugee populations is limited research into interventions aimed at facilitating posttraumatic growth is in its infancy and has received even less attention (Joseph & Linley, 2006). Nonetheless researchers have begun to explore whether posttraumatic growth can be facilitated through the use of interventions following trauma (Stanton et al., 2002) and through training prior to traumatic events (Tedeschi & McNally, 2011).

A systematic review of the current state of research into posttraumatic growth amongst refugee populations will contribute to the understanding of the phenomenon within this population and identify variables that contribute to posttraumatic growth amongst refugees. This information may in turn inform clinical interventions aimed at promoting psychological growth. To the author's knowledge, a review of this body of research has not been conducted to date.

The following chapter presents the aim of the review, the methodology and results. The results are combined and presented under relevant sub-headings representing common themes in the literature. These include results of measured PTG, the relationship between PTG and posttraumatic stress (PTS), gender and age differences, support for the Tedeschi and Calhoun's (1996) five-factor model and the use of therapy to promote PTG. The chapter concludes with a summary of the findings and the implications for therapists and suggestions for future research. Limitations of the current review and the reviewed studies are discussed.

Aim

The aim of this chapter is to systematically review the PTG literature in relation to refugees who have experienced adversity or trauma. The review will consider whether the phenomenon occurs across different refugee populations, the processes that mediate posttraumatic growth and the use of therapy to promote posttraumatic growth in this population. The review will consider implications for clinical interventions by health practitioners to facilitate posttraumatic growth amongst refugee populations.

Methods

Articles obtained for the review were identified through systematic searches of the electronic databases CINAHL plus Full Text, Proquest, PsychARTICLES, PsychINFO, Scopus and Web of Science. In addition reference lists of the obtained articles were scanned for any missed studies. The key terms "posttraumatic growth", "positive change", "benefit finding", "stress-related growth" and "adversarial growth" were combined with the search terms "refugee", "humanitarian entrant", "asylum seeker" and "displaced person" for the searches. All possible search combinations within the identified databases were conducted.

The articles included in this review are those that contribute to the body of knowledge relating to posttraumatic growth in refugee populations following resettlement. Given that interest in the area of growth following adversity commenced in the 1980s, the search was limited to studies published from 1980 until May 2013. The review is focused on studies that have examined posttraumatic growth in adult refugees. While in most cases samples included adults 18 years and above, one study explored PTG in young people aged 17 to 20 years. Given the majority of participants were adults and the limited number of studies in this area, this study was retained

for the review. Participants were those recognised in the study as refugees, humanitarian entrants, asylum seekers or forced migrants from any country. While no limitations were placed on the resettlement country included papers were limited to those published in English. Published, peer-reviewed articles and theses based on quantitative and qualitative research relating to the topic were included.

Once the search process was completed the authors independently screened the generated article titles. Those that did not meet the search criteria were excluded. The abstracts of the retained articles were again independently examined with those meeting the search criteria retained.

Results

The initial search yielded a total of fifty-six studies, thirty-two of these were eliminated during Stages 1 and 2 of the screening process leaving nineteen that met the full inclusion criteria. A further two articles were excluded as they were found to be based on the same research published in different formats. One journal article also appeared as a book chapter (Powell et al., 2003); the other, a thesis, was later published as a journal article (Rodgers, 2012).

Of the seventeen retained articles, fifteen were peer-reviewed journal articles and the remaining two dissertations. While the search criterion was open to studies published after 1980 the retained papers were all published in the last ten years from 2003 with a large number published in the last three years. The majority of the studies were quantitative with a retrospective cross-sectional design, while five of the studies used a qualitative approach. Only one study, Ai, Tice, Whitsett, Ishisaka and Chim (2007), used a longitudinal design. Two studies that tested the use of therapeutic interventions used an experimental approach with one utilising a pretest/posttest design (Gregory & Prana, 2013) and the second a randomised controlled trial (Hijazi, 2012). All studies were reliant on self-report measures to obtain information regarding posttraumatic growth. Table 19.1 presents a brief summary of the review articles. The table includes the authors and date published, the sample size, gender breakdown and the research design for each of the studies. Where reported, ethnicity, religion, resettlement location and time since trauma are included in the table. Also reported is the measurement tool of PTG and the major findings in relation to PTG.

Posttraumatic growth

Each of the reviewed articles reported the existence of PTG within their sample. Fourteen of the studies used a self-report questionnaire as a measure of PTG with eleven of those utilizing Tedeschi and Calhoun's (1996) Posttraumatic Growth Index (PTGI). The remaining three studies used qualitative approaches to analyse interview data.

