Under Construction: The Impact of Socialized Gender on Posttraumatic Growth

by

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Abstract

Trauma caused by seismic events can change the trajectory of someone's life for better or worse. If left unresolved, it can cause physical, emotional, spiritual, and cognitive impairment. However, if processed optimally, it can lead to positive transformation. Utilizing Tedeschi and Calhoun's (1995) theory of Posttraumatic Growth (PTG), this capstone explores how aspects of socialized gender constructs impact an individual's likelihood of experiencing measurable growth in personal strength, new possibilities, relating to others, appreciation of life, and spiritual change after an experience of trauma. Sociocultural beliefs regarding traditional masculinity appear to reduce growth outcomes for men. In contrast, social scripts regarding femininity seemingly allow women to engage in the PTG process. As such, this capstone is intended to increase access to PTG for all genders and to help counselling psychologists identify barriers to growth. Gaps and limitations in the published literature are identified, including suboptimal study designs, inconsistency of measures, overemphasizing positive growth outcomes, and difficulty conceptualizing and quantifying broad multifaceted concepts such as trauma. This capstone provides recommendations on future directions for research into PTG in the field of counselling psychology. Findings from the literature are then used to generate hypotheses and potential recommendations for consideration regarding gender-sensitive and trauma-informed therapy and how therapists might consider applying an integrative PTG framework to current practices.

Keywords: Gender roles, posttraumatic growth, trauma, trauma-informed therapy

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Chapter 1: Introduction

Traumatic experiences typically cause emotional distress that can impact an individual's emotional, physical, spiritual, interpersonal, and cognitive functioning (Tedeschi & Calhoun, 2006; Tedeschi & Moore, 2021). Given the fact that posttraumatic symptoms infiltrate nearly all facets of life, research has historically focused on the harmful psychological aspects of trauma. However, in the aftermath of these events, there is also potential for growth. From interpersonal trauma to chronic illness, various trauma experiences have been studied to better understand what fosters the phenomenon Tedeschi and Calhoun (1995) define as Posttraumatic Growth. The research literature also sheds light on common variables that impede growth, gender being one of them (Adjorlolo et al., 2022; Cundiff et al., 2023; Lewis et al., 2022; Vishnevsky et al., 2010).

The purpose of this capstone is to provide counsellors with insight into the impact that gender constructs have on experiences of trauma and Posttraumatic Growth. This chapter presents an overview of the topic, outlining the prevalence of trauma experiences, the theoretical origins of transformative growth, and gender differences in each. I also consider the significance of gender differences in posttraumatic growth within the literature and how an understanding of gender differences may elevate counsellors' provision of trauma-informed care. Social constructionism is the lens applied in this paper. Finally, my positional statement is presented, important terms are defined, and an overview of further chapters is outlined.

Topic Overview

The American Psychological Association (APA) defines trauma as a disruptive event that causes fear, helplessness, or other such emotions that are intense enough to significantly impact the individual's attitude, behaviour, and overall functioning (2018a). Such events include (but are not limited to) war, serious injury, sexual violence, witnessing death, and natural disaster.

Similar to Tedeschi & Calhouns' (1996) conceptual understanding of trauma, the APA (2018a) suggests that traumatic events often challenge the preconceived belief that the world is safe and predictable. Common symptoms fall into several categories: intrusive memories of the event (e.g. flashbacks, nightmares, etc.); avoidance behaviours (e.g. substance misuse, avoiding smells, places, people, objects, etc.); persistent changes in cognitions and/or mood (e.g. negative or flat affect, loss of motivation, memory loss, etc.); and changes in arousal or reactivity (e.g., self-destructive behaviour, loss of focus, insomnia, etc.) (American Psychiatric Association [APA], 2013).

To gain insight into the prevalence of trauma, the World Health Organization (WHO) Mental Health Survey Consortium found that of 68,894 participants across 24 countries, 70% of respondents experienced at least one traumatic event in their lifetime, and 30% experienced more than one traumatic experience (Kessler et al., 2017). Similarly, the Survey on Mental Health and Stressful Events found that approximately 64.9% of Canadian adults reported at least one traumatic experience (Government of Canada, 2021). While many people recover after a traumatic event, others' symptoms worsen and can impact their lives for years. When symptoms persist long-term, they may be clinically significant and result in a diagnosis of Posttraumatic Stress Disorder (PTSD). In Canada, approximately 8% of the population screened positive for PTSD, and the prevalence of positive PTSD screenings is 10.2% among women and 5.7% (Government of Canada, 2021).

While men are more likely to experience a traumatic event (Olff, 2017), women are two to three times more likely to be diagnosed with PTSD than men (APA, 2013). In Canada, the prevalence of screening positive for PTSD is 10.2% among women compared to 5.7% among men (Government of Canada, 2021). However, a literature review by Christiansen and Berke

(2020) on gender and sex-based differences in Posttraumatic Stress Symptoms (PTSS) revealed that little research involving human subjects has been done to understand why. Of the 19 studies in the review, two found that conformity to hegemonic masculinity and masculine gender role stress are both positively correlated to anxiety and PTSD symptoms. Another found that the internalized belief that men must be self-reliant, tough, and dominant, and avoid feminine traits positively correlated with higher PTSD symptoms in military men. In contrast, King et al (2013) observed that while men reported higher levels of nightmares and emotional numbing than women, women were more likely to report re-experiencing and difficulties concentrating than men (the effect sizes were relatively small). Although the literature is mixed, there is evidence to support the existence of gender differences in mental health outcomes following trauma; women are more likely to express higher levels of distress in response to trauma and higher rates of growth as well.

