Expanding Posttraumatic Growth: An Examination of Male Survivors of Sexual Violence

by

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Abstract

Societal discourses and rigid gender norms, tenaciously reinforced by media representations, prevent men from being recognized as survivors of sexual violence (Gulas, McKeage, & Weinberger, 2010; Heber, 2017). Consequently, research on the ability of male survivors of sexual violence to acquire positive characteristics as a result of their victimization, termed posttraumatic growth (PTG), is limited (Tedeschi & Calhoun, 2004a). This thesis assesses the experience of PTG for male survivors of sexual violence, specifically analyzing the role of gender norms, coping styles, and service access in the production, or lack thereof, of PTG. Through the concepts of gender norms and coping, the experience of PTG for male survivors is contextualized, providing insight into how these forces individually and collectively facilitate or hinder the experience of PTG.

A qualitative comparative analysis is conducted in order to establish a configuration of causal factors that are associated with the presence and absence of PTG for male survivors (N=9). Only one of the five hypotheses this thesis tests are supported; high stability (no interruption) of service access is associated with PTG. This thesis argues that the use of coping styles and service access is intertwined with conflicts between their gender and victimization, where male survivors utilize certain forms of coping or services depending on the degree to which they need to regain feelings of control.

Keywords: posttraumatic growth; male survivors; sexual violence; gender norms; coping; service access

To my dad; thank you for your undying love and support

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Table of Contents

List of Tables

List of Figures

Chapter 1. Introduction

The medicalization of trauma, whereby emotional reactions to and distress associated with life events are considered personal health issues or symptoms of a disorder, emphasizes the negative symptomatology survivors of trauma commonly experience (Conrad, Mackie, & Mehrotra, 2010, p. 1943; Leifer, 2000, p. 6). Research on sexual violence is not immune to this trend; the negative traumatic symptoms that male survivors of sexual violence experience have been well documented (Coxell & King, 2010; Tewksbury, 2007; Walker, Archer, & Davies, 2005a). Common psychological and emotional consequences of sexual violence for male survivors include shame, sexual confusion, fear, depression, anger, and posttraumatic stress disorder (PTSD) (Bullock & Beckson, 2011; Coxell & King, 2010, Lowe & Rogers, 2017). Considerable attention has also been drawn to the compounding of trauma that occurs for male survivors, as many male survivors wait exceptionally long periods of time before seeking help (King & Wollett, 1997; Walker, Archer, & Davies, 2005b).

This thesis, however, moves away from this focus on symptomatology and joins a growing body of research that centres on positive outcomes. The acquisition of positive characteristics as a result of a traumatic experience has been termed posttraumatic growth (PTG) (Tedeschi & Calhoun, 2004a, p. 5). PTG encompasses five domains of growth, namely a greater appreciation of life, recognition of personal strengths, closer interpersonal relationships, increased spirituality, and a realization of new life pathways (Calhoun & Tedeschi, 2006, p. 6; Tedeschi & Calhoun, 1996, p. 457). These five categories of change have been well documented to occur in female and child sexual violence survivors (Cole & Lynn, 2010; Easton, Coohey, Rhodes, & Moorthy, 2013 Frazier, Conlon, & Glaser, 2001; Frazier, Tashiro, Berman, Steger, &

Long, 2004); a point of significance for this thesis is whether these results are subsequently reproducible and generalizable to the male survivor population. Research on female sexual violence survivors has discovered that positive changes can begin as quickly as two-weeks following the traumatic experience, with the most common positive alterations being increased empathy for others in similar situations, better relationships with family members, and a greater appreciation of life (Frazier et al., 2001). This thesis argues that coping techniques, gender norms and service access become particularly relevant when discussing PTG for male survivors of sexual violence.

The process of coping, conscious efforts made by an individual to deal with a stressful or traumatic event, is consistently linked to PTG (Borja, Callahan, & Long, 2006; Cole & Lynn, 2010; Kaye-Tzadok & Davidson-Arad, 2016; Lazarus & Folkman, 1984; Leech & Littlefield, 2011). Coping styles that centre on emotional processing and meaning-making, whereby the individual assigns meaning to the traumatic experience, are more likely to facilitate PTG (Easton et al., 2013, p. 216). Most commonly, active coping, positive reframing, the use of emotional or instrumental support, acceptance coping and religious coping are positively correlated to the experience of PTG (Ahrens, Abeling, & Hinman, 2010; Brooks, Lowe, Graham-Kevan, & Robinson, 2016; Frazier et al., 2004; Kaye-Tzadok & Davidson-Arad, 2016; Leech & Littlefield, 2011). Conversely, some forms of coping, mainly behavioural disengagement and substance abuse, appear to hinder the ability of individuals to experience PTG (Arpawong et al., 2015; Tuncay & Musabak, 2015). Males are, however, more likely than their female counterparts to engage in the forms of coping that are negatively associated with PTG (Higgins, Duxbury, & Lyons, 2010; McSorley, McCaughan, Prue, Parahoo, Bunting, & O'Sullivan, 2013; Samulowitz,

Gremyr, Eriksson, & Hensing, 2018), giving reason to believe that the experience of PTG for male survivors of sexual violence may be different than the current research on female survivors.

Gender norms elicit strict definitions of masculinity and what it means to be a "man" (Whitley, Madson, & Zeigler-Hill, 2018, p. 478). Stereotypical male gender norms include emotional stoicism, toughness, sexual prowess, and dominance (Levant & Richmond, 2007, p. 131). Problematically, these gender norms are not congruent with experiencing sexual victimization; as a result, male survivors may be unlikely to process the traumatic experience in a way that facilitates PTG. For example, common positive correlates with PTG include making meaning of the traumatic experience, using coping that centres on processing emotions, and accessing social support (Frazier et al., 2004). Male survivors who strongly adhere to stereotypical images of manhood may be less inclined to engage in these processes as they are perceived as feminine (Rudman & Fairchild, 2004, p. 171). In fact, research has found that men are more likely to endorse male gender norms as a way to regain feelings of masculinity and control when they perceive threats to their manhood (Vandello & Bosson, 2013). As sexual violence is a gendered experience more in line with femininity, male survivors may be more likely to compensate for their victimization by acting harmoniously with male gender norms, preventing them from engaging in the behaviours positively correlated with PTG. Instead, male survivors may be more prone to using avoidant coping or emotionally or socially withdrawing, processes that have been negatively correlated with the experience of PTG (Nielsen & Knardahl, 2014, p. 148). Therefore, adherence to gender norms may moderate the ability of male survivors to experience PTG.

Lastly, the prolonged delay in service access common of male survivors raises questions regarding the efficacy of service provision in promoting positive growth for these individuals

(Litz, Gray, Bryant, & Adler, 2002). The majority of evaluative research centres on the ability of services to remove the negative consequences the individual is experiencing (Roepke, 2015); service provision has not been adequately assessed in relation to PTG. Even further, most research has narrowly considered the effectiveness of therapeutic intervention, neglecting to scrutinize the ability of other services to produce PTG (e.g., victim services or crisis lines). A substantial issue then, and one of the focuses of this research, is whether service provision promotes positive growth for male survivors of sexual violence.

Thus, the goal of this thesis is to establish the possible configuration of factors associated with PTG, or the lack thereof, for male survivors of sexual violence. More specifically, this thesis assesses the role of coping techniques, gender norms, and service access in the experience of PTG for male survivors of sexual violence. In order to meet the goal of this thesis, five more chapters are presented, as follows.

Chapter 2 will outline the current knowledge surrounding the issues of trauma, male sexual victimization, and service provision. In particular, this chapter argues that the medicalization of trauma has forced research to centre on the negative symptomatology of traumatic experiences. Thus, research is abundant regarding the experience of sexual victimization, including the common negative symptoms for male survivors of sexual violence and the various barriers to help-seeking for males. This research focus has excluded the ability for individuals to experience positive changes as a result of their trauma. This chapter therefore also describes the experience of posttraumatic growth, the various categories of change, and the specific growth development for sexual violence survivors.

Chapter 2 will also provide the conceptual framework of gender norms and coping mechanisms. Hegemonic expectations produce the normative behaviour expected of males, creating gender norms of dominance, emotional stoicism, and assertiveness (Whitley et al., 2018). This chapter will discuss the various facets of gender norms and how they may influence male survivors of sexual violence. These gender norms, however, can negatively impact the ability for male survivors of sexual violence to engage in the emotional processing and meaning-making necessary for effective coping (Krok, 2015). The various coping styles in response to sexual victimization, including how they relate to male survivors and the production of PTG, is provided. Lastly, Chapter 2 closes with the overarching research question, as well as the five hypotheses this thesis tests.

Chapter 3 presents the methodological approach utilized within this thesis. It concentrates on an overview of the participant demographics, the sampling procedure of convenience sampling, the variables of interest and their operationalization, the survey instruments used, and the method of qualitative comparative analysis (QCA). A detailed data analysis plan is presented, including the steps of a QCA and a description of each variable.

Chapter 4 displays the results of the QCA. Analyses are conducted for both the presence and absence of growth with the post-test condition variables. One solution exists for the presence of PTG and three for the absence of PTG. These results are contextualized and discussed specifically and broadly as they relate to the overall literature in Chapter 5. This thesis argues that a desire to regain feelings of control and agency influence the male survivor's use of coping and service access and whether these factors are related to the presence or absence of PTG.

Lastly, Chapter 6 provides a conclusion to this thesis. The main findings are reviewed, followed by the limitations of this thesis and directions for future research. The largest limitation of this thesis is its sample size and the use of convenience sampling, preventing this thesis from making concrete claims of generalizability. As this thesis is exploratory, a number of research avenues exist. First and foremost, configurational research is needed with larger sample sizes in order to distinguish generalizability to the entire male survivor population. Since this thesis was only able to assess gender norms and coping styles, more research is needed to understand the various established correlates of PTG within the male survivor population, as well as analyzing the specific role of service access.

Chapter 2. A Review of the Literature and Conceptual Framework

The medicalization of trauma has forced a unilateral concentration on the negative consequences of traumatic experiences, removing from analysis the potential for positive outcomes and changes. Literature is beginning to recognize the ability of individuals to develop positive characteristics as a result of their traumatic experience, termed posttraumatic growth (PTG) (Joseph & Linley, 2008). Research on PTG and sexual violence has indicated that survivors commonly experience positive changes such as increased empathy and greater recognition of personal strengths (Frazier et al., 2001). Yet, much of the knowledge surrounding PTG and sexual violence excludes the male survivor population from analysis. The complexities of masculinities, such a gender norms and coping techniques give reason to believe that the experience of PTG for male survivors may be different than the current research on female and child survivors. Furthermore, limited research exists on therapy and other services' role in producing and facilitating PTG, again focusing exclusively on the healing of negative symptomatology. This thesis aims to address these substantial gaps.

This chapter encompasses the following sections: (1) the current knowledge surrounding trauma, sexual violence, and common negative consequences; (2) the field of positive psychology and the growing body of research that illustrates positive changes from trauma; (3) the complexities of masculinities as potential moderators of trauma and growth; and (4) how service provision can promote posttraumatic growth.

2.1. Trauma and its Negative Consequences

2.1.1. Conceptualizing Trauma

The experience of trauma is a relatively common occurrence, with a vast majority of individuals experiencing at least one traumatic event throughout their lifetime[1] (May & Wisco, 2016, p. 234; Webber, Kitzinger, Runte, Smith, & Mascari, 2017, p. 249). The word trauma originates from the Greek, plainly meaning physical or psychological wounds or injuries (Berger, 2015, p. 8; Wilson, 2006, p. 1). In its origin, the concept of trauma was predominately applied to survivors of massive disasters who showed identifiable physical injuries (Schott, 2009). It has since become "psychologized" based on the notion that traumatic injuries can occur on the psychological as well as the physical level. Psychological trauma has proved to be a difficult term to conceptualize and define due largely to individual variance in the experience of trauma (Weathers & Keane, 2007, p. 108). As a result, since its original conception, trauma has been outlined in a number of ways. The *Diagnostic Manual of Mental Disorders* (DSM-V) defines trauma very strictly, as:

> direct personal experience of an event that involves actual or threatened death or serious injury, or other threats to one's physical integrity; or witnessing an event that involves death, injury or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (APA, 2013, p. 274).

Others have defined trauma more in relation to psychological processing, where it is the suffering that results from experiencing an extremely painful event that threatens individuals' perceptions and coping strategies (Berger, 2015, p. 9). Psychological trauma has also been

[1]This thesis recognizes that while the experience of trauma is common, it is not a definitive response to stressful or painful events or experiences. Many individuals who undergo the same or similar events will not subsequently experience trauma. As such, this thesis presents a generalized view of trauma and its consequences and recognizes that such trajectories and outcomes may differ for each individual.

conceptualized as particularly stressful situations that disrupt the multi-level psychological functioning of an individual, producing shifts in an individual's beliefs, relationships, and their own self-concept (Matsumoto, 2009, p. 574; Schimmenti, 2017, p. 1). Some researchers state that trauma requires a degree of repression and deferment that impedes the individual from processing the event, subsequently increasing the extent of negative symptomatology (Gerbode, 2006, p. 155).

Types of psychological trauma

There are two common types of psychological suffering that can occur with interpersonal victimization: relational and betrayal trauma. Relational trauma involves a breach of an important relationship that provides the individual with physical or emotional security (Gomez, Lewis, Noll, Smidt, & Birrell, 2016, p. 166). Maltreatment is not required for relational trauma to occur, but can transpire when any pivotal relationship is lost, ruined, or negatively affected (e.g., the death of a child) (Gomez et al., 2016, p. 166). Relational trauma has the potential to generate betrayal trauma, where an individual's trust is violated by key stakeholders in their life (Freyd, 1996, p. 9). Research (Freyd, 1996; Goldsmith, Freyd, & DePrince, 2012) has found that events with high levels of betrayal are more likely to produce trauma and negative consequences than those situations with lower levels of betrayal. Betrayal trauma is likely to occur in cases of child abuse, sexual assault by an acquaintance, or intimate partner violence, as a relationship exists between the perpetrator and the survivor (Goldsmith et al., 2012, p. 548).

This subsection focused on the definitional components of trauma. The next subsection will centre on the medicalization of trauma that has forced the field of traumatology to concentrate on negative symptomatology.

2.1.2. Traumatology and the Medicalization of Trauma

Traumatology is "the investigation and application of knowledge about the immediate and long-term consequences of highly stressful events and the factors that affect those consequences" (Figley & Boscarino, 2012, p. 1114). Traumatology emerged from the physical and medical world of trauma, focused on healing and treating wounds and ailments, such as femoral fractures (Manzini, Manzini, Cesana, & Riva, 2016, p. 430). It has since shifted to include psychological trauma, but still in a medicalized manner (Stein, Kaminer, Zungu-Dirwayi, & Seedat, 2006, p. 2). Through medicalization, the process of taking nonmedical problems and treating them as medical issues or disorders, trauma has developed into a diagnosable construct which heavily relies on medical and psychological treatment (Conrad, 1992, p. 209; Gomez et al., 2016, p. 170). For example, posttraumatic stress disorder (PTSD) is the most consistently cited traumatic disorder, characterized by regular flashbacks of the traumatic event, avoidance and retreating behaviours from stimuli that reminds the individual of the traumatic incident, and alterations of the self (e.g., feelings of guilt) (Warren, 2006, p. 111). In order to treat PTSD, clinicians have exceedingly relied on the use of medical intervention (Conrad, 2005, p. 4); in an analysis of veterans being treated for PTSD, roughly 66% of veterans were treated medically with antidepressants (Abrams, Lund, Bernardy, & Friedman, 2013, p. 145). Another study found that in a community sample of adults, approximately 77% of patients with PTSD, 82% of patients with depression, and 89% of patients with comorbid PTSD and depression obtained a prescription for some form of psychotropic medication (Mellman, Clark, & Peacock, 2003, p. 1619). These results illustrate the pharmacological push that trauma treatment has taken due to the medicalization of trauma and traumatology (Mellman et al., 2003, p. 1619).

The medicalization of trauma has created medical definitions of previously nonmedical problems, subsequently requiring the use of medical experts and diagnostic criteria that did not exist prior (Conrad, 2005, p. 4). Experts are now needed in order to define and treat psychological disorders, providing clinicians and psychiatrists with the agency and authority to label psychological suffering, prescribe pills, as well as to deliver therapeutic interventions (Conrad, 2005, p. 8). Experts within the field follow the DSM-V, which further reduces trauma to a diagnosable construct. Psychological disorders cannot be diagnosed until the clinician follows strict diagnostic criteria based on scientific evidence, such as the DSM-V (Pilgrim, 2002, p. 592). While beneficial in the sense that clinicians cannot loosely label individuals as mentally ill, this requirement inevitably reduces trauma to that of a checklist that is easily explainable, generalizable, and observable. The language and discourse surrounding trauma also reflects medicalization. Before medicalization, trauma was described using non-psychological language; now, however, trauma is discussed using medical jargon (Davis, 2006, p. 52). Hence, the medicalization of trauma is persistent within the field of trauma and traumatology and has constructed the perception of medical experts and drugs to be understood as the panacea for all ailments (Double, 2002, p. 900).

Often this medicalization is criticized, especially due to the stigma that can arise from labelling individuals with disorders, such as PTSD, and the effects of pharmacotherapy (Leifer, 2000, p. 6). The obsession with diagnoses induces a culture of a "pill for every ill," leading to inappropriate prescriptions and human suffering (Leifer, 2000, p. 6; Stein et al., 2006, p. 2). The medicalization of trauma has seen an increase in more minor experiences receiving psychological and medical treatment, raising the number of individuals with minimal symptoms acquiring medical help (Double, 2002, p. 902). In this sense, the medicalization of trauma may

lessen human suffering to that of a practical problem to which the answer is psychotropic medication and/or therapeutic intervention (Double, 2002, p. 902). It is argued that through the process of medicalization, individuals are stripped of simplistic, nonmedical language to describe their experiences and are no longer included within the decision making of their own predicaments (Szasz, 1994). With the over-use of medicalized language, experts, and solutions, the medicalization of nonmedical problems has given individuals a new master status of a "medicalized self," whereby the individual defines themselves in line with their "medical" issues (Murray, 2007, p. 10). The medicalization of trauma has therefore hindered the development of traumatology, as the medical focus has created a unilateral formulation of trauma and people's experience of it (Stein et al., 2006, p. 2).

As a result of medicalization, traumatology has disproportionately concentrated on the negative consequences of trauma that can be treated and removed from the client. Yet, since traumatology as a discipline is interested in the trajectory of changes that occur following a traumatic event, traumatology is also concerned with the inquiry of positive effects and growth that may occur from these highly stressful events. By focusing on the positive symptoms that can emerge from traumatic experiences and engaging in interventions to foster these results, traumatology can shift away from such heavy medicalization.

This subsection focused on the field of traumatology and the medicalization of the experience of trauma. The next subsection will concentrate on sexual violence as a form of trauma, with specific attention to male survivors.

2.1.3. Sexual Violence and Male Survivors

Due to the impact of the feminist movement, sexual violence has been recognized as a serious issue in North America since the 1970s (Davies, 2002, p. 203). Sexual violence is defined inconsistently, and this variance contributes largely to the difference in prevalence rates (stricter definitions have resulted in smaller prevalence rates and vice versa) (Garland & Bennett, 2017, p. 4; Peterson, Voller, Plusny, & Murdoch, 2011, p. 16). "Sexual assault" is predominately used in academia as a synonym of rape; however, sexual assault neglects to encompass a wide range of sexual acts, such as sexual harassment or child sexual abuse (Garland & Bennett, 2017, p. 4). As a result, this thesis opts for the more encompassing term of "sexual violence," referring to "any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object" (World Health Organization [WHO], 2017, para. 4).

The experience of sexual violence is widespread, where roughly one in three females and one in six males have experienced it at some point in their lifetime (WHO, 2017, para. 1; 1in6, 2018, para. 1). Researchers argue, however, that the estimates of sexual violence against males may lack validity; circumstances such as gender norms and acceptability of experiencing sexual violence as a male contribute to lower reporting rates of violence for males than their female counterparts[2] (Hammond, Ioannou, & Fewster, 2016, p. 138). The experience of sexual

[2]This thesis recognizes that female sexual violence is also underreported and that these forces also influence willingness to report for females. Research has, however, illustrated that underreporting is more widespread for male survivors than females.

victimization has been largely equated with the female gender as victimization is seen as a form of weakness, which is more synonymous with femininity (Cima, 2017, p. 4). As a result, men have been deemed immune from sexual victimization, which has subsequently limited academic inquiry. The following subsections present the current knowledge on the experience of sexual violence for male survivors.

Help-seeking behaviours of male survivors

Male survivors of sexual violence struggle with seeking help and reporting their victimization. In an analysis of 115 male survivors of sexual violence, only 17 men had reported to the police and the average wait-time since their victimization before survivors sought help from a counselling organization was 16.4 years (King & Woollett, 1997, p. 581). Moreover, in one study, only 17.6% of male survivors sought professional help following their sexual victimization (Masho & Alvanzo, 2010, p. 239). Many male survivors resort to using crisis hotlines as they perceive a lack of support available to them (Young, Pruett, & Colvin, 2016, p. 8). Male survivors have primarily been found to utilize the crisis lines either to disclose their victimization or for referrals to formal counselling as they are unaware of those services that are available (Young et al., 2016, pp. 8-9). While male survivors are less likely than their female counterparts to receive service recommendations from crisis workers, male survivors are also more likely to decline any resources offered (Young et al., 2016, p. 10).

Barriers to help-seeking for male survivors

Barriers to reporting for male survivors of sexual violence fall under three main areas: the influence of rape myths, victim blaming, and the psychological consequences of shame and identity conflicts (Javaid, 2015, p. 84). Rape myths are false views and prejudicial beliefs about

the perpetrators and the survivors of sexual violence (Hammond et al., 2016, p. 136). The most consistently cited rape myths against male survivors of sexual violence are:

> (a) men cannot be raped; (b) "real men" can defend themselves against rape; (c) only gay men are victims and/or perpetrators of rape; (d) men are not affected by rape (or not as much as women); (e) a woman cannot sexually assault a man; (f) male rape only happens in prisons; (g) sexual assault by someone of the same sex causes homosexuality; (h) homosexual and bisexual individuals deserve to be sexually assaulted because they are immoral and deviant; and (j) if a victim physically responds to an assault he must have wanted it (Turchik & Edwards, 2012, pp. 211-212).

These rape myths often permeate into the way male survivors process their victimization and into service providers, criminal justice personnel, and friends or family members' beliefs surrounding the legitimacy of the male survivors' claims (Coxell & King, 2010, pp. 381-383). Male survivors may internalize these rape myths, believing that they are unable to be sexually violated, re-working the violence as a consensual act, blaming themselves for the violence, or deeming their experience undeserving of reporting (Fisher & Pina, 2013, p. 57; Hammond et al., 2016, p. 138). Because of these rape myths and the gendering of sexual violence, male survivors may subsequently feel shame and conflicts with their masculinity if they adhere to the beliefs that sexual violence only happens against females and that males should be able to defend themselves against their potential sexual victimization (Tewksbury, 2007, p. 19). As a result, male survivors in these circumstances may not feel worthy of reporting to the police or accessing services (Hammond et al., 2016, p. 138).

When members of the public legitimize and reproduce these rape myths, male survivors are at an increased risk of negative reactions as a response to their sexual victimization disclosure. Male survivors have the potential to be repudiated as survivors by family, police, and service providers (Donne et al., 2017; Donnelly & Kenyon, 1996; Javaid, 2015; Kassing &

Prieto, 2003; Rich & Seffrin, 2013); to be blamed for their victimization (Davies, Pollard, & Archer, 2006; Davies & Rogers, 2006); and subsequently experience re-victimization as a result of these negative responses (Jackson, Valentine, Woodward, & Pantalone, 2017). For example, one analysis of counsellors discovered that counsellors-in-training were not immune to rape myths, but that many counsellors endorsed harmful rape myths that led to blaming their male clients for the sexual violence (Kassing & Prieto, 2003, p. 459). These negative reactions severely discourage male survivors from disclosing the violence, seeking help, and/or reporting to the police.

As a result, the adherence to rape myths subsequently can lead to victim blaming, a severe barrier to male survivors reporting and seeking help. As males are perceived to be physically dominant and capable of defending themselves against unwanted advances, male survivors are often blamed behaviourally for their victimization, where individuals blame their actions, or lack thereof, as the cause for the sexual violence (Davies & Rogers, 2006, p. 369). The sexual orientation of the survivor and sex of the perpetrator have also been shown to influence the degree of victim blaming; homosexual male survivors assaulted by males and heterosexual male survivors assaulted by females are subsequently attributed more blame for their victimization as they are perceived to have consented to the sexual encounter (Davies et al., 2006, pp. 276-277). In cases where the perpetrator is female, male survivors are blamed more for their victimization as all men should be able to overcome sexually passive and weak females, as characterized by gender norms and roles (Fisher & Pina, 2013, p. 57). As such, many male survivors resist reporting and help-seeking for fear of the potential blame they may receive from interpersonal connections, criminal justice personnel, and/or service providers.

Not only do the potential reactions of others impede male survivors' ability to report and seek help, but so too do psychological consequences that arise from their sexual victimization. Many male survivors experience shame and conflicts with masculinity and sexual identity following their sexual victimization (to be discussed in the next section); this may impede their ability to come forward with allegations of sexual violence. As mentioned previously, males are expected to be capable of defending themselves, and their perceived inability to wean off the attack can lead to shame and conflicts of masculinity (Walker et al., 2005a, p. 77). Moreover, a common rape myth associated with male sexual victimization is that an erection and/or ejaculation proves consent (Turchik & Edwards, 2012, p. 212). While a normal physiological response irrespective of consent, if a male survivor physically responds to the violence, the survivor may believe they agreed to the sexual encounter (Javaid, 2015, p. 84). In cases where the perpetrator is not of the sex the survivor is sexually attracted to, this can cause serious conflicts to their sexual identity, and in some instances, shame (for example, if they have negative views of homosexuals and were assaulted by a man) (Javaid, 2015, p. 84). Thus, these feelings of shame and identity confusion may seriously obstruct a male survivor's willingness to report and seek help, as their victimization may be seen as dubious or blameworthy.

This subsection centred on the general knowledge surrounding sexual violence victimization and male survivors. The next subsection will focus on the specific negative consequences commonly experienced by male sexual violence survivors.

2.1.4. Negative Consequences of Sexual Violence for Male Survivors

Sexual violence is a crime that frequently produces trauma among its survivors (Peterson et al., 2011, p. 19). It is important to note that the degree of psychological trauma for male

survivors has been found to be correlated to the sex of the perpetrator (Peterson et al., 2011, p. 20). An analysis by Struckman-Johnson and Struckman-Johnson (1994) discovered that male survivors experience less psychological distress when sexually assaulted by female perpetrators as opposed to male assailants (p. 111). These results introduce the importance of sex role socialization and gender norms into the intricacies of male sexual victimization and the subsequent trauma survivors experience. Given the societal expectation and gender norm that males are constantly searching for sexual opportunities, heterosexual males are assumed to have consented to this sexual encounter with the prospective female (Javaid, 2016, p. 288). It is easier for a heterosexual male survivor to re-frame the sexual violence as consensual when it is perpetrated by a female, as this is congruent with current gender norms and his own sexuality (Javaid, 2016, p. 288; Struckman-Johnson & Struckman-Johnson, 1994, p. 113). Thus, in cases of female perpetrated violence, heterosexual male survivors may experience less psychological trauma because they can avoid labelling the event as sexual violence (Struckman-Johnson & Struckman-Johnson, 1994, p. 113).

This section divides the psychological and emotional consequences of sexual violence into six subsections[3]: fear; psychological disorders (e.g., PTSD); identity confusion in relation to sexual orientation and gender; condemnation of the self (e.g., self-blame or shame); anger; and interpersonal consequences[4].

[3]This list is in no way exhaustive, but instead encompasses the most commonly reported consequences.