The PTGI is a twenty-one-item measure using a six-point Likert scale. Scores range from 0 to 126 with higher scores reflecting greater perceived growth (Tedeschi & Calhoun, 1996). Results of the six studies that reported PTGI total mean scores are tabled (Table 19.2). Mean total PTGI scores ranged from 35.82 to 76.68. The highest PTGI mean score resulted from a large sample of Tibetan refugees residing in India (Hussain & Bhushan, 2011). This result may indicate that there is something specific to this group that encourages PTG. A likely explanation is that Tibetans follow a Buddhist philosophy that may support PTG. This idea is discussed in greater detail in the discussion section on cultural factors.

Table 19.1 Summary of review articles

<i>Authors and date</i>	<i>Sample Total, Gender Breakdown</i>	<i>Research Design</i>	<i>Ethnicity</i>	<i>Religion</i>	<i>Location</i>	<i>Time elapsed since relocation</i>	<i>Measure of PTG</i>	<i>PTG Key Findings</i>
Ai, A. L., Tice, T. N., Whitsett, D. D., Ishisaka, T., & Chim, M. (2007)	50, 54% M, 46% F	Longitudinal prospective	Kosovar	96% Muslim	Washington State, USA	Minimum of 10 months	Fifty item Stress Related Growth Scale.	No relationship between PTSD symptoms and PTG. Hope and cognitive coping showed a positive association with PTG
Copping, A., Shakespeare-Finch, J., & Paton, D. (2010).	15, 53% M, 47% F	Qualitative study using grounded theory	Sudanese	100% Christian	Tasmania, Australia	3 months to 5 years		Found values associated to PTG where present prior to trauma and assisted PTG.
Gregory, J.L., & Prana, H. (2013).	49, 41% M, 59% F	Pretest/post test design	Ivorian	No data	Liberia	No data	PTGI	Significant increase in PTG reported following intervention.
Hall, B. J., Hobfoll, S. E., Palmieri, P. A., Canetti-Nisim, D., Shapira, O., Johnson, R. J., & Galea, S. (2008).	190, 44% M, 56% F	Cross sectional	Israeli	70% reported to be religious.	Gaza	Data obtained prior to relocation	6 items of Conservation of Resources Evaluation	PTG related to lower likelihood of probable PTSD but not MDD ($\alpha = .66$) PTG (M = 10.11, SD = 4.62)
Hijazi, A. M. (2012).	53, 49% M, 51% F	Randomized Iraqi controlled trial	Iraqi	75% Chaldean Catholic, 15% Mandeian, 9% Muslim Arab	Detroit, Michigan, USA	Mean 2.4 years (SD = 2.4)	PTGI	Significant increase in PTG reported at 2 and 4 months following NET intervention.
Hussain, D., & Bhushan, B. (2011).	226, 50% M, 50% F	Cross sectional design	Tibetan	No data reported; however a Buddhist influence is implied.	Dharmshala, Himachal Pradesh, India	No data	PTGI	Positive correlation between PTS and PTG reported. PTGI total (M = 76.68, SD = 9.39)

Hussain, D., & Bhushan, B. (2013).	12, 67% M, 33% F	Qualitative study using interpretive phenomenological analysis.	Tibetan	No data	Dharmshala, Himachal Pradesh, India	No data	PTGI	Three themes consistent with PTG theory emerged: change in outlook, personal strength and meaningful relationships.
Jayawickreme, D. E. R. (2011).	237, 69% M, 13% F, 4% U	Cross sectional	Tamil	No data	Sri Lanka	No data	PTGI Short Form	Two factor structure found. Significant gender differences in PTG noted. No relationship was found between PTG and PTSD, depression or functioning. PTG found amongst all participants. Four factors emerged personal, social, religious and mental health.
Kim, H. K., & Lee, O. J. (2009).	5, 60% F, 40% M	Qualitative Phenomenological	North Korean	No data	South Korea	No data		PTG reported, PTGI Total (M = 68.92, SD = 16.77). Found a positive relationship between PTG and: hope, religiosity, negative religious coping and perceived social support.
Kroo, A., & Nagy, H. (2011).	53, 83% M, 17% F	Cross sectional design	Somali	76% reported to be a great deal religious (Muslim)	Hungary	No data	PTGI	Support for PTG was found. PTG was found to coexist with trauma and to alter religious beliefs. Scores from PTGI range from 66% to 89%.
Mattoon, L. (2011).	11, 100% F	Qualitative utilizing the narrative approaches of life story interview and Artistic Inquiry	Uganda and Vietnam	55% Protestant 36% Catholic	California and Uganda	2-27 years since most recent trauma	PTGI	Curvilinear relationship between post traumatic symptoms and growth
Nuttman-Shwartz, O., Dekel, R., & Tuvai-Mashiach, R. (2011).	269, 37% M, 63% F	Cross sectional	Israeli (from Gaza strip)	84.9% reported being religious	Israel	No data	PTGI	