First introduced during the positive psychology movement, Posttraumatic Growth (PTG) refers to the positive psychological changes that occur in the aftermath of difficult life events (Tedeschi & Calhoun, 1996). Tedeschi and Calhoun (1996) theorize that experiences severe enough to overwhelm our systems impact cognitive schemas (the cognitive structures that help guide perception, information processing, and organization of schema-relevant categories) and that long-held beliefs reshape our understanding of our relationships, identity, decision-making abilities, and purpose. Many studies have found significantly higher rates of PTG in populations with PTSD (Schubert et al., 2019). The severity of the circumstance may explain the relationship between trauma intensity and growth. For instance, adult children caring for their highly dependent parents fighting cancer scored higher in PTG compared to caregivers whose parents had more autonomy (Teixeira & Pereira, 2013). Traumatic events bring to light the

unpredictability and uncontrollability of our lives. When we are left to process what happened to us and restructure our understanding of the world, we can incorporate trauma into new, stronger schemas (Calhoun & Tedeschi, 2006). In other words, a renewed appreciation for our relationships, understanding of our identity, and the meaning we give these experiences lead to growth.

Research on PTG has gained popularity within the past decade and has yet to reach its peak (Kou et al., 2021). When investigating research trends, Kou et al. (2021) found that from 1996 to 2020, researchers identified a number of variables that foster PTG, gender being one of them. While there is some evidence to support the claim that women experience higher rates of PTG than men (Adjorlolo et al., 2022; Kalaitzaki, 2021; Vishnevsky et al., 2010), gender has been a periphery focus. As such, the research on gender differences in PTG is limited. However, of the studies that primarily focus on gender, many hypothesize that socialized gender roles may impact outcomes for men and women. Garnering a better understanding of the context of growth as it relates to gender will help counsellors address barriers (e.g. coping, social support, help-seeking, and disclosure), and potentially improve outcomes.

Statement of the Problem

Traumatic experiences are common. When initial normative stress responses become unmanageable in the long term, distressing events have the potential to fundamentally impact survivors' emotional, physical, cognitive, behavioural, and social functioning (APA, 2013; Tedeschi & Moore, 2021). If left untreated, trauma can cause chronic health issues, including but not limited to gastrointestinal, cardiovascular, and neurological ailments (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Further, survivors may develop mental health issues such as depression, anxiety, PTSD, and substance misuse. However, parallel

to the negative consequences of trauma are positive psychological outcomes. Fostering growth requires counsellors to know about risk and protective factors that help or hinder personal transformation to successfully provide Trauma-Informed Care (TIC).

Purpose Statement

While trauma is common, so are experiences of transformational growth. In fact, a meta-analysis of the literature suggests that 58-80% of individuals retrospectively report PTG (Kou et al., 2021). The purpose of this capstone is to analyze notable theories and models of PTG and the cognitive, social, and spiritual processes that contribute to growth outcomes. As such, this capstone will attempt to synthesize the research and answer the following questions:

1. How does gender role socialization impact posttraumatic growth?
2. How might counselling psychologists apply a PTG framework to trauma-informed practices?

Guiding Theories

The lens of this capstone is social constructionism. This broad interdisciplinary framework assumes that our understanding of the world is created in a social context (Marecek et al., 2004). While there is no specific definition or leading theory of social constructionism, notable works accept and share four theoretical assumptions regarding conventional knowledge: it is not objective, it is culturally relative, it is socially sustained, and it is linked to social action. Essentially, social constructionism assumes that reality is co-constructed, and that language, beliefs, attitudes, and behaviours are organized into social and cultural narratives. Meaning is dependent on time and place, so constructs can change as social realities evolve. Take, for example, Western constructs of beauty and how standards have changed over time. As social

actors, we create and maintain these standards and narratives. This applies to constructs of gender and the beliefs, attitudes, and behaviours we attribute to them.

Two notable gender-specific theories under the umbrella of social constructionism provide more depth to sociocultural gender constructions and how they influence human behaviour: Bem's (1981) Gender Schema Theory and Eagly & Wood's (2012) Social Role Theory. Similar to Tedeschi and Calhoun's Theory of PTG (1995), Bem's theory examines cognitive schemas, making it an obvious choice to utilize in this capstone to help provide insight into how gender schemas influence our self-perceptions, preferences, attitudes, and behaviours as children, as well as our internalized gender role beliefs regarding masculinity and femininity as adults. Similarly, Social Role Theory furthers the discussion of sociocultural influences on human behaviour and intrapersonal and interpersonal experiences of trauma. Overall, these theories help identify the contexts of trauma and PTG and the relationship between these experiences and socialized gender constructs.

In addition to using a social constructionism lens, this capstone also incorporates a trauma-informed framework. Trauma-informed care (TIC) is the process of adapting all interactions, policies, and environments with an awareness of personal, historical, racial, and systemic traumas to prevent re-traumatization and reduce the risk of harm (Koury et al., 2022). Harris and Fallot (2001) highlight five principles of TIC: safety, trustworthiness, choice, collaboration, and empowerment. Essentially, mental health professions provide physically and emotionally safe, welcoming, and inclusive environments. They are trustworthy by being transparent and patient, by maintaining and respecting boundaries, and by clearly communicating processes, upcoming transitions, and expectations. They honour choice through client autonomy, providing information on available options and maintaining balance and flexibility.

Collaboration means working with rather than for clients, seeking feedback, and acknowledging power dynamics. Finally, trauma-informed counselling psychologists empower clients by recognizing client strengths, providing validation and affirmation, using person-first language, and building upon hope.