[4]The following list does not preclude female sexual assault survivors from experiencing the same consequences, but this discussion only focuses on the male experience of these symptoms.

Fear

There are three main types of fear that male survivors may experience during and following the sexual violence: fear for one's life, fear of being alone with men, and fear of disclosure (Davies, Walker, Archer, & Pollard, 2010, p. 29; Struckman-Johnson & Struckman-Johnson, 1994, p. 110). One study found that approximately 74% of male survivors who were victims of stranger rape and 58% who were victims of acquaintance rape reported fearing for their life at the time of the assault (Davies et al., 2010, p. 29). Further, it is common for male survivors to fear injury during the assault, if the survivor attempted to prevent the attack (Struckman-Johnson & Struckman-Johnson, 1994, p. 112). This presents a quandary, where a male survivor may fear injury upon resisting but may also experience self-blame, guilt and victim blaming if he failed to counterattack in order to stop the assault (Anderson & Lyons, 2005, p. 1400; Davies et al., 2006, p. 276; Struckman-Johnson & Struckman-Johnson, 1994, p. 112). An overwhelming majority of male survivors of stranger rape (roughly 95%) and over two-thirds of survivors of acquaintance rape (68%) experience fear of being alone with men following the assault (Davies et al., 2010, p. 29; Struckman-Johnson & Struckman-Johnson, 1994, p. 107). Many men also experience fear of disclosing the sexual violence to family and friends, as well as to professionals (Davies, 2002, p. 206; Lowe & Rogers, 2017, p. 40). This fear can stem from a variety of issues, such as fear of being disbelieved or fear of being deemed homosexual if heterosexual and assaulted by a man (Davies, 2002, p. 208; Lowe & Rogers, 2017, p. 41).

Psychological disorders

Sexual violence survivors are at an elevated risk of developing psychological disorders, such as depression, anxiety, and PTSD[5] (Choudhary, Smith, & Bossarte, 2012, p. 31). The co-occurrence (comorbidity) of depression and anxiety have been found to be higher among sexual violence survivors than the general population (Choudhary et al., 2012, p. 33; Nickerson et al., 2013, p. 444). PTSD is also more common among sexual violence survivors versus the general population, where "following rape, about 35% to 50% of victims come to suffer from PTSD within the first 3 months, and for many victims the disorder will become chronic causing significant distress for years after the assault" (Elklit, Due, & Christiansen, 2009, p. 38). Further, PTSD is also frequently comorbid with other disorders, including anxiety and depression (Elklit et al., 2009, p. 39; Nickerson et al., 2013, p. 444).

Interestingly, distortions regarding sex and beliefs about power may increase the likeliness of developing PTSD for male survivors (Snipes, Calton, Green, Perrin, & Benotsch, 2017, p. 2456). Believing that consensual sex involves control and power was a significant moderator for the development of PTSD for some male survivors in Snipes and colleagues' (2017) study (p. 2464). The more men equate sexual interactions as a power dynamic or a way to obtain power, the more likely being sexually victimized will threaten their power beliefs (Snipes et al., 2017, p. 2464). When their power beliefs were threatened, a negative shift in their

[5]PTSD occurs when a traumatic event transpires, causing the individual to have feelings of "intense fear, helplessness, or horror. The symptoms must include persistent re-experiencing of the assault, persistent avoidance of reminders of the rape, numbing of general responsiveness, and persistent symptoms of increased arousal" (Daane, 2017, p. 98). In order to be diagnosed with PTSD, these symptoms must cause significant damage to the individual's life (i.e., social and occupational repercussions) and must occur for longer than one month (Warren, 2006, p. 110).

worldview occurred which subsequently increased the risk of developing PTSD (Snipes et al., 2017, p. 2464).

Identity confusion

Approximately 70% of Walker and colleagues' (2005a) adult male participants divulged severe and long-term confusion with their sexuality and masculinity (p. 76). This confusion is most often exhibited by males who are sexually victimized by other males (Coxell & King, 2010, p. 385). Heterosexual male survivors may begin to question their heterosexuality, as well as exhibit some form of externalized homophobia, expressing homophobic remarks and views towards gay men or other male survivors (Davies et al., 2010, p. 26). Homosexual male survivors may exhibit internalized homophobia, hating themselves and their sexual orientation, and even questioning the truthfulness of their homosexuality (Davies, 2002, p. 208; Davies et al., 2010, p. 26). This confusion may be furthered in cases where the male is aroused or ejaculates, as many believe that these functions cannot happen involuntarily or without consent (Bullock & Beckson, 2011, p. 203; Groth & Burgess, 1980, p. 809). Physically responding to the sexual violence causes many male survivors to question their sexuality if perpetrated by the sex they are not attracted to, which can cause serious problems and conflicts with their self-identity (Tewksbury, 2007, p. 30). Further, many male sexual violence survivors struggle with feelings of masculinity, grappling with the misbelief that males should be strong enough to prevent the attack (Walker et al., 2005a, p. 76).

Condemnation of the self

A common emotional consequence for male survivors of sexual violence is self-blame and feelings of guilt. Related to a confusion of masculinity, 80% of male survivors in Walker and colleagues' (2005a) study blamed themselves for their victimization, as they believed they

should have been able to prevent and/or end the sexual violence (p. 77). Guilt is also common when the male survivor feels they opened themselves to victimization, blaming their individual actions as a cause for the sexual violence, such as being in the wrong location or not fighting back (Walker et al., 2005a, p. 77). Feelings of shame and embarrassment are similarly typical responses for male survivors, following the same reasons as above (Tewksbury, 2007, p. 19). Tewksbury (2007) hypothesizes that feelings of shame and embarrassment can promote self-harm, as it is shame that fosters self-blame, which can subsequently lead to self-harm (p. 29).

Anger

Many male survivors experience deep feelings of anger and fantasizing about retaliation (Groth & Burgess, 1980; Kassing & Prieto, 2003; Peterson et al., 2011). In one analysis, adult male survivors of sexual violence reported double the level of anger and irritability than their male counterparts who did not experience sexual violence (Elliot, Mok, & Briere, 2004, p. 207). The manifestation of anger and hostility may be directed at any stimulus within the survivors' environment, including friends, family, support services, or the perpetrator (Tewksbury, 2007, p. 30).

Interpersonal consequences

The trauma endured by male survivors can also have interpersonal consequences. Eighty-five percent of Walker and colleagues' (2005a) sample experienced emotional distancing from other individuals, and roughly 73% exhibited withdrawal from their family and friends (p. 75). The various negative symptoms that male survivors experience can permeate into interpersonal relationships, destructively impacting the survivors' ability to relate, socialize, empathize, and trust (Tambling, 2012, p. 393).

This section focused on the ways in which trauma is being conceptualized and how the medicalization of trauma has forced research attention on negative trauma symptomatology. This section also provided an overview of the male experience of sexual violence, including the common psychosocial repercussions. The next section will discuss the movement of positive psychology as it allows for an assessment of the positive changes and growth that may arise from experiencing a traumatic event.

2.2. Positive Psychology and Posttraumatic Growth

2.2.1. Positive Psychology

Psychology, like traumatology, has predominately concentrated on the medicalization of the mind and human problems, classifying and healing psychological conditions as they arise in the DSM-V (Joseph & Linley, 2008, p. 4). Because of this medicalization, clinical psychology has framed discussions of trauma and traumatic events to disproportionately emphasize the negative consequences (Seligman & Csikszentmihalyi, 2000, p. 7). This focus on pathology led psychologists to conceptualize clients as submissive beings who simply react to their environment (Hefferon & Boniwell, 2011, p. 5; Seligman & Csikszentmihalyi, 2000, p. 8). This conceptualization, therefore, focuses on the attributes and situations that make individuals fail, neglecting to ask what makes individuals succeed (Hefferon & Boniwell, 2011, p. 5). Martin E.P. Seligman introduced positive psychology as a method to counteract the medical model of psychology and shift the attention from "weak and deficient" to "strong and healthy," attempting to make individuals' lives more rewarding and beneficial (Compton, 2005; Joseph & Linley, 2008, p. 5; Moneta, 2014). Positive psychology studies the various positive emotions and traits that can emerge and be facilitated through suffering (Seligman, Steen, Park, & Peterson, 2005, p.

410). Positive psychology incorporates ideas from a range of influencers, such as Aristotle's concept of morality and how to live a good life, Bentham and Mill's utilitarian view of happiness, James' understanding of emotions, and humanistic psychology's focus on positive attributes (Compton, 2005; Hefferon & Boniwell, 2011).

Well-being and the role of emotions

The focus of individual "bettering" has led positive psychology to concentrate on two forms of well-being: hedonic and eudaimonic (Moneta, 2014, p. 2). Hedonic well-being derives from hedonism, where pleasure in one's life is the main focus (Compton, 2005, p. 11). Hedonic well-being incorporates the hedonistic element of pleasure-seeking in relation to social interactions, centring on happiness and other positive emotions about the individual's life (Compton, 2005, p. 11; Moneta, 2014, p. 2). Eudaimonic well-being, conversely, is concerned with an individual's potential by maintaining and balancing optimal functioning through resiliency and environmental mastery (Compton, 2005, p. 12; Moneta, 2014, p. 2). It is important to note that these two forms of well-being may not co-occur in each individual and the type of well-being that is fostered is largely dependent on the individual and the psychologist (Moneta, 2014, p. 2).

In order to promote well-being, positive emotions are the cornerstone of positive psychology (Hefferon & Boniwell, 2011, p. 24). The broaden-and-build theory is particularly important in explaining the beneficial role that experiencing positive emotions can have for individuals (Fredrickson, 2001, p. 219; Fredrickson, 2005, pp. 122-123; Higgs, 2010, p. 75). The experience of positive emotions has been shown to broaden the individual's "momentary thought-action repertoires" and build personal resources, such as social abilities or better cognitive capabilities (Fredrickson, 2001, p. 219). Negative emotions, conversely, limit the

momentary thought-action repertoire, and as such, positive emotions can be used as a way to counteract the effects of experiencing negative emotions, a phenomenon termed the undoing hypothesis (Fredrickson, 2001, p. 221). If an individual faces a stressful event or negative emotions, subsequently experiencing positive affect can make the body return to normal physiological functioning much faster than other forms of emotion; however, there has been some debate among positive psychologists in terms of which emotions are key to well-being (Fredrickson, 2005, p 128; Hefferon & Boniwell, 2011, p. 25; Watson, 2005, p. 107). Some theorists operationalize ten key emotions: gratitude, interest, pride, hope, love, amusement, serenity, joy, inspiration, and awe (Hefferon & Boniwell, 2011, p. 26; Watson, 2005, p. 107). Others categorize based on primary and secondary emotions, recognizing that positive emotions such as joy and acceptance are primary and can subsequently produce secondary emotions, such as love and optimism (Moneta, 2014, p. 21).

Given that positive psychology recognizes the room for positive consequences following suffering, the next subsection will concentrate the positive change of posttraumatic growth.

2.2.2. Posttraumatic Growth

Albeit in a limited fashion, researchers (Borja et al., 2006; Cadell, Regehr, & Hemsworth, 2003; Cole & Lynn, 2010) are beginning to address and analyze the positive consequences that can occur following a traumatic event, including sexual violence. Posttraumatic growth (PTG) is the development of valuable changes, such as a greater appreciation of life or increased empathy that occur following the experience of a traumatic event (Cole & Lynn, 2010; Easton et al., 2013). PTG occurs when the individual surpasses their pre-trauma state and acquires more positive characteristics than they previously had; however, PTG is not guaranteed, nor does it

"occur as a direct result of trauma. It is the individual's struggle with the new reality in the aftermath of trauma that is crucial in determining the extent to which [PTG] occurs" (Tedeschi & Calhoun, 2004a, p. 5). The experience of trauma severely alters a survivors' worldview and identity, including beliefs about personal safety and control (Tedeschi & Calhoun, 2004a, p. 5). Thus, a key aspect of PTG is whether the individual is able to positively modify their schema, where incorporating the trauma into their schema in a healthy manner increases the likeliness the individual will experience PTG (Joseph & Linley, 2008, pp. 10-11; Tedeschi & Calhoun, 2004a, p. 5).

Recognizing three broad categories of positive changes that occur post-trauma (changes in self-perception, interpersonal relationships, and philosophy of life), Tedeschi and Calhoun (1996) developed five domains of growth: a greater appreciation of life, closer intimate relationships, recognition of new possibilities for one's life, greater personal strength, and spiritual change. A greater appreciation of life is a common subsequent change in individuals following a traumatic event, including sexual violence (Calhoun & Tedeschi, 2006, p. 6). This is demonstrated by an increased sense of happiness and gratitude for what one has in life, increased thankfulness for their own existence, no longer taking life "for granted," and a change in individual priorities in life and life practices (Berger, 2015, p. 83; Calhoun & Tedeschi, 1999, p. 14; Calhoun & Tedeschi, 2006, p. 6; Tedeschi & Calhoun, 1996, p. 457). Closer intimate relationships have been consistently cited as a positive change for sexual violence survivors (Frazier & Berman, 2008; Frazier et al., 2001). Changes under this domain can occur in how the survivor relates to others, introducing a stronger sense of intimacy, understanding, meaning, empathy, and compassion (Calhoun & Tedeschi, 2006, p. 5; Tedeschi & Calhoun, 2004a, p. 6).

In some individuals, the traumatic event allows them to recognize new possibilities for their life, for example, a different career path or new activities (Calhoun & Tedeschi, 2006, p. 5). Greater personal strength has been documented to occur following a traumatic event because it corrects the unrealistic individual view of invulnerability, namely that unfortunate events will not happen to oneself (Calhoun & Tedeschi, 1999, p. 13). As a result, this increase in vulnerability can subsequently produce an increase in perceived strengths, whereby enduring such a traumatic event demonstrates to the survivor that they are strong and capable of overcoming horrible experiences (Calhoun & Tedeschi, 2006, p. 5). Lastly, changes in spirituality are more common after some time has passed since the traumatic incident occurred, as individuals may initially question their faith; however, some individuals do report stronger feelings of spirituality and have more involvement in their respective faith as a result of their traumatic experience (Calhoun & Tedeschi, 1999, p. 15). This domain is not entirely limited to religion, as individuals have been documented to engage more frequently in existential questioning, and Tedeschi and Calhoun (2006) indicate this as an aspect of spiritual growth (p. 6).

It is important to note, however, the identified flaws of PTG as an outcome. The individual's pre-trauma state is rather inaccessible, limiting the ability of researchers and evaluators to know whether the individual surpassed this pre-trauma state (Frazier, Tennen, Gavian, Park, Tomich, & Tashiro, 2009, p. 912). Further, PTG and the evaluation of PTG, relies almost exclusively on self-reports of growth, raising the question of whether PTG is merely perceived growth, not actual growth (Nolen-Hoeksema & Davies, 2004, pp. 60-61). Yet, the experience of PTG, be it perceived or actual, is beneficial to the individual's well-being (Cahoun & Tedeschi, 2006, p. 15). More specifically, so long as the individual perceives positive growth,

then the individual will subsequently accumulate the benefits associated with that growth (Calhoun & Tedeschi, 2006, p. 15).

This subsection centred on the general understanding of PTG. The next subsection will outline the specific research on PTG for sexual violence survivors.

2.2.3. Posttraumatic Growth for Sexual Violence Survivors

It is important to note that the experience of positive changes and PTG is not dependent upon negative consequence but rather can occur independently and simultaneously with negative trauma symptoms (Cole & Lynn, 2010, p. 121; Frazier & Berman, 2008, p. 164). A significant relationship between positive and negative changes has been found to exist (Frazier et al., 2001; Linley, Joseph, & Goodfellow, 2008). In general, individuals who experience more positive changes subsequently report fewer negative consequences and symptoms (Frazier et al., 2001, p. 1052). More specifically, positive changes of the self and spirituality are likely to lead to a decrease in reported depression and PTSD symptoms for female survivors of sexual violence (Frazier et al., 2001, p. 1052). Similar results were also found in Linley et al.'s (2008) study, where individuals who reported more positive changes were less likely to experience PTSD, anxiety, and depression symptoms six-months following their initial data collection (p. 884). This subsection will present the personal and interpersonal positive changes that research has found to occur following sexual violence.

Changes within the self

Not uncommonly, survivors report a greater appreciation for life following their sexual violence (Frazier et al., 2001, p. 1051; Frazier, Conlon, Steger, Tashiro, & Glaser, 2006, p. 12). A greater appreciation of life was found to occur in two-thirds of child sexual assault survivors

(both male and female) in Woodward and Joseph's (2003) study, including "living in the present" and new life perspectives (p. 279). Escaping a potentially life-threatening event not only produces a greater appreciation for life and what one has but also enables the survivor to better identify personal strengths (Frazier et al., 2001, p. 1051; Frazier et al., 2006, p. 12). Surviving the traumatic experience shows the individual that they have strengths and are capable of facing adversity (Frazier et al., 2006, p. 12). Both a greater appreciation of life and recognition of personal strengths have been found to be particularly important in reducing distress for survivors (Frazier et al., 2001, p. 1054). More specifically, individuals who are better able to identify personal strengths and have a greater appreciation of life subsequently have less distress than those individuals who are not able to engage in the same behaviour (Frazier et al., 2001, p. 1054). Spiritual well-being is another common positive change many survivors experience, where several survivors experience a new sense of purpose and meaning following the sexual violence (Frazier et al., 2001, p. 20154; Frazier et al., 2006, p. 12). In some cases, individuals may develop a closer relationship with God or spiritual beings (Frazier et al., 2001, p. 1054). An increase in assertiveness and feelings of personal control have also been found to occur for sexual violence survivors (Frazier et al., 2006, p. 12).

Interpersonal changes

One of the most common changes sexual violence survivors experience is increased empathy (Frazier et al., 2001; Frazier et al., 2006). In fact, 80% of Frazier and colleagues' (2001) female participants reported experiencing an increase in empathy and empathetic expressions towards other individuals in similar situations (p. 1051). In some cases, this increase in empathy subsequently boosted survivors' willingness and interest in aiding other sexual violence survivors (Frazier & Berman, 2008, p. 167). Another common positive change is the

development of stronger interpersonal relationships, especially with family members (Frazier et al., 2001, p. 1051; Frazier et al., 2006, p. 12; Woodward & Joseph, 2003, p. 278). Because of the traumatic event, some survivors may have an increased appreciation for those in their life, causing them to express gratitude more frequently and mend issues within the relationship (Cadell et al., 2003, p. 281). Moreover, for many survivors, the experience of sexual violence reaffirms trust in close family and friends (Woodward & Joseph, 2003, p. 279).

The timeline and stability of changes

Positive changes and PTG can begin relatively quickly following the assault (Frazier et al., 2001, p. 1051). Increased empathy and stronger interpersonal relationships occurred most frequently only two-weeks following the sexual violence and remained stable throughout Frazier et al.'s (2001) one-year study (p. 1051). This finding indicates that positive changes do not require a long recovery process, but instead can be facilitated shortly after the assault transpired (Frazier et al., 2001, p. 1053). At the two-week mark, changes in the self and spirituality were less common, beginning instead to be most frequently reported following the two-month period and similarly remained stable at one-year (Frazier et al., 2001, p. 1051). Yet, even though their participants were receiving therapy, Frazier and colleagues (2001) contended that these changes happened independently of the number of counselling sessions attended (p. 1050). They do not address, however, whether these changes occurred (and remained stable) because of the therapy, introducing the need for research in this domain.

This section focused on positive psychology and the ability for individuals to experience PTG following a traumatic event. Specifically, this section presented the limited research on PTG for sexual violence survivors. The next section will discuss the knowledge surrounding

masculinities and the ability of gender norms and coping techniques to act as moderators of trauma and PTG.

2.3. The Complexities of Masculinities as Potential Moderators of Posttraumatic Growth

2.3.1. Masculinities

Masculinity refers to the "practices, behaviours, attitudes, sexualities, emotions, positions, bodies, organizations, institutions, and all manner of expectations culturally associated with (though not limited to) people understood to be male" (Pascoe & Bridges, 2016, p. 4). Important to all masculinities is the relationship between males and females, as masculinities cannot exist without femininities (Connell & Messerschmidt, 2005, p. 848). Masculinities research is a fluid and intersectional endeavour, with a variety of new conceptualizations, reformulations, and forms of masculinities arising. Raewyn Connell (1995; 2005) has argued for this pluralized approach to masculinities, as one singular form of masculinity is unable, and insufficient in attempting, to describe all men; four major categories of masculinities have since been developed and will be discussed below: hegemonic masculinity, subordinated masculinity, complicit masculinity, and marginalized masculinity (p. 76).

Hegemonic masculinity

Hegemonic masculinity was originally conceptualized by Connell (1995/2005) as the type of masculinity that normalizes, legitimizes, and situates males on the top of the gender hierarchical structure (p. 77). Of importance to Connell's (1995/2005) hegemonic masculinity is a relational concept, where hegemonic masculinity is only significant as it relates to femininity and nonhegemonic masculinities (p. 77). This first form of hegemonic masculinity attracted a

number of criticisms, including confusion over the concept of masculinity in general and who embodied hegemonic masculinity, whether hegemonic masculinity is simply the reification of power, and original conceptions of the masculine subject (Messerschmidt, 2016, p. 11). Connell and Messerschmidt (2005) reformulated hegemonic masculinity following these criticisms, recognizing that not all masculinities represent the desire for total dominance of males over females and establishing the need for a holistic approach to the gender hierarchy that recognizes both the subordinated and dominated groups. Importantly, Connell and Messerschmidt (2005) emphasized the locational qualities of hegemonic masculinities, where this form of domination exists and interacts at local, regional, and global levels (p. 849). The local level refers to male supremacy over females that occurs in face-to-face contexts, specifically recognizing the dynamic hierarchal role of hegemony as associated with intersections of class, ethnicity, and age (Connell & Messerschmidt, 2005, p. 849). The regional level emphasizes how constructs of appropriate gender roles are established and maintained that support and perpetuate hegemonic authority within a specific culture, and the global level furthers this on a widespread scale (Connell & Messerschmidt, 2005, p. 849).

Since these reformulations, Messerschmidt (2016) has developed important considerations for the concept of hegemonic masculinity. Messerschmidt (2016) proclaims that missing from the analysis of masculinities are two forms of nonhegemonic masculinities: dominant and dominating masculinities (p. 33). In order to truly understand hegemonic masculinity and its influence, he suggests that it is first necessary to grapple with the role of dominant, dominating, and other nonhegemonic masculinities, especially since hegemonic masculinities may also be dominant and/or dominating (Messerschmidt, 2016, pp. 33-34). It is important to note, however, that dominant or dominating masculinities cannot be hegemonic if

they do not socially reinforce the patriarchy (Messerschmidt, 2016, p. 32). Messerschmidt (2016) states:

> "dominant" masculinities refer to the most powerful or the most widespread types in the sense of being the most celebrated, common, or current forms of masculinity in a specific social setting; "dominating" masculinities involve commanding and controlling specific interactions and exercising power and control over people and events – "calling the shots" and "running the show." Neither dominant nor dominating masculinities necessarily legitimate hierarchical gender relations between men and women, between masculinity and femininity, and among masculinities (p. 32).

Subordinated masculinity

Subordinated masculinity is represented as having minute power and influence; Connell (1995/2005) uses homosexual males as a key example, where oppression situates homosexual males on the bottom of the male gender hierarchy (p. 78). Discourse has been well established and constructed in order to exclude certain individuals from achieving masculine status (e.g., "wuss" or "sissy") and these individuals represent a subordinated masculinity (Pascoe & Bridges, 2016, p. 19).

Complicit masculinity

This form of masculinity refers to masculinities which benefit from hegemonic masculinities and the subordination of females but are not directly contributing to this subordination (Pascoe & Bridges, 2016, p. 19). Complicit masculinity recognizes that the number of males who project hegemonic masculinity is actually quite few in number; however, the masses of males gain value from the existence of hegemony, thus representing complicit masculinity (Connell, 1995/2005, p. 79). Thus, this form of masculinity recognizes the patriarchal structures that give their gender power yet are unwilling to attack and remove these hierarchal systems (Connell, 1995/2005, p. 79).

Marginalized masculinity

The previously discussed masculinities (hegemonic, subordinated and complicit) refer to masculinities internal to gender, whereas marginalized masculinity represents masculinity in relation to other structures, such as ethnicity or class (Connell, 1995/2005, p. 80). The intersection between ethnicity and masculinities becomes important in white constructions of masculinity; for example, Connell (1995/2005) distinguishes between the black sports star seen as the golden image of masculinity versus the black rapist who is used for political campaigns (p. 80). While white males are afforded the same positive representations as black sports stars, they rarely are attributed the same negative characteristics as the black rapist. Thus, the relationship between marginalization and the allowance of the dominant hegemonic masculinity becomes important (Connell, 1995/2005, pp. 80-81). It is this relationship that allows black sports stars, for example, to be offered status and strong masculine reputations, but prevents all black males from being labelled in the same manner (Connell, 1995/2005, p. 81).

This subsection centred on the current knowledge surrounding the different forms and types of masculinities. Drawing on this literature, the next subsection will focus on gender norms that have arisen from role theory and how these norms may work to impede PTG for male survivors of sexual violence.

2.3.2. Role Theory and Gender Norms

Role theory examines the influence of a multitude of different roles, such as gender, on individual processing and behaviour (Callero, 1994; Hilbert, 1981). Role theory recognizes that each individual has a number of roles and that each role establishes guidelines for how individuals should behave (van der Horst, 2016). Originally, role theory was conceptualized

within structuralism or interactionism (van der Horst, 2016). Structuralist conceptualizations (for example, Linton, 1936) focus on the context surrounding the individual, acknowledging roles as an influencer of behaviour, whereas interactionalist conceptualizations (for example, Goffman, 1959) argue that roles are instead adapted and utilized through interpersonal interactions. Yet, more recently, the two perspectives have been combined, identifying the role of both societal and individual influence on behaviour (Callero, 1994; Hilbert, 1981; Stryker, 2002). In this perspective, roles are seen more as cultural objects, where

> roles are real insofar as they are recognized, accepted, and used to accomplish pragmatic interactive goals in the community…[; however,] a role is distinct from cultural objects such as democracy and capitalism in that roles are ultimately used to construct the self… Another feature of a cultural object is that in addition to practical and interactive reality, it also has a symbolic or cognitive reality… [It has been argued] that roles need not be tied to particular positions or specific networks; thus it is at the cognitive level that the transcendent quality of a cultural object is appreciated. The role of golfer, for example, is experienced at the physical level of playing the game, at the level of interaction in discussions about the game, and in a more abstract cognitive representation of what it generally means to be a golfer (Callero, 1994, p. 232).

While role theory has manifested in a number of ways, the concepts of gender roles and norms as a result of role theory will be centred on for the remainder of this thesis.

Important in this analysis is an examination of the malleability of the various roles prescribed for males and females (Kray, Howland, Russell, & Jackman, 2017, p. 98). One of the main premises of this theory is that rather than qualities being innate, they are instead ascribed to genders through historical positionings, where females are stereotypically represented as communal through their previous homemaker role and males are positioned as competent and capable through their prior breadwinner role (Harrison & Lynch, 2005, p. 227). While more females are occupying breadwinner positions and more males are inhabiting homemaker roles, the fact that gender roles persist constructs this behaviour as atypical and therefore, illegitimate,

thus re-establishing the status quo (Harrison & Lynch, 2005, p 227). Of importance, then, becomes how malleable individuals perceive these gender norms. A study conducted by Kray and colleagues (2017) established how males' beliefs regarding the fixedness of gender roles influenced their adherence to the status quo. They found that the more males believed that gender roles are fixed and unchangeable, the more males defended and adhered to the status quo; moreover, males who believed gender roles are fixed were more likely to identify as a "man," think they possess more desirable characteristics typical of a "man," and subsequently trust that the current system that positions males in power is fair and just (Kray et al., 2017, p. 19). The perceived malleability of gender roles and norms thus presents an interesting analysis into male victimization, where the more fixed male survivors identify their roles to be, the more likely they may be to self-blame; feel shame; dissociate from support networks; use avoidance coping techniques, such as substance abuse; and evade emotional processing of the traumatic incident. This, therefore, may inhibit potential PTG.