(Continued)

Table 19.1 (Continued)

<i>Authors and date</i>	<i>Sample Total, Gender Breakdown</i>	<i>Research Design</i>	<i>Ethnicity</i>	<i>Religion</i>	<i>Location</i>	<i>Time elapsed since relocation</i>	<i>Measure of PTG</i>	<i>PTG Key Findings</i>
Powell, S., Rosner, R., Butollo, W., Tedeschi, R. G., & Calhoun, L. G. (2003).	64, 39% M, 61% F	Cross sectional	Former Yugoslavian	No data	Sarajevo, Bosnia and Herzegovina	3.5 years after war	PTGI Bosnian translation	Low PTGI Total (M = 35.82, SD = 18.09). No relationship was found between PTS and PTG. Support was not found for Tedeschi & Calhoun's 5 factors, a three factor solution was found.
Rodgers, S.T. (2012).	62, 100% F	Cross sectional	Latina (from Colombia 52% El Salvador 21% and Guatemala 11%)	71% Catholic	New York City, NY, USA	6 or more years	PTGI Spanish short form	Reports presence of stress and moderate levels of PTG. Converted PTGI total M = 74.4
Sutton, V., Robbins, I., Senior, V., & Gordon, S. (2006).	8, 12% M, 88% F	Qualitative using Interpretative Phenomenological Analytical Analysis	No data	62% Christian 38% Muslim	United Kingdom	Unclear		Reported varied levels of PTG and co-existence of distress and positive change.
Teodorescu, D. S., Siqveland, J., Heir, T., Hauff, E., Wentzel-Larsen, T., & Lien, L. (2012).	55, 58% M, 42% F	Cross sectional	Eastern Europe 40%, Middle East 26%, Africa 16%, Far East 13%, Latin America 6%	64% Muslim	Norway	Mean 16.7 years	PTGI Short Form	Low PTG reported Converted PTGI M = 47.4 (SD = 10.1). A significant negative association between PTSD symptoms and PTG was found.
Vazquez, C., Cervellon, P., Perez-Sales, P., Vidales, D., & Gaborit, M. (2005).	115, 42% M, 48% F	Naturalistic study	El Salvador	No data	El Salvador	No data	The Community Cohesion Interview.	66% of the sample reported growth or learning

Table 19.2 Summary of PTGI total mean

<i>Authors and date</i>	<i>Sample size and setting</i>	<i>Mean PTGI Score</i>	<i>Standard Deviation</i>
Hijazi (2012)	53 Iraqi refugees settled in USA	49.5 (Control at baseline)	23.9
		43.5 (Control at 4 months)	18.1
		48.5 (Intervention group baseline)	23.8
		58.3 (Intervention group at 4 months)	23.56
Hussain & Bhushan (2011).	266 Tibetan refugees settled in India	76.68	9.39
Kroo & Nagy (2011).	53 Somali refugees living in Hungarian reception centres	68.92	16.77
Powell, et al. (2003).	64 former Yugoslavia refugees living in Sarajevo.	35.82	18.09
Rodgers (2012).	62 Latina women living in New York City	74.4	
Teodorescu, et al. (2012).	55 psychiatric outpatients with a refugee background living in Norway	47.4	10.1

Relationship between posttraumatic stress and posttraumatic growth

While all studies reported the existence of PTG and coexistence of posttraumatic stress symptoms (PTSS), inconsistent results were found between studies that explored the relationship between PTSS and PTG. Three of the studies reported no relationship between PTSS and PTG (Ai, Tice, Whitsett, Ishisaka, & Chim, 2007; Jayawickreme, 2011; Powell et al., 2003) while two reported a negative relationship (Hall et al., 2008; Teodorescu et al., 2012), one study reported a positive association (Hussain & Bhushan, 2011), and one reported a curvilinear relationship (Nuttman-Shwartz, Dekel, & Tuval-Mashiach, 2011). The discrepancy in these results is puzzling and is considered further in the following discussion.