Utilizing a TIC framework is a necessary prerequisite to PTG. Mental health care professionals must understand the nuances of trauma and how it can influence survivors' engagement in treatment, therapeutic interactions, and responsiveness to interventions (SAMHSA, 2014). They must also maintain awareness of social and cultural scripts that guide experiences, identify expressions of distress and understand their role in helping their clients facilitate change without *expecting* it (Calhoun & Tedeschi, 2006). If counsellors remain unaware of the impact of social and cultural scripts throughout each stage in the process of growth, they may be unable to identify even the most subtle signs of change. As such, they may end up miscategorizing some clients as "poor copers" and underestimating their capacity for PTG. Further discussion on applying an integrative PTG framework can be found in Chapter 3. For more information on TIC, see The Institute on Trauma and Trauma-Informed Care's *Trauma-informed organizational change manual* (Kourey et al., 2022; http://socialwork.buffalo.edu/trauma-manual), BC Ministry of Child and Family Development's *Healing families, helping systems: A trauma-informed practice guide for working with children, youth and families* (2017; https://www2.gov.bc.ca/assets/gov/health/child-teen-mental-health/trauma-informed_practice_guide.pdf), and *Expert companions*: *Posttraumatic growth in clinical practice* in Calhoun and Tedeschi's *Handbook of posttraumatic growth: Research and practice* (2006; https://ebookcentral.proquest.com/lib/cityuseattle/detail.action?docID=1733962).

Contribution to the Field

Topics related to trauma and gender have been broadly studied and gender differences are evident in trauma events (e.g. Carlson & Slovak, 2008) and trauma symptoms (e.g. Rzeszutek et al., 2016). Further, researchers have also examined the relationship between gender and PTG (e.g. Adjorlolo et al., 2022), social support (e.g. Cundiff et al., 2023), help-seeking behaviour (Akbar & Witruk, 2016), and coping strategies (e.g. Prati & Pietrantoni, 2009; Shigemoto et al., 2019; Swickert & Hittner, 2009) which are integral to the PTG process. Many studies primarily use gender as a control variable, but few examine the relationship between socialized gender constructs and PTG (Lewis et al., 2022; Vishnevsky et al., 2010). This capstone informs the discussion on gender differences in each PTG domain and helps identify internalized beliefs about gendered behaviours that help or hinder growth. Furthermore, it identifies gaps in the literature and provides recommendations for future directions in research and therapeutic practice. This paper contributes to counsellors' understandings of socialized gendered behaviours, trauma, and PTG in order to elevate trauma-informed services. It also provides counsellors with insights into both protective and risk factors that may impact PTG outcomes. Additionally, it outlines suggestions or ideas for future research to empirically test suggestions and inform further study.

Method

Utilizing a thematic approach, I searched the literature using the City University Library and Google Scholar to ensure I gathered as many articles as possible. Articles were found in the following online databases: PsychINFO, ProQuest, Sage Journals, Taylor & Francis Online, and eBook Central. Because there has not been extensive research on the topic of gender roles and posttraumatic growth, I conducted a wide-scope search with a variety of keywords including

*posttraumatic growth (*with variations *post-traumatic* and *post traumatic*), *gender differences*, *gender roles*, and *trauma*. I excluded studies with abstracts that were not published in the English language; however, I did include research from various cultures to get a full understanding of gender socialization across cultures. Additional exclusions include articles that were difficult to source beyond access granted by the City University Library; research conducted with variables that were irrelevant to the field of counselling psychology; and studies that did not use PTG assessment measures (e.g. PTG-I or SRGS). Due to these limits, this review includes research that dates past ten years (from 2009 to the present day) as well as classical texts and updated models (e.g. Zoellner & Maercker, 2006) regarding the theoretical frameworks applied to this capstone (e.g. Tedeschi & Calhoun, 1996).

Articles included in this capstone come from a variety of primary, secondary, and tertiary sources to ensure a holistic view based on researchers' firsthand experiences, analyses of multiple perspectives, and a general understanding of the main concepts and theories. I included both qualitative and quantitative research to gather empirical data as well as common narratives of theories and concepts. Moreover, college, community, and mixed samples were included, as well as articles that focused on a wide range of traumatic experiences in hopes of gathering as many perspectives as possible.

Reflectivity and Positionality Statement

As a cis-gendered, heterosexual Caucasian woman who grew up in Western society, I understand that I view the world through a specific lens. I was adopted by a middle-class couple who previously adopted my brother from an orphanage in Romania a couple of years prior to my adoption. My parents owned their own businesses and were married until I was a teenager. I recognize my privileged upbringing, especially since it was gifted to me by circumstance. My

life could have easily been much different, and my brother's life could have been as well. Due to my own upbringing, I have always had an insatiable curiosity about nature working in tandem with nurture; I am interested in understanding how our social environments shape who we are, how we behave, what we believe, and what we value.

Not surprisingly, my upbringing led to my interest in post-modern frameworks that assume human beings create their own realities, including gender constructs that provide individuals with certain scripts to follow based on their gender identity. Growing up, I experienced the social repercussions of being a "tomboy" during elementary school. I also observed the social consequences of my brother expressing feminine traits. Volunteering with women-centred organizations allowed me to gain insight into similarities and differences in gender-specific traits and behaviours across different cultures. With these background experiences, I approached this topic through the lens of social constructionism to identify how men, women, non-binary, transgender, and gender-diverse individuals experience and express trauma, as well as to understand how they engage with the process of growth in the aftermath of a traumatic experience. If we can gain insight into the relationship between socialized gender constructs and mental health, we can better help identify what we, as counselling psychologists, can do to help survivors thrive.