Gender socialization establishes gender roles. Gender socialization is the process through which each individual understands what they can and cannot do as a function of their gender (Pascoe & Bridges, 2016, p. 7). As early as six months, infants are able to differentiate between male and female voices and by 14 months, they are able to accurately pair male and female voices with a photograph of the appropriate gender (Lips, 2014, p. 11). Thus, gender socialization starts occurring early in one's life to place individuals into the neatly defined categories of male or female. Psychologists argue that gender socialization occurs by offering rewards and punishments to children for acting in a manner congruent or contrasting to their appeared gender; for example, a girl being praised for "behaving just like mommy" or a boy being ridiculed for "throwing like a girl" (Disch, 2009, p. 107). These rewards and punishments

encourage children to behave harmoniously with their gender so as to receive rewards and avoid punishments, which subsequently enables children to actively search for social cues on the appropriate behaviour for their gender (Lorber, 2009, p. 113).

Cognitive psychologists recognize that once children identify two socially accepted gender categories, one of which they belong to, in-group and out-group associations are made (Lips, 2014, p. 12). Children begin to make more positive evaluations of the gender they belong to (the in-group) and are more curious about acquiring information about their in-group; therefore, this knowledge search motivates children to adhere to their own gender (Lips, 2014, p. 12; Lorber, 2009, p. 113). This process of gender socialization creates rigid gender norms (socially acceptable behaviours and roles for each gender) that persist well into adulthood; males and females are socially bound to remain in line with their prescribed gender norms in all social contexts (Barker, Ricardo, Nascimento, Olukoya, & Santos, 2010, p. 539; Kassing, Beesley, & Frey, 2005, p. 313). In many contexts, these gender norms are hierarchical in nature, ascribing men in dominant roles and women in passive positions (Lips, 2014, p. 14). Boys are socialized into becoming strong and leading men, and conversely, girls are socialized into weak and delicate women (Javaid, 2016, p. 288). As a result, masculinity is often displayed through the acquisition and exertion of power, whereas femininity is expressed through subservient actions (Lis, 2014, p. 14). Therefore, individuals who disobey gender roles and norms are also subsequently rebelling against this prescribed gender hierarchy (Lips, 2014, p. 14).

Gender norms are developed and maintained by the dominant groups within society and as such, male gender norms reflect what men have defined to represent hegemonic masculinity (Whitley et al., 2018, p. 478). Male gender norms have usually been conceptualized under four categories: "(1) 'no sissy stuff' (that men should avoid feminine things), (2) 'the big wheel' (that

men should strive for success and achievement), (3) ‘the sturdy oak’ (that men should not show weakness), and (4) ‘give ‘em hell’ (that men should seek adventure, even if violence is necessary” (David & Brannon, 1976; Levant & Richmond, 2007, p. 131). These four broad categories foster a number of behavioural and personality traits, such as dominance, aggressiveness, a focus on winning, risk-taking, and emotional stoicism (Whitley et al., 2018, p. 478). Interestingly, however, is that while masculinity is rather elusive, men consistently attempt to obtain masculine status through the reproduction and obedience of male gender norms (Vandello & Bosson, 2013, p. 103).

These gender norms represent a network of gender stereotypes. Gender stereotypes are not solely descriptive, that is narratives of what males and females are like, but are also prescriptive in nature (Lips, 2014, p. 25). Prescriptive gender stereotypes represent what males and females should be like, therefore creating the rules for how males and females should behave in order to obey societal expectations of gender (Lips, 2014, p. 25). For example, when a man is told he “throws like a girl,” not only is he differentiated from typical men, but is also associated with women as he is seen as breaching the prescriptive male stereotype of strength (Lips, 2014, p. 25). Prescriptive gender stereotypes have been found to be more rigid for males than females, where males are harassed intensely for not appearing masculine enough (Lips, 2014, p. 26). In one study, male participants who were told they scored high on a feminine knowledge test refused to publicize their scores and demonstrated stronger adherence to masculine qualities in a subsequent follow-up as compared to those males who were told they scored low on the same test (Rudman & Fairchild, 2004, p. 169). Thus, failing to fall within the category of “male” is particularly shameful for men.

In many cases, males who have been sexually victimized represent a challenge to the current gender hierarchy as they open the potential for "weakness" to the dominance that the male gender exudes. As mentioned previously, these strict gender roles create the illusion that males are unable to be sexually violated especially by a female, contributing largely to the development and maintenance of current rape myths. Gender role conflict may occur when a male is sexually violated, as the actions and events of the victimization contradict the current prescribed norms and abilities of the male gender (Kassing et al., 2005, p. 313). This gender role conflict can influence the degree to which self-blame occurs for the male survivor (Kassing et al., 2005, p. 313). Shame underpins this gender role conflict, as the male survivor may feel embarrassed with himself for failing to live up to societal expectations and standards of masculinity (Tewksbury, 2007, p. 29). For example, as discussed, deeply believing that men should be able to protect themselves and stop an unwanted attack may lead some male survivors to blame themselves more for the assault than if they did not hold such a belief (Kassing et al., 2005, p. 313).

Gender norms and PTG

The limited research on PTG following a traumatic event has demonstrated that females are more likely to experience positive changes than males, a difference that may be influenced by gender norms (Easton et al., 2013, p. 211). As mentioned previously, one study has shown that the more males are told they represent feminine traits, the more likely they are to exhibit shame and adhere stronger to masculine qualities (Rudman & Fairchild, 2004, p. 171). This may occur for male survivors of sexual violence as the experience of sexual violence is considered outside the realm of masculinity, and as such, male survivors may overcompensate by adhering more strongly to stereotypical gender norms. Therefore, male survivors of sexual violence may

internalize feelings of femininity and sense a betrayal of masculine prescriptive norms, leading to shame, self-blame, and greater adherence to masculine traits. A higher adherence to stereotypical masculine behaviours may preclude the ability of male survivors to achieve PTG, as these men are more likely to avoid emotional processing with the goal of being perceived as strong and dominant and not weak and submissive. Moreover, these men may be more likely to utilize avoidant coping (to be discussed in the next section) and both emotional distancing and avoidant coping have been found to be negatively correlated with PTG (Frazier et al., 2004; Tuncay & Musabak, 2015). Thus, after experiencing a traumatic incident that is characteristically associated with the female gender, male survivors may take extreme measures to reobtain a masculine status, neglecting to engage in many of the behaviours research on PTG has demonstrated necessary for growth (Vandello & Bosson, 2013, p. 103).

Critique of gender roles and norms

Pleck (1981) has successfully critiqued the use of gender roles, more specifically sex roles, for the synonymous use of norm and personality, where theorists have often incorrectly argued that the various sex roles and the desire to conform to these roles define individuals' personalities and psychological adjustment. It has also been argued that role theory, and subsequently gender norms, overemphasizes the prescriptive nature of these roles and the effect it has on individuals (Connell, 1995/2005, p. 26). Therefore, while gender norms may represent a framework for what men and women should be like, it does not determine nor does each individual automatically and unequivocally strive to reproduce these norms. Individuals still have a sense of autonomy in their representation of gender that goes beyond a desire to conform to rigid norms (Butler, 2004, p. 8). Thus, the concept of gender norms too strongly assumes that

these norms become ingrained within personality and erroneously reduces gender to the individual (Berke, Wilson, Mouilso, Speir, & Zeichner, 2015, p. 509).

Pleck (1981) showed that the existence of a functionalist sex role theory thwarts changes to the status quo that promotes hegemony, as feelings of meagreness prevent subordinated individuals from challenging the system (p. 160). Instead, Pleck (1981) advocated for a "model of the male sex role which allowed that sex role conformity might be psychologically dysfunctional; that the role norms might change, and at times ought to; and that many people did violate norms, and might suffer retribution, so many people also overconformed" (as cited in Connell, 1995/2005, pp. 25-26). Such a model would remove the problems related to biological determinism tied to sex role theory and gender roles (Connell, 1995/2005, p. 26). As such, the gender role identity paradigm which emphasized determinism has since been replaced with the gender role beliefs paradigm (Luyt, 2015, p. 209). This paradigm reflects the assumption that both males and females are pressured to maintain and adhere to gender norms, recognizing, however, that these pressures are not always followed (Luyt, 2015, p. 209).

Gender norms as they arise from role theory, inherently undercut the importance of power relationships (Connell, 1979). Gender norms, while they ascend from social interactions, are more focused on the individual, subsequently analyzing their effect on the micro-level (Messner, 1998, p. 258). Yet, this individualistic lens ignores the meso- to macro-level structures and interactions that encourage power divides between males and females (Messner, 1998, p. 258). Even further, the prescriptions ascribed to roles assume mutuality between roles, which consequently undervalues the various power structures that exist and create hierarchical systems (Connell, 1979, p. 10). The ignorance of power within the concept of gender norms further precludes rebellion from analysis. More specifically, gender norms cannot adequately assess nor

explain the existence of individuals who defy prescriptive gender norms, such as men who represent more stereotypical feminine traits and vice versa (Connell, 1979, p. 13). Deviance is typically used to describe these individuals, yet this term fails to incorporate the element of resistance to gender norms that is present within rebellion (Connell, 1979, p. 13).

In addition, gender norms as a concept reflect a dichotomy of gender (Luyt, 2015, p. 210). It is flawed to assume that masculinity and femininity, and subsequently gender norms, are mutually exclusive concepts; more specifically, the characteristics of what makes a man versus a woman are not necessarily polar opposites (Luyt, 2015, p. 210). These lines become even more blurred in instances of transgendered identities (Butler, 2004).

Despite these flaws, gender norms as a concept allow this thesis to assess how varying degrees of adherence to male gender norms influences male survivors' development of PTG. Importantly, this thesis does not assume that each male abides by gender norms entirely or similarly. Rather, the measurement scale used (MRNI-SF to be discussed in the next chapter) reflects individual variance in the obedience of these norms, permitting an analysis of the varying degrees of masculine norms and the potential for positive growth. The strength of reproducing gender norms is a crucial variable to this study; for example, it may be that only male survivors of sexual violence who strongly adhere to stereotypical masculine norms are subsequently stunted in their ability to achieve PTG as they are more intensely pursuing masculine status than those individuals who weakly follow male gender norms. If male survivors actively follow traditional male gender norms, then the experience of sexual violence, as it is predominately associated with the female gender, may encourage gender role conflict (Kassing et al., 2005, p. 103). This potential for gender role conflict cannot adequately be assessed without gender norms as a concept.

Moreover, gender norms grant an assessment of the interplay between gender and service access. In particular, male survivors of sexual violence have been found to wait exceptionally long periods of time before seeking out services for their trauma (King & Woollett, 1997). This delay in service access has been linked to male gender norms and help seeking behaviour, where men are required to maintain emotional stoicism and are discouraged from utilizing emotional and social support in times of stress and trauma (Addis & Mahalik, 2003, p. 5). Thus, the concept of gender norms allows this thesis to analyze how strongly a male survivor adheres to typical masculine norms and how that subsequently influences their help-seeking behaviour. More specifically, this thesis includes variables on the intensity and stability of service access, reflecting the type of service and whether service use is interrupted.

This subsection centred on the concept of gender norms and how adherence to these norms may influence the development of PTG for male survivors of sexual violence. The next subsection will focus on coping as a concept and the role of coping in PTG.

2.3.3. Coping

Coping first arose in Lazarus' (1966) discussions of stress, where he contended that there are three processes within experiencing stress. First, the individual engages in primary appraisal, which is the process of identifying an event as a stressor (Lazarus, 1966). Next, the individual develops a potential response to this stressor, the process of secondary appraisal (Lazarus, 1966). The last process, coping, occurs when the individual implements their established response (Lazarus, 1966). Many researchers have described this model as linear, where one must go through each process sequentially and may only advance once progress has been made (Carver, Scheier, & Weintraub, 1989, p. 267). More accurately, however, these processes occur

cyclically, where an individual may perceive an event as less stressful once adequate coping mechanisms have been established (Carver et al., 1989, p. 267).

Definitions of coping vary considerably, largely due to the fact that coping can encompass a wide range of behaviours in response to stress (Eisenbarth, 2012, p. 486). Coping, however, is most consistently defined as the "cognitive and behaviour[al] efforts to manage the internal and external demands of situations that are appraised as stressful" (Lazarus & Folkman, 1984; Scheenan, van der Horn, de Koning, van der Naalt, & Spikman, 2017, p. 185). Key to the concept of coping is how the individual identifies and evaluates the difficult event, their assessment of available resources, and how they decide to respond the event (Nielsen & Knardahl, 2014, p. 142). Coping, therefore, requires that the individual recognizes the existence of a problem (whether real or imagined) and applies effort to develop a solution (Ray, Lindop, & Gibson, 1982, p. 385). In this regard, coping is often referred to as a strategy, technique, or mechanism in order to embody coping as a purposeful action (Ray et al., 1982, p. 385). While coping has a direction and purpose, coping may occur consciously (i.e., the individual chooses a specific plan of action to overcome the challenging situation) or unconsciously (i.e., the individual engages in coping strategies without awareness) (Ray et al., 1982, p. 385).

Research has debated the existence of stable coping mechanisms, where individuals are predisposed to certain forms of coping over others (Carver et al., 1989, p. 270). Some scholars argue that coping mechanisms form from personality; more specifically, that different personality characteristics induce certain coping styles to be used more frequently and consistently than others (Bosmans, van der Knaap, & van der Velden, 2015; Garriz, Gutierrez, Peri, Bailles, & Torrubia, 2015). This position has been contested, where researchers instead assert that the process of coping is dynamic and cyclical (much like Lazarus' initial discussions

of stress) (Carver et al., 1989, p. 270). In this stream, the acquisition of one singular form of coping style is counterproductive as it binds an individual to one mechanism, instead of providing them with the autonomy to choose a coping style specific to each unique experience of stress (Carver et al., 1989, p. 270).

Moreover, research has also established that coping mechanisms often intermingle and as such, should not be considered as mutually exclusive (Eisenbarth, 2012, p. 486). As a result, it has been recommended that analyses of coping avoid assessing coping styles independently of one another but instead utilize patterns of coping that evaluate various coping techniques interdependently (Eisenbarth, 2012, p. 486; Nielson & Knardahl, 2014, pp. 142-143). For this reason, Eisenbarth (2012) has argued for a cluster analysis in evaluating coping strategies:

> cluster analysis is a promising method for identifying subgroups of individuals with different coping profiles. This analytic technique identifies groups of individual cases defined by similarities among multiple dimensions of interest. For example, research has demonstrated that individuals can be categorized into groups on the basis of distinctive coping profiles that differentiate people on a multitude of health outcomes: including depression, stress, psychological adjustment, life satisfaction, and quality of life. These investigations demonstrate that coping strategies likely operate in conjunction with one another, and that researchers may gain a deeper understanding of coping by identifying subgroups of individuals based on their coping profiles (p. 486).

Cluster analyses can subsequently aid in developing profiles of coping that move away from neatly defined categories of different techniques (Eisenbarth, 2012, p. 486).

Few studies have utilized a cluster analysis approach in order to distinguish the various patterns of coping. Nielsen and Knardahl (2014) established three coping profiles from their sample of Norwegian workers, thus demonstrating the interdependency of coping strategies (pp. 147-148). The first profile comprised of individuals who engaged in more active forms of coping, such as the use of support or planning, and less avoidance coping, such as substance

abuse; the second cluster consisted of those who utilized more avoidance coping strategies and less active coping techniques; and finally, the third profile involved those who scored low on all forms of coping techniques as compared to the first two groups (Nielsen & Knardahl, 2014, p. 147). Thus, coping as a concept allows the analysis to centre on how the various coping techniques influence behaviour and psychological bettering both individually and collectively.

Important to the process of coping is meaning, which has generally been conceptualized as the individual's "perception of significance" (Park & Folkman, 1997, p. 116). There are two forms of meaning: global and situational (Krok, 2015, p. 197). Global meaning refers to the individual's broad beliefs and goals about the world, subsequently influencing perceptions of the past and present, as well as anticipations about the future (Park, 2016, p. 1235). Global meaning encompasses two dimensions: assumptions regarding order and motivation (Park & Folkman, 1997, p. 116). Assumptions regarding order reflect the distribution of positive and negative occurrences; for example, strongly adhering to the just world belief, where good people experience positive events and vice versa may cause individuals who perceive themselves as good to struggle with making meaning when a negative life event occurs (Park & Folkman, 1997, p. 118). Motivation, otherwise known as goals, gives individuals a direction and purpose in life, regardless of whether these goals are conscious to the individual (Krok, 2015, p. 197). This goal acquisition has been found to be a strong correlate of overall life adjustment following a stressful or traumatic incident (Park & Folkman, 1997, p. 119). One of the best examples of global meaning is the use of religion to understand and give meaning to traumatic events (Park & Folkman, 1997, p. 121), a form of coping called religious coping.

Situational meaning combines the individual's broader global meaning and the specific life events the individual is currently experiencing (Park, 2016, p. 1235). As situational meaning

appraises each life event, it is subsequently associated with the style of coping the individual uses (Krok, 2015, p. 197). There are three components within situational meaning: the appraisal of meaning, search for meaning, and meaning as an outcome (Park & Folkman, 1997, pp. 121-122). Appraisal of meaning first occurs when the individual assesses the stressful occurrence and attempts to assign personal significance to this event (Park & Folkman, 1997, p. 121). This process is heavily influenced by the individual's own goals and beliefs, as well as their conceived solutions to the stressful event (Park, 2016, p. 1235). This personal nature signifies the individual variance in the experience of trauma and subsequent use of coping styles, where stressful events differ in their traumatic effect based on each individual appraisal of meaning and available resources to cope (Park & Folkman, 1997, p. 122).

The search for meaning component is most relevant to the coping process. This component occurs after an individual has deemed an event as stressful and requires the individual to begin meaning-making (Krok, 2015, p. 198). In general, most individuals respond to stressful events by attempting to develop a solution to fix the problem; however, in extremely traumatic incidents, such as victimization, this is not always possible (Park & Folkman, 1997, p. 124). In these instances, meaning-making is particularly important in order to buffer the negative effects of the traumatic event (Krok, 2015, p. 197). The role of meaning-making is to diminish the inconsistencies between an individual's global meaning and their appraised meaning (Skaggs & Barron, 2006, p. 538). As mentioned, individuals who strongly adhere to a just world belief may have particular difficulty adjusting and assigning meaning following a traumatic incident (Park & Folkman, 1997, p. 124). The meaning-making process is considered completed when this discrepancy between the appraised and global meaning is eliminated, either by altering the appraised meaning to align it with the global meaning or vice versa (Keil, 2004, p. 661).

This progression of reducing incongruencies between appraised and global meaning can result in significant changes to one's global meaning, the process of which is referred to as meaning as an outcome (Park, 2016, p. 1235). Psychological adjustment is more likely to occur when these inconsistencies are alleviated as the individual is able to work towards their beliefs and goals once again (that is, their new global meaning) (Park, 2016, p. 1236). Yet, changes that occur to global meanings, either through assimilation or accommodation, are not necessarily beneficial to the individual (Park, 2016, p. 1235). For example, survivors of sexual violence may experience meaning-making by increasing feelings of vulnerability and a lack of agency (Park & Folkman, 1997, p. 131). When global and appraised meanings are unable to mesh, individuals enter a period of rumination that can lead to depression and poor psychological adjustment (Park & Folkman, 1997, p. 131; Skaggs & Barron, 2006, p. 539). Rumination is likely to occur when individuals seek out causal explanations for why the traumatic event happened to them but fail to find satisfying answers (Park & Folkman, 1997, p. 131).

Coping has generally been conceptualized under two main categories: emotion-focused and problem-focused. Emotion-focused coping concerns responding to and reducing the emotional consequences of the traumatic event, whereas problem-focused coping centres on finding a solution to the stressful problem (Baker & Berenbaum, 2007, p. 96). Emotion-focused coping can include a variety of different mechanisms, such as positive reappraisal, denial, acceptance, or seeking social support (Carver et al., 1989, p. 268). Problem-focused coping includes approaches aimed at acquiring information, planning, or making decisions; methods to obtain resources, such as new skills, that will allow the individual to understand and deal with the stressor; and instrumental actions specific to the particular incident (Folkman & Moskowitz, 2000, p. 650). As such, problem-focused coping seems distinct from meaning-making as it

focuses on tangible, instrumental actions; but, problem-focused coping is deceivingly meaningful (Folkman & Moskowitz, 2000, p. 650). First, problem-focused coping "involves identifying situation-specific goals that engage the individual and focus his/her attention, and second, the enactment of problem-focused coping makes it possible for the individual to feel effective and experience situational mastery and control. Both of these meaning-based functions of problem-focused coping are critical for positive well-being" (Folkman & Moskowitz, 2000, p. 650).

Most stressful or traumatic incidents do evoke both problem- and emotion-focused coping; however, problem-focused coping tends to occur more frequently in response to events where individuals perceive there are actions that can be done in order to lessen their distress, while emotion-focused coping is more likely to occur when individuals perceive the event must be emotionally endured (Carver et al., 1989, p. 267). This distinction, nevertheless, has been deemed too simplistic (Carver et al., 1989, p. 267). Moreover, these categories are not hierarchical; rather, each category has counterintuitive forms of coping within them (Carver et al., 1989, p. 168). For example, as mentioned, both denial and positive reinterpretation of the events are included within emotion-focused coping, seemingly polar opposites from each other (Carver et al., 1989, p.268).

Research has argued the ineffectiveness of the emotion-focused forms of coping for two main reasons (Baker & Berenbaum, 2007, 96). As emotion-focused coping includes contradictory forms of coping within the broad category, such as approach and avoidance mechanisms, analyzing the effect of emotion-focused coping becomes dubious at best (Roth & Cohen, 1986; Stanton, Kirk, Cameron & Danoff-Burg, 2000). Further, the scales used to assess emotion-focused coping are contended to confuse coping efforts with suffering (Baker & Berenbaum, 2007, p. 96). For example, items such as "I get upset and let my emotions out," is

not clearly a coping technique as opposed to a response to distress (Baker & Berenbaum, 2007, p. 96). As such, the literature has chosen to centre on a subset of emotion-focused coping, called emotion-approach coping. This form of emotion-based coping occurs when an individual actively recognizes, processes, and articulates his or her emotions, thus focusing on the active element of emotion-based coping instead of the passive components (Baker & Barenbaum, 2007, p. 96).

Coping is a differential experience and there is no singular "healthy" way to cope in order to reduce the stress and negative symptomatology associated with pain and trauma (Cook & Hayes, 2010; Keil, 2004). Nevertheless, research has evaluated the various coping mechanisms in terms of their ability to promote or hinder PTG for sexual violence survivors and this literature will be presented here. Typically, research has categorized various coping styles as "adaptive" or "maladaptive," yet constructing coping in this manner is harmful and laced with assumptions regarding what is normative and adaptive versus atypical and maladaptive. As such, this thesis uses three categories of coping void of (explicit) value assumptions: self-sufficient, socially-supported and avoidant coping.

Self-sufficient coping

The category of self-sufficient coping includes the following types of coping: positive reframing, acceptance, planning, active, and humour, each of which will be discussed in detail below. The process of meaning-making is required in order for positive reframing, acceptance, and active coping mechanisms to be utilized. As mentioned, meaning-making promotes cognitive restructuring that incorporates the experienced victimization in a way that removes blame from the individual (Easton et al., 2013, p. 216). When survivors are able to understand the event, place blame onto the perpetrator, and appreciate how the abuse or assault is related to

emotions, survivors report higher levels of growth than when this meaning-making is not present (Easton et al., 2013, p. 216). Yet, meaning is not void from planning coping, as while it is a problem-focused coping technique it still does require the individual to connect action to the traumatic event and make subsequent meaning through behaviour (Folkman & Moskowitz, 2000, p. 650).

Positive reframing. Positive reframing, or positive reappraisal, is a category of coping that aims to reframe traumatic incidents in a positive manner, which has been connected with positive emotions following these traumatic events (Folkman & Moskowitz, 2000, p. 650; Moore, Varra, Michael, & Simpson, 2010, p. 93). The role of positive reframing in the production of PTG has been narrowly assessed with sexual violence survivors (Kaye-Tzadok & Davidson-Arad, 2016), but research with other forms of traumatic incidents, such as 9/11 victims (Butler et al., 2005), veterans with lower-limb amputations (Tuncay & Musabak, 2015), and individuals living with HIV (Garrido-Hernansaiz, Murphy, & Alonso-Tapia, 2017) has indicated that positive reframing is associated with higher levels of PTG.

Acceptance coping. Acceptance coping strategies fall under the domain of emotion-approach coping and focus on an expression of emotions and cognitive restructuring, where individuals accept the event that transpired and deal with it emotionally (Cole & Lynn, 2010, pp. 121-122; Frazier et al., 2004, p. 27). Acceptance coping requires that the individual not only identifies and understands their experience of distress, but also that the individual connects the distress to the situation while behaving efficiently throughout the experienced suffering (Perez, Chartier, Koopman, Vosvick, Gore-Felton, & Spiegel, 2009, p. 89). Acceptance coping therefore refers to the individual processing the traumatic incident without any resistance (Cook & Hayes, 2010, p. 186). Importantly, "acceptance [coping] may involve recognizing the factors one can

and cannot change about a stressful situation; thus, acceptance [coping] may promote feeling capable of overcoming new challenges, but may call attention to one's limitations as well" (Litman & Lunsford, 2009, p. 989). Hence, acceptance coping is not guaranteed to lead to positive outcomes, as if the individual concentrates only on their limitations, this may cause a degree of distress. That being said, analyses assessing the role of acceptance coping in promoting or hindering PTG have found that acceptance coping is most commonly associated with fostering positive growth (Cole & Lynn, 2010, pp. 121-122; Frazier et al., 2004, p. 27).

In one analysis of female sexual violence survivors, those who used acceptance coping mechanisms were more likely to experience early positive changes compared to those who used avoidance coping strategies (e.g., social and emotional withdrawal) (Frazier et al., 2004, p. 27). Acceptance coping has been found to be the strongest correlate of immediate growth, occurring as little as two weeks after the sexual violence (Frazier et al., 2004, p. 27).

Planning coping. Planning as a form of coping refers to cognitive assessments of how to deal with the traumatic event (Noda, Takahashi, & Murai, 2018, p. 179). Planning coping requires the individual to develop an action plan of the necessary steps needed in order to effectively heal from the experienced trauma (Litman & Lunsford, 2009, p. 984). This form of coping has been narrowly assessed in relation to sexual violence survivors, however, the limited literature has indicated that focusing on some kind of planning is positively correlated with PTG for female child sexual assault survivors (Kaye-Tzadok & Davidson-Arad, 2016, p. 555). A combined effect between the personality trait of hardiness and problem solving has been argued, where those who are hardier and engage in active problem solving are subsequently more likely to achieve PTG (Cole & Lynn, 2010 pp. 114-115). Hardiness is a personality disposition characterized by a commitment to life goals and a belief of control over life events (Bonanno,

2004, p. 25). Hardy individuals have been found to appraise traumatic situations as less negative and detrimental than those individuals without this personality trait, which can work to minimize the distress experienced and promote positive changes (Bonanno, 2004, p. 25; Cole & Lynn, 2010, p. 122).

An important connection between acceptance and planning coping has been found in relation to positive growth following a stressful event (Litman & Lunsford, 2009, p. 989). A study by Litman and Lunsford (2009) sought to assess the role of coping in subsequent growth and diminishment (e.g., feelings of helplessness) in a variety of stressful occurrences. A mediating relationship was found, where "the frequency of using acceptance and planning enhanced the development of self-efficacy, which along with positive reinterpretation, predicted greater growth" (Litman & Lunsford, 2009, p. 989). While this study did not measure PTG explicitly, instead using the stress-related growth scale (a measure which assesses changes in the self, feelings of autonomy, and optimism), it has important implications for PTG research (Litman & Lunsford, 2009, p. 985). It should be evaluated whether acceptance and planning coping have separate or combined influences on PTG, whether positive reinterpretation is necessary for PTG, and whether these findings remain consistent in a sample of violent crime survivors.

