

Assessing Strengths, Resilience, and Growth to Guide Clinical Interventions

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Recently, the field of mental health has incorporated a growing interest in strengths, resilience, and growth, psychological phenomena that may be associated with healthy adjustment trajectories and profitably integrated into strategies for clinical assessment and practice. This movement constitutes a significant shift from traditional deficit-oriented approaches. Addressing clinical practitioners, this article (a) provides a broad overview of these constructs and phenomena, (b) discusses their relevance for clinical assessment and intervention, and (c) describes selected strategies and approaches for conducting assessments that can guide intervention.

Clinical psychologists and other mental health practitioners have traditionally focused on what “goes wrong” for clients and how to treat it (Cowen, 1999). More recently, the field has seen a growing emphasis on wellness enhancement (Cicchetti, Rappaport, Sandler, & Weissberg, 2000; Cowen, 1994), the development of competence (Masten, 2001; Masten & Coatsworth, 1998), and human strengths and growth (Calhoun & Tedeschi, 1998, 1999; Seligman & Csikszentmihalyi, 2000; Tedeschi & Calhoun, 1995, 2004). Such work has a substantial history (Cowen & Kilmer, 2002; Tedeschi & Calhoun, 1995; Tedeschi, Park, & Calhoun, 1998), with roots including Hollister’s (1965) introduction of the concept of *strens*, that is, experiences that enhance or strengthen people psychologically, contrasting with the prevailing emphasis on negative experiences, as well as Antonovsky’s (1979) use of the term *salutogenesis* to describe processes that contribute to healthy physical and psychological outcomes, challenging the field’s emphasis on pathogenesis and processes associated with dysfunction.

Such shifts in orientation go beyond the heuristic or semantic; they have clear practical implications. In fact, numerous applied domains, clinical frameworks, and promising practices have incorporated a strengths focus (Burns & Goldman, 1999; Stroul & Friedman, 1986), integrated findings from resilience research (Luthar & Cicchetti, 2000; Richardson, 2002), and acknowledged client growth in the aftermath of trauma (Calhoun & Tedeschi, 1998, 1999; Tedeschi, Park, & Calhoun, 1998). In this article we seek to (a) provide a broad conceptual overview of the constructs

relevant to these approaches, (b) discuss their relevance for clinical assessment and intervention, and (c) describe selected strategies and approaches for conducting evaluations that can guide intervention.

Assessing Strengths: A Shift in Focus

Traditionally, clinical assessment has focused on identifying symptoms, problem behaviors, emotional concerns, deficits, and functional difficulties. Although clearly a requisite component and primary goal of many assessments, this deficit- or problem-focused approach may reduce the range of information sought and considered, limiting the clarity of the picture painted by the evaluation and emphasizing negative aspects of individuals and situations (Harniss, Epstein, Ryser, & Pearson, 1999). In contrast, Epstein and Sharma (1998) define strength-based assessment as

the measurement of those emotional and behavioral skills, competencies, and characteristics that create a sense of personal accomplishment; contribute to satisfying relationships with family members, peers, and adults; enhance one’s ability to deal with adversity and stress; and promote one’s personal, social, and academic development. (p. 3)

With its focus on clients (whether a child, an adult, or a family) as bearers of unique talents, skills, resources, life experiences, and unmet needs, this approach has received growing attention.

Methods for Assessing Strengths

Informal, qualitative methods for assessing strengths (e.g., listening to clients’ narratives for evidence of strengths, interests, hopes, etc., instead of simply working through a protocol) can be a part of any assessment process (Saleebey, 1996), and clinicians from a variety of perspectives have informally practiced strengths-based assessment (VandenBerg & Grealish, 1996). For instance, in addition to addressing presenting concerns, many clinicians integrate non-pathology-oriented questions (“Why don’t we pause for a moment and talk first about what Johnny does well?”; “Let’s discuss what goes well between you two and what drew you to him?”; “Tell me what you’re good at and what makes you proud”). However, such strengths-based approaches have not been the

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subject of the same empirical and psychometric attention as more pathology- or deficit-oriented approaches (Harniss et al., 1999).