Psychological predictors of posttraumatic growth

Few of the studies explored the role of psychological predictors of PTG among refugee samples. Hope and cognitive coping were found to be positively associated with PTG while avoidance coping was found to have a negative relationship with PTG (Ai et al., 2007). Support was found for the role of hope in the development PTG (Kroo & Nagy, 2011). In addition higher scores on cognitive emotional regulation strategies were found to be associated with higher PTG (Hussain & Bhushan, 2011). Of the nine cognitive coping strategies tested in this study, four (positive re-focussing, refocus on planning, putting in perspective and catastrophizing) were found to partially mediate the relationship between traumatic experience and PTG.

Gender

In general PTG research, females tend to score higher on both stress symptomology and PTG (Linley & Joseph, 2004). Even when exposed to similar traumatic events women tend to experience greater levels of distress. It is theorised that higher levels of distress may be sufficient to shatter previously held assumptions and promote schema change and PTG (Tedeschi & Calhoun,

2004). Among the few studies in the current review that considered gender differences in PTG, two were consistent with findings elsewhere. Hussain and Bhushan (2011) found that females scored higher on PTG along with trauma and PTSS. Jayawickreme (2011) also reported a significant difference in PTG amongst Sri Lankan men and women, with women scoring higher, although their sample included only 13% women.

A third study, however, found no gender difference in PTG among a sample of refugees from the former Yugoslavia following war (Powell et al., 2003). The overall PTGI mean score in this sample was found to be low and thought to be a reflection of high levels of trauma hindering the PTG process. This effect may have impacted both genders equally or perhaps women more so given that women would generally score higher on PTG. Alternatively these results could be a reflection of cultural gender differences.

Age

Age effects were reported in Powell et al. (2003). A significant result was found for the factor changes in self/positive life attitude with the older age group reporting less growth in this area. Rather than age Hussain and Bhushan (2011) examined generational differences in PTG amongst two generations of Tibetan refugees relocated to India. Total PTG difference between the generations was not significant; however, significant differences were found in three of the five sub-factors. First-generation Tibetan refugees scored higher on personal strength and spiritual change while second-generation participants scored higher on new possibilities. First-generation refugees reported greater PTSS.

Use of therapy to facilitate posttraumatic growth

Two studies researched the effect of a specific therapy on PTG in a refugee sample. Compared to a waitlist control group, Hijazi (2012) found that Iraqi refugees provided with three sessions of Narrative Exposure Therapy showed increased PTG at two and four month follow-ups. A trend towards reduced PTSD symptoms was noted but was not found significant at the four-month follow-up. Gregory and Prana (2013) reported a significant increase in PTG as measured by the PTGI following delivery of the Companion Recovery Model to forty-nine Ivorian participants. A third study reported positive effects resulting from the use of a therapeutic interviewing technique (Mattoon, 2011). These initial results show promise for the effectiveness of therapy to facilitate PTG and will be further discussed.

Support for Tedeschi and Calhoun's (1996) five-factor model

To measure PTG, Tedeschi and Calhoun (1996) developed the Posttraumatic Growth Inventory. Five factors or scales emerged from analysis using the PTGI: New Possibilities, Relating to Others, Personal Strength, Spiritual Change and Appreciation of Life. Tedeschi and Calhoun's original five-factor model of PTG was not replicated amongst refugee samples. Jayawickreme (2011) reported a two-factor model while Powell et al. (2003) reported a three-factor solution.

Discussion

The articles reviewed here consistently reported the existence of PTG and the coexistence of PTG and PTSS. The results support that PTG frequently occurs among refugee samples that have experienced often prolonged and complex trauma. The results provide evidence to support that

PTG occurs across many different cultural groups and is likely a universal phenomenon. The co-occurrence of PTG and PTSS found in all studies is consistent with Tedeschi and Calhoun's (2004) PTG model, which purports PTG and PTSS develop from the same events and share similar processes such as rumination.

The importance of PTG to clinicians and health professionals rests in its relationship to mental health outcomes and quality of life. Much research into PTG has attempted to determine whether a relationship between posttraumatic stress symptoms and growth exists and the nature of such a relationship should it exist. Although many studies have explored this relationship, the findings have been inconsistent, and the nature of the relationship remains unclear (Linley & Joseph, 2004). As in other PTG literature, the relationship between posttraumatic stress and growth amongst refugee populations in the current review was found to be inconsistent and confusing with studies reporting null findings, positive, negative and curvilinear relationships.