Interestingly, this lack of research may be indicative of the gendered focus within research on sexual violence. More specifically, problem-focused forms of coping are more often engaged in by men than women (Baker & Berenbaum, 2007, p. 112) and as such, scholars centring on the production of PTG for female sexual violence survivors may either find a weak to non-existent relationship between planning coping and PTG or may choose not to assess this form of coping at all. To illustrate, the majority of research in this domain centres on the

emotion-approach forms of coping, such as acceptance or religion (Ahrens et al., 2010; Cole & Lynn, 2010; Frazier et al., 2001; Kaye-Tzadok & Davidson-Arad, 2016; Lev-Wisel, Amir, & Besser, 2005), as well as avoidance styles of coping as possible detriments to the development of PTG (Easton et al., 2013; Frazier et al., 2004; Frazier & Berman, 2008).

Active coping. Active coping refers to dynamic attempts to remove the negative effects of the experienced traumatic incident from one's life (Carver et al., 1989, p. 268). As such, active coping is a form of problem-focused coping as it focuses on taking action in order to return back to pre-trauma baselines and functioning (Carver et al., 1989, p. 268). Active coping has been found to be positively associated with PTG among survivors of violent crime (Brooks et al., 2016). In fact, active and religious coping were found to be the strongest predictors of PTG in all three of Brooks and colleagues (2016) populations (university students, survivors of violent crime and trauma workers). Yet, a later analysis indicated that active coping may not have a direct effect in the production of PTG, but that it may only lead to PTG with stressful situations where it is possible for the individual to evoke change (Brooks, Graham-Kevan, Robinson, & Lowe, 2019, p. 237).

Humour coping. Humour coping is the strategy of incorporating a sense of humour into the experience of trauma, which subsequently lessens the perceived threat of the incident (Park & Folkman, 1997, p. 128). Humour coping has been theorized to be productive in the development of PTG so long as it removes attention away from the traumatic incident (Nielsen & Knardahl, 2014, p. 143). Humour coping has also not been extensively assessed for sexual violence survivors. Yet, for patients with leukemia (Karami, Kahrazei, & Arab, 2018) and HIV caregivers (Cadell, 2007), humour has an important role in producing PTG. More specifically, humour acts as a way to lighten the mood, to remember "good times" (as was the case of HIV

caregivers who lost their partner), and relieve stress, allowing the individual to establish a sense of hope and consequently positively grow (Cadell, 2007; Karami et al., 2018).

Self-sufficient coping and social support. Acceptance, active, and planning coping strategies are related to social support (which influences a style of coping that will be discussed next), where these coping mechanisms may provide the survivor with a social support network or encourage the survivor to seek out support (Daane, 2017, p. 104). Acceptance and active coping encourage survivors to utilize their current support circles (e.g., friends and family) in order to make meaning and emotionally process their victimization (Daane, 2017, p. 104). Moreover, planning may encourage individuals to seek social support, either formal or informal, for their trauma in order to help them find an appropriate solution.

Socially-supported coping

There are four forms of socially-supported coping: the use of emotional support, the use of instrumental support, religion, and venting. These coping styles will be discussed in detail below.

The use of emotional and instrumental support. Emotional support encompasses efforts to receive understanding and moral support in response to a stressful event (Carver et al., 1989, p. 269). Alternatively, instrumental support is the process of pursuing information or assistance related to a traumatic incident (Carver et al., 1989, p. 269). Both emotional and instrumental support are not mutually exclusive and often coexist (Carver et al., 1989, p. 269). A negative relationship has been found between external support and feelings of helplessness and pessimism, where the more support received, the less the individual holds these negative emotions (Litman & Lunsford, 2007, p. 989). This relationship therefore clearly indicates the

positive impact external support has on reducing stress. Emotional and instrumental support have both been correlated with increased positive changes (Leech & Littlefield, 2011, p. 296). Either type of support has the potential to encourage survivors to make positive associations, increasing the likelihood that the survivor achieves PTG (Leech & Littlefield, 2011, p. 296).

The dynamics and strength of the relationship between PTG and emotional and instrumental support vary between studies. Some studies have found that any kind of social support is effective in promoting PTG in the sexual violence survivor, where individuals who have stronger support networks are more likely to experience early positive changes following the assault (either individually or interpersonally) (Frazier et al., 2004, p. 27). Yet, the strength of the relationship between social support and positive change has been found to be moderated by different correlates. Initially, Frazier and colleagues (2001) found that acceptance or avoidant coping styles, the perceived control over the recovery process, and taking precautions were significant moderators of social support, but their subsequent analysis (2006) found religious coping and control over the recovery process to be the significant moderators. Thus, the perceived control over the recovery process seems to be the strongest moderator between social support and PTG following sexual violence, where survivors with stronger support experience more positive changes because they perceive more power over their recovery (Frazier et al., 2006, p. 19).

Research has also assessed how the source and perception of emotional or instrumental support influence the development of PTG. It was found that informal and formal support are both correlated with PTG; specifically, positive reactions from friends, family, and service providers are associated with positive changes in female sexual violence survivors (Borja et al., 2006, p. 911). Only negative reactions from informal support networks have been found to be

correlated with more distress (Borja et al., 2006, p. 911). It has also been suggested that it is not the support that is associated with positive changes per se, but it is the perception and satisfaction of this social support that facilitates PTG in sexual violence survivors (Linley & Joseph, 2004, p. 16). Hence, as long as the survivor identifies the support to be positive, there is still a possibility of positive changes (Linley & Joseph, 2004, p. 16). This result has been challenged by contradictory findings, where a nonclinical sample of men abused as children by clergy members found that participants' perceptions of the support after their disclosure was not correlated with positive changes (Easton et al., 2013, p. 216). Yet, this result could be due to the specific population, that is, only men who were abused by clergy members (Easton et al., 2013).

Religious coping. Religious coping occurs when the individual uses their spiritual faith in order to make sense and understand the sexual violence (Ahrens et al., 2010, p. 1253). Religious coping may serve a number of functions, such as a form of emotional support, a method of acceptance coping, and a new way to regain feelings of control following the traumatic incident (Carver et al., 1989, p. 270; Pargament, Koenig, & Perez, 2000, p. 521). Twenty-one various religious coping strategies have been identified, such as praying for a miracle, reformulating the traumatic experience as part of God's plan, or using God for support and direction (Pargament et al., 2000, pp. 522-524). In some instances, religious coping may be used as a last resort when all other attempts at coping have failed (Park & Folkman, 1997, p. 129). In this sense, individuals' new sense of faith provides meaning to the sexual violence and helps to answer questions of why this happened and contributes solutions (Park & Folkman, 1997, p. 129). Yet, religious coping can be both positive and negative (Pargament, Smith, Koenig, & Perez, 1998, p. 712); "positive religious coping includes a variety of methods that help individuals feel close to God, see meaning in life, and feel spiritually connected to others.

Negative religious coping involves religious struggle and disconnection. Such struggles may occur when negative life events lead individuals to question the existence and benevolence of God" (Ahrens et al., 2010, p. 1244).

Positive religious coping, where the survivor maintains feelings of closeness to their God and is able to feel spiritually connected to other individuals, has been shown to reduce depression and increase psychological well-being for female rape survivors (Ahrens et al., 2010, p. 1254). More specifically, in one analysis, female survivors often drew upon the idea of God to aid in their healing from the sexual violence, attempted to help others, and more actively engaged with the church (Ahrens et al., 2010, p. 1249). Conversely, negative religious coping has been correlated with higher rates of depression for female sexual violence survivors (Ahrens et al., 2010, p. 1257). While this correlation has been found to occur, Ahrens and colleagues (2010) found that very few female survivors in their sample actually engaged in negative religious coping as indicated by dissatisfaction with their religion or God (p. 1249). Instead, female sexual violence survivors often used religion as a form of avoidance, such as using praying or church activities to distract them from their traumatic experience (Ahrens et al., 2010, p. 1249). Thus, in this regard, religious coping may have adverse effects on healing.

Venting. Coping through venting is the process of "letting emotions out," as opposed to keeping them within (Duhachek, 2005, p. 46). Venting has been shown to either be deleterious or ineffectual in the production of PTG. In one analysis of breast cancer survivors, venting negative emotions was positively associated with psychological distress, not PTG (Bussell & Naus, 2010, p. 63). Moreover, venting has also been shown to be a suppressor variable, where it does not have a direct effect on the outcome of PTG, but influences other predictor variables (Ogińska-Bulik & Kobylarczyk, 2015, p. 714). In this particular case, controlling the use of venting

thereby increases the predictive power of humour and openness to new experiences in the development of PTG (Ogińska-Bulik & Kobylarczyk, 2015, p. 714).

Avoidant coping

The main forms of coping under avoidance are denial, self-blame, self-distraction, substance abuse, and behavioural disengagement, all of which will be discussed below. These forms of avoidant coping have been found to be highly associated with increased psychological distress following any stressful event (Nielsen & Knardahl, 2014, p. 148). Avoidant coping mechanisms may prevent the survivor from engaging in many of the processes that have been positively correlated with PTG, such as emotional processing, social connectedness, and meaning-making (Bonanno, 2004, p. 25; Cole & Lynn, 2010, p. 114; Frazier & Berman, 2008, p. 172). In this regard, decreasing the use of avoidant coping has been associated with an increase in PTG for sexual violence survivors (Frazier et al., 2004, p. 27). Yet, variance has also been found within this research, where denial, self-blame, and self-distraction have been associated with both psychological distress and growth (Lelorain, Bonnaud-Antignac, & Florin, 2010).

Denial. Denial is often defined as attempts to negate the reality of the event (Carver et al., 1989, p. 270). The efficacy of denial as a coping mechanism is largely debated within academia, where:

> it is often suggested that denial is useful, minimizing distress and thereby facilitating coping. Alternatively, it can be argued that denial only creates additional problems unless the stressor can profitably be ignored. That is, denying the reality of the event allows the event to become more serious, thereby making more difficult the coping that eventually must occur. A third view is that denial is useful at early stages of a stressful transaction but impedes coping later on (Carver et al., 1989, p. 270).

Research is mixed on the role of denial in the experience of PTG. Some scholars have found a harmful effect of denial, where it impedes the ability for trauma survivors to develop PTG (e.g., Tuncay & Musabak, 2015); conversely, others have found a positive role of denial in the production of PTG (e.g., Arandia, Mordeno, & Nalipay, 2018; Gangstad, Norman, & Barton, 2009; Lelorain et al., 2010). In an analysis of female intimate partner violence survivors, individuals who attempted to ignore or reject their experiences were more likely to experience PTG (Arandia et al., 2018, p. 2860). This has been explained in terms of denial representing a cognitive strategy, where it provides the survivor with a mechanism to suppress negative memories of their victimization so as to allow them the ability to focus on positive attributes (Arandia et al., 2018, p. 2860). Still, the role of denial within PTG has not been clearly established nor assessed for sexual violence survivors.

Self-blame. Self-blame refers to making personal causal attributions as to why the traumatic incident occurred (Kaye-Tzadok & Davidson-Arad, 2016, p. 553). Mixed results have also been found for self-blame as a form of coping in relation to PTG. In particular, some studies have found that self-blame hinders PTG production (Ye, Chen, & Lin, 2018, p. 3), as blaming oneself prevents the necessary meaning-making from occurring. In one analysis of individuals living with HIV/AIDS, the more PTSD symptoms an individual had, the more likely they were to self-blame, subsequently diminishing their ability to achieve PTG (Ye et al., 2018, p. 6). Thus, self-blame may inhibit PTG as it relates to other psychological consequences of traumatic experiences. Contrarily, other research has found a positive effect between self-blame and PTG. It has been argued that a degree of blame is helpful in providing individuals with feelings of control in their lives after the traumatic incident (Kaye-Tzadok & Davidson-Arad, 2016, p. 551). The positive effects of self-blame, however, may only be limited to the growth category of

philosophy of life, not all forms of PTG (Garrido-Hernansaiz, Murphy, & Alonso-Tapia, 2017, p. 3265).

Self-distraction. Coping through self-distraction is the action of using other tasks in order to avoid psychological processing of the traumatic incident (García, Barraza-Peña, Wlodarczyk, Alvear-Carrasco, & Reyes-Reyes, 2018, p. 2). Common examples of this form of coping include engulfing oneself in work or engaging in activities that allow the individual to focus on the task at hand, instead of thinking about their victimization (García et al., 2018, p. 2). Consistent with denial and self-blame, the ability for self-distraction to aid in the development of PTG has mixed results. One analysis with cancer survivors found that self-distraction had no effect (neither negative or positive) in the production of PTG (Schroevers, Kraaij, & Garnefski, 2011, p. 170). Yet, when assessing the potential for PTG within a sample of paramedics, self-distraction was found to be positively correlated with the experience of PTG (Ogińska-Bulik & Kobylarczyk, 2015, p. 43). It is possible, therefore, that self-distraction may be beneficial in producing PTG for the witnessing of traumatic events (i.e., paramedics), but is ineffectual when experiencing life-threatening events (i.e., cancer patients).

Substance abuse. The use of alcohol or drugs as a form of coping is characterized by engaging in these substances in order to quell unwanted emotions and psychological consequences of the traumatic event, as well as to process and "get through" the incident (McSorley et al., 2013, p. 629). Substance abuse has consistently been found to be negatively correlated with the production of PTG (Arpawong et al., 2015; Kissil, Nino, Jacobs, Davey, & Tubbs, 2010). Interestingly, however, cigarette or hard drug use is unrelated to the development of PTG; only alcohol or marijuana use has been found to harm PTG production (Arpawong et al., 2015, p. 487).

Behavioural disengagement. Behavioural disengagement includes efforts aimed at removing oneself from the situation, even going so far as giving up attempting to deal with the stressful event (Carver et al., 1989, p. 269). It is hypothesized that this form of coping is most likely to occur when the individual anticipates negative outcomes to arise (Carver et al., 1989, p. 269). Overall, research has found that behavioural disengagement is negatively related to PTG, where the more an individual engages in this form of coping, the less likely they are to achieve PTG (Butler et al., 2005; Tuncay & Musabak, 2015).

Gender differences in coping

Research has established differences between genders in patterns of grieving, which subsequently affects coping mechanisms. It has been found that males and females have different "feelings rules," rules which govern the expression of feelings, establishing which emotions are appropriate to show and which should be supressed (Doka & Martin, 2001, p. 40). These feelings rules are largely influenced by gender norms, where males generally struggle with expressing emotions other than anger when grieving or dealing with loss (Doka & Martin, 2001, p. 41). This coincides with gender norms of strength and assertiveness, where anger portrays dominance instead of weakness and other emotions tend to emulate feebleness (Doka & Martin, 2001, p. 40). Thus, these feeling rules act as scripts for the appropriate coping mechanisms for each gender.

Significant differences between males and females in coping techniques in response to a wide range of stress have been established. Research on gender differences in coping with stress in dual-earner families (Higgins, Duxbury, & Lyons, 2010), colorectal cancer (McCaughan, Prue, Parahoo, McIlfactrick, & McKenna, 2011), prostate cancer (McSorley et al., 2013), and chronic pain (Samulowitz et al., 2018) have identified that males are more likely to cope with

stress by withdrawing, avoiding, and planning, whereas females are more likely to use social support and focus on emotions. One study found that males coping with the loss of a child were more likely to take the role of "providers, protectors, and problem-solvers," which lessened the degree to which they were willing to receive help (Doka & Martin, 2001, p. 41).

Gender norms and coping techniques

Gender norms may preclude the ability of male survivors to positively grow by affecting the coping techniques used. Since males are socialized to avoid emotions and problems, these gender norms prevent many male survivors from processing the sexual violence in a way that allows for growth and positive changes (Addis & Mahalik, 2003, p. 6; Thompson, 2001, p. 32). In general, the emotional stoicism that is stereotypical of the male gender inhibits male survivors from using coping strategies that are based on emotional processing, as emotionality is perceived as a weakness to the male gender (Cole & Lynn, 2010, p. 114; Mezey, 1992, p. 132). Male survivors are much more likely to engage in avoidant coping strategies, such as substance abuse or behavioural disengagement (Leech & Littlefield, 2011, p. 306). Moreover, the negative consequences of shame, self-blame, and identity confusion that are common for male survivors further hinder individuals from meaning-making and understanding the sexual violence, which as mentioned, is a key factor in facilitating positive changes (Easton et al., 2013, p. 212). This may occur as these negative symptoms promote internalization of the sexual violence, which prevents them from attempting to place the blame correctly on the perpetrator and understand the legitimacy of their emotions.

Even further, research has indicated that substance use is viewed as an indicator of masculinity for men, as "the ability to consume and tolerate large quantities of alcohol is often viewed as reflective of a male's level of masculinity whereas those who refrain from drinking or

drink less are often viewed as more feminine. By engaging in behaviours perceived to be more masculine, men can demonstrate their status and assert dominance within the peer group," subsequently ensuring acceptance from the male group (Whitley et al., 2018, p. 478). In this regard, male survivors of sexual violence may choose to cope in ways that are more congruent with their prescribed gender norms in an attempt to regain feelings of masculinity. By using substance abuse as a form of coping, male survivors may reclaim their perceived loss of masculinity and demonstrate to their male ingroup that they are still a "man" (Vandello & Bosson, 2013, p. 103).

The adherence to gender norms and rape myths increases the likeliness that male survivors will be met with harmful reactions upon disclosure. Adverse informal and formal disclosures can contribute to secondary victimization, which occurs when survivors perceive negative reactions from those they disclose to, consequently producing subsequent negative symptoms (Jackson et al., 2017, p. 276). Sexual violence survivors are vulnerable and extremely attentive to the reactions of those they are disclosing to, where even somewhat mixed reactions can increase feelings of shame and self-blame (Campbell & Raja, 1999; Rich & Seffrin, 2013, p. 682). Reactions such as disbelief (e.g., "men cannot be raped"), victim blaming (e.g., "you should have fought back"), and minimization (e.g., "it should not emotionally upset you") are common responses to male survivors, increasing the potential to produce further psychological trauma and re-traumatization (Jackson et al., 2017, p. 276). Thus, in the case of male sexual violence, the positive reactions that are necessary to promote positive changes and PTG when using external support as a form of coping may not be accomplished. In fact, it has been shown that negative social reactions to disclosures and self-blame are the two most common reasons individuals engage in avoidant coping (Daane, 2017, p. 104). The likeliness of both of these

elements occurring is particularly high for male survivors of sexual violence, increasing the chance that avoidant coping is used, as the option to use social support as a coping mechanism may not be feasible, straining the potential for male survivors to achieve PTG.

Yet, gender norms also have the potential to produce PTG for male survivors of sexual violence. This effect is dependent upon the degree to which the male survivor engages in planning coping, which has been identified to be used more by men than women (Samulowitz et al., 2018). Given the prescriptive gender norms of men always being dominant and in charge (Levant & Richmond, 2007, p. 133), male survivors of sexual violence may resort to planning coping as a way to regain control of themselves and their lives. Developing a plan and taking action is much more in line with masculine norms than discussing emotions and focusing on feelings (Kassing & Prieto, 2003; Levant & Richmond, 2007), and this form of coping still allows the survivor to effectively deal with the traumatic event (Litman & Lunsford, 2009, p. 984). In these cases, the use of planning coping may help facilitate the experience of PTG for male survivors of sexual violence. Thus, the effect of gender norms may not be completely detrimental to the production of PTG within male survivors.

Critique of coping

One of the largest concerns regarding the use of coping as a concept is the lack of clear and consistent coping categories (Skinner, Edge, Altman, & Sherwood, 2003, p. 216). Coping categories, or ways of coping, are the different mechanisms used in order to deal with stressful or traumatic events, such as acceptance, religion, denial, or emotional support (Skinner et al., 2003, p. 216). As this field has failed to neatly categorize the different ways of coping, research has invariably used a number of different terms for the same style of coping (Dewe, O'Driscoll, & Cooper, 2010, p. 26). For example, the category of positive reframing has also been discussed as

positive reinterpretation or positive reappraisal; the category of avoidance is commonly referred to as distraction; and socially-supported as social or emotional support or support seeking (Cole & Lynn, 2010; Easton et al., 2013; Eisenbarth, 2012; Frazier et al., 2004; Noda et al., 2018). Moreover, the categories used in this thesis (self-sufficient, socially-support, and avoidant) were chosen as they represent one organization reflected in the coping questionnaire COPE (to be discussed in the next chapter); however, not only do other categories and organizations exist in the general coping literature, inconsistency is also present within grouping coping forms for the COPE questionnaire. The result is an inability for comparative and amalgamated research, as each coping category is unique to the specific study (Skinner et al., 2003, p. 217).

Further criticisms arise in the overarching categories of problem-focused and emotion-approach coping. The borders of problem- and emotion-centred coping are fuzzy and unclear, causing distinction between the two to be problematic (Skinner et al., 2003, p. 227). Coping as a process does not always neatly fit into well-defined categories as it encompasses an excess of behaviours and thoughts (Dewe et al., 2010, p. 31). As such, many coping styles can fit into both problem- and emotion-focused coping (Lazarus, 1966, p. 293); "for example, making a plan not only guides problem solving but also calms emotion. Venting not only escalates negative emotion but also interferes with implementing instrumental actions" (Skinner et al., 2003, p. 227). Even further, some forms of coping seem to fall outside the realm of both emotion- and problem-focused coping (Skinner et al., 2003, p. 227). To illustrate, external support as a form of coping is removed from the self as an active agent and is instead centred on other people, therefore failing to meet the criteria for either emotion- or problem-based coping (Skinner et al., 2003, p. 227). As a result, most research today has steered away from conceptualizing coping within the strict categories of problem-focused and emotion-approach.

Similarly, critiques have also arisen regarding the distinction between approach and avoidant coping. Approach coping positions an individual toward the traumatic event, encouraging them to deal with the stressor, whereas avoidance coping orients the individual away from the incident (Roth & Cohen, 1986, p. 813). Problems appear when classifying types of coping within these categories, as some forms of coping are not easily placed within neat categories (as with problem- and emotion-focused coping) (Skinner et al., 2003, p. 228). For example, external support is typically conceptualized as a form of approach coping as it is argued to draw the individual toward the appropriate resources necessary to deal with the traumatic incident; yet, it can also be reasoned that external support is a form of avoidance as it positions the individual away from the trauma and towards other people (Skinner et al., 2003, p. 228).

Additionally, conceptualizations of approach and avoidance coping have been laced with value assumptions regarding the positive or negative aspects of these styles of coping (Skinner et al., 2003, p. 228). More specifically, approach coping has been considered in terms of the positive forms of coping that aid healing and psychological well-being; conversely, the detrimental effect avoidance coping has on well-being has been highlighted (Skinner et al., 2003, p. 228). Because of this, conceptualizations of approach coping often incorporate forms of coping that are actually avoidance-based, but positive in value, and vice versa (Skinner et al., 2003, p. 228). For instance, social support is rarely considered within avoidance categories, even though it orients the individual away from the stressor; moreover, aggression as a form of coping is indiscriminately excluded from conceptualizations of approach coping as it is negative in nature (Skinner et al., 2003, p. 228).

Regardless of these critiques, the concept of coping is important to this thesis. The inclusion of a variety of coping mechanisms provides a more wholesome analysis of the role of

coping in the development of PTG. The literature on PTG development and sexual violence survivors has characteristically centred on acceptance and approach styles of coping, while infrequently incorporating avoidance coping mechanisms (Cole & Lynn, 2010; Easton et al., 2013; Frazier et al., 2004; Frazier & Berman, 2008). As a result, the concept of coping within this thesis allows analysis to go deeper than past literature, measuring the impact of coping on three factors (self-sufficient, socially-supported and avoidant coping). This thesis will be able to assess broadly how coping impacts the development of PTG for male survivors of sexual violence, looking at patterns of higher order categories of coping (self-sufficient, socially-supported and avoidant) and their patterns of association with PTG.

This new knowledge can also help further understanding of how service provision may produce PTG. In particular, recognizing more completely which coping styles are positively associated with PTG, service providers and counsellors can incorporate a model of care focused on fostering these beneficial coping styles so as to help promote PTG. Similar to gender norms, coping as a concept is also influential in regard to explaining service access. Coping styles may help explain patterns of service access for male survivors of sexual violence; for example, male survivors who utilize more planning, acceptance, or external support styles of coping may be less likely to interrupt service access as opposed to those who utilize self-blame, substance abuse, or behavioural disengagement coping techniques.

Lastly, the dual effect of coping and gender norms as concepts are exceptionally important to this thesis. The use of these two concepts permits an assessment of how adherence to gender norms and coping styles relate to the development of PTG for male survivors of sexual violence. Thus, the individual variance in obedience of masculine norms can be linked to their subsequent use of coping techniques to examine the combined effect on PTG. For example, male

survivors who intensely follow male gender norms may be more inclined to use substance abuse or behavioural disengagement in order to cope, as these forms of coping are more in line with stereotypical representations of masculinity (Whitley et al., 2018, p. 478). As such, the joint effect of strong adherence to male gender norms and coping through substance abuse or behavioural disengagement may negatively impact the ability of these survivors to achieve PTG.

This section focused on the complexities of masculinity and their role in PTG, namely how gender norms and coping techniques common to the male gender may affect the experience of PTG for male survivors of sexual violence. The next section will look at how service provision may be able to facilitate PTG for male survivors of sexual violence.

2.4. Service Provision for Sexual Violence Survivors and its Role in Posttraumatic Growth

Service provision within Canada for male survivors of sexual violence is fairly limited (Gagnier, Collin-Vezina, & de la Sablonniere-Griffin, 2017). The organizations that do exist, however, offer a number of different services designed to promote psychological bettering (Du Mont, Macdonald, White, & Turner, 2013, p. 2679). These services range from counselling (both individual and group), crisis hotlines, victim services and legal aid. The majority of evaluative studies of service provision focus on therapeutic intervention, specifically its ability to reduce negative symptomatology (Roepke, 2015). Evaluative research on the role of service provision in producing PTG is extremely scarce, with the limited literature establishing a framework for how therapy can promote positive growth (other forms of service provision have been neglected from this framework). As a result, this section will focus on this body of knowledge, presenting the ways in which therapy provision may foster PTG.

2.4.1. Producing Positive Changes

While the limited research on the positive consequences of traumatic events has focused on what changes occur and what factors are associated with these changes, little scholarship has been dedicated to how service provision may facilitate this growth. Early therapy provision can be important in maintaining positive changes over the long-term (Frazier et al., 2006, p. 3). It was found that individuals who reported high levels of positive change at the two-week mark of Frazier and colleagues (2006) study were less distressed than those individuals who reported change later on (p. 3). As such, clinicians have a significant role in facilitating and maintaining early positive changes. The role of the clinician is as a facilitator to demonstrate the ways the survivor can enhance their own sense of control, connectedness with others, and develop productive coping mechanisms (Berger, 2015, p. 151).

The role of the clinician as a guide has a number of important steps. It is imperative that clinicians enter into the framework of the survivor, understanding the survivor's worldview and refraining from imposing personal beliefs and values (Calhoun & Tedeschi, 1999, p. 55; Tedeschi & Calhoun, 2004b, p. 412). Clinicians must work to normalize emotions, establishing to male clients that experiencing and having emotions is normal and acceptable (Cordova, 2008, p. 192; Tedeschi, Calhoun, & Groleau, 2015, p. 507). Normalizing emotions prevents survivors from avoiding their feelings, especially shame and self-blame, if they understand the reasons for their emotions and that they are not unique in these experiences (Cordova, 2008, pp. 192-193; Vossler, Steffen, & Joseph, 2015, p. 436). Once emotions have been normalized, clinicians can then focus on guiding the male survivor's meaning-making and understanding (Easton et al., 2013, p. 212). Since "high levels of physiological arousal are obstacles to expressing emotions [and] problem solving," clinicians can teach clients cognitive-behavioural coping skills in order

to increase the survivor's feelings of control (Cordova, 2008, p. 195). These cognitive-behavioural skills also confront negative thoughts, increasing the ability for positive thinking and subsequent growth (Cordova, 2008, p. 195; Tedeschi et al., 2015, p. 507).