In recent years, in addition to the multiple available and widely used measures for documenting symptoms and problem behaviors in clinical settings, researchers have developed psychometrically sound scales that assess clients' assets. For example, the Behavior Assessment System for Children (Reynolds & Kamphaus, 1992) includes both adaptive and problem behaviors (clinical scales include Conduct Problems, Anxiety, and Depression but also Adaptability, Leadership, and Social Skills), as does the Teacher-Child Rating Scale (Hightower et al., 1986; Perkins & Hightower, 2002), containing Behavior Control, Assertiveness, Task Orientation, and Peer Social Skills subscales. Although few scales are solely strength based or developed specifically to assess competencies, one such measure is the Behavioral and Emotional Rating Scale (Epstein & Sharma, 1998), a 52-item scale that assesses the strengths and competencies of children and adolescents (ages 5–18) across Interpersonal Strength, Family Involvement, School Functioning, Intrapersonal Strength, and Affective Strength. The Behavioral and Emotional Rating Scale yields norm-referenced standard scores and a global strength quotient for children and youth diagnosed with emotional and behavioral disorders, as well as nondiagnosed youngsters.

Clinical Implications: Why Assess Strengths?

Although many individuals or families might be surprised when asked to describe or identify their strengths (Handron, Dosser, McCammon, & Powell, 1998), when assets and risks are both assessed, clients are more likely to experience the intervention as affirming and empowering, even motivating (Cowger, 1994; Saleebey, 1996). Moreover, such an approach sends a clear message that one is recognizing a client's identity and competencies beyond his or her presenting concerns and diagnostic profile (Saleebey, 1996). Thus, the assessment process (in addition to its product) carries substantial weight, and attending to the whole person can create a different, more positive set, influence the power differential between client and professional, and positively impact client-therapist rapport (Cowger, 1994; Harniss et al., 1999). In child work, assessing strengths as well as problems can prove fruitful in communicating with caregivers; a strengths orientation can foster supportiveness and trust, facilitate positive caregiver-practitioner relationships, and redirect caregivers from focusing only on the child's symptoms or problem behaviors.

Beyond these positive relational influences, assessing strengths (a) yields a more holistic, balanced view of the individual that can help place the evaluation within a context; (b) identifies competencies and resources that can be built on in developing a treatment plan and monitored in evaluating outcomes; and (c) in turn, provides clinicians with further direction in their interventions (Cowger, 1994; Epstein, 1999; Harniss et al., 1999). For example, the Behavioral and Emotional Rating Scale manual (Epstein & Sharma, 1998) details several uses for the scale, including (a) identifying strengths and need areas for intervention, (b) informing goals for individualized treatment plans, (c) documenting progress in a strength area as a consequence of specialized services, and (d) identifying children with limited resources.

Knowledge and understanding of a client's strengths can also help professionals to reframe and redefine problems so that they

can be addressed from a solution-focused perspective (Handron et al., 1998); the focus of interventions can be shifted from seeking to "fix" a problem to enhancing and building on a characteristic or behavior (Harniss et al., 1999). For example, a child's clinician seeking collateral information from a teacher via the Teacher-Child Rating Scale may learn that, by the teacher's account, the youngster shows high levels of positive peer social skills but struggles at times with staying on task until an assignment's completion. The student's scholastic performance and adjustment may benefit from involvement in a cooperative learning/peer-tutoring intervention that capitalizes on his or her strengths in the social arena, channeling them in a positive manner.

The Relevance of Resilience to Practitioners: Assessing and Applying the Construct

In accord with the growing attention to strengths and what "goes right" in development, the construct of *resilience*, effective coping and adaptation in the face of major life stress, has been the focus of burgeoning recent interest (Cowen, Work, & Wyman, 1997; Luthar, 2003; Luthar, Cicchetti, & Becker, 2000; Masten, 2001; Masten & Coatsworth, 1998). Although resilience can be achieved at any point in the life span (e.g., Shiner & Masten, 2002; Werner & Smith, 1992), most work in the area has focused on children. This research has identified factors that relate to resilience and appear to serve a protective function under conditions of stress, reducing risk for adjustment problems and increasing the likelihood of positive health outcomes.