In alignment with the grounding theory of this capstone, I acknowledge that my understanding of the world is rooted in my sociocultural identity and social location. I attempted to minimize bias by implementing strategies such as defining the project scope and research questions, identifying inclusion and exclusion criteria for articles within the review, and defining keywords and search terms to stay within the defined scope.

Definition of Terms

Gender bias refers to the beliefs that influence stereotypes and preconceived notions regarding abilities and characteristics that men and women have (American Psychological Association [APA], 2018b).

Gender roles refer to the social roles and behaviours that are determined by social and cultural contexts and assigned to each gender (APA, 2018b).

Gender conflict refers to when an individual experiences distress when their behaviour does not align with gender roles (APA, 2018b).

Hegemonic (traditional) masculinity refers to the idealized, dominant, and stereotypical traits (e.g. dominant, aggressive, independent, leader, unemotional, braven, and tough), social roles (financial provider), and physical features (e.g strong) that are often prescribed to boys and men (Chandler & Munday, 2020).

Posttraumatic growth (PTG) refers to positive changes in an individual after experiencing a life-altering, seismic traumatic event (Tedeschi & Calhoun, 1996).

Resilience refers to an individual's ability to adapt in the face of adversity (Lapore & Revenson, 2004; as cited in Calhoun & Tedeschi, 2006).

Stress-related growth (SRG) refers to positive changes that an individual may experience after going through a highly stressful event (Schaefer & Moos, 1992). While similar, this differs from PTG as SRG events range from everyday life stressors to seismic events (Calhoun & Tedeschi, 2006).

Sex refers to an individual’s biological and physiological characteristics (e.g. reproductive organs, hormones, etc.) that categorize an individual as male, female, or intersex.

Socialized gender refers to the behaviours, meanings, values, and overall characteristics that are ascribed to different sexes in different cultures and at different times.

Trauma refers to the emotional, cognitive, and physical repercussions of living through a seismic event (Tedeschi & Calhoun, 1996).

Traditional femininity refers to idealized, dominant, and stereotypical traits (e.g. emotional, nurturing, collaborative, supportive, and tender), social roles (e.g. homemaker), and physical features (e.g. elegant) that are often associated with girls and women (Chandler & Munday, 2020).

Outline of Capstone Project Chapters

The following chapters discuss the nuances of socialized gender and the process of PTG. The literature review in Chapter 2 provides a solid understanding of the theory and model of PTG, what differentiates it from similar theories, models, and concepts, and an overview of social constructionism and how it pertains to socialized gender. This section of the paper then analyzes beliefs regarding masculinity and femininity and discusses how they may act as protective or risk factors in fostering PTG. Throughout this thorough review, recommendations for counsellors and researchers are provided. Chapter 3 applies insights from the literature review to recommend how counsellors can apply the theory of PTG to trauma-informed services and existing modalities. I provide ideas on effective interventions and modalities that can foster PTG. This section also includes information on how to identify growth and realistic expectations that counsellors should have from survivors.

Chapter 2: Literature Review

While trauma research has primarily focused on negative symptoms, there is a growing interest in positive change after trauma (Kou et al., 2021). There is evidence to suggest that gender impacts the types of trauma events an individual may experience, their psychopathology, and their capacity for transformational growth (APA, 2013; Government of Canada, 2021; Olff, 2017; Vishnevsky et al., 2010). To gain further insight, it is important to examine the theoretical foundations of PTG and social constructions of gender, and thereafter to discuss how sociocultural attitudes impact various PTG processes.

Posttraumatic Growth

While the term "Posttraumatic Growth" is relatively new, the concept of growth after suffering is woven throughout history. Tragedy is a well-known plotline throughout literary works, and early civilizations like the Hebrews and Greeks all wrote about the potential for positive growth after life-changing events. In ancient philosophy, Stoics and Epicureans thought suffering was central to living (White, 2013). To them, suffering was an opportunity for self-mastery. In Buddhism, the first of the four Noble truths is that life is suffering. Certain sects of Christianity believe that suffering is necessary for wisdom and inspiration and that once an individual endures suffering, they can positively impact the people around them (Tedeschi & Calhoun, 1996). Overall, some religions believe that spiritual inauguration cannot be achieved without it.

Research in the field of psychology explores the concept of growth after trauma. Existential psychologists Anshen and Fromm (1948) proposed that individuals would reach their potential-otherwise known as self-actualization through facing unavoidable tragedies in life, isolation, and death. Once challenged, individuals express their growth through love and work. Victor Frankl

(1963) hypothesized that individuals reach self-actualization when they find meaning in their suffering and guilt. Maslow's (1943) hierarchy of needs focuses on various levels of individual needs and the growth and development that occur once they have been achieved. He believed that human beings find creative ways to progress toward self-actualization. In contrast to these religious, philosophical, and psychological foundations of suffering, Aaron Antonovsky's (1979) concept of salutogenesis shifted the focus from the symptoms of trauma to how people stay healthy in the face of stress. In the 1990s, positive psychology brought with it a wave of research that focused on Stress-Related Growth (SRG), resilience, and growth after trauma, otherwise known as Posttraumatic Growth (PTG) (Calhoun & Tedeschi, 2006). During this time, Tedeschi and Calhoun (1995) introduced their theory of PTG, which suggested that unexpected, life-altering, traumatic events could lead to growth if individuals found meaning in their suffering.