One hypothesis is that the level of the distress experienced moderates the level of PTG. It is proposed that PTG is highest when the level of posttraumatic stress is moderate and lower when lower or higher doses of trauma are present, thus producing a curvilinear relationship (Butler et al., 2005). Nuttman-Shwartz et al. (2011) reported a curvilinear relationship between psychological distress and PTG in their study of 269 Israeli residents who were forced to relocate from their homes in the Gaza Strip. While causal assumptions cannot be made due to the cross-sectional nature of the study, the authors propose that posttraumatic symptomatology at higher levels may be overwhelming and limit PTG and at lower levels may be insufficient to produce the processes that are thought to lead to PTG. Powell et al. (2003) report that their results lend support to the curvilinear hypothesis. While no linear relationship was found in their sample of refugees from the former Yugoslavia exposed to war, high levels of exposure to traumatic events are reported along with relatively low levels of PTG ($M = 35.82$, $SD = 18.09$). It could be assumed that the high levels of trauma produced greater distress, which in turn hindered psychological growth.

Teodorescu et al.'s (2012) finding of a significant negative association between PTSD symptoms and PTG along with relatively low levels of PTG may represent the downward slope of the inverted-U, curvilinear relationship if the sample were to include participants experiencing a high level of distress. This may be the case as the sample was derived from psychiatric outpatients. It would be reasonable to assume that clients seek treatment due to higher levels of symptomatology, which may impede their ability to engage in the cognitive processing required for PTG.

Support for a curvilinear relationship between PTSS and PTG has been found elsewhere (Butler et al., 2005) and is reported to be the current dominant explanation for the nature of the relationship (Joseph, Murphy, & Regel, 2012).

The time passed since trauma occurred has also been demonstrated to have an effect on outcomes. Helgeson et al. (2006), in a meta-analysis of general PTG research, considering only Western samples, found greater positive effects on well-being when the time since trauma was greater than two years and conversely that PTG was related to greater distress when the time since trauma was less than two years. Roughly half of the articles presented here did not report time since trauma, and of those that did, the period of time ranged from 3 months to 27 years. Only one of the reviewed articles (Hussain & Bhushan, 2011), considered time since trauma as a factor in their study. These authors considered differences among first-generation and second-generation Tibetan refugees. First-generation refugees were those relocated from their homeland while second-generation refugees were generally born in exile. No difference between the groups was found in traumatic experience or PTG totals; however, first-generation refugees scored higher on PTSS and the PTG factors of personal strength and spiritual change, while second-generation refugees scored higher on new possibilities. These results appear to relate more to generational and age differences than time since trauma.

In addition, trauma that has existed over an extended period of time may have a different impact on PTG. For example in some communities, political unrest or war has occurred over entire lifetimes, and it is possible that exposure to trauma has become part of life. Under these circumstances, assumptions that the world is a safe and benevolent place may not have developed, and assumptions are likely to be very different to the world assumptions of those living in more fortunate circumstances (Copping, Shakespeare-Finch, & Paton, 2010).

Given the differences in samples, level of distress and time since trauma it a possibility that different phases of PTG are being measured. Helgeson et al. (2006) propose the possibility that different studies may be measuring different phases of the PTG process. For example early coping, actual changes and cognitive processes may represent different phases of PTG.

In a study of Israeli's forced to relocate from the Gaza strip, Hall et al. (2008) found that PTG was related to a lower likelihood of probable PTSD but not Major Depressive Disorder (MDD). These authors suggest that the key to PTG amongst this sample may have been actual behavioural change rather than cognitive processes. The participants in the study had chosen to resist instructions to relocate, and in so doing, it was suggested that the participants had actualized their growth cognitions, resulting in a lower likelihood of psychological distress. Refugee groups in other studies appear to have had less control over their situations.

Severity of the trauma reaction may in part explain some of the different findings. Boals, Steward and Schuettler (2010) proposed that, if the impact of trauma did not have a profound effect on core beliefs, study results could be diluted. These authors demonstrated that excluding results from traumatic events that were not central to core beliefs produced greater effect sizes and recommended that future studies exclude data that fail to produce a moderate impact on the participants' core beliefs.