Clinicians and researchers alike agree about the relevance of the construct; however, operational definitions of *resilience* have varied, and many consider resilience to be a personal trait or attribute of an individual, rather than a dynamic developmental process reflecting positive adjustment despite adversity (see Cowen, 2001, and Luthar et al., 2000, for cogent discussions of these concerns). Despite such issues, common findings have emerged from resilience research, suggesting three main clusters of variables that appear to facilitate positive adaptation under conditions of risk: (a) individual attributes or characteristics, including positive temperamental or dispositional qualities; good intellectual functioning; self-efficacy; positive self-worth; perceived competence; sound problem-solving skills; internal locus of control; accurate and realistic attributions of control; and positive future expectations, or a sense of optimism; (b) a warm, nurturant family environment; quality parenting and a structured, stable home; a sound relationship with a primary caregiver; and (c) broader contextual variables such as positive extrafamilial support sources and identification models; links with extended family support networks; effective schools; connections to prosocial organizations; and neighborhood qualities (Luthar et al., 2000; Masten, 2001; Masten & Coatsworth, 1998; Werner & Smith, 1992; Wyman, Sandler, Wolchik, & Nelson, 2000). Connections with competent, caring adults in the family and community, good intellectual functioning, self-regulation skills, and positive self-views and self-system functioning are among the most consistently reported (Luthar et al., 2000; Masten, 2001; Wyman et al., 2000).

Although some researchers have identified symptomatology among participants identified as "resilient" (Luthar, Doernberger, & Zigler, 1993), by many definitions, one's presentation for services in a clinical setting would preclude such classification.

Nevertheless, the literature can provide useful information to providers regarding strategies to inform assessment and guide clinical intervention. As Luthar and Cicchetti (2000) noted, even in circumstances where problems have developed and crystallized, a resilience framework includes an emphasis on strengths and assets that may be harnessed in work for positive change. As such, assessments can address potential resilience-facilitating resources, and intervention goals can include enhancing assets and facilitating protective processes, in addition to ameliorating symptoms (Masten, 2001).

It is important to note that these potential protective influences stem from multiple levels of the client's context, that is, individual, family, and community. Qualities of the individual may surely antecede or correlate with resilience, but resilience may often be associated with factors external to the individual, including aspects of their families (and caregiving environments) and characteristics of their wider contexts (Luthar et al., 2000; Werner & Smith, 1992). Thus, rather than viewing a goal of evaluation as assessing resilience per se, it may be more appropriately framed as seeking to assess factors associated with positive adjustment, competence in core domains, and healthy outcomes under adversity.

Methods of Assessing Resilience

Numerous authors have developed and used checklists, scales, or interviews seeking to assess "resilience" (e.g., Baruth & Carroll, 2002), risk and protective factors in their clients' lives (e.g., Vance, Fernandez, & Biber, 1998), or competence in one or more domains (e.g., Ewart, Jorgensen, Suchday, Chen, & Matthews, 2002). In some cases, professionals may choose to use validated instruments to assess specific potential protective factors that have been found to relate to resilient adaptation and may be particularly salient in the population with which they work. For instance, given the consistent identification of a warm, supportive family milieu as an important factor associated with resilience, measures addressing family functioning could be profitably integrated into the assessment process. One such instrument, the Family Environment Scale (Moos & Moos, 1994), assesses perceptions across Relationship (e.g., subscales include Cohesion, Expressiveness, Conflict), Personal Growth (e.g., Active-Recreational Orientation, Independence, Intellectual-Cultural Orientation), and System Maintenance (e.g., Organization, Control) dimensions. Another, the Family Assessment Device (Epstein, Baldwin, & Bishop, 1983), assesses family functioning across Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behavior Control, and General Functioning scales. The latter scale can provide a global screen of family functioning. The use of such ratings can facilitate discussion about the family and diverse aspects of its functioning, begin the process of change by providing information about family climate, and inform well-targeted interventions to promote family growth by identifying strengths and areas in need of attention within a given family (Moos & Moos, 1994; see Moos & Moos, 1983, for more on the clinical use of the Family Environment Scale). Other measures may be used to assess more specific components of family functioning or parenting, such as parent-child relationships (Wyman et al., 1999) or adaptive approaches to discipline (Slater & Power, 1987).