Clinicians must foster the survivor's cognitive processing through active listening and encouraging the survivor to continue constructive cognitive changes (Tedeschi & Calhoun, 2004b, p. 413). This step does not try to solve any issues raised, but the purpose is to listen and reassure the survivor's thoughts (Joseph & Linley, 2006, p. 98). Through this listening, the next step is to identify elements of growth and label them as such for the survivor (Tedeschi & Calhoun, 2004b, p. 414). It is necessary that clinicians focus on the successful aspects of the struggles the survivor is having as opposed to the trauma, as growth in many instances can arise from the overcoming of struggle (Joseph & Linley, 2006, p. 98). Lastly, the clinician can help the survivor develop a useful and constructive narrative about their struggle which can allow the survivor to become cognizant of their own growth and accomplishments (Joseph & Linley, 2006, p. 98; Tedeschi & Calhoun, 2004b, p. 415). In some instances, the male survivor may not have disclosed the sexual violence to friends or family at the point of therapeutic intervention. In these cases, the clinician can coach the survivor through potential disclosure scenarios, with the goal of increasing social support for the survivor (Cordova, 2008, p. 193; Tedeschi et al., 2015, p. 508).

This section outlined the brief knowledge on how therapeutic intervention may foster PTG for survivors of sexual violence. This body of literature demonstrates the need for research into other forms of service provision that are offered to male survivors, including crisis hotlines and victim services. The next section will outline the overarching research question that guides this thesis, as well as the five hypotheses this thesis tests.

2.5. Research Questions and Hypotheses

This thesis seeks to understand the role of gender norms, coping mechanisms, and service access in promoting or hindering posttraumatic growth (PTG) for male survivors of sexual violence. As such, the following research question guides this thesis: "how do gender norms, coping mechanisms, and service access interact in their association with posttraumatic growth for male survivors of sexual violence?" In order to answer this research question, it is further broken down to "what factors, or combination of factors, are associated with posttraumatic growth for male survivors of sexual violence?" This led to the formation of five hypotheses, each of which will be discussed in detail below.

2.5.1. Hypothesis One: Lower Endorsement of Traditional Masculine Norms is Associated with Posttraumatic Growth for Male Survivors of Sexual Violence

As mentioned in the previous chapter, when men are told that they score high on feminine knowledge tests, they refuse to publicize their scores and more strongly adhere to stereotypical masculine norms (Rudman & Fairchild, 2004, p. 169). As the experience of sexual violence is gendered and equated more with females, male survivors of sexual violence may in turn more strongly adhere to stereotypical gender norms as a way to regain their masculine status (Vandello & Bosson, 2013, p. 103). Unfortunately, however, highly following these gender norms may prohibit male survivors' ability to achieve PTG as these typical male norms restrict emotionality and prohibit men from showing weakness (Levant & Richmond, 2007, p. 131). Yet, it is this emotional awareness and processing that has been positively correlated with the experience of PTG (Cole & Lynn, 2010; Frazier et al., 2004). Thus, this thesis hypothesizes that male survivors of sexual violence who demonstrate a lower endorsement of traditional masculine norms are more likely to experience PTG than those survivors who express higher endorsement.

Subsequently, male survivors of sexual violence who strongly adhere to male gender norms are anticipated to experience a lack of growth.

2.5.2. Hypothesis Two: Male Survivors of Sexual Violence Who Use Self-Sufficient Coping Styles are More Likely to Experience Posttraumatic Growth

Men are more likely to utilize planning coping (a form of self-sufficient coping) or avoidant coping and are less likely to engage in socially-supported coping when responding to trauma (Baker & Berenbaum, 2007; Samulowitz et al., 2018). Self-sufficient coping styles have commonly been associated with PTG for sexual violence survivors, including acceptance, positive reframing, and planning coping (Cole & Lynn, 2010; Easton et al., 2013; Frazier et al., 2004). Conversely, avoidant coping styles, while there is some debate with specific forms of coping under this category, have more consistently been negatively associated with PTG (Arpawong et al., 2015; Butler et al., 2005; Kissil, Nino, Jacobs, Davey, & Tubbs, 2010; Tuncay & Musaback, 2015; Ye, Chen, & Lin, 2018). As such, this thesis hypothesizes that male survivors of sexual violence who use coping styles that fall under the higher-order categories of self-sufficient coping are more likely to experience PTG. Further, male survivors of sexual violence who engage frequently in the coping techniques that fall under the higher-order category of avoidant coping are expected to experience an absence of PTG.

2.5.3. Hypothesis Three: Male Survivors of Sexual Violence Who Have Higher Endorsement of Traditional Masculine Norms but Use Self-Sufficient Coping are More Likely to Experience Posttraumatic Growth

Stronger adherence to gender norms may prevent male survivors from utilizing socially-supported coping styles as it requires them to reach out to resources and support networks, thereby demonstrating weakness (Rudman & Fairchild, 2004; Vandello & Bosson, 2013;

Whitley et al., 2018). Thus, the use of self-sufficient and avoidant coping become more likely for male survivors. In general, males are more likely to use the coping techniques of planning (self-sufficient coping), substance abuse, and behavioural disengagement (avoidant coping) (McCaughan et al., 2011; Samulowitz et al., 2018), where PTG is positively correlated with planning and negatively correlated with the latter two (Arpawong et al., 2015; Kaye-Tzadok & Davidson-Arad, 2016; Tuncay & Musabak, 2015). The use of self-sufficient coping styles may consequently serve as a protective variable for men who strongly endorse stereotypical male gender norms as it allows male survivors to develop a necessary action plan and make meaning, without showing vulnerability (Litman & Lunsford, 2009, p. 984). This thesis hypothesizes that male survivors of sexual violence who intensely follow and adhere to male gender norms that are postulated to hinder PTG may still achieve this growth if they utilize self-sufficient coping. Male survivors who have a high endorsement of male gender norms and use avoidant coping are therefore speculated to experience a lack of PTG.

2.5.4. Hypothesis Four: Male Survivors of Sexual Violence Who Have Stable Service Access (Without Interruption) are More Likely to Experience Posttraumatic Growth

Stable service access is hypothesized to produce a formal social support network, whereby male survivors of sexual violence, through the constant use of services, have individuals they can trust and confide in with the details of their victimization (Frazier et al., 2004). This social support has been consistently linked to PTG (Frazier et al., 2004; Kaye-Tzadok & Davidson-Arad, 2016). While this stable service access may be able to build important relationships and support for the survivor, it may also allow and aid the survivor in making meaning, and work on helping the survivor utilize coping styles linked with PTG (Berger, 2015, p. 151). Moreover, research has indicated that PTG may require time in order to develop

(Casellas-Grau, Ochoa, & Ruini, 2017, p. 2011), and irregular use of services may inhibit this timeline. Therefore, this thesis hypothesizes that male survivors who use services without interruption (i.e., stable) are more likely to experience PTG than those survivors who interrupt their service. Unstable and irregular service access is conversely predicted to be associated with an absence of PTG for male survivors of sexual violence.

2.5.5. Hypothesis Five: Male Survivors of Sexual Violence Who Intensely Use Services are More Likely to Experience Posttraumatic Growth

Four main types of services exist: crisis lines, victim services, and individual and group therapy. Crisis lines and victim services are less intense of a demand and commitment for male survivors; more specifically, crisis lines are used whenever the male survivor deems fit and victim services typically only last as long as an individual's legal case or until they receive the appropriate referrals. Yet, individual and group therapy are much more intense; they require male survivors to make weekly or bi-weekly commitments for around an hour. This higher level of intensity of the service may be more likely to promote PTG in male survivors due to the frequency in which the survivor is required to work through the trauma (Berger, 2015, p. 151; Tedeschi & Calhoun, 2004b). Moreover, previous research has demonstrated that social support is positively correlated with PTG (Frazier et al., 2004). As such, therapeutic intervention with the same counsellor may be much more likely to produce PTG due to the in-person bond (or group bond in the case of group therapy) with the same individual(s). Conversely, while victim services and crisis lines certainly afford male survivors with support, they are usually only used for immediate care and do not provide survivors with the same individual(s) to grow a true support network (Colvin, Pruett, Young, & Holosko, 2017, p. 974). Consequently, this thesis hypothesizes that male survivors of sexual violence who access services more intensely (i.e.,

group or individual therapy) are more likely to experience PTG than those individuals who access services less intensely (i.e., crisis lines or victim services). These less intense forms of services are subsequently speculated to be linked to a lack of growth for male survivors.

This section outlined the guiding research question and the five hypotheses this thesis tests. The final section is a concise conclusion to the literature review and conceptual framework chapter.

2.6. Conclusion

The above illustrates the current comprehension regarding the trauma male sexual violence survivors experience, the positive changes that can occur following sexual violence, the role of gender norms and coping mechanisms in the production of posttraumatic growth (PTG), and the ways in which service provision can produce positive outcomes. Male survivors experience a range of trauma symptoms following the sexual violence, such as PTSD, self-blame, anger, and identity confusion (Walker et al., 2005b). Female and child sexual violence survivors commonly report experiencing all categories of PTG, most consistently citing increased empathy, stronger interpersonal relationships, a greater appreciation of life, and better recognition of personal strengths (Frazier et al., 2001; Frazier et al., 2006). Yet, a number of factors can preclude a male survivor's ability to experience PTG, most notably being the influence of gender norms and specific coping styles (Borja et al., 2006; Cole & Lynn, 2010; Frazier et al., 2004). Male gender norms of strength and assertiveness create an illusion of immunity to victimization. The stronger a male survivor adheres to these gender norms, the less likely they may be to experience PTG as they may subsequently be less willing to emotionally process the event and utilize positive reframing or external support coping styles. The majority

of research on the role of service provision in the production of PTG has centred on therapy; however, this literature represents more of a framework for how services may assist PTG, failing to extensively evaluate its effectiveness (Roepke, 2015). For example, clinicians play an important role in facilitating positive changes in survivors and serve as a guide in order to enable positive reframing or external support coping as well as diminish any negative influence of gender norms (Berger, 2015).

A recurring theme of this literature review and conceptual framework is the considerable dearth of knowledge surrounding male sexual victimization. The literature surrounding PTG has focused on female or child sexual violence survivors, creating the need for research to assess growth within the male survivor population exclusively. Thus, it is the goal of this research to contribute to this under-developed area of insight in two distinct ways. The main goal of this research is to examine the main configurations of factors associated with PTG for male survivors of sexual violence. This research will establish the role of gender norms, coping mechanisms, and service access in the experience, or lack thereof, of PTG for male survivors of sexual violence. Therefore, this research aims to add to the limited literature on building positive outcomes through traumatic events, asking the research question, "how do gender norms, coping mechanisms, and service access interact in their association with posttraumatic growth for male survivors of sexual violence?" From this research question, the following five hypotheses emerged:

1. *Lower endorsement of traditional masculine norms is associated with posttraumatic growth for male survivors of sexual violence;*
2. *Male survivors of sexual violence who use self-sufficient coping styles are more likely to experience posttraumatic growth;*

3. *Male survivors of sexual violence who have higher endorsement of traditional masculine norms but use self-sufficient coping are more likely to experience posttraumatic growth;*

4. *Male survivors of sexual violence who have stable service access (without interruption) are more likely to experience posttraumatic growth; and*

5. *Male survivors of sexual violence who intensely use services are more likely to experience posttraumatic growth.*

Chapter 3. Methodological Approach

This chapter describes the research design and the various methodological components. It includes an overview of the participants, sampling procedure, variables of interest, instruments used, methods, and data analysis plan.

3.1. Participants and Sampling Procedure

Recruitment was two-fold. A total of 46 sexual violence organizations within Canada were contacted for recruitment. Of these 46, only nine agreed to aid in recruitment. The participating sexual violence organizations are: the Community Counselling Centre of Nipissing; Klinic Community Health; the Newfoundland and Labrador Sexual Assault Crisis and Prevention Centre; the Centre for Treatment of Sexual Abuse and Childhood Trauma; the Sexual Assault Centre Hamilton Area; the Sexual Assault Centre for Quinte and District; the Sexual Assault Centre London; the Sexual Assault Crisis Centre Windsor; and the BC Society for Male Survivors of Sexual Abuse. These agencies posted the recruitment posters within their waiting rooms or counsellors' offices, handed posters to clients as they checked-in, or posted it on their website. Recruitment also took place online through forums that catered to sexual violence survivors, such as Hope 24/7 and iSurvive.

In order to be eligible to participate, individuals were required to identify as male, be 18 years or older, and currently be accessing services from a sexual violence organization within Canada. The contacted organizations and online forums recruited a total of 14 participants. Participants were contacted one month after completing the pre-test in order to complete the post-test. Only nine participants completed both the pre- and post-test, further reducing the sample size.

3.1.1. Participant Demographics

Table 1 provides the sociodemographic information for the nine participants who completed both the pre- and post-test. Participants are overrepresented within ethnicity and the country they were born in, limiting the ability of this thesis to generalize beyond Canadian born Caucasians. Moreover, most individuals utilized individual therapy, restricting the effect of other forms of service access, such as crisis lines. Since no one utilized group therapy by itself, but instead always in tandem with individual therapy, the singular role of group therapy is also unable to be assessed. Two participants (22.22%) indicated they interrupted their service access for longer than the four weeks participants had between tests. It is possible that these individuals confused their timelines (memory bias) or were interrupting their service access at the time they completed the pre-test. Most participants experienced sexual violence as a child by a male perpetrator, further limiting this thesis' ability to generalize.

Participants within this sample also frequently experienced two or more forms of sexual violence (N=4, 44.44%), illustrating previous findings that many individuals often experience more than one incident of sexual violence after their first encounter (Finkelhor, Ormrod, & Turner, 2007; Tillyer, Gialopsos, & Wilcox, 2016). Of those who experienced multiple incidents of sexual violence, 75% (N=3) experienced at least one of these incidents in childhood. This replicates previous research that has indicated that individuals who experience violence as children are more likely to experience similar (if not the same) forms of violence (Widom, Czaja, & Dutton, 2008).

Table 1. Sociodemographic Information

Demographic	Descriptives
Age	Mean = 43, with a low of 18 and a high of 66 66.67% (N=6) of participants are over the age of 30
Education	Bachelor's degree (N=1, 11.11%) College degree (N=5, 55.56%) High school diploma (N=2, 22.22%) Grade 12 equivalent (N=1, 11.11%)
Currently employed	Yes (N=5, 55.56%) No (4, 44.44%)
Ethnicity	Caucasian (N=7, 77.78%) Indigenous (N=1, 11.11%) Middle Eastern (N=1, 11.11%)
Country born	Canada (N=8, 88.89%) Egypt (N=1, 11.11%)
Sexual orientation	Heterosexual (N=5, 55.56%) Bisexual (N=3, 33.33%) Homosexual (N=1, 11.11%)
Experienced sexual violence	As a child (younger than 18 years) by a male perpetrator (N=6, 66.67%) As a child by a female perpetrator (N=2, 22.22%) As an adult by a male perpetrator (N=2, 22.22%) Witnessed sexual violence as a child by a male and female perpetrator (N=1, 11.11%for both male and female perpetrators) As an adult by a female perpetrator (N=1, 11.11%) Witnessed sexual violence as an adult by a male perpetrator (N=1, 11.11%)
Service access	Individual therapy (N=6, 66.67%) Group therapy (N=4, 44.44%) Victim services (N=4, 44.44%) Support lines (N=1, 11.11%)
Comorbidity of service access	Used two or more services (N=5, 55.56%) Individual and group therapy (N=4, 80%)
Length of service access	Mean = 25 months
Service interruption and length	Most participants interrupted their service use (N=5, 55.56%) for an average of 60 weeks

This subsection outlined the recruitment process and participants of this thesis. The next subsection will centre on convenience sampling, including its limitations and strengths.

3.1.2. Convenience Sampling

Convenience sampling is a form of non-probabilistic sampling where each individual does not have an equal likelihood of being included in the study (Schonlau, Fricker, & Elliot, 2002, p. 8). This form of sampling is commonly used to gather members of the population of interest that meet practical criteria, such as any geographic requirements or availability (Etikan, Musa, & Alkassim, 2016, p. 2). Convenience sampling, therefore, rests on self-selection to participate in the study (Schonlau et al., 2002, p. 33). Because this form of sampling is based on convenience, it is typically used with exploratory studies (Newing, 2011, p. 72).

Critique of convenience sampling

Since convenience sampling requires individual initiative in order to participate, key flaws arise. Crucially, those who decide to participate may be (and likely are) different than those who decide not to participate (Sousa, Zauszniewski, & Musil, 2004, p. 130). This voluntary aspect of convenience sampling increases the likeliness that those who participate are those who feel stronger about the research topic than those who choose not to participate (Sousa et al., 2004, p. 130). Therefore, convenience sampling introduces a level of bias to the research (Wallen & Fraenkel, 2001, p. 138). In this particular thesis, only those individuals who frequented the sexual violence centres that agreed to participate or the online forums that allowed research postings were able to participate. The possible pool of participants additionally dwindled to those who saw the recruitment poster. Clearly, not all who see the poster participate, further lessening available participants. Thus, participants' perceptions and progress may differ than if a truly random sample was incorporated. For example, male survivors who do not feel any psychological progress from their service access may not have chosen to participate in this study. In this regard, a random sample may have found completely different factors associated with

PTG for male survivors of sexual violence. Convenience sampling thereby significantly reduces the researcher's ability to make claims of representativeness and subsequently, generalizability (Wallen & Fraenkel, 2001, p. 138).

Despite this, convenience sampling is extremely helpful in providing access to hard-to-reach populations (Schonlau et al., 2002, p. 33). Very few resources and services within Canada exist for male survivors of sexual violence and those that are available, are not frequented as often as those for female survivors (largely due to stigma and perceptions of masculinity) (Gagnier et al., 2017). As such, gaining access to this population is difficult and random sampling may be a formidable task. This thesis expected to receive a lower response rate; this expectation led to the use of qualitative comparative analysis (QCA) in order to make modest generalizations about the data received from smaller sample sizes (to be discussed in a later section) (Berg-Schlosser, De Meur, Rihoux, & Ragin, 2009). The exploratory nature of this thesis coupled with the use of QCAs overcomes this limitation of convenience sampling as high-level generalizations are not the goal. This thesis makes no claims of representativeness for the entire population of male survivors of sexual violence but is instead interested in making soft inferences about the population of male survivors of sexual violence who utilize support services.

This section demonstrated the recruitment process, the various participant demographics and the use of convenience sampling. The next section will operationalize the variables of interest and provide information on the survey instruments used.

3.2. Variables of Interest and Survey Instruments

3.2.1. Operationalization of Variables

The case of interest, outcome variable and various condition variables will be defined as they pertain to this specific thesis and analysis. Male survivors of sexual violence represent the case of interest and are defined as any individual who identifies as a male who has experienced some form of sexual violence. Sexual violence, as previously defined, is "any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object" (World Health Organization [WHO], 2017, para. 4). This thesis also includes the witnessing of sexual violence within its definition of sexual violence. This traumatic experience may have happened at any point in the individual's life (child or adult), by a male or a female.

The outcome variable, PTG, is defined as the acquisition of positive characteristics that the individual develops because of their traumatic experience (Cole & Lynn, 2010; Easton et al., 2013; Tedeschi & Calhoun, 2004a). The total score is composed of five categories of change: a greater appreciation of life, closer intimate relationships, recognition of new possibilities for one's life, greater personal strength, and spiritual change (Tedeschi & Calhoun, 1996). Increased feelings of gratitude and happiness for what one has in life, a change in individual priorities in life, and an increased thankfulness to be alive demonstrates a greater appreciation of life (Calhoun & Tedeschi, 1999; Calhoun & Tedeschi, 2006; Tedeschi & Calhoun, 1996). Increased feelings of intimacy, empathy and meaning between current relationships (be it family or friends) commonly define the experience of closer intimate relationships (Calhoun & Tedeschi, 2006;

Tedeschi & Calhoun, 2004a). When the individual realizes a new path for their life, such as a different career, the ability for new possibilities for one's life is illustrated (Calhoun & Tedeschi, 2006). Greater personal strength refers to an increase in perceived strengths, where the individual believes that they are strong and able to overcome adversity (Calhoun & Tedeschi, 1999). An increased sense of connectedness with God defines changes in spirituality; however, spirituality is not limited to religion, as existential questioning is also an aspect of spiritual growth (Tedeschi & Calhoun, 2006). While data is collected on each domain of change within PTG, this thesis utilizes the overall total score from the Posttraumatic Growth Inventory Short Form (PTGI-SF) in order to understand whether PTG is achieved. This outcome variable is represented by a continuum, with scores representing the degree of PTG achieved on a scale from 0.0 to 1.0.

There are a number of condition variables included in this analysis. Adherence to gender norms reflects the degree to which each male survivor supports traditional male gender norms, such as the requirement for males to always want sexual encounters, for males to be strong, and for males to be in charge. Coping refers to the individual's attempt to manage the various psychosocial demands of traumatic events (Scheenan et al., 2017). This thesis utilizes three categories of coping: self-sufficient, socially-supported, and avoidant. Self-sufficient coping includes any form of coping that the individual can maintain on their own, without the use of other individuals or faiths (e.g., planning, acceptance, or positive reframing). Socially-supported coping, conversely, refers to those coping styles that rely on the help of others (be it services or friends and family) or religions, such as the use of emotional or instrumental support or religious coping. Lastly, avoidant coping includes the various forms of coping that prevent the individual from processing the event emotionally and making meaning, such as substance abuse or denial. It is important to note that the category of avoidant coping is not inherently negative; as mentioned

in Chapter 2, certain forms of coping within this category have both positive and negative effects on the production of PTG. As with PTG, scores on each factor are collected, but only the total score is used in the analysis. These condition variables are all represented on a continuum, with the degree of membership ranging from 0.0 to 1.0.

Utilizing services without interruption defines stable service access; for example, if group therapy has weekly sessions, the individual does not skip a session or drop-out of the therapy before completion. Stability of service access is dichotomized for ease of analysis and is represented as either unstable (interruption of service access and therefore, irregular users) or stable (no interruption of service access and therefore, regular users). The intensity of service use is defined as the demand the particular service places on the individual. For example, individual and group therapy are considered to be more intense, as they necessitate the individual to come to weekly or bi-weekly sessions and place more emotional requirements upon the individual (i.e., to work through the sexual violence). Conversely, crisis lines and victim services are less intense as they are used when the survivor wants, periodically through a survivor's legal case, or when seeking referrals. These condition variables are dichotomous, where membership is either 0 or 1. The specific calibration of all condition variables and the outcome variable are in subsection 3.5.

This subsection operationalized the case of interest, the outcome variable, and the various condition variables. The next subsection will provide details on the various survey instruments used, including their strengths and weaknesses.

3.2.2. Survey Instruments

This thesis uses four questionnaires (see appendices A-D). The pre-test consists of a sociodemographic questionnaire which provides the participant demographic information

discussed above, the Brief Coping Orientation to Problems Experienced (COPE) which gauges coping mechanisms, and the Male Role Norms Inventory Short Form (MRNI-SF) which evaluates adherence to male gender norms. The post-test includes two questions on whether interruption of service access occurred since the pre-test, the Brief COPE, MRNI-SF, as well as the PTGI-SF which assesses PTG. The following subsections will discuss the Brief COPE, MRNI-SF, and PTGI-SF in detail.

It is important to note, however, that all questionnaires administered are self-reported. This presents inherent flaws to the methodology, such as misrepresentation, as well as recall, memory and perception issues (Baldwin, 2000; Bradburn, 2000; Kihlstrom, Eich, Sandbrand, & Tobias, 2000; Tourangeau, 2000). It has long been documented that individuals will alter their responses on self-report data in order to appear more positive to the researcher or to adjust the results of the research (either positively or negatively) (Baldwin, 2000, p. 5). This flaw is one that becomes particularly relevant for the perceived negative forms of coping (e.g., substance abuse), the degree to which participants adhere to male gender norms (e.g., they may downplay the extent to which they endorse more problematic statements, such as "a man should always be the Prime Minister of Canada" or "homosexuals should not be allowed to marry"), as well as the level of growth they have experienced (e.g., they may be more inclined to rank higher growth so as to not feel negative about their current psychological state).

The ability of participants to recall and the strength of their memory is another challenge to the use of self-reported data. Most problematically, memory issues affect the ability of participants to accurately report their experience of PTG. Participants are asked the degree to which they have experienced the positive change as a result of their sexual violence; therefore, it is quite an arduous task for participants to separate these changes from their pre- and post-

victimized self. Even further, emotional states have been shown to affect the ability to remember events, and given the highly traumatic extent of sexual victimization, the validity of participants' responses can be called into question (Kihlstrom et al., 2000, p. 81).

Yet, there is no ethical way to test the experience of PTG in a purely objective approach, and as such, self-reported data remains the most effective way to understand this concept, despite the limitations of such a method (Baldwin, 2000, p. 5). Moreover, while memory issues and misrepresentation might cloud the data, it is much more problematic to use other methods to gauge the use of coping mechanisms and adherence to gender norms. Male survivors are more likely to be candid and honest about their use and agreeance of more socially-unacceptable coping and gender beliefs through anonymous surveys than face-to-face. Given the high number of coping mechanisms and the various factors that compose the endorsement of gender norms, self-report surveys also provide an optimal way to gather data on such a breadth of topics.

The Brief Coping Orientation to Problems Experienced (COPE)

The COPE Inventory was first established by Carver and colleagues (1989) in order to analyze a variety of coping styles. In its full form, the COPE Inventory has 60 questions with 15 subscales (Brasileiro et al., 2016, p. 2). Yet, due to its extensive and repetitive nature, the COPE Inventory has been found to be particularly burdensome for its respondents (Carver, 1997, p. 93). In acknowledgement of these limitations, Carver (1997) developed the Brief COPE, a subset of the COPE Inventory with only 28 questions (14 scales, 2 questions each). The following scales, or forms of coping, are included within the Brief COPE: self-distraction, active coping, denial, substance use, use of emotional support, behavioural disengagement, venting, use of instrumental support, positive reframing, self-blame, planning, humour, acceptance, and religion

(Carver, 1997, p. 96). Responses are scored on a 4-point scale, where 1 represents "I haven't been doing this at all" and 4 signifies "I've been doing this a lot" (Brasileiro et al., 2016, p. 3).

This thesis utilizes a 3-factor structure; the three factors are self-sufficient, socially-supported and avoidant coping (Litman, 2006). The coping strategies of active coping, planning, positive reframing, humour, and acceptance fall within the factor of self-sufficient coping (Gutiérrez, Peri, Torres, Caseras, & Valdés, 2007; Litman, 2006). The use of emotional support, the use of instrumental support, religion, and venting fit within the category of socially-supported coping (Gutiérrez et al., 2007; Litman, 2006). Lastly, self-distraction, denial, substance use, behavioural disengagement, and self-blame are within avoidant coping (Gutiérrez et al., 2007; Litman, 2006). This thesis chose this particular factor analysis for two reasons. First, a three-factor analysis has a small number of categories sufficient for a QCA to be conducted, without overly complicating or simplifying the results (Berg-Schlosser et al., 2009, p. 28; Schneider & Wagemann, 2010, p. 402). Second, this particular factor analysis removes inconsistencies found with other structures; for example, some analyses remove some forms of coping from evaluation or group based on the perceived positive or negative effect (Brasileiro et al., 2016, p. 8).