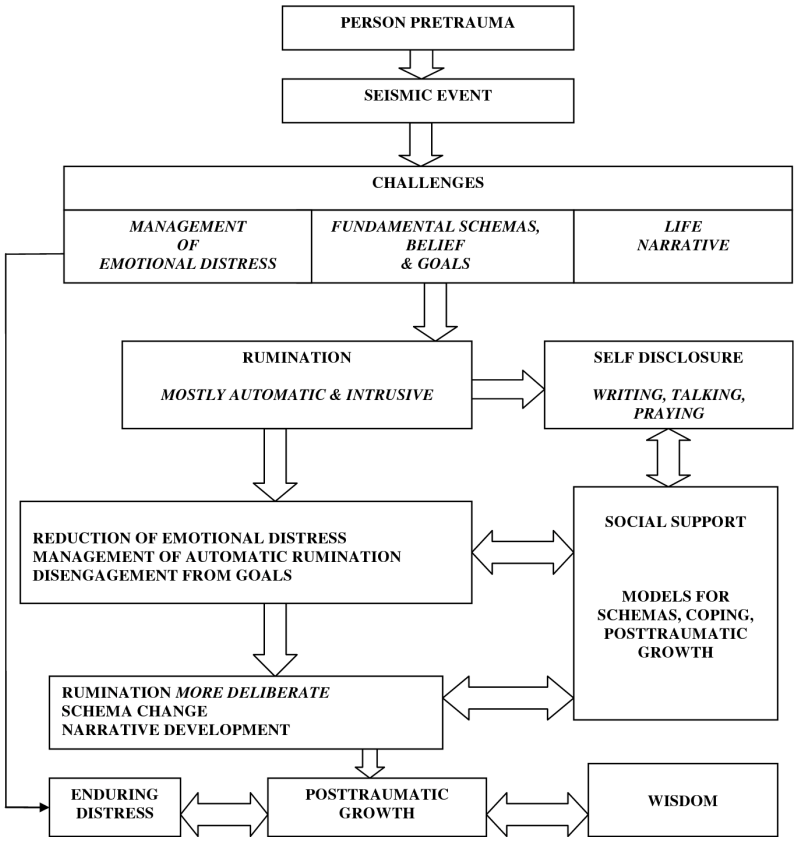
Building upon Janoff-Bulman's (1992) research on the assumptive world, Tedeschi and Calhoun's (1995) theory of PTG focuses on personal strength, new possibilities, relating to others, appreciation of life, and spiritual change. According to the theory, the higher the impact of the event, the more likely it is that someone will experience PTG through rumination, emotional regulation, personal narrative, personal characteristics and nature of the circumstance, sociocultural influences, and life wisdom. Studies on a wide range of traumatic experiences that utilize multiple populations suggest that a higher proportion of people experience growth after trauma rather than receive an official diagnosis of a trauma-related psychological disorder (Calhoun & Tedeschi, 2006). However, growth is not *because* of the trauma itself, but rather the struggle to *recalibrate* our understanding of the world in the aftermath. From this observation, Tedeschi and Calhoun (1996) developed the Model of Posttraumatic Growth (one of the most

widely referenced models) and Schaefer and Moos (1992) introduced the Model of Life Crisis and Personal Growth.

Tedeschi and Calhoun's Model of Posttraumatic Growth

Based on their theory of PTG, Tedeschi and Calhoun's (1995) model of growth suggests that seismic events trigger an interconnected process with a series of challenges people must overcome. As seen in Figure 1, when an individual experiences trauma, their previous goals, fundamental understandings of themselves, beliefs, and purpose shift. They often experience emotional dysregulation and distress, and to recalibrate, they must re-examine their beliefs to create a new life narrative. To do this requires rumination, self-disclosure, social support, and the ability to manage and even endure emotional distress.

Figure 1: Model of Posttraumatic Growth (Tedeschi and Calhoun, 1995)



Rumination and Cognitive Processing

In the adoption of their trauma narrative, individuals often ruminate on the event and must accept the loss of what once was to adapt and move forward (Tedeschi & Calhoun, 1995). Rumination, or "turn[ing] over in the mind," is a form of cognitive processing in which an individual reminisces, problem-solves, or attempts to make sense of an event (Martin & Tesser, 1996; as cited in Calhoun & Tedeschi, 2006). While it may have a negative undertone, the model of PTG distinguishes intrusive, brooding rumination from intentional, reflective rumination, wherein the latter contributes to a contemplating process that helps an individual comprehend what happened to them. This lays the foundation for acceptance, and the individual can then assess their circumstances to find the resources they need to move forward. However, this takes time and trauma survivors often experience intrusive rumination before reflection.

PTG is fostered through acceptance coping, positive reframing, instrumental support, planning, active coping and positive religious coping; PTG is hindered by avoidance coping strategies such as substance misuse (Alamdar & Zhang, 2019). When processing trauma, survivors often think back to the event to understand what happened (Calhoun & Tedeschi, 2006). In the aftermath, individuals may experience distressing flashbacks or continuously ask themselves what they could have done differently (Olff, 2017). While intrusive rumination may seem counterproductive, research suggests that it is necessary for growth. For instance, when studying individuals diagnosed with cancer, Ogińska-Bulik (2018) found that *both* intrusive and reflective rumination led to positive changes in relationships and a greater appreciation for life. Similarly, Kelly et al. (2017) found that stroke survivors who deliberately ruminated while engaging in both active and denial coping were more likely to report PTG. These findings align with Calhoun and Tedeschi's (2006) theory that cognitive processing and emotional engagement

co-exist and individuals simultaneously cope and experience residual stress. Further, revisiting the event gives individuals the opportunity to find meaning.