Scales reflecting individual correlates of resilient functioning—for example, self-efficacy (Cowen et al., 1991), perceived compe-

tence (Harter, 1985), realistic control attributions (Wannon, 1990), coping styles (Carver, Scheier, & Weintraub, 1989), future expectations (Wyman, Cowen, Work, & Kerley, 1993), or optimism (Scheier, Carver, & Bridges, 1994)—may also be employed and used as self-report measures. For instance, Harter's (1985) Self-Perception Profile for Children assesses youngsters' perceived competence across multiple domains: Scholastic Competence, Social Acceptance, Global Self-Worth, Behavioral Conduct, Athletic Competence, and Physical Appearance. Subscales from this measure have been among the most powerful discriminators of children demonstrating stress-resilient versus maladjusted outcomes (Hoyt-Meyers et al., 1995) and can shed light on domains of competence on which interventions can build.

Alternatively, informed by the domains assessed on such measures, clinicians can use questions during intake or evaluation that home in on or reflect potential protective factors, such as self-efficacy or perceived social support. For instance, in attempting to understand a client's sense of efficacy (Cowen et al., 1991), a clinician could ask, "How sure are you that things will work out for you when you have to try something new and challenging?" Follow-ups could include prompts assessing one's belief about meeting task demands when "someone counts on you to do something important," "you have to figure something out by yourself," or "you're faced with a problem in an important relationship." Similarly, family or social support measures (Wills, Vaccaro, & McNamara, 1992; Wyman et al., 1999) could be examined for questions that may be modified and easily integrated into one's assessment framework: for example, "How much can you count on your friends and family when you need them?" "Do you have someone who really 'gets' you and understands how you feel?" "Other than your folks, do you feel as though there are adults and people who care about you and will help you?" Strategies for coping could be assessed in a similar manner: for example, "What do you tend to do when you're faced with a problem or stressful situation? How do you handle it?" "What do you do when you're stressed?" "When you're upset, what do you usually do?" (e.g., Work, Levinson, & Hightower, 1987). More broadly, clinicians can inquire about times when things felt more under control or a client's life was going more smoothly and wonder, "What got you through—what did you do then?" Research may help clinicians choose maximally sensitive items that may yield predictive power similar to that obtained with the sometimes lengthy global measures (Kilmer, Cowen, & Wyman, 2001, 2002).

A Shift in Strategy: Why Assess Resilience?

Professionals may certainly use these methods to assess specific potential resources or protective factors via published measures or more qualitative interviews guided by resilience research findings or the content of relevant measures. However, at its core, the primary action (and principal value) of assessing resilience may be the underlying shift in strategy and of the framework within which one functions clinically. Clinicians will continue to inquire about a finite number of core functional domains—home, school, and friends for children and youth; home, work, and relationships for adults—but they will use a modified agenda. Specifically, in addition to identifying adjustment difficulties to be addressed, they will be attending to multiple resources and potential protective factors that can be targeted to enhance existing competencies,

promote healthy adjustment trajectories, and foster resilient adaptation.

In some cases, this shift in assessment strategy will warrant an expansion of focus. Because child work tends to be more systemic, with the necessary inclusion of the caregivers and relevant collaterals (e.g., teachers, pediatricians) in the assessment process and treatment planning (e.g., caregivers are typically involved in regular consultation or therapy; interventions may include school-based components), this shift in scope may be more pronounced among those working with adults. In adult work, although extra-individual factors (work concerns, relationship issues) are addressed through assessment and treatment, the emphasis tends to be at the individual client level in scope and focus. Utilizing the resilience literature to guide a strategy of assessment and treatment planning that takes into account aspects of the individual's ecological context, one that goes beyond how the individual can change, clinicians can identify factors and systems, both formal and informal, that may be fruitfully incorporated into the intervention.