Critique of the Brief COPE. Not unique to the Brief COPE, but instead an issue within the coping literature in general, is the difficulty and inconsistency in conceptualizing ways of coping. Unfortunately, this limitation has trickled down to the formulation and execution of the Brief COPE, where extreme variance exists with different factors. The problem with the Brief COPE lies with the discrepancy in definitions and use of higher-order categories (Wang et al., 2018, p. 163). Thus, while the lower-order categories (e.g., acceptance, substance use, or use of emotional support) remain the same with each use, the higher-order categories that these forms

of coping are grouped into lack uniformity (Wang et al., 2018, p. 163). Two- and 3-factor structures are used most frequently, where 2-factor analyses group ways of coping as either "adaptive" or "maladaptive" and 3-factor analyses focus on the approach, avoidant, and self-sufficient aspects of coping (Wang et al., 2018, p. 163). Yet, lower-order categories are not unequivocally able to fit into each factor, where some ways of coping can fit into multiple factors. For example, in one factor analysis, the category of "venting" has been contradictorily included within the higher-order category of avoidant coping or socially-supported coping (Wang et al., 2018, p. 163).

Yet, the Brief COPE is advantageous in its brevity, a particularly important benefit for this thesis due to the number of questionnaires administered. Moreover, while certain criteria are used inconsistently across studies, this is more a limitation regarding ease of generalizability and tracking of literature, as opposed to the questionnaire itself.

This subsection outlined the Brief COPE, its factors, strengths and limitations. The next subsection will discuss the MRNI-SF.

The Male Role Norms Inventory Short Form (MRNI-SF)

Levant and colleagues (1992) developed the MRNI in order to capture both traditional and non-traditional male gender norms. In its original form, the MRNI has 57 questions with eight subscales (seven representing traditional male norms and one for non-traditional) (Levant, Hall, & Rankin, 2013, p. 1), yet a revised version (MRNI-R) demonstrated that 39 questions with seven factors was more accurate and representative (dropping the non-traditional subscale) (Levant et al., 2013, p. 1). Once more, in order to avoid respondent exhaustion, a short-form of the MRNI-R was created, representing 21 questions (3 questions for each factor) (Levant et al.,

2013, p. 1). The seven factors are restrictive emotionality, self-reliance through mechanical skills, negativity towards sexual minorities, avoidance of femininity, importance of sex, dominance, and toughness (Levant et al., 2013, p. 6). Respondents answer a 7-point scale, where 1 represents "strongly disagree" and 7 denotes "strongly agree," with higher scores indicative of a higher endorsement of male gender norms (Levant et al., 2013, p. 3).

Critique of the MRNI-SF. While the bifactor model (that is, the seven factors) has been established as the most representative, a significant flaw arises with this execution. In particular,

> previous bifactor model specifications of the MRNI-SF have varied considerably in the extent to which correlations are allowed among the specific factors. The specification for a classic bifactor model forces all factors to be completely orthogonal; thus partitioning item level variance into only two sources: the general factor and the item's intended specific factor. However, in the initial validation study of the MRNI-SF, Levant and colleagues (2013) allowed all of the specific factors to intercorrelate with each other, and in a later study, certain correlations were freed based on modification indices. If a bifactor structure is the best representation of the MRNI-SF's dimensionality, then it is important for investigators to identify the effects of different ways of specifying the model for future research and practice (McDermott et al., 2017, p. 725).

Despite this, the MRNI-SF is found to be reliable, valid, and has measurement invariance (the construct of male gender norms is being measured across various populations and settings) (Gerdes, Alto, Jadaszewski, Auria, & Levant, 2018; Levant et al., 2013; McDermott et al., 2017). The MRNI-SF overcomes many of the limitations of other questionnaires on this construct, as it is able to capture the multidimensional nature of male gender norms (Levant et al., 2013, p. 9; Thompson & Bennett, 2015, p. 118).

This subsection discussed the MRNI-SF, including its strengths and limitations. Next, the PTGI is presented.

The Posttraumatic Growth Inventory Short Form (PTGI-SF)

Tedeschi and Calhoun (1996) originally developed the PTGI in order to accurately capture the concept of PTG. The PTGI has five factors, each one representing a category of PTG, with 21 questions. In order to reduce the extent of participant exhaustion, this thesis selects the PTGI-SF. The PTGI-SF has only 10 questions total (2 questions on each factor) (Cann et al., 2010, p. 129). The five factors are: relating to others, new possibilities, personal strength, spiritual change and appreciation of life (Cann et al., 2010; Tedeschi & Calhoun, 1996). Responses are scored on a 6-point scale, where 0 denotes "I did not experience this change as a result of my sexual violence" and 5 signifies "I experienced this change to a very great degree as a result of my crisis" (Cann et al., 2010, p. 130).

Critique of PTGI-SF. The largest critique with the PTGI-SF has to do with its self-reported nature. More specifically, PTGI-SF, and the concept of PTG in general, rests on retroactive reporting, where the accuracy of participants' memory is significantly called into question (Kaur et al., 2017, p. 2; Tedeschi, Addington, Cann, & Calhoun, 2014, p. 350). As mentioned, because this tool requires participants to rate the degree of positive change since their victimization, separating pre- and post-states is an onerous task. Even further, it is possible that individuals may confuse psychological bettering with positive changes (Kaur et al., 2017, p. 2). Thus, the PTGI-SF may not be measuring actual growth, but perceived growth. Regardless of this, the PTGI-SF has been found to have considerable reliability and validity across a number of types of trauma and different populations and is noted as the best measure to capture PTG (Cann et al., 2010; Taku & Oshio, 2015; Tedeschi, Cann, Taku, Senol-Durak, & Calhoun, 2017).

This section defined the variables of interest and illustrated the various survey instruments used within this thesis, including their strengths and limitations. The next section will discuss the method of QCA that will be used to analyze the data.

3.3. Qualitative Comparative Analysis

Traditional correlational analysis, such as regression, is not able to provide information on the specific factors for each particular individual that influence the outcome or dependent variable(s) (Berg-Schlosser et al., 2009, p. 8). In this sense, the single statistic that is produced in traditional correlational (or inferential) analysis cannot be applied to every individual in the sample; therefore, conclusions and inferences from such a procedure will invariably apply fairly well to some cases, but not others (Berg-Schlosser et al., 2009, p. 8). As an alternative to traditional statistics, a QCA provides the researcher with a way to link specific configurations of factors to the outcome, as observed in individual cases. This approach is consistent with the notion of "equifinality," which recognizes that different combinations can lead to the same outcome (Elliot, 2013, p. 1). Further, since traditional correlational analysis centres on the mean of the sample, it often ignores or removes outliers from analysis (Berg-Schlosser et al., 2009, p. 8). Yet, outliers can provide valuable insight into a given phenomenon, and as such, equifinality does not necessarily exclude solutions which only apply to one case on the basis that they are "noise" or "irrelevant" to the phenomenon of interest (Berg-Schlosser et al., 2009, p. 8).

While some forms of traditional inferential statistics permit an assessment of the influence of multiple independent variables on a dependent variable (e.g., multiple regression), the combined role of a variety of factors as observed in specific cases is indiscernible from these methods (Elliot, 2013, p. 2). QCAs, however, are more complex, allowing an evaluation of

multiple conjuctural association or causation (Berg-Schlosser et al., 2009, p. 8). Multiple conjuctural causation, or equicausality, are combinations, or multiple combinations, of conditions within a given analysis that produces the outcome variable (Berg-Schlosser et al., 2009, p. 8). In some cases, multiple conjunctural causation may occur when a condition has a varying impact on the outcome, dependent on its context (Berg-Schlosser et al., 2009, p. 8). Given this complexity, QCAs are able to move beyond a single model that explains the data best to provide a holistic explanation from the varying conditions (Ragin, 1987, p. 167).

The relevance of QCA for this thesis rests with the notion that not only do individuals react differently to intervention, but the role of the varying coping styles and adherence to gender norms may not interact in a manner that a "line of best fit" would be applicable and useful in describing the results. As such, due to its with congruence with the principles of equifinality and equicausality, in order to answer the research question and test the described hypotheses, a QCA will be conducted.

Charles Ragin (1987) first introduced QCA, which is utilized in order to compare cases on a variety of factors and provide the researcher with the ability to make modest generalizations with smaller sample sizes (average N of 15-20) (Berg-Schlosser et al., 2009, p. 11). Ragin's (1987) QCA has five main characteristics; first, it incorporates a case-based approach whereby each case is required to be viewed as a whole throughout the entirety of analysis (Marx, Rihoux, & Ragin, 2014, p. 119). In this sense, QCA requires that parts of each case are understood as they relate to other cases, but also, the combined effect of these cases as it creates a whole must also be comprehended (Marx et al., 2014, p. 119). As such, cases are characterized as configurations of variables (Marx et al., 2014, p. 119). Next, QCAs are comparative, which

allows similarities and differences to be analyzed across cases through a truth table[6] (Marx et al., 2014, p. 119).

Third, QCA centres around an explanatory model that allows contradictions in the data (i.e., where a specific configuration is related to both the presence and the absence of a particular outcome) to be revealed and resolved (Marx et al., 2014, pp. 119-120). This resolution is critical to allowing QCAs to act as an explanation and expansion on theory (Ragin, 2005, p. 34). Because of this explanatory model, QCAs are able to speak to multiple conjunctural causation (Berg-Schlosser et al., 2009, p. 8). Lastly, QCA provides researchers with the opportunity to reduce the empirical complexity of their data so as to increase parsimony (i.e., simplicity) (Marx et al., 2014, p. 120).

QCA serves five different research purposes. The first, most basic use of QCAs is descriptive, simply summarizing data allowing for data exploration (Berg-Schlosser et al., 2009, p. 15; Marx et al., 2014, p. 116). QCA may also be used in order to check the coherence of the data and causal conditions (Berg-Schlosser et al., 2009, p. 15; Marx et al., 2014, p. 116). Third, QCA permits the assessment of hypotheses and theories (Berg-Schlosser et al., 2009, p. 16; Marx et al., 2014, p. 116). Closely related, QCA can also be used to evaluate the researcher's ideas or proposals further permitting data exploration (Berg-Schlosser et al., 2009, p. 16; Marx et al., 2014, p. 116). Lastly, QCA may also be used to develop and evaluate new theories (Berg-Schlosser et al., 2009, p. 16; Marx et al., 2014, p. 116).

QCA "require[s] that each case be broken down into a series of features: a certain number of condition variables and an outcome variable" (Berg-Schlosser et al., 2009, p. 12). The best

[6]A truth table displays the researcher's data in a matrix that demonstrates all conceivable causal conditions.

practice maintains that the number of conditions remains relatively low as the higher the number of conditions, the more individualized the case of interest becomes (Berg-Schlosser et al., 2009, p. 28; Schneider & Wagemann, 2010, p. 402). This individualization thereby prevents an analysis of variance and regularity across cases (Berg-Schlosser & De Meur, 2009, p. 28). For this thesis, male survivors of sexual violence represent the case of interest and the outcome is PTG. The following are the established conditions for which PTG may be made possible or hindered for male survivors: adherence to gender norms (high versus low); coping techniques (self-sufficient, socially-supported and avoidant); stability of service access (regular user versus irregular user); and intensity of service access (intense versus not intense).

3.3.1. Crisp versus Fuzzy Sets

Crisp-set qualitative comparative analyses (csQCA) are the simplest and most frequently used QCA method (Rihoux & De Meur, 2009, p. 33). csQCAs are used with binary data, where cases are either "in" (represented as 1) or "out" (represented as 0) of a set (Ragin, 1998, p. 108). This form of analysis thereby rests on Boolean algebra, most importantly the concept of Boolean minimization (Rihoux & De Meur, 2009, p. 35). Boolean minimization is the ability to reduce mathematical expressions into simpler equations by removing variables that do not have an influence on the outcome from the equation (Rihoux & De Meur, 2009, p. 35). To illustrate, the condition variable can be removed from the equation if both the presence and the absence of a condition variable produce the same outcome when in tandem with other variables.

Fuzzy-set qualitative comparative analyses (fsQCA), conversely, extend membership beyond "in" or "out," allowing varying degrees to account for partial affiliation (Ragin, 2009, p. 89). Four main forms of fuzzy sets exist: three-value, four-value, six-value, and continuous

(Ragin, 2009, p. 91). In all fuzzy sets, scores range from 0 to 1, with varying degrees within to represent different affiliations (Ragin, 2009, p. 91). For example, in a three-value fuzzy set, 1 = fully in; 0.5 = neither fully in nor fully out; and 0 = fully out (Ragin, 2009, p. 91). In comparison, in a six-value fuzzy set 1 = fully in; 0.9 = mostly but not fully in; 0.6 = more or less in; 0.4 = more or less out; 0.1 = mostly but not fully out; and 0 = fully out (Ragin, 2009, p. 91). Thus, in all forms of fsQCA, qualitative anchors exist at both 0 and 1 (Schneider & Wagemann, 2010, p. 403). It is important to note that fsQCAs permit the use of crisp-set variables (that is, binary variables) within its analysis, but that fsQCAs also incorporate variables on a continuum of membership. This thesis uses a fsQCA, incorporating both dichotomous and multi-level variables (see section 3.4 for specific calibration).

3.3.2. Critique of QCAs

Crisp- and fuzzy-set QCAs both have limitations. csQCAs, as they require dichotomous variables, inherently oversimplify the actuality of the results (Sehring, Korhonen-Kurki, & Brockhaus, 2013, p. 14). Similarly, the use of dichotomous variables may not be practicable or easily definable in each case (Sehring et al., 2013, p. 14). Yet, csQCAs are particularly easy to perform and can be used in instances with a small number of cases (Sehring et al., 2013, p. 14). fsQCAs, conversely, permit "gradual assessment [and…] better description of the complexity of the factors [, but] requires more cases to establish significant findings [and] may result in a large number of logical remainders" (Sehring et al., 2013, p. 14). While these limitations exist, a QCA is best suited for this thesis as it provides the strongest analysis for small sample sizes. Given this thesis uses convenience sampling and only has nine participants, QCA allows combinations of variables to occur with these methodological weaknesses. Yet, the average sample size for QCAs is 15-20, with the smallest sample size usually being 10 (Berg-Schlosser et al., 2009, p. 11). As

such, this thesis is limited in the ability to make the modest generalizations that QCAs permit, given the smaller than average sample size. This limitation is noted, and this thesis avoids making any claims of generalization. QCA, however, best allow this thesis to understand how the different factors tested interact to produce or hinder PTG.

This section centred on the methods of QCA that this thesis uses. The next section will present the data analysis plan.

3.4. Data Analysis Plan

The survey software LimeSurvey is utilized for both the pre- and post-test; all data is exported from LimeSurvey into an excel spreadsheet which includes the nine participants who completed both the pre- and post-test.

3.4.1. Qualitative Comparative Analysis Steps

In a QCA, the data is first entered and presented in typical matrix form, where the data in the rows represent each individual case and the data in the columns reflect the various condition variables and the specific outcome (rightmost column) (see table 2 for raw scores).[7]

Table 2. Raw Scores

id	service	stable	preselftotal	presocialtotal	preavoidanttotal	pretotmrni	coperself	copesocial	copeavoid	masconorm	growth
1	4	0	32	20	29	66	-3	-1	0	30	19
2	2	0	24	20	12	84	6	4	-1	-11	44
3	4	1	20	20	24	59	9	0	-3	-3	15
4	5	1	26	23	27	34	0	-1	-10	2	35
5	1	1	19	18	30	44	8	10	-8	-12	26
6	3	0	18	14	27	24	-3	-3	-4	4	26
7	4	1	21	23	21	45	3	0	-4	-8	27
8	6	0	28	16	30	23	-6	1	-12	-2	11

[7]These raw scores represent the change from the pre- to the post-test.

14	2	1	33	26	19	71	-5	-3	-3	-10	40

After data entry, all necessary raw data is recalibrated to represent a membership score between 0 and 1. In a csQCA, scores that are "fully in" are represented as a 1, whereas those that are "fully out" are denoted as a 0 (Rihoux & De Meur, 2009, p. 42). In a fsQCA, three important anchors are established within calibration: full non-membership (always denoted as 0), full membership (always represented as 1), and the "crossover point, where there is maximum ambiguity regarding whether a case is more 'in' or 'out' of a set" (Ragin, 2009, p. 90). With the fuzzy-set data, this thesis utilizes two crossover points (see table 4 for calibration description), thus employing a four-value fuzzy set. This particular calibration is useful as participants are not identical across the coping, gender norm, and growth variables (Ragin, 2009, p. 90). Using this four-value fuzzy-set provides the best account for the varying degree of membership reflected within the sample, without losing important information (Ragin, 2009, p. 90). As such, fsQCAs take continuous level variables and convert them into categorical variables on a scale from 0 to 1.

Table 3. Variables and their Calibration

Condition/Outcome *Operationalization*	Score	Calibration Description
Adherence to gender norms (pretotmrni; mascnorm) The degree to which traditional masculine norms are supported	0 0.4 0.6 1	Not adhering to gender norms to any degree Somewhat adhering to gender norms, but mostly not Mostly adhering to gender norms, but somewhat not Fully adhering to gender norms
Self-sufficient coping (preselftotal; copeself) The degree to which self-sufficient coping techniques are utilized; includes active, planning, positive reframing, humour, and acceptance coping	0 0.4 0.6 1	Not utilizing self-sufficient coping to any degree Somewhat using self-sufficient coping styles, but mostly not Mostly using self-sufficient coping, but somewhat not Fully using self-sufficient coping
Socially-supported coping (presocialtotal; copesocial)	0	Not utilizing socially-supported coping to any degree

The degree to which socially-supported coping techniques are utilized; includes the use of emotional and instrumental support, religion, and venting	0.4 0.6 1	Somewhat using socially-supported coping styles, but mostly not Mostly using socially-supported coping, but somewhat not Fully using socially-supported coping
Avoidant coping (preavoidanttotal; copeavoidant) The degree to which avoidant coping techniques are utilized; includes self-distraction, denial, substance use, behavioural disengagement, and self-blame	0 0.25/0.4 0.75/0.6 1	Not utilizing avoidant coping to any degree Somewhat using avoidant coping styles, but mostly not Mostly using avoidant coping, but somewhat not Fully using avoidant coping
Service access (service) The intensity of service use; includes victim services, crisis lines, and individual and group therapy	0 0.25 0.75 1	Not intensely accessing services; using only crisis lines Somewhat using services intensely; using victim services Mostly using services intensely; using only one form of therapy or a combination of a therapy and victim services Using services intensely; using both individual and group therapy or using both therapies and victim services
Stability of service access (stable) Whether service use is interrupted	0 1	Service use is uninterrupted Service use is interrupted
Posttraumatic growth (growth) The degree to which positive characteristics are developed because of the sexual violence	0 0.4 0.6 1	No growth is experienced Somewhat experienced growth, but mostly not Mostly experienced growth, but somewhat not Fully experienced growth

Important to calibration is the definition of cut-off points. The cut-off points for calibration are established through theoretical, substantive, or technical grounds (Rihoux & De Meur, 2009, p. 42). The best practice maintains that cut-off points are justified through theoretical or substantive reasoning; however, technical thresholds are permitted with smaller sample sizes (Ragin, 2009, p. 93; Rihoux & De Meur, 2009, p. 42). This thesis utilizes technical thresholds, due to the limited number of participants, where cut-off points are established by the distribution of cases on a continuum. In order to establish cut-off points, the process of visual binning is utilized, where cases are ordered from lowest to highest and the cut-off points are chosen based on the distribution. This method is selected in order to prevent an inflation or

deflation of the results, as there are not enough participants to necessarily adequately reflect theoretical or substantive cut-off points.

QCA allows for the negation of scores. In a fsQCA, negated scores are calculated by subtracting their non-negated membership score from 1 (Ragin, 2009, p. 94); for example, an individual who mostly experienced growth (represented as 0.6) would have a negated score of 0.4. Within the output, the tilde sign ("~") or the variable written in lowercase letters (e.g., "growth") are used to demonstrate negation. This thesis negates PTG scores in order to account for the combination of causal configurations related to an absence of growth.

After data has been calibrated (and negated if necessary), the next step is the formulation of truth tables. Once more, a truth table displays the researcher's data in a matrix that demonstrates all conceivable causal conditions. QCAs are most consistently run (this thesis included) using the R package "QCA" (Dusa, 2019a), which allows the negation of variables, the construction of truth tables, and the analysis of necessity and sufficiency. A necessary condition variable is one where the occurrence of the outcome variable does not happen unless the specific condition variable is present (Dul, 2018, p. 1; Legewie, 2013, p. 9). The researcher must conduct a necessary condition analysis in order to determine which condition variables are necessary within the dataset. A condition can be interpreted as necessary in a fsQCA if the scores on the condition variable across the sample are higher than or equal to the outcome variable (Schneider & Grofman, 2006, p. 34). This is demonstrated on a scatterplot if all cases fall below the diagonal line (Schneider & Grofman, 2006, p. 36). In a csQCA, a condition variable is considered necessary if every instance the outcome variable is 1 within the truth table, the condition variable is also 1. In other words, a necessary factor is one that will always be present in order for an outcome to occur (Schneider & Grofman, 2006, p. 33).

A sufficiency analysis is also required in order to determine what condition variables are sufficient in explaining or accounting for the outcome variable; specifically, a sufficient condition variable is capable of creating the outcome on its own, either alone or in combination with other factors (Legewie, 2013, p. 9). A condition can be understood as sufficient in a fsQCA if the scores on the condition variable across the sample are lower than or equal to the outcome variable (Schneider & Grofman, 2006, p. 34). This is illustrated on a scatterplot if all cases fall above the diagonal line (Scneider & Grofman, 2006, p. 36). In a csQCA, condition variables can be seen as sufficient if all rows within the truth table where the condition variable equals 1, the outcome variable also equals 1 (Schneider & Grofman, 2006, p. 33).

After the truth tables have been constructed, the next step is minimization analysis, which reveals the solutions for the outcome variable. During this step, the researcher must decide the solution coverage. Solution coverage denotes the percentage of the outcome that is covered by the solution term (Wagemann & Schneider, 2010, p. 7). As mentioned, QCA's main assumption is that an outcome can be best explained by an interplay of conditions, known as multiple conjunctural causation (Wagemann & Schneider, 2010b, p. 27). As such, each condition variable is tested in tandem with the outcome variable, so as to demonstrate the necessary combinations for the outcome to be achieved.

Solutions are presented in the following format:

conditionvariable1*CONDITIONVARIABLE2 + conditionvariable3 =
OUTCOMEVARIABLE

The output, or solutions, speak to the absence or presence of a condition or outcome variable. Lowercase letters represent the absence or low use of a variable, whereas uppercase letters denote the presence or high use of a variable. The outcome variable will be represented in

uppercase letters unless the researcher negated the outcome, in which case, the use of the negated outcome variable will be represented in lowercase letters. The solution uses asterisks ("*") to mean "and," while plus signs ("+") are used to represent "or." Therefore, the above example indicates that the low use of condition variable one and the high use of condition variable two or the low use of condition variable three is associated with the outcome variable (in its non-negated form).

In tandem with the solutions, QCA output also includes solution coverage tables. These tables provide the researcher with the raw coverage (covS in output), unique coverage (covU in output), sufficiency inclusion score (incl in output), and proportional reduction in inconsistency (PRI in output) for the entire solution, as well as each subset (e.g., the specific groupings of variables, such as "conditionvariable1*CONDITIONVARIABLE2" or "conditionvariable3"). Coverage, in general, provides the researcher with information regarding the percentage of the outcome that is accounted for using a particular solution (Wagemann & Schneider, 2010, p. 7). A low coverage does not indicate a lack of empirical evidence; for example, a solution that demonstrates equicausality may have a low coverage, yet still illustrate important findings (Roig-Tierno et al., 2017, p. 17). Raw coverage exemplifies what percentage of the outcome variable is explained by a specific solution, whereas unique coverage describes the percentage of the outcome variable that is *entirely* explained by a specific solution (Wagemann & Schneider, 2010, p. 7).

Sufficiency inclusion score signifies the inclusion cutoff for the existence of the outcome variable, therefore representing the specific consistency of each solution (Dusa, 2019a, p. 59). The consistency score represents the degree to which causal combinations will produce the outcome variable (Ragin, 2009, p. 109). Unlike coverage, a low consistency score indicates that

the solution is not supported by empirical evidence (Roig-Tierno, Gonzalez-Cruz, & Llopis-Martinez, 2017, p. 17). If a sufficiency inclusion score is high for the presence of an outcome, it is logically expected that the sufficiency inclusion score will be low for the absence of an outcome, or vice versa (Dusa, 2019b, p. 135). Yet, in some instances, this is not the case, where both the presence and the absence of an outcome may have a high sufficiency inclusion score (Dusa, 2019b, p. 135). In these cases, the PRI is used to determine which solution is best suited for the outcome variable, where whichever PRI score is higher is retained as the appropriate solution (Dusa, 2019b, p. 135). For example, if the solution for the presence of an outcome has a PRI score of 1 and the absence of an outcome has a PRI score of 0, the solution for the presence is kept as sufficient (Dusa, 2019b, p. 135).

This section outlined the data analysis plan, including the steps to QCA. The next section will conclude the methodology chapter.

3.5. Conclusion

This chapter centred on the methodological components of this thesis. In attempting to understand the factors related with PTG for male survivors of sexual violence, this thesis seeks to answer the research question "how do gender norms, coping mechanisms, and service access interact in their association with posttraumatic growth for male survivors of sexual violence?"

Recruitment took place within nine sexual violence organizations and online forums. A total of 14 participants were recruited through these means, but after attrition, 9 participants remain. This thesis uses convenience sampling, where participants are gathered non-probabilistically through self-selection (Schonlau et al., 2002). Each participant is administered four questionnaires at both the pre- and post-test. Both the pre- and post-test include a socio-

demographic questionnaire, the Brief COPE and the MRNI-SF. The post-test additionally has the PTGI-SF. In order to answer this research question and test these hypotheses, a QCA is conducted. QCAs allow the researcher to compare cases on multiple factors and subsequently make moderate generalizations with smaller samples (Berg-Schlosser et al., 2009).

Chapter 4. Results

This chapter presents the findings of the fsQCA. The results from the post-test are presented, which represents the degree of change from the pre- to the post-test.

Table 4 presents the fuzzy-set membership scores for the outcome of PTG and the six causal conditions. In total, three of the nine cases fully experienced growth (score =1), three mostly experienced growth (score = 0.6), two somewhat experienced growth (score = 0.4) and one did not experienced growth at all (score = 0).

Table 4. Membership Scores from Calibrated Data

Id	service	stable	copeself	copesocial	copeavoid	mascnorm	growth
1	1	0	0	0	0	0	0
2	0.25	0	0.6	0.6	0	1	1
3	1	1	1	0	0.25	0.6	0.4
4	1	1	0	0	1	0.4	1
5	0.75	1	1	1	0.75	1	0.6
6	0	0	0	0	0.25	0.4	0.6
7	1	1	0.4	0	0.25	0.6	0.6
8	0.75	0	0	0	1	0.6	0.4
14	0.25	1	0	0	0.25	1	1

In order to determine which condition variables are necessary within the dataset, a necessary condition analysis is conducted. In regard to the fuzzy-set variables, no condition variables are necessary for the presence or absence of PTG (see appendix E and F for the necessity scatterplots of all variables). Further, the truth tables are presented in tables 5 and 7 and demonstrate that neither crisp set condition variable (service or stable) are necessary for the presence or absence of PTG.

A sufficiency analysis is also conducted to determine which condition variables are sufficient in explaining or accounting for the outcome variable. None of the fuzzy-set condition

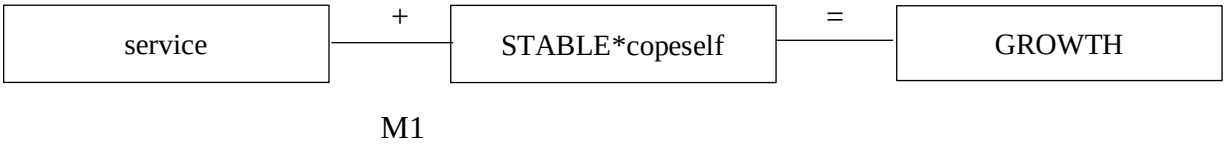
variables follow this pattern and therefore, no conditions can be deemed as sufficient for the presence or the absence of PTG (see appendix G and H for the sufficiency scatterplots of all variables). Moreover, presented below are the truth tables (see tables 5 and 7) which indicate that neither of the crisp-set variables (service and stable) are sufficient condition variables for the presence or absence of PTG.