Although many of the studies reported exposure to severe and prolonged traumatic events, the different measures of trauma symptomology ranging from self-report to a clinically administered scale prevent direct comparison. Some studies measured symptoms against PTSD criteria while others measured stress symptomology. It is therefore unclear how the severity of trauma impacted on PTG among refugee samples.

It appears the relationship between PTG and PTSS is complex particularly amongst refugee populations, and current research is still in the early stages of unravelling the nature of the relationship. More stringent research taking into consideration the time since trauma, the level of distress and PTG over time may provide clearer insight into the phenomenon.

Psychological predictors

Few of the studies of PTG in refugee populations explored psychological predictors. Cognitive coping was considered in two studies. Within these, one study considered rumination, which is proposed by Tedeschi and Calhoun (2004) to play a major role in development of PTG. In Hussain and Bhushan's (2011) sample of Tibetan refugees, rumination was not found to be a significant predictor of PTG. No explanation is offered, and it remains unclear whether rumination has a role in development of PTG in other refugee groups.

No studies could be found that considered personality factors, in refugee groups, which are thought to impact PTG. Optimism and hope are discussed in two of the studies. Interestingly hope, but not optimism, was positively related to PTG in both studies (Ai et al., 2007; Kroo & Nagy, 2011). It suggests that hope, compared to optimism, appears more emotional and motivational. Hope offers the perception of ability to effect positive change, which in turn provides motivation to overcome the impacts of trauma (Ai et al., 2007). A possible link between faith and spiritual support with hope is offered. Faith is discussed further under the heading of religious coping.

In their sample of Kosovar war refugees, Ai et al. (2007) found that cognitive coping was positively associated with PTG while a negative relationship was found between avoidance coping and PTG. Hussain and Bhushan (2011) found that higher scores on cognitive emotional regulation strategies were associated with higher PTG. Of the nine cognitive coping strategies tested, four – positive refocussing, refocus on planning, putting in perspective and catastrophizing – partially mediated the relationship between traumatic experience and PTG. It appears logical that that positive coping strategies such as positive refocussing, refocusing on planning and putting into perspective facilitate growth through positive change in thought patterns; however, the relationship with catastrophizing appears less clear. It would seem intuitive that catastrophizing would intensify negative thought patterns resulting in less growth; however, the researchers suggest the possibility that catastrophizing acts as a catalyst for schema change that in turn leads to growth. Tedeschi and Calhoun's (2004) notion that a sufficient level of trauma is required to shatter previous schemas is used to support the hypothesis (Hussain & Bhushan, 2011).

Evidence of psychological factors that promote and hinder PTG is important to the field of clinical psychology. Clinicians can encourage those processes that promote PTG. At this time research into the psychological processes that facilitate growth in refugee populations insufficient to inform clinical practice.

Cultural factors

While some similarities can be drawn between the experiences of refugees from different cultural groups, many cultures have unique beliefs or customs that may impact on their experience as a refugee. These differences may also influence development and experience of PTG. Many cultural practices that may impact on development of PTG were noted throughout the studies. For example Tibetan culture is heavily influenced by Buddhist beliefs such as compassion for others and the “law of karma”. A qualitative study of Tibetan refugees revealed that these beliefs aided growth following adversity. Through belief in karma and past deeds, Tibetans were able to find meaning and acceptance of events that had occurred in their lives (Hussain & Bhushan, 2013). The Tibetans were also found to have pride in their culture and a willingness to make collective efforts to preserve their way of life creating meaning beyond their own survival. The particular beliefs and practices of the Tibetans were found to be conducive to the PTG process, which may explain the high level of PTG reported in a study of a large sample of Tibetans (Hussain & Bhushan, 2011).

Evidence of cultural influence was also found in studies of other cultural groups. Hispanics in the USA were found to believe in divine intervention, which was thought to foster hope among this group (Rodgers, 2012). Collectivism among the Sudanese was found to promote support-seeking behaviour and a sense of shared experience (Copping et al., 2010). A similar collective bond was reported among Tibetans (Hussain & Bhushan, 2013). Evidence that cultural factors influence PTG highlight the value of existing cultural resources and social supports available in some cultural groups. These findings reinforce the need for culturally sensitive practice.