For instance, informed by an assessment process mindful of resilience findings and sensitive to the specific social and cultural context of those with whom they work, practitioners can seek to ensure that their clients are linked with formal or informal services that relate to factors or systems that appear associated with resilience. For example, they might choose to utilize dyadic, attachment-oriented therapy or other efforts to improve parent-child relationships, enhance the bond between parent and child, and facilitate nurturant caregiving, as the caregiving system appears to be crucial to positive development (Masten & Coatsworth, 1998).

In many cases, assessments may suggest the need to incorporate services beyond those focusing on the individual client or family in the context of formal treatment. Some children may be targeted for participation in structured services or after-school programs outside of formal mental health treatment's traditional realm (e.g., 21st Century Community Learning Center programs) to improve their academic skills and performance. Notably, several service delivery approaches endorse the integration of informal services and supports (VandenBerg & Grealish, 1996), whether to develop talents or address a client's sense of efficacy, improve capacities for self-regulation, or work to increase available social support. For example, clinicians could seek links with informal support sources or mentoring programs such as Big Brothers or Big Sisters (Masten & Coatsworth, 1998). Other natural arenas for positive adult role models and support sources include a child's school (a favored teacher or coach), scouts, and faith- or community-based youth groups. Such assessment and intervention strategies are consistent with the urgings of the recent Surgeon General's report on mental health to develop culturally appropriate services that transcend mental health's traditional "focus on the 'identified client' to embrace the community, cultural, and family context of a client" and become "connected with established, accepted, credible community supports" (U.S. Department of Health and Human Services, 1999, p. 186).

Such efforts are not limited to children. An adult client who enjoys and shows competence in cooking, for instance, may benefit from enhancing this skill in the context of a community-based course or cooking group, as well as the additional structure, social contact, and possible support linkages that would evolve from such

involvements. Adults can also be encouraged to volunteer in arenas that support their competencies, seek out relevant support or interest groups, grow their involvement in their faith communities or religious organizations, or take part in their neighborhood organizations. As a step that empowers and supports, many parents of children struggling with disorder have been linked with advocacy efforts, sometimes becoming advocates themselves (McCammom, Friesen, & Spencer, 2001).

Regardless of population, such services must be coordinated and well integrated. Scholars have cautioned against oversimplified resilience-based intervention approaches, including fragmented services or efforts to target individual competencies or skills with little attention to the client's larger context (Luthar & Cicchetti, 2000). Instead, a multifaceted approach to intervention is advocated; targeting multiple potential risk or protective influences rather than one or two in isolation greatly increases the likelihood of positive adjustment (Luthar & Cicchetti, 2000; Masten & Coatsworth, 1998).

Beyond Resilience: Posttraumatic Growth

An emerging area of study and clinical focus that, like resilience, emphasizes the capacities of people to respond well to adversity is *posttraumatic growth* (PTG). Unlike resilience, however, PTG (Tedeschi & Calhoun, 1996, 2004; Tedeschi et al., 1998) refers to reports of positive changes in individuals that occur as the result of attempts to cope in the aftermath of traumatic life events. People who display resilience have adjusted successfully despite adversity, whereas persons who experience PTG are transformed by their struggles with adversity. It is important to note that the struggle in the *aftermath* of the trauma, not the trauma itself, produces the PTG. The term *posttraumatic growth* appears to capture the essentials of this phenomenon because it emphasizes that transformative positive changes (a) occur most distinctively in the aftermath of trauma rather than during lower level stress, (b) appear to go beyond illusion, (c) are experienced as an outcome rather than a coping mechanism, and (d) require a shattering of basic assumptions about one's life that traumas provide but lower level stress does not.

Research in PTG has typically involved adults, and a significant body of work has identified correlates of PTG and supported Calhoun and Tedeschi's (1998) hypothesized model for the process among adults (Calhoun & Tedeschi, 2001). Although few studies have examined the phenomenon in nonadults, preliminary evidence suggests that this growth process occurs, to some degree, among children and youth (Cryder, Kilmer, Tedeschi, & Calhoun, in press; Horowitz, Loos, & Putnam, 1997; Milam, Ritt-Olson, & Unger, 2004).