Table 5 presents the truth table for the post-test condition variables for the presence of growth. Contradictions and remainders for reduction are included in each minimization analysis. Minimization revealed one major solution for the experience of PTG (solution coverage 0.95) (see figure 1 and table 6). Low service intensity or high stability of service access and low use of self-sufficient coping styles are associated with PTG for male survivors of sexual violence.

Table 5. Truth Table for PTG

	service	stable	copeself	copesocial	copeavoid	mascnorm	out	n	incl	PRI
1	0	0	0	0	0	0	1	1	1.000	1.000
14	0	0	1	1	0	1	1	1	1.000	1.000
18	0	1	0	0	0	1	1	1	1.000	1.000
50	1	1	0	0	0	1	1	1	1.000	1.000
51	1	1	0	0	1	0	1	1	1.000	1.000
33	1	0	0	0	0	0	0	1	0.000	0.000
36	1	0	0	0	1	1	0	1	0.667	0.000
58	1	1	1	0	0	1	0	1	0.800	0.000
64	1	1	1	1	1	1	0	1	0.800	0.571

Notes. "out" = output value; "n" = the number of cases in configuration; "incl" = sufficiency inclusion score; "PRI" = proportional reduction in inconsistency.



M1

Figure 1. Solution for PTG

Notes. * means 'and;' + means 'or.' Uppercase letters represent the presence of a condition and lowercase represents the absence of a condition. M1 refers to solution 1.

Table 6. Solution Coverage for PTG

Solution	inclS	PRI	covS	covU
service	0.867	0.810	0.464	0.330
STABLE*copeself	1.000	1.000	0.464	0.330
M1	0.918	0.887	0.795	

Notes. * means 'and.' Uppercase letters represent the presence of a condition and lowercase represents the absence of a condition. M1 refers to solution 1.

Tests were also conducted on the conditions related to an absence of growth at the post-test. Table 7 provides the truth table for the absence of growth with the post-test conditions. Minimization yielded three main solutions for the absence of PTG (solution coverage 0.95) (see figure 2 and table 8). High service intensity and low stability of service access or (1) high use of self-sufficient coping and low use of socially-supported coping styles; (2) high service intensity, high use of self-sufficient coping and low use of avoidant coping; or (3) high stability of service access, high use of self-sufficient coping styles, and low use of avoidant coping are associated with the absence of PTG for male survivors of sexual violence.

Table 7. Truth Table for the Absence of PTG

	service	stable	copeself	copesocial	copeavoid	mascnorm	out	n	incl	PRI
33	1	0	0	0	0	0	1	1	1.000	1.000
36	1	0	0	0	1	1	1	1	1.000	1.000
58	1	1	1	0	0	1	1	1	1.000	1.000
1	0	0	0	0	0	0	0	1	0.667	0.000
14	0	0	1	1	0	1	0	1	0.000	0.000
18	0	1	0	0	0	1	0	1	0.000	0.000
50	1	1	0	0	0	1	0	1	0.471	0.000
51	1	1	0	0	1	0	0	1	0.294	0.000
64	1	1	1	1	1	1	0	1	0.533	0.000

Notes. "out" = output value; "n" = the number of cases in configuration; "incl" = sufficiency inclusion score; "PRI" = proportional reduction in inconsistency.

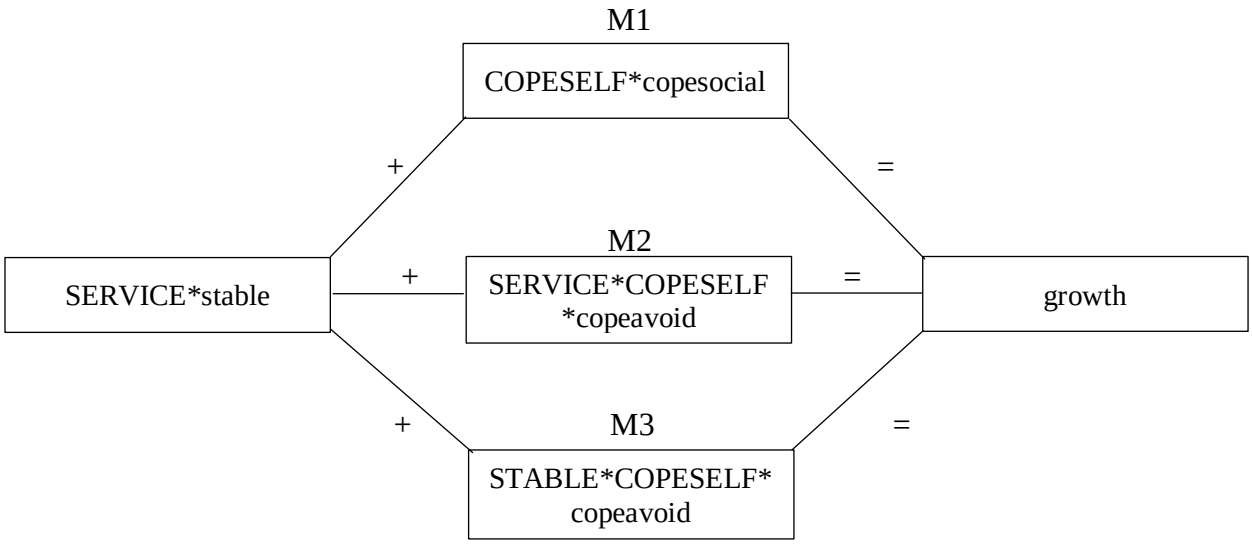


Figure 2. Solutions for the Absence of PTG

Notes. * means 'and;' + means 'or.' Uppercase letters represent the presence of a condition and lowercase represents the absence of a condition. M1 refers to solution 1, M2 is solution 2, and so on.

Table 8. Solution Coverage for the Absence of PTG

Solution	inclS	PRI	covS	covU	(M1)	(M2)	(M3)
SERVICE*stable	0.800	0.750	0.471	0.471	0.471	0.471	0.471
COPESELF*copesocial	0.556	0.200	0.294	0.000	0.294		
SERVICE*COPESELF*copeavoid	0.758	0.333	0.368	0.000		0.368	
STABLE*COPESELF*copeavoid	0.893	0.571	0.368	0.000			0.368
M1	0.732	0.596	0.765				
M2	0.838	0.718	0.838				
M3	0.838	0.718	0.838				

Notes. * means 'and;' + means 'or.' Uppercase letters represent the presence of a condition and lowercase represents the absence of a condition. M1 refers to solution 1 and so on.

This section presented the results of the fsQCA. The next section will discuss these results.

Chapter 5. Discussion

The goals of this thesis are to establish the configuration of factors associated with PTG, or the lack thereof, for male survivors of sexual violence. In particular, this thesis assesses the role of gender norms, coping mechanisms, and service access in the experience of PTG. This thesis is guided by the overall research question of "how do gender norms, coping mechanisms, and service access interact in their association with posttraumatic growth for male survivors of sexual violence?" This research question is further broken down to "what factors, or combination of factors, are associated with posttraumatic growth for male survivors of sexual violence?" Five hypotheses are formulated and tested to answer the research question. This chapter discusses each hypothesis and whether it has been confirmed. It also contextualizes these results within the broader literature and knowledge surrounding this topic.

5.1. Endorsement of Gender Norms and Coping Mechanisms

5.1.1. The Effect of Gender Norms on PTG

Based on traditional male gender norms, such as emotional stoicism and strength, this thesis hypothesizes that a lower endorsement of these norms is associated with PTG for male survivors of sexual violence (hypothesis one). The underlying assumption behind this hypothesis is that these stereotypical norms inhibit the necessary psychological processes for PTG to occur, such as meaning-making and the use of social support (Levant & Richmond, 2007, p. 131). Yet, adherence to gender norms is not found within the solutions for either the presence or absence of PTG. Therefore, this thesis finds no support for hypothesis one, where adherence to gender norms is unrelated to both the presence and absence of PTG for male survivors of sexual violence.

5.1.2. The Effect of Different Coping Styles on PTG

Consistently, research on a range of trauma survivors has showcased that self-sufficient coping techniques are positively correlated with PTG (Cole & Lynn, 2010; Leech & Littlefield, 2011). While variance exists in this literature regarding the efficacy of lower-order coping styles in the production of PTG, for ease of analysis this thesis tests the broader, higher-order categories. As such, this thesis hypothesizes that male survivors of sexual violence who use self-sufficient coping styles are more likely to experience PTG (hypothesis two). Yet, the results indicate that this hypothesis is unsupported, where the use of self-sufficient coping is most consistently related to the absence of PTG in tandem with patterns of service access.

The use of self-sufficient coping to a high degree, as well as avoidant coping to a small degree and **either** high intensity services or stable service access (coverage of 36.8% each) is related to an absence of PTG at the post-test. It is possible that the high service intensity and stability are cause for the change in the use of self-sufficient (either from low to high or remaining at high) and avoidant (either from high to low or remaining at low) coping. The intensive and stable service access is able to lower the male survivor's use of avoidant coping mechanisms, while subsequently raising their use of self-sufficient coping. On the surface, this seems to be a combination potentially accounting for the presence of growth, given the current knowledge surrounding PTG. Yet, the effect of the lower-order styles of coping that encompass these categories may be different than research has previously seen or conceptualized (Bonanno, 2004; Frazier & Berman, 2008; Litman & Lunsford, 2009; Nielsen & Knardahl, 2014; Perez et al., 2009).

It may be that male survivors of sexual violence are unable to utilize self-sufficient coping in the same advantageous way that has been found to occur for female sexual violence survivors (Cole & Lynn, 2010; Easton et al., 2013; Frazier et al., 2001; Frazier et al., 2004). More specifically, male survivors may have a difficult time incorporating sexual violence into their schema due to the conflict between their victimization and gender, subsequently affecting their ability to make meaning, understand their emotions, and appropriately place blame onto the perpetrator, all of which contribute to the success of self-sufficient coping (Easton et al., 2013; Folkman & Moskowitz, 2000; Park & Folkman, 1997). In their attempt to understand the causal reasons for their victimization, male survivors of sexual violence may be unable to find satisfying answers beyond their own personal fault (Litman & Lunsford, 2009, p. 989; Park & Folkman, 1997, p. 131). This process is likely to encourage a state of rumination, whereby male survivors incessantly focus on their victimization, limitations, and negative affect and experiences, thereby leading to poor psychological adjustment and preventing the production of PTG (Litman & Lunsford, 2009, p. 989; Skaags & Barron, 2006, p. 539). This rumination may then increase the extent to which male survivors withdraw and isolate themselves as a form of avoidant coping. This form of avoidant coping, known as behavioural disengagement, is regularly linked to disrupting an individual's ability to achieve growth (Tuncay & Musabak, 2015).

While the total category of avoidant coping has been found particularly detrimental to the development of PTG (Bonanno, 2004; Cole & Lynn, 2010; Frazier & Berman, 2008), there is considerable debate on the effect of the lower-order categories that encompass avoidant coping (Lelorain et al., 2010). Specifically, denial, self-blame and self-distraction have been found to both facilitate and hinder the experience of PTG within a range of trauma survivors (Arandia et

al., 2009; Kaye-Tzadok & Davidson-Arad, 2016; Ogińska-Bulik & Kobylarczyk, 2015), while substance abuse and behavioural disengagement have consistently shown negative effects on the development of PTG (Arpawong et al., 2015; Tuncay & Musabak, 2015). In the case of male survivors of sexual violence, it could be that the former lower-order categories actually facilitate PTG, while the latter impede growth. In these particular solutions (high self-sufficient coping, low avoidance coping, and either high service intensity or high service stability), it could be that the intensity and stability of the service access are actually lessening the degree to which male survivors engage in the former lower-order avoidant coping styles. For example, attributing blame onto oneself is erroneous and deleterious under the category of self-sufficient coping, yet helpful and productive (to a certain extent) under the category of avoidant coping (Easton et al., 2013, p. 216; Kaye-Tzadok & Davidson-Arad, 2016, p. 551). Thus, service providers may be attempting to completely remove self-blame as it has been shown to prevent effective meaning-making (Easton et al., 2013, p. 216), even though it may provide male survivors with a regained sense of control (under the coping style of self-blame) (Kaye-Tzadok & Davidson-Arad, 2016, p. 551).

Yet, if their rumination does not encourage the use of avoidant coping techniques (as seen in the previous solution), it appears as if stable service access is able to diminish the extent to which male survivors of sexual violence use self-sufficient coping in a harmful manner. More specifically, male survivors of sexual violence who do not interrupt their service access and lessen their use of self-sufficient coping styles are more likely to experience PTG (coverage of 46.4%).

Thus, the use of self-sufficient coping to a high degree, while beneficial to the production of PTG for female sexual violence survivors, is damaging to the development of PTG for male survivors. It seems as if service provision for male survivors is unable to foster the use of self-sufficient coping styles in a productive fashion, instead contributing to its detriment. Stable service access contributes to both the presence and absence of PTG, where the male survivors who do not interrupt their service access and use self-sufficient coping to a low degree are likely to achieve PTG, and those who do not interrupt service access, use self-sufficient coping to a high degree and avoidance coping to a low degree likely experience a lack of growth. High service intensity, however, is only related to the absence of growth when coupled with the high use of self-sufficient coping styles.

5.1.3. The Combined Effect of Gender Norms and Coping Styles on PTG

Resting on the literature above, this thesis also hypothesizes that male survivors who have a higher endorsement of traditional masculine norms but use self-sufficient coping are more likely to experience PTG (hypothesis 3). As mentioned, previous research indicates that avoidant coping techniques should stunt PTG, while self-sufficient coping should foster PTG (Easton et al., 2013; Frazier et al., 2004; Nielsen & Knardahl, 2014). Because male survivors are more likely to utilize planning (a form of self-sufficient coping) and are less likely to socially engage in times of trauma (Doka & Martin, 2001; Samulowitz et al., 2018), it is hypothesized that self-sufficient coping will offset the postulated negative effects of a high endorsement of gender norms on the development of PTG. Yet, the results of hypothesis one indicate that gender norms are unrelated to the absence or presence of PTG, and hypothesis two demonstrates that self-sufficient coping styles are most consistently associated with the absence of PTG. Therefore,

strongly endorsing masculine norms and engaging in self-sufficient coping is unrelated to the production of PTG and subsequently, no support is found for hypothesis three.

5.2. Stability and Intensity of Service Access

5.2.1. The Effect of Stable Service Access on PTG

The fourth hypothesis, that male survivors of sexual violence who have stable service access (without interruption) are more likely to experience PTG, is supported. As mentioned, high service stability coupled with the low use of self-sufficient coping techniques (coverage of 46.4%) is related to the presence of PTG. In these cases, it is likely that service providers are able to lessen the degree in which male survivors utilize self-sufficient coping styles in a manner that prevents growth. Instead, male survivors, through their stable service access, may learn that their current use of self-sufficient coping styles is contributing to distress, thereby diminishing their use of such methods. For example, acceptance coping (a form of self-sufficient coping) has been found to be the strongest correlate for immediate growth after a traumatic incident (Frazier et al., 2004, p. 27). Acceptance coping requires an individual to understand the factors related to their traumatic incident, including those that the individual has and does not have control over (Litman & Lunsford, 2009, p. 989). A potential by-product of acceptance coping, then, is an obsession of personal limitations and faults (Litman & Lunsford, 2009, p. 989). Yet, incessantly focusing on personal faults stunts PTG, instead contributing to distress and an absence of growth (Skaags & Barron, 2006, p. 539). Through stable service access, the male survivor may lessen the degree to which he engages in these harmful forms of self-sufficient coping, advancing the ability of male survivors to achieve PTG.

The strongest combination for a lack of PTG is low service stability in tandem with high service intensity (coverage of 47.1%). In order to understand why only irregular use of intense services is related to the absence of PTG, and not the irregular use of non-intense services, it is important to assess the difference between these services. Victim services and crisis lines are used at the will of the survivor, providing the survivor with control regarding the duration and time of each "session" (Young et al., 2016). The goal of victim services and crisis lines is to validate the experience of each survivor, and as such, these services do not require clients to discuss topics they feel uncomfortable with and instead provide the client with the agency to direct the conversation (Young et al., 2016). Individual or group therapy, conversely, is more controlled by the therapist. These services require set weekly or bi-weekly appointments, longer sessions, and require the survivor to understand and discuss their emotions (the conversation of which is directed by the therapist) (Berger, 2015). Therapeutic intervention, therefore, may be more confronting to the male survivor than victim services or crisis lines.

As therapeutic intervention requires male survivors to openly and freely assess emotions, understand the event, and provide meaning to it (Tedeschi & Calhoun, 2004b), the male survivor may be more closed within sessions, contributing to the lack of growth achieved (Komiya, Good, & Sherrod, 2000, p. 141). As research has consistently noted, key to the success of therapeutic intervention is the individual's openness, an element that may not exist with male survivors of sexual violence (Carrillo, Rojo, Sanchez-Bernardos, & Avia, 2001; Komiya et al., 2000). In one analysis, openness was found to significantly predict willingness to seek help, yet being male, attaching stigma to therapeutic intervention, and not remaining open predicted a reluctance to utilize support services (Komiya et al., 2000, p. 141). For male survivors of sexual violence, this

is particularly likely given male gender norms of emotional stoicism and independence (Komiya et al., 2000, p. 141).

As sexual victimization is predominately viewed as a feminine issue (Heber, 2017), many male survivors experience conflicts with their masculinity (Walker et al., 2005a). As such, clinicians must work within a limited time frame to alter existing schemas of what a "man" should be like and normalize more negative emotions (Cordova, 2008, pp. 192-193). In these cases, the clinician may be forced to spend more time dissecting and reconstructing the individual's masculinity to incorporate the sexual violence in a way that provides the male with control (Cordova, 2008, p. 195). Yet, the lack of openness and resistance to therapeutic intervention may taint the male survivor's perception of the support (Linley & Joseph, 2004). Research has indicated that even a negative perception of social support is negatively correlated to the experience of PTG (Linley & Joseph, 2004). This combination of the confrontational nature of therapy and the survivor's closedness to, and negative perception of, therapeutic intervention may interact to explain why irregular use of intense services is related to a lack of PTG.

Further, as more intense services, such as individual or group therapy, require more active participation, it is reasonable that using these services irregularly contributes to an absence of PTG. Irregular use of intense services may contribute to more distress for the survivor, as they are grappling with new information provided by the therapist, but are attempting to understand it on their own (Lee et al., 2006). As therapeutic intervention is much more confronting to the client, these services disrupt the male survivor's current schema and conceptualizations of the world (Berger, 2015). Thus, using these services irregularly sets the male survivor back, as they

may struggle with these alterations alone without the necessary supports (Lee et al., 2006). In these cases, the male survivor may enter a period of rumination, which further increases their emotional and social withdrawal, subsequently furthering unstable service access (Litman & Lunsford, 2009, p. 989).

5.2.2. The Effect of Service Intensity on PTG

The fifth and final hypothesis, that male survivors who intensely use services are more likely to experience PTG, is unsupported. In fact, the reverse is found to be true. Male survivors of sexual violence with low service intensity, such as victim services or crisis lines, are more likely to achieve PTG (coverage of 46.4%). Victim services or crisis lines tend to provide more immediate, concrete support to male survivors. For example, victim services aid in helping male survivors with legal difficulties and crisis lines are used mainly for referrals to other support options (Colvin et al., 2017; Young et al., 2016). Victim services or crisis lines, therefore, are very problem-oriented, shifting away from emotions per se and onto fixing problems in the short-term. In this regard, victim services or crisis lines are very in-tune with the higher-order category of problem-oriented coping. Research has indicated that men are more likely to utilize forms of coping that fall under the scope of problem-focused coping, as it allows a clear plan of action to be formulated void of emotions (McCaughan et al., 2011; Samulowitz et al., 2018). Thus, these lower intensity services may actually be better suited to facilitate PTG for male survivors of sexual violence as they are used as a method of planning.

The low service intensity of victim services and crisis lines may importantly be able to provide male survivors with a regained sense of control and agency. For example, many male survivors call crisis hotlines as a first step to tell their story of victimization; “the inner conflict of wanting to articulate and share a deep, potentially traumatic, and personal experience and yet

remain anonymous appears to be a common experience for male survivors of sexual assault" (Young et al., 2016, p. 9). As such, crisis lines, in particular, provide male survivors with an anonymous forum in which they are able to communicate their experience, on their terms. Moreover, research on crisis line callers has demonstrated that male survivors are much more likely than their female counterparts to abruptly hang up the phone, demonstrating the importance of retaining a sense of control for the survivor, as opposed to the support worker (Young et al., 2016, p. 10).

High service intensity, conversely, is only associated with an absence of PTG. These results give evidence that traditional therapeutic intervention is ineffective in promoting PTG, and instead, may have an adverse impact. These results therefore demonstrate a need for further research into the role of service provision, and more specifically, the effect of therapy and the specific influence of the clinician. Research has indicated that early therapeutic intervention is significant in preserving positive changes over the long-term (Frazier et al., 2006, p. 3); thus, it is possible that this thesis is unable to account for the effects of intense services due to the small time difference between the pre- and post-test (only one month).

These findings are interesting given that emotional or instrumental social support, or merely a positive perception of the support has consistently been tied to the development of PTG (Borja et al., 2006; Frazier et al., 2001; Frazier et al., 2004; Linley & Joseph, 2004). The use of social support may not be easily utilized for male survivors of sexual violence and may instead cause psychological distress. The negative effect of rape myths has been well-documented, causing individuals to blame and deny male survivors' experience of victimization (Coxell & King, 2010; Fisher & Pina, 2013; Hammond et al., 2016; Turchik & Edwards, 2012). As such, male survivors of sexual violence who attempt to access services may subsequently be

revictimized by negative reactions from service providers. Counsellors and service providers are not immune to these noxious beliefs, and as such, male survivors of sexual violence may have previous or current negative interactions with their service access (Kassing & Prieto, 2003, p. 459). Thus, using crisis lines in particular provide the male survivor with an anonymous platform to share their story. While it does not completely negate the potential for harmful reactions, the male survivor is in more control to end the "session" whenever they feel a negative response and they do not have the added frustration of potentially hurtful facial expressions. Conversely, therapeutic intervention increases the risk of revictimization as the male survivor may receive negative reactions from reception, other clients (if predominately female), as well as the therapist. The role of rape myths cannot be excluded from analysis and may contribute to the finding that less intense forms of service access are related to the presence of growth, whereas more intense forms are associated with the absence.

The first two subsections discussed and explained the findings of this thesis in relation to the broader literature. The next subsection will summarize the factors associated with both the presence and absence of PTG for male survivors of sexual violence and conclude this chapter.

5.3. Factors Associated with PTG

These hypotheses provided valuable insight into the factors associated with PTG for male survivors of sexual violence. Patterns of service access are particularly relevant to the experience of growth, or lack thereof, for male survivors of sexual violence. Specifically, stable service access and lower intensity services are important to the development of PTG; conversely, unstable service access and high intensity services are related to the absence of PTG. Stable service access and lower intensity services appear to be associated with PTG due to their ability to protect the male survivor's masculine image, instead of creating conflicts with their

masculinity. This is likely due to the non-threatening nature of these services; that is, victim services and crisis lines are able to establish the basic support necessary to facilitate PTG, while providing the male survivor with an increased sense of agency and control and not intimidating their ideas of masculinity (Colvin et al., 2017; Young et al., 2016).

Intense services, contrarily, confront male survivors' pre-existing schemas and may clash with their ideas of masculinity. Unstable service access requires male survivors to deal with these new worldviews without the aid of support, potentially leading to a state of rumination and avoidance. Thus, while research has theorized that therapeutic intervention should have a positive effect on the experience of PTG, this effect is not supported within this thesis. Instead, it appears as if therapeutic intervention is deleterious to the production of PTG for male survivors of sexual violence.

The positive effect of self-sufficient coping previous research has demonstrated (Colen & Lynn, 2010; Frazier et al., 2004) is not replicated within this thesis. In fact, the reverse is true, where the use of self-sufficient coping is most consistently tied to the absence of PTG for male survivors of sexual violence. It is likely that male survivors use self-sufficient coping in a manner that centres on their negative emotions, personal limitations, and the creation of action plans that are insufficient in achieving PTG (Folkman & Moskowitz, 2000; Litman & Lunsford, 2009). Service provision may erroneously aim to increase the use of self-sufficient coping, as self-sufficient coping is postulated to be positive. Yet, if the male survivor uses self-sufficient coping in a way that emphasizes their own blame, this is detrimental to the male survivor's ability to achieve PTG and may contribute to the absence of PTG found within this thesis.

As such, only one of the five hypotheses this thesis tests are supported. In particular, stable service access (hypothesis four) is related to PTG. The solutions demonstrate that the

configurations of variables that lead to growth are much simpler than those that lead to an absence; hence, it is easier for clinicians and researchers to focus on the factors that lead to PTG as these are variables that are more readily promoted.

Chapter 6. Conclusion

This thesis seeks to understand the factors associated with PTG for male survivors of sexual violence. More specifically, recognizing the under-developed nature of research for male survivors, this thesis looks at the role of gender norms, coping techniques and service access in the development of PTG. This chapter will review the key findings, address the limitations of this thesis, and direct attention to areas of future research.

6.1. Key Findings

Only one of the five hypotheses are supported. This thesis provides support for the role of stable service access in fostering and hindering the potential for male survivors of sexual violence to experience PTG. That is, stability of service access is important in the production of PTG; unstable service access is consistently found in the solutions for the absence of PTG (hypothesis two). Interestingly, however, only low intensity services, such as crisis lines or victim services, are beneficial to the development of PTG for male survivors, whereas therapeutic intervention is deleterious to this growth. It is likely that these less intense forms of services are able to provide male survivors with the minimum threshold of support needed in order to foster growth without confronting their images of masculinity. As such, hypothesis five, that high intensity services would foster PTG, is unsupported. Similarly, no support is found for the role of gender norms in the production of PTG (hypothesis one).

The use of self-sufficient coping appears to have a negative influence on the production of PTG for male survivors of sexual violence, contributing instead to the absence of growth. This contradicts research within the field of PTG, where research has constantly found that these forms of coping are positively correlated with PTG (Easton et al., 2013; Leech & Littlefield,

2011). Yet, this new finding may be due to the analysis of configurations of causal combinations that relate to the presence and absence of PTG, as traditional research methods used in previous research are not able to demonstrate differences between cases. Thus, no evidence is found to support hypothesis two and three.

6.2. Limitations

The ability of this thesis to generalize to the broader population of male survivors of sexual violence is extremely limited. Due to the small sample size and the use of convenience sampling, generalization is a formidable task. While the method of QCA was used in order to address this concern, the attrition from the pre- to post-test still poses a threat to external validity. This thesis is careful to avoid concrete claims of generalizability; however, the case-by-case analysis permitted under QCA ensures the validity of the results found. That is, because QCA looks at each individual case, the number of participants does not weaken the validity of the results, as these specific cases and solutions will exist no matter how large the sample size. The larger the sample size, the more potential configurations that will exist within the sample; this does have the ability to change the relative importance and coverage of the existing solutions within this thesis.

Connected to the weak ability for this study to generalize, another limitation arose regarding recruitment. Recruitment was slow and initially only consisted of the nine sexual violence organizations listed in the methodology chapter. Recruitment began in October and in two months, only five participants were recruited. Because of time constraints to finish this thesis, an ethics modification was made to include online recruitment. This form of recruitment provided the researcher with nine more participants within a two-week time span. Thus, the

method of recruitment relying solely on individuals who entered the nine participating sexual violence organizations is a limitation of this thesis. While this could not have been foreseen, it is nonetheless a limitation that significantly lowered the number of participants.