Social Support and Disclosure

While individuals are ruminating, they may reach out for support from safe social environments. Social support helps with personal narratives by offering different perspectives that can be integrated into new schemas and help craft new meanings (Prati & Pietrantoni, 2009; Tedeschi & Calhoun, 2006). Further, the degree to which individuals engage in self-disclosure and their perception of the response to it may also play a role. Research suggests that those who felt they received a positive response report higher PTG; "having the social resources available by non-professionals allows individuals to create a new schema or narrative in response to feeling understood, listened to, and supported by another person (Kamen et al., 2016; as cited in Schaer, 2021). It can also be a reciprocal process wherein the process of finding meaning can cause vicarious PTG for those who offer support (Tedeschi & Calhoun, 2006). Further, socially shared schemas can be challenged after widespread traumatic events and lead to a widespread belief that society has reached a turning point which can motivate social change.

While social support may play an integral role in some individuals' experience of PTG, research suggests that it may not always mediate PTG; it is important to consider additional circumstances. For instance, Prati and Piertratoni (2009) suggest that individuals caring for their sick loved ones must undergo role shifts, so they are likely to decrease their involvement in social activities. However, participants who increased spiritual engagement found religious coping helped facilitate meaning-making and transformation.

Wisdom and Life Narrative

Human beings often create a narrative of their life that is shaped by interpersonal relationships, culture, and spiritual beliefs (Calhoun & Tedeschi, 2006). The narrative is often made up of episodic stories that are organized chronologically and reinforced by our social interactions and environment. Trauma deconstructs these narratives, but there is reason to believe there is a relationship between PTG and narrative reconstruction. Individuals who have experienced PTG often report experiences with self-discovery, self-love, and a renewed appreciation for life, wellness, relationships, and spiritual beliefs in the aftermath of the traumatic event (Calhoun & Tedeschi, 2006; Slade et al., 2019). In Slade et al.'s (2019) qualitative study participants spoke about acquiring the ability to access, accept, and be mindful of difficult feelings, and felt as if they had taken their lives back. They became interested in activities that increased their overall physical and psychological well-being, such as art, sports, and nature. Focusing on their interpersonal relationships and spiritual or religious beliefs increased their capacity for empathy and desire to give back. Similarly, survivors of Intimate Partner Violence (IPV) share common experiences of a renewed appreciation for life, rebuilding their sense of self, and living a life filled with the peace and happiness they did not have in their abusive relationships (D'Armore et al., 2018). Many trauma survivors even go on to advocate for others with similar experiences.

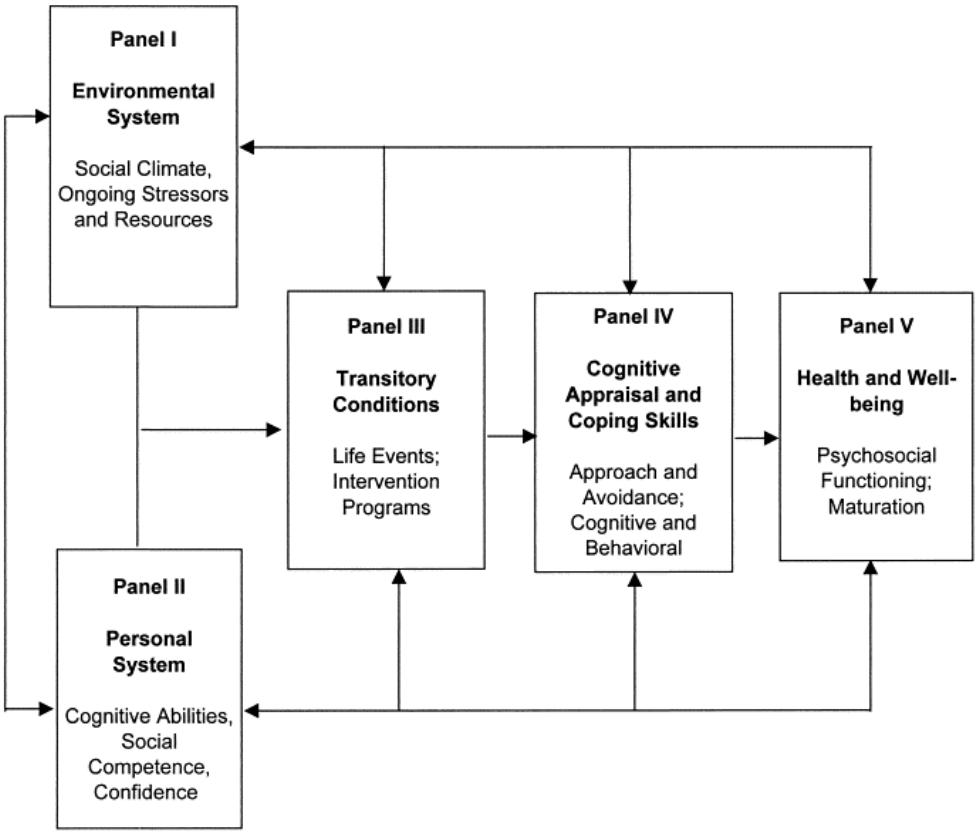
Cultural background plays a significant role in how individuals not only experience trauma but also shape how they cope and find meaning (Feng et al., 2024). For instance, Feng et al. (2024) found a positive correlation between spiritual well-being and PTG when studying women diagnosed with gynecological cancer. Within this cultural context, spiritual beliefs such as Buddhism, Taoism, and Daoism foster a positive and tranquil outlook on life. Additionally, there

is an emphasis on family within Chinese cultures, and researchers hypothesize that this form of social support in tandem with spiritual practices (e.g. mediation) and beliefs (e.g. e.g. accepting destiny) all contribute to PTG.