It is important to underscore that persons who report PTG may not be able to leave all of their distress behind. Indeed, many indicate that they are still suffering from the aftermath of trauma, although they may recognize that they have experienced some benefit. Continuing distress may be important to produce the cognitive processing of trauma that results in PTG, consolidating the changed perspectives on self, others, and the way of living that is discovered in PTG. Therefore, PTG has a paradoxical nature: It comes from great distress, and it is often maintained through continuing distress. In fact, many persons who report PTG may also report *less* of a sense of well-being than those who evidence

resilience. This is relevant to clinicians who treat survivors of trauma, because individuals who experience significant levels of PTG will not necessarily experience a commensurate decrease in their levels of distress, or an increase in their happiness. However, levels of distress and well-being may change significantly over time in the aftermath of traumatic life events.

The kinds of positive changes individuals experience in their struggle with the aftermath of trauma are reflected in a measure of PTG developed on the basis of interviews with many trauma survivors, the Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996). This instrument includes five domains of PTG: improved relationships, new possibilities for one's life, a greater appreciation for life, a greater sense of personal strength, and spiritual development.

Paradoxically, at the same time trauma survivors report one or more of these domains of growth, they also tend to report an increased sense of vulnerability, congruent with the fact that they have suffered in ways they may not have been able to control or prevent (Janoff-Bulman, 1992). However, a common theme in the experience of persons who have faced major life challenges is an increased sense of their own capacities to survive and prevail (Calhoun & Tedeschi, 1999). Also, a need to talk about the traumatic events sets in motion tests of interpersonal relationships—some people pass, others fail, with sometimes surprising results. Trauma survivors may become most intimate with others who have suffered through similar traumatic circumstances and therefore experience a greater sense of compassion for others who experience life difficulties (Tedeschi & Calhoun, 2004).

Traumas that raise issues of the mortality of the survivor and others may set in motion fundamental existential questions about death and the purpose of life. In response, survivors may report a shift in their value systems and perspectives such that they appreciate and value the "smaller things" in life more, or they may report changes in religious, spiritual, and existential components of philosophies of life. Although the particular beliefs are contingent on the individual's initial belief system and cultural context, trauma survivors may report that after a period of spiritual or existential quest, their philosophies of life are more fully developed, satisfying, and meaningful to them.

Methods of Assessing PTG

As mentioned above, the PTGI (Tedeschi & Calhoun, 1996) is a validated instrument that has been factor analyzed and can be used to assess PTG in five domains. It is a 21-item, Likert scale that has been used with a variety of populations. Some items were selected from the PTGI to produce a 13-item version for more convenient use by clinicians (Calhoun & Tedeschi, 1999). Another instrument is the Stress-Related Growth Scale (Park, Cohen, & Murch, 1996), a 50-item scale that has not produced separate factors of growth (Cohen, Hettler, & Pane, 1998). The scales may also be considered as templates for discussion with trauma survivors, so that the clinician covers the array of changes represented in the inventory during discussions with the client. Because PTG may be a particularly sensitive issue to raise among some survivors (e.g., bereaved parents are often loathe to consider that anything good could come from the death of their child), it is best to use the inventory itself only after some discussion of growth has occurred.

Practitioners can also assess PTG by listening to their clients. In describing ways to facilitate the PTG process, Calhoun and Tedeschi (1999) emphasize that clinicians listen carefully to the language of the trauma survivor and judiciously join the client in this way of communicating. It is crucial that clinicians respect and work within the existential framework that clients have developed or are trying to rebuild in the aftermath of a trauma, even if that framework seems to include "positive illusions" (Taylor & Brown, 1988). Certain benign cognitive distortions may be noted when working with clients dealing with traumatic circumstances, and clinicians may need to have a degree of tolerance and respect for the use of some benign cognitive biases.