Due to these recruitment troubles, this thesis was forced to lessen the time in-between the pre- and post-test to one month. As such, this thesis cannot completely exclude the possibility of a testing effect. A testing effect occurs when the pre-test measures effect the post-test measures, as the pre-test provides indicators to the participant about the study's goals, or they simply carryover their answers to the post-test (Morgan, Gliner, & Harmon, 2000, p. 530). Given the short time between the pre- and post- test, as well as identical measures for coping and adherence to gender norms, a testing effect is likely. Unfortunately, due to feasibility, this thesis had no choice but to lessen its time period. Future research is required to replicate this thesis but with an appropriate time period in between the pre- and post-test, in order to effectively rule out the influence of a testing effect.

It appeared as if the survey software used was not user-friendly. A number of individuals entered the survey and provided their name and email address (asked for the post-test) but did not answer any of the survey questions. By mistake, when participants who filled out the pre-test were contacted for the post-test, one individual who only provided his name and email address was given the post-test. This individual filled out the entirety of the post-test, indicating that perhaps some individuals in the pre-test were unable to save and/or submit their responses. Technical problems related to the survey software, therefore, may have had an impact on the number of participants, and thus the ability of this thesis to make any form of modest generalizations.

This thesis is interested in establishing the configurations of factors that are associated with PTG, and a lack thereof. This thesis included within its analysis some factors that can be understood as dynamic, that is, they change (e.g., the use of coping styles). However, this thesis is unable to understand whether these changes are due to intervention, as it is unknown where each participant is in their trajectory of change. As it was not possible to recruit participants before they utilized services for the first time (some of the organizations contacted indicated that they rarely get one new male client per month), this thesis is also weak in its ability to understand the true effectiveness or impact of intervention.

6.3. Directions for Future Research

Addressing the principal issue of this thesis, future research should utilize larger sample sizes in order to make concrete claims of generalizability. One of the main impetuses for conducting this research is that the bulk of current knowledge is based on female only or child sexual violence survivor samples, thus questioning the ability for this understanding to be generalized to male populations. Unfortunately, however, due to the small sample size and sampling procedure, the ability for modest generalizations are weakened. Therefore, to overcome this limitation and to develop a clear understanding of the factors associated with PTG for male survivors of sexual violence, research with large samples and random sampling is required. In tandem, this research must also include a longer time period in between the pre- and post-test so as to reduce the possibility of a testing effect.

Research within the field of PTG has largely centred on the PTGI in order to capture growth. It may also be beneficial for future research to supplement questionnaires with interviews in order to gather a deeper understanding. This method may be particularly useful for

those studies interested in the associated factors of PTG. For example, religious coping has both positive and negative dimensions as illustrated by previous research (Ahrens et al., 2010). Yet, the Brief COPE does not distinguish the use of religious coping in a positive or negative way; it merely only captures whether the individual engages in a particular style of coping. In this regard, interviews provide the researcher with a better understanding of how each coping mechanism (or other factors the researcher is assessing) is used and its relation to the construct of interest (that is, PTG). A caveat, however, is that this method may be more prone to representation bias, where participants may be more likely to lie to appear favourable to the researcher. Thus, this should only be used as an addition to the questionnaires.

Research on the topic of PTG and survivors of sexual violence is by no means complete; a myriad of areas need further research. First, research on PTG and sexual violence has almost exclusively focused on gender, neglecting to assess the role of ethnicity, sexuality or class within its development. Therefore, research is needed to understand the role of individual and societal structures within the experience of PTG for survivors of sexual violence (both male and female). This analysis would therefore afford the ability to comprehend multi-structural influences and provide a more complex understanding of PTG and its related factors.

Second, evaluative studies are needed to grasp the role of various services in the production of PTG. Currently, the limited evaluative studies focus indiscriminately on therapy, neglecting other forms of services such as victim services or crisis lines. Interestingly, however, this thesis provides support for the latter in more effectively producing PTG for male survivors. While this thesis incorporated certain elements of service access into its assessment of PTG, specific therapies (e.g., cognitive behavioural therapy), as well as victim services or crisis lines need to be evaluated exclusively for their ability to promote or hinder PTG. Moreover, this

thesis is unable to assess the singular effect of group therapy, as all participants who used this service also engaged in individual therapy.

Specific to the male survivor population, the correlates of PTG require more research. As research has invariably used female or child sexual violence survivor samples, research is needed to test each correlate within a male-only sample. This thesis assesses the correlate of coping techniques, but social support (the use and perception of) (Frazier et al., 2004) and personality characteristics (e.g., hardiness) (Cole & Lynn, 2010) still must be evaluated. Again, due to the complexities of masculinities, it cannot be assumed that the results from these previous studies can be generalized to the male population. Moreover, while male survivors have been evaluated on the role of higher-order categories of self-sufficient, socially-support and avoidant coping, missing still is the effect of lower-order categories. That is, the influence and difference between planning, self-blame, and the use of instrumental support (for example) in the development of PTG for male survivors of sexual violence should be assessed.

This thesis failed to accumulate substantial information regarding the perpetrators of the sexual violence and the events that surrounded the victimization. While this thesis knows the gender of the perpetrator and the type of sexual violence, more information would be beneficial for future research. As societal perceptions, and statistics based on reported crimes, generally claim that males are disproportionately the perpetrators of sexual violence against all genders and ages, collecting information on the perpetrator and the sexual violence becomes paramount. Research, however, is beginning to find evidence to counteract this perception depending on the sex of the survivor; for example, in Canada "women almost exclusively reported that they were sexually assaulted by a man (99%), while similar proportions of men reported that they were sexually assaulted by a man (52%) or a woman (48%)" (Conroy & Cotter, 2017, pp. 13-14).

Future research should ensure more variables related to the perpetrator and sexual violence are included in order to provided richer analyses.

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Appendix A. Sociodemographic Questionnaire

Pre-Test

1. How old are you?
    a. Numeric box response that will allow them to enter two digits

2. What is the highest degree you have obtained?
    a. High school diploma
    b. College diploma
    c. Bachelor's degree
    d. Master's degree
    e. Doctoral degree
    f. None of the above
    g. Other

3. Are you employed?
    a. Yes
    b. No

4. What ethnic origin do you identify with?
    a. Caucasian
    b. Afro-Canadian
    c. Asian (e.g., Chinese)
    d. South Asian (e.g., Indian)
    e. Indigenous
    f. Middle Eastern
    g. Caribbean
    h. Latin American
    i. Other

5. What country were you born in?
    a. Text box response for them to answer

6. What is your sexual orientation?
    a. Heterosexual
    b. Homosexual
    c. Bisexual
    d. Other (please specify)

7. Please check which type of sexual violence you experienced. Check all that apply.
    a. Sexual violence as a child (younger than 18 years old) by a male perpetrator
    b. Sexual violence as a child (younger than 18 years old) by a female perpetrator
    c. Sexual violence as an adult (18 years or older) by a male perpetrator
    d. Sexual violence as an adult (18 years or older) by a female perpetrator

e. Witnessing of sexual violence as a child (younger than 18 years old) by a male perpetrator
f. Witnessing of sexual violence as a child (younger than 18 years old) by a female perpetrator
g. Witnessing of sexual violence as an adult (18 years or older) by a male perpetrator
h. Witnessing of sexual violence as an adult (18 years or older) by a female perpetrator
i. Other (please specify)

8. What services have you used through this organization? Please check all that apply.
    a. Individual therapy
    b. Group therapy
    c. Victim services
    d. Support line
    e. Other (please specify)

9. How long have you used these services? In months.
    a. Numeric box response that will allow them to enter three digits

10. Has this service been interrupted?
    a. Yes
    b. No

11. If you answered yes to Question 10, for how long has this service been interrupted (in weeks)?
    a. Numeric box response that will allow them to enter three digits

Post-Test

1. Have you interrupted service use since you completed the first questionnaire?
    a. Yes
    b. No

2. If you answered yes to the above question, for how long has this service been interrupted (in weeks)?
    a. Numeric box response that will allow them to enter two digits

Appendix B. The Brief COPE

These items deal with ways you've been coping with the stress in your life since you experienced the sexual violence. There are many ways to try to deal with this experience; these items ask what you've been doing to cope with the sexual violence. Obviously, different people deal with things in different ways, but I'm interested in how you've tried to deal with it. Each item says something about a particular way of coping. I want to know to what extent you've been doing what the item says. How much or how frequently. Don't answer on the basis of whether it seems to be working or not – just whether or not you're doing it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

1 = I haven't been doing this at all
2 = I've been doing this a little bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

1. I've been turning to work or other activities to take my mind off things.
2. I've been concentrating my efforts on doing something about the situation I'm in.
3. I've been saying to myself "this isn't real."
4. I've been using alcohol or other drugs to make myself feel better.
5. I've been getting emotional support from others.
6. I've been giving up trying to deal with it.
7. I've been taking action to try to make the situation better.
8. I've been refusing to believe that it has happened.
9. I've been saying things to let my unpleasant feelings escape.
10. I've been getting help and advice from other people.
11. I've been using alcohol or other drugs to help me get through it.
12. I've been trying to see it in a different light, to make it seem more positive.
13. I've been criticizing myself.
14. I've been trying to come up with a strategy about what to do.
15. I've been getting comfort and understanding from someone.
16. I've been giving up the attempt to cope.
17. I've been looking for something good in what is happening.
18. I've been making jokes about it.
19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.
20. I've been accepting the reality of the fact that it has happened.
21. I've been expressing my negative feelings.
22. I've been trying to find comfort in my religion or spiritual beliefs.
23. I've been trying to get advice or help from other people about what to do.
24. I've been learning to live with it.
25. I've been thinking hard about what steps to take.
26. I've been blaming myself for things that happened.
27. I've been praying or meditating.
28. I've been making fun of the situation.

Appendix C. MRNI-SF

Please indicate to what degree you agree or disagree with the following statements, where

1 = Strongly disagree
2 = Disagree
3= Somewhat disagree
4 = Neutral
5 = Somewhat agree
6 = Agree
7 = Strongly agree

1. A man should never admit when others hurt his feelings.
2. Men should have home improvement skills.
3. Men should watch football games instead of soap operas.
4. A man should not turn down sex.
5. It is important for a man to take risks, even if he might get hurt.
6. Men should be the leader in any group.
7. Homosexuals should never kiss in public.
8. A man should prefer watching action movies to reading romantic novels.
9. Men should be able to fix most things around the house.
10. Men should be detached in emotionally charged situations.
11. Homosexuals should never marry.
12. The Prime Minister of Canada should always be a man.
13. When the going gets tough, men should get tough.
14. A man should be ready for sex.
15. Boys should prefer to play with trucks rather than dolls.
16. Men should not be too quick to tell others that they care about them.
17. All homosexual bars should be closed down.
18. A man should always be the boss.
19. A man should know how to repair his car if it should break down.
20. I think a young man should try to be physically tough, even if he's not big.
21. Men should always like to have sex.

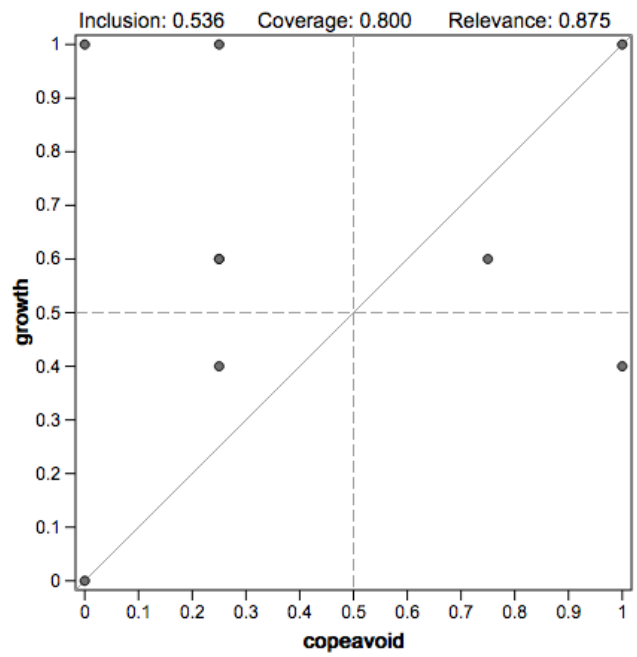
Appendix D. PTGI-SF

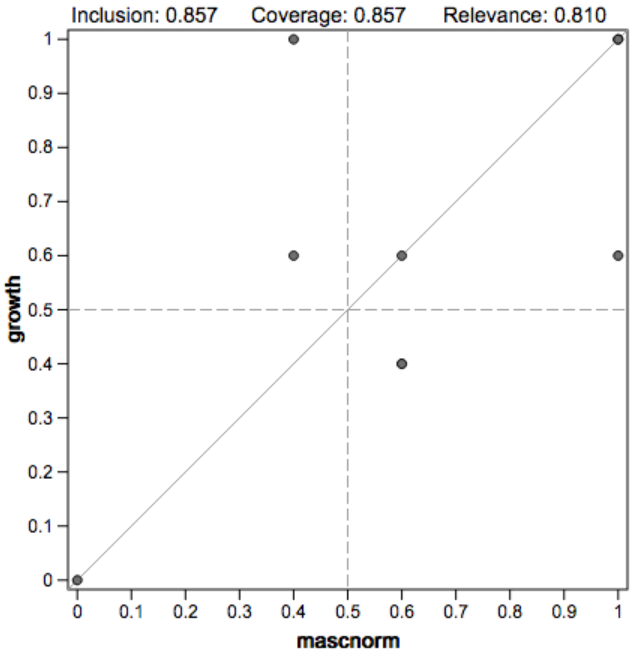
Indicate for each of the statements below the degree to which this change occurred in your life as a result of your sexual victimization, using the following scale:

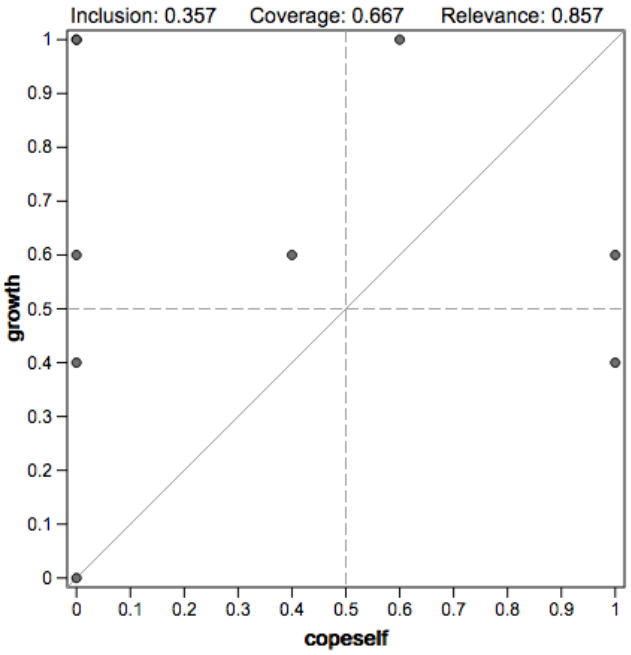
0 = I did not experience this change as a result of the sexual violence
1 = I experienced this change to a very small degree as a result of the sexual violence
2 = I experienced this change to a small degree as a result of the sexual violence
3 = I experienced this change to a moderate degree as a result of the sexual violence
4 = I experienced this change to a great degree as a result of the sexual violence
5 = I experienced this change to a very great degree as a result of the sexual violence

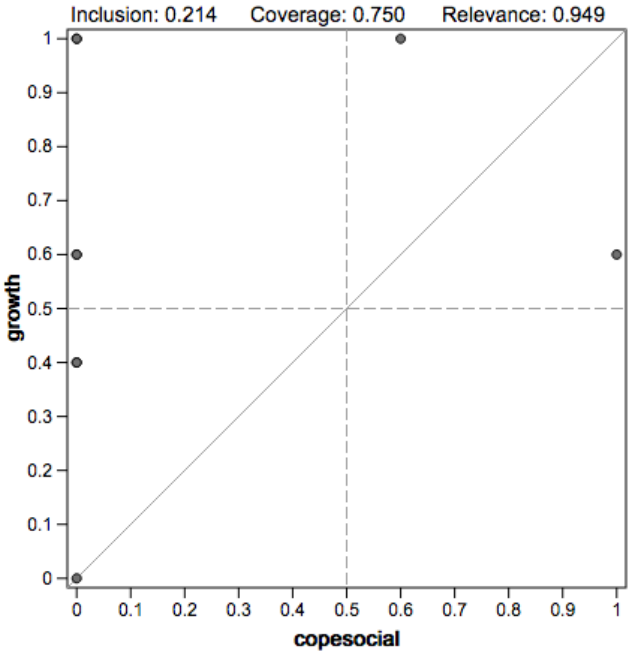
1. I have changed my priorities about what is important in life.
2. I have a greater appreciation for the value of my own life.
3. I am able to do better things with my life.
4. I have a better understanding of spiritual matters.
5. I have a greater sense of closeness with others.
6. I established a new path for my life.
7. I know better that I can handle difficulties.
8. I have a stronger religious faith.
9. I discovered that I'm stronger than I thought I was.
10. I learned a great deal about how wonderful people are.

Appendix E. Necessity Scatterplots for the Presence of PTG

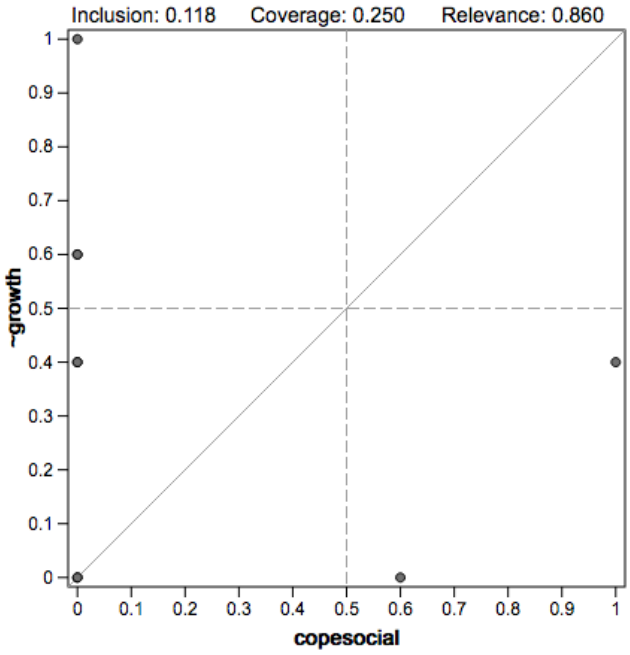


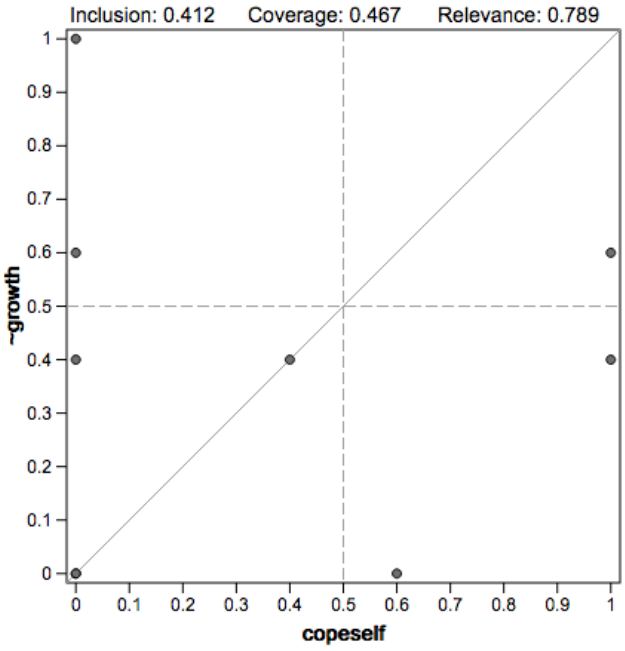


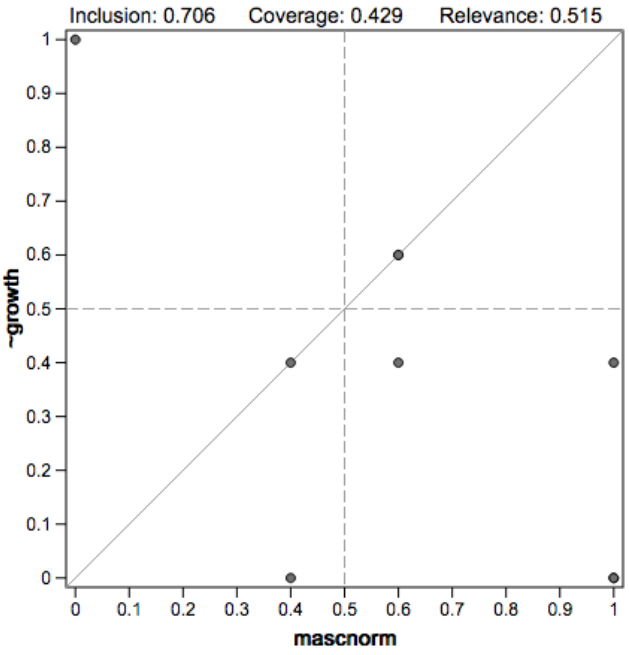


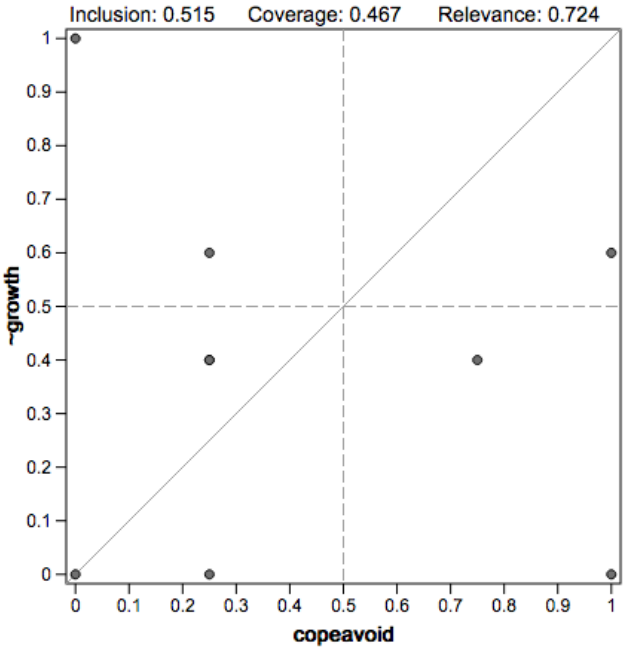


Appendix F. Necessity Scatterplots for the Absence of PTG

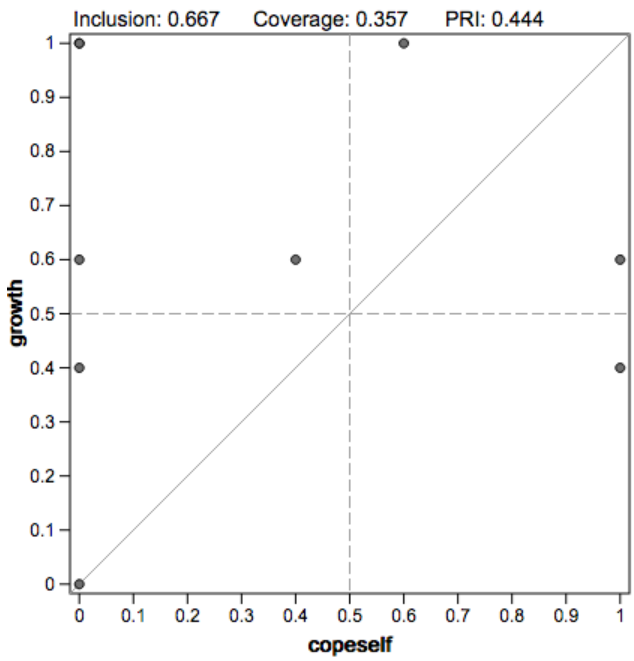


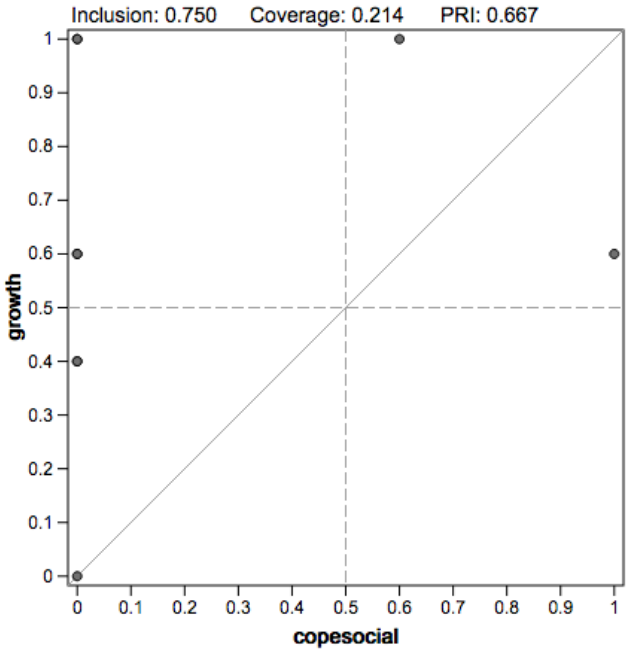


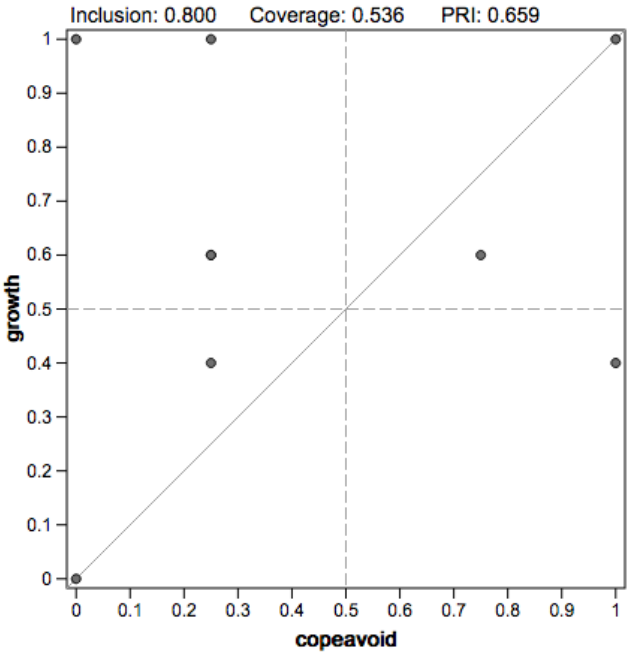


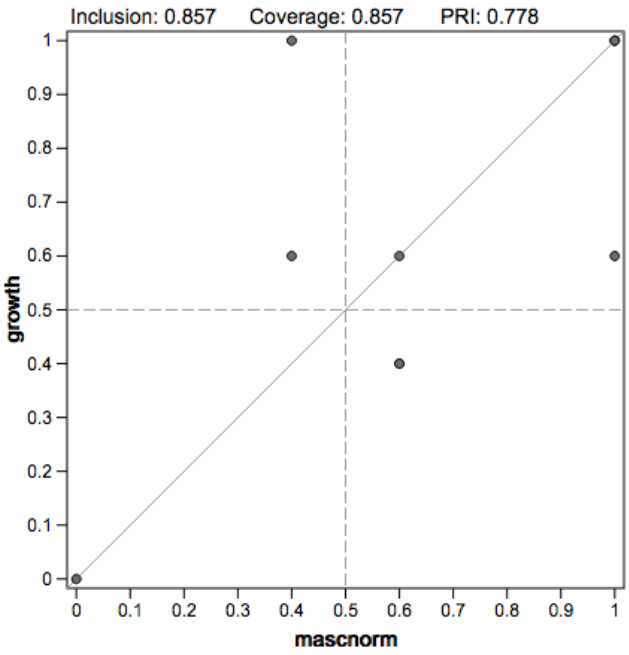


Appendix G. Sufficiency Scatterplots for the Presence of PTG









Appendix H. Sufficiency Scatterplots for the Absence of PTG