Shaefer and Moos Model of Life Crises and Personal Growth

Around the same time as Tedeschi and Calhoun, Schaefer and Moos (1992) introduced their Model of Life Crisis and Personal Growth to better understand life changes after crisis and transitions. They observed that after experiencing major stressors some individuals undergo enhancements in major areas of life and defined this change as Stress-Related Growth (SRG). To gain insight into growth processes, Schaefer and Moos (1992) studied different factors that may have contributed to these individuals' experiencing a new sense of self and greater appreciation for life. These factors include pre-existing personal and social resources, adaptive coping skills, and environmental circumstances that impact the experience of trauma. Their model focuses on three areas of life: social resources (such as better relationships with friends), personal resources (such as self-esteem), and new or improved coping skills (such as problem-solving). These areas are represented in five panels of the model to demonstrate how personal and environmental factors shape an individual's cognitive appraisal and coping after major life stress; cognitive appraisal/coping influences SRG.

Figure 2: Model of Life Crisis and Personal Growth (Schaefer & Moos, 1992)



Environmental System

Environmental system resources include socioeconomic status, family, and quality of life determinants, as well as the individual's relationship with social networks and the support they receive from them (Schaefer & Moos, 2001). Growth occurs when an individual's environment is capable of supporting them during traumatic events, whether it be emotionally, financially, or otherwise. For instance, individuals who experience the loss of a loved one have better outcomes when they have social support systems and positive family functioning than those who do not. Cohesive and expressive families show less distress and depressive symptoms and are more socially adjusted (Kissane et al., 1997; as cited in Schaefer & Moos, 2001). Similarly, Siegel et al. (2005) found that emotional support, not practical support, positively predicted SRG for

women diagnosed with HIV. The authors surmised that this may have contributed to participants' re-evaluation of significant relationships, fostered a deeper connection between family and friends, and allowed for emotional expression, which contributed to meaning-making and processing of the event.

Personal System

Personal system resources include marital status, gender, education level, age, spiritual/religious beliefs, health status, prior crisis experience, and personality traits such as self-efficacy, optimism, and self-confidence (Zoellner & Maercker, 2006). Regarding personality traits, SRG outcomes are not only positively correlated with high self-esteem, but people who experience SRG show improvements in self-esteem, ability to problem solve, and interpersonal skills, and report higher satisfaction in their relationships (Popa & Podea, 2013). Age is also an important factor in SRG. In a study with a large sample of 1,995 adults, Ogle et al. (2013) found that older adults who experienced trauma in childhood had worse psychological health and more PTSD symptoms in later adulthood than those who experienced trauma in young and middle adulthood. While age is part of the personal system, the author’s results on impaired psychosocial functioning suggest that participants with childhood trauma reported lower scores on subjective happiness, social support, and coping in later adulthood. Similarly, research on grief has shown that both age and experience with loss impact SRG outcomes (Schaefer & Moos, 2001). Authors hypothesize that losing a spouse at a young age may come with additional responsibilities such as now being a single parent or increased financial stress due to mortgage payments. Furthermore, religious beliefs help with meaning-making and may also indirectly help growth by connecting individuals to social resources.

Transitory Conditions

Life crisis and transition include severity, duration, timing of the life crisis, and perceived controllability (Park et al., 1996). For instance, when studying bereavement, Parkes and Weiss (1983) found that bereaved spouses had better outcomes when their terminally ill spouses were sick for longer (as cited in Schaefer & Moos, 2001). Similarly, research on grief and bereavement suggests that it is difficult to find meaning in death that occurs suddenly, unexpectedly, or is associated with stigma (e.g. suicide). In contrast, when studying whether disease stage, number of symptoms, and time since diagnosis of HIV predicted SRG outcomes, Siegel et al. (2005) found that these trauma characteristics did not predict SRG for the women in their sample. The researchers hypothesize that for the women in the study, the stigma of the diagnosis itself may have been enough to alter cognitive schemas and long-held beliefs, so severity and symptoms had no effect. Overall, characteristics of the life crisis combined with the conditions in which the life stressor was experienced have been hypothesized to contribute to the likelihood of SRG (Schaefer & Moos, 2001).

Cognitive Appraisal and Coping

Cognitive appraisal and coping are an interrelated process that is pivotal in adapting to trauma (Schaefer & Moos, 2001). Strategies such as positive reframing can help with minimization and meaning-making. Those who use approach coping and actively try to find meaning experience higher rates of SRG than those who use avoidance coping and are unable to take action. For instance, when studying the relationship between SRG and the racism that Asian international students and workers experienced during the COVID-19 pandemic, researchers found higher levels of overall resilience and the use of active, problem-focused coping strategies for participants who experienced SRG (Oh et al., 2022). In general, the literature suggests that

active coping strategies help individuals mitigate psychological distress by helping them navigate stressors and engage in self-reflection.

Differentiating Posttraumatic Growth, Stress-Related Growth, and Resilience

Tedeschi and Calhoun's (1996) and Schaefer and Moos's (1992) models of growth in response to trauma and life stressors have a number of similarities. First, both PTG and SRG are *outcomes* of trauma. Further, both suggest that there are a number of personal, cultural, and environmental factors that contribute to personal transformation. For instance, researchers observed that distal cultural values (e.g. Western ideologies) and proximal subcultures (e.g. social networks) impact social scripts and narrative frameworks that shape how an individual understands trauma and how they engage with trauma processing. Similarly, both PTG and SRG models include personal characteristics and social resources as contributors to the growth process. However, while similar, Tedeschi and Calhoun (2006) maintain that PTG is a process that occurs after major events that have an enormous effect such as terminal illness or natural disaster, but SRG can occur in the face of everyday or chronic stressors (Park et al., 1996; Schaefer & Moos, 1992). Yet as research has progressed, many authors use the terms interchangeably. Even though Schaefer and Moos (1992) defined their theory as Stress-Related Growth, researchers have cited this term in their research but designed their study using Tedeschi and Calhoun's (1996) theory as the foundation. Similarly, other researchers have designed their studies using Schaefer and Moos's (1992) theory as the foundation but defined outcomes as PTG. Additionally, many of the studies featured in this review used both PTG and SRG outcome measures. Thus, while differences have been acknowledged and defined, researchers have blurred the lines and now equate SRG to Tedeschi and Calhoun's (1996) definition of PTG. Moreover, Tedeschi and Calhoun's (1996) theory and model of PTG has the highest citation

frequency with 2,353 mentions between 1996-2020 (Kou et al., 2021). As such, this paper will apply Tedeschi & Calhoun's (1996) conceptualization of PTG to define growth after trauma.