Religious coping

Religious coping was found to be an important factor in PTG across many of the cultures considered in the review. The Sudanese were found to attribute traumatic experience to fate and god (Copping et al., 2010). Faith, prayer and accepting fate were found to be central to posttraumatic growth in Somali refugees in Hungary (Kroo & Nagy, 2011). Of a sample of refugees following an earthquake in El Salvador, 88% report using religion as a means of coping (Vazquez, Cervellon,

Perez-Sales, Vidales, & Gaborit, 2005). Mattoon (2011) found that, not only did religious beliefs influence PTG, but also in many of the participants, PTG was found to have an impact on people's religious beliefs.

The importance of religious coping in the development of PTG across the different cultural groups and religions was one of the most consistent findings across the studies reviewed. This finding has implications for therapists and host countries working with refugees. It is important to note that religious coping among these cultures was often seen as a positive coping strategy. This view may be opposed to that of some Western mental health professionals who often consider religious coping as a form of avoidance (Copping et al., 2010). These results serve as a reminder that mental health professionals working with clients from different cultures should familiarise themselves with the cultural and religious backgrounds of their clients and be careful not to minimise the importance of religious coping on trauma recovery (Mattoon, 2011).

Support for Tedeschi and Calhoun's (1996) five-factor model

Tedeschi and Calhoun's (1996) five-factor model of PTG was not replicated amongst refugee samples. A two- and three-factor model was found in the studies that attempted to explore the factor model. While the results were in line with Tedeschi and Calhoun's model, these results may suggest that the PTGI measures different concepts among different refugee groups. In the studies presented here, the PTGI was often translated to other languages for use with refugee groups. It is possible that meaning was lost between translations. Further research into the relevance of this measure in different cultural groups is required.

Copping et al. (2010) found that PTG outcomes identified by Tedeschi and Calhoun (1996) such as strength, appreciation of life, religious changes and relationships with others were present as coping strategies rather than resulting from traumatic experience, which they explain as a possible artefact of prolonged experience of conflict. Given the cultural differences identified, it is possible that PTG has different meaning and processes among different cultural groups.

The use of therapy to facilitate posttraumatic growth

Only two studies were found to consider the effect of a therapeutic intervention on posttraumatic growth in a refugee population. Gregory and Prana (2013) report that a ten-module (thirty-six-hour) Companion Recovery program delivered to forty-nine Ivorian refugees living in Liberia resulted in significant PTG. The Companion Recovery Model encourages processing of trauma and implementation of positive change through psycho-education, development of counselling skills and selection of a companion to share traumatic experience. PTG was measured using the PTGI before and after the implementation of the program. A significant increase in PTG was identified. The results of this study could have been strengthened through use of a control group to rule out the possibility that a factor other than the intervention contributed to the PTG found among the sample. While PTG is often associated with increases in well-being as discussed previously, it would have been interesting to know what benefits the participants gained alongside PTG and if the gains were maintained over time. The authors suggest that this type of program is a cost-effective means of addressing trauma reactions and empowering refugees to support their peers in refugee centres or camps.

Hijazi (2012) found that Iraqi refugees provided with three 60–90 minute sessions of Narrative Exposure Therapy showed significant increases in PTG at two- and four-month follow-ups

as compared to a randomised waitlist control group. A trend towards reduced PTSD symptoms in the intervention group was noted, however, was not found significant at the four-month follow-up. Narrative Exposure Therapy is a manualized short-term intervention drawing on traditional cognitive and behavioural PTSD treatments. The therapy involves processing emotional reactions through repeated telling of the individual's traumatic events and creating a cohesive narrative. The aim is symptom reduction through gradual habituation. Encouraging results were found for this brief therapy.

While not using a psychological intervention, Mattoon (2011) reported anecdotal healing effects from the use of life story interview and artistic inquiry with refugee participants from Vietnam and Africa. Several of the participants from this study found that telling their story was validating and useful in processing events that had occurred in their lives. Some of the participants had never before shared their stories with others. The sharing of life stories was also found to be useful amongst Sudanese refugees in Australia (Copping et al., 2010). These authors identified the value in support groups within Sudanese culture who as a collectivist society are accustomed to seeking support from each other. Refugee groups often share a common experience of suffering regardless of individual difference in stories. Among the Sudanese, reflective counselling was found to be unsatisfactory with a cultural preference for seeking direction and advice noted in this group.

While the results of these studies are encouraging, particularly around the use of narrative therapies amongst certain populations, further research to support the effectiveness is required including whether current treatments for PTSD also produce PTG and what therapies enhance PTG are required to inform clinical practice in this area.