Using the PTGI as a guide, clinicians will be able to become more sensitive to the meaningful changes in themselves that trauma survivors mention, even though they may not actually identify such changes as a representation of PTG. Clinicians can take note of these changes by listening to trauma survivors' reports of positive changes produced by the challenges of coping with trauma and can then determine when it will be useful to label these changes for clients. In this type of assessment, clinicians must have good knowledge of the domains and elements of PTG, listen for and attend to clients' accounts of the experience of growth, and remember the kind of language used by clients in describing this experience. Later, clinicians may label the experience in a way that makes the growth experience cognitively salient for their clients, while raising these issues in ways that reflect discoveries that their clients themselves are making.

In assessing PTG a clinician may say, "You may have heard people say that they have found some benefit in their struggle with trauma. Given what has happened to you, do you think that is possible?" Or, a clinician who has heard a specific kind of benefit mentioned by a client may encourage additional elaboration by saying, "You mentioned last time that you noticed that you and your wife have grown closer since this happened. Can you tell me more about this closeness?" A further exploration might be, "What is it about this struggle that has produced this closeness?"

Unlike the assessment of other aspects of a client's presentation, the assessment of PTG is not done at the outset of psychotherapy. Typically, PTG does not enter into the conversations of trauma survivors until a good deal of time has passed, perhaps several months. Upon the first descriptions of positive changes that result from the challenges of coping, the clinician confronts the question of when to begin this assessment. Of course the listening itself is part of the assessment, but the clinician also must decide when the trauma survivor is ready for more focused questioning about these changes, on the basis of statements made about unexpected positive aspects of trauma survival.

The Clinical Importance of a Focus on PTG: Why Assess the Phenomenon?

Assessment of PTG that goes beyond listening is difficult to distinguish from intervention, because the labeling and discussion of the apparent growth can encourage further development of the cognitive processing of trauma into growth (Calhoun & Tedeschi, 1998, 2004). This processing can be a distressing experience at times, and some clinicians may feel tempted to shy away from it. Despite the possibility that such distress may facilitate therapeutic movement, others may view symptom relief as the primary goal

and not see the purpose of the greater depth of cognitive processing that assessment of PTG requires. Assessing trauma survivors for the PTG experience is useful even though it may not necessarily relieve distress and may at times increase it. Distress is somewhat easier to tolerate if one recognizes a meaningful and valuable aspect to the experience; it is more difficult to live with trauma that has no redeeming value. A life narrative that includes the aftermath of trauma as having value, not merely despite the trauma but because of it, has a more emotionally powerful positive quality and may motivate survivors to do something positive and possible with the memories of trauma, rather than tackle the virtually impossible task of trying to forget.

Conclusion: Summary and Implications

The phenomena at the heart of this article—strengths, resilience, and growth—though distinct constructs, share considerable conceptual variance. The incorporation of each into one's clinical framework offers substantial potential benefits, and the inclusion of strategies to assess strengths, factors associated with resilient adaptation, and growth in the aftermath of trauma accords well with many competence-enhancement or skill-building approaches used in critical incident stress management and short-term solution-focused work, as well as narrative, constructivist approaches to psychotherapy (Calhoun & Tedeschi, 2000; Neimeyer, 2004; Pals & McAdams, in press).

The strategies, areas considered, and means of assessment described here are consistent with the operating procedures of many clinicians. Their integration into practice, with the consistent and specific assessment of strengths, resilience, and PTG, and the use of such assessment findings to inform and guide well-targeted plans for treatment, may require a modification or expansion of one's underlying clinical framework. However, in light of the evidence that mental health's traditional medical model orientation or deficit focus is insufficient, attending to and assessing positive factors and pursuing means to facilitate their development or enhancement is a logical step. This article considers strategies for assessing these constructs and presents clinicians with a number of instruments that can be used in whole or in part to determine the degree to which strengths, resilience, and growth are part of the clinical picture. These measures can also serve as the basis for more informal clinical discussion of such aspects of clients' experiences and capabilities, perhaps leading to the identification of assets and resources that may serve as the foundation for clinical intervention or action plans.

It may be more fruitful, in the long term, to work to establish means by which clinicians can build on clients' strengths, harness and promote the development of empirically identified factors associated with resilient adjustment across multiple levels of influence, and facilitate PTG. Such efforts may not only enhance the health and well-being of clients in the context of their current presenting concerns but potentially reduce their need for formal mental health services in the future.

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