Limitations and conclusions

The overreliance on cross-sectional design is a common criticism of posttraumatic growth research. This criticism is certainly applicable to the research of PTG in refugee populations. Future studies that utilise methodologically sound research designs including longitudinal studies and control groups may help to clarify some of the inconsistencies in current research.

The reliance on self-report questionnaires to measure PTG has also been a major criticism (Coyné & Tennen, 2010). The ability to accurately self-report the extent to which a traumatic event influenced positive change has been described as a difficult and complex task in which people often overestimate past distress. A recent study (Frazier et al., 2009) demonstrated that amongst a sample of college students self-reported growth was not related to actual growth measured pre- and posttrauma. This study does not challenge the existence of PTG but rather the ability of self-report measures to identify actual PTG. More sensitive measures may be required to distinguish perceived growth from illusory growth and actual growth.

A major confounding factor in the study of PTG amongst refugee populations is that the change in environment under some circumstances produces not only relief from threat but actual new opportunities (i.e. housing, job prospects and education) that may not have been possible in the country of origin (Copping et al., 2010). Refugees relocated to another country have been found to report higher levels of PTG than those internally displaced (Jayawickreme, 2011), and refugees living in temporary housing reported lower levels of growth than did those in independent housing (Nuttman-Shwartz et al., 2011). In order to control for this factor, researchers need to consider the refugees current and previous environmental factors. In the absence of baseline data, researchers could possibly obtain data from a control group from their previous environment.

Limitations of the current review

To the authors' knowledge, all articles that met the inclusion criteria available in the databases searched were obtained for the review. It remains a possibility, however, that some articles were missed. While an effort was made to include unpublished works to avoid a bias toward positive findings, it is probable that unpublished papers have been missed. Non-English-language publications were also excluded. In addition while an effort was made to search reference lists for missed articles, a systematic search for "grey literature" was not conducted and may have been overlooked here. The review therefore is limited to those studies that met the search criteria and may not be a comprehensive overview of all research conducted in this area.

Implications and relevance to clinical psychology

The results obtained here have several implications for clinicians and mental health practitioners. First, it appears clear from the mixed results and rich data from qualitative studies that each culture has different background history, customs and beliefs. It is not news that cultural competence is required when working with different cultural groups. However, it is important that clinicians consider the role that religious coping may play in development of PTG. Second, given that PTG occurs without intervention, it is important to consider the cultural values and practices already present amongst refugee groups and encourage local, traditional coping resources and social support (Kroo & Nagy, 2011). The use of support groups and storytelling may be useful among some cultural groups. Given that hope was found to be a contributing factor to PTG, clinicians have a role in restoring hope and teaching coping strategies (Ai et al., 2007).

It is also important to heed the warning of Tedeschi and Calhoun (2004) that, in the process of encouraging growth care, should be taken not to minimise the very real and damaging impacts of trauma. Until more appropriate culturally sensitive options become available clinicians would be wise to use traditional evidence-based methods to treat PTSD symptoms.

Conclusions and recommendations for future research

This chapter provides a systematic review of research that has explored PTG in adult refugee populations. To date, this area has received limited attention; however, recent interest in the field generated by global growth in refugee populations, combined with interest in positive psychology, has seen sufficient research produced to warrant a review.

Systematic search of electronic databases resulted in seventeen studies matching the search criteria. Differing research methodologies and samples have made direct comparison unfeasible; however, the results taken together provide interesting insight into current knowledge and gaps in PTG research into refugee populations. The results demonstrate that perceived PTG occurs in refugees originating from many different nations and cultural groups. These results support the notion that PTG is a cross-cultural phenomenon.

Research to date has failed to consistently identify the nature of the relationship between PTG and posttraumatic stress symptoms although some support was found for a curvilinear relationship whereby greater PTG is found when moderate levels of stress is present. Some evidence was found to support the use of narrative exposure therapy and the Companion Recovery Program to promote PTG in certain refugee populations; however, much more research is required to establish the effectiveness of these and other interventions in refugee populations.

As research in this area is relatively new, there is much scope for future research. Further research is required to help determine the nature of the relationship between PTG and PTSS

and effective use of therapy to promote PTG. Further studies to test the validity of the PTGI in different cultural groups is required. Future research should take into consideration the effects of time since trauma and the severity of trauma responses. New studies would benefit from the consistent use of a measure of trauma symptomology that would allow for comparisons to be made between studies. Research designs that undertake longitudinal and experimental designs where appropriate may produce valuable evidence to add to the growing literature on posttraumatic growth in refugee populations.

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