Alongside SRG, another related term that is important to distinguish is resilience. There are various definitions of resilience, but in the broadest sense, it can be defined as the dynamic processes of an individual's ability to adapt in the face of adversity (Lapore & Revenson, 2006). To help define resilience, Lapore and Revenson (2006) use the analogy of a tree withstanding a storm. Wind and rain may disrupt the branches and leaves, but when the storm passes, the tree does one of three things: either the storm did not disturb it; it grows back the branches and leaves it lost; or it reconfigures to something new. These conceptualizations of resilience are analogous to resistance, recovery, and reconfiguration; when people are faced with stressors, they may appear invulnerable, return to their lives as usual, or grow in response to their trauma. However, resilience is something an individual may possess prior to trauma and it does not require them to re-examine their core beliefs and the various facets of their lives. Although one potential outcome is a profound transformation, it is not necessary to be considered "resilient" (Elam & Taku, 2022). Alternatively, PTG is the process in which someone may not possess the same ability to adapt but is forced to face psychological challenges that shift their core beliefs and they grow as a result.

Measuring Posttraumatic Growth

Currently, the most commonly used validated measures are Park et al.'s (1996) Stress-Related Growth Scale (SRGS) and Tedeschi & Calhoun's (1995) Posttraumatic Growth Inventory (PTG-I). The PGT-I is based on Tedeschi and Calhoun's (1996) theory of PTG and is designed to assess growth within the five domains of the model: personal, strength, relating to others, new possibilities, spiritual change, and appreciation of life. Research on changed

perspectives of trauma survivors indicates that these five measures were the most common (Tedeschi & Calhoun, 1996). The assessment tool includes 21 items on a scale of 0 (I did not experience this change as a result of my crisis) to 5 (I experienced this change to a very great degree as a result of my crisis). It was standardized on a university population with an internal consistency reliability of .90 and the five subscale alphas ranging from .67 to .85. Research suggests that the PTG-I has good internal consistency, acceptable test-retest reliability, and scores on the scale are approximately normally distributed (Calhoun & Tedeschi, 2006; Tedeschi & Calhoun, 1996). Additionally, it has acceptable convergent validity (Boals & Schuler, 2019).

The other standardized measure of PTG is the SRGS. This assessment tool was influenced by Schaefer and Moo's (1992) conceptual model to measure determinants of posttraumatic growth: the respondent's personal and environmental characteristics; characteristics of the negative life event; and coping behaviour (including cognitive processing and acceptance) (Park et al., 1996). The SRGS is a self-report measure that asks participants to rate themselves on a scale of 0 (not at all) to 2 (a great deal) in terms of how their life has changed in areas that include personal resources, social relationships, life philosophy, and coping skills (as cited in Calhoun & Tedeschi, 2006). This measure was validated with several studies utilizing university students who experienced a number of stressful life events such as loss, heartbreak, and illness. It was found to have good test-retest reliability and internal consistency of .95. There is evidence to suggest it is a valid measure (Park et al., 1996). It also has acceptable convergent validity (Boals & Schuler, 2019). Originally, the scale included 50 items but has since had several adaptations, including short-form versions that include the highest loading items.

Clinical Applications of PTG

In general, there is some evidence to suggest that counselling can increase PTG for survivors, but effects vary widely based on a number of factors including the method of intervention, trauma type, gender, etc. For instance, Mutisya & Owuor (2018) investigated the relationship between PTG and psychotherapy after the Garrissa terrorist attack. They found that survivors who attended over 10 counselling sessions reported the highest overall PTG-I scores (mean = 82.06 out of 100) compared to participants who only attended the critical incident debrief (mean = 74.95 out of 100) (Mutisya & Owuor, 2018). To provide deeper insight into the relationship between variables in the quantitative phase, Mutisya and Owuor (2018) also collected qualitative data from those with higher PTG-I scores. Participants reported that attending therapy helped them accept their reality, grieve the loss of their friends, and process denial. While qualitative data is less generalizable, the qualitative phase had rich narratives that showcased the benefits of therapy for PTG within this population. Similarly, Ramos et al. (2017) found that women diagnosed with breast cancer who participated in group therapy had higher PTG when compared to the control group, suggesting that group interventions that focus on psychoeducation, disclosure, emotional regulation skills, and narrative development are effective in promoting PTG.

While few PTG modalities exist, Roepke's (2015) meta-analysis on psychosocial interventions and PTG found three common therapeutic approaches throughout the literature that have been shown to increase growth outcomes: written or spoken self-expression/disclosure, cognitive-behavioural therapy, and novel psychosocial interventions that directly promote growth. According to Roepke (2015), approaches that focus on self-expression and disclosure have a reasonable amount of empirical evidence to suggest an effective trauma-informed

approach. The author references studies on military veterans, sexual assault survivors, and women with breast cancer that found expressive writing increased PTG. However, this approach may not be impactful for all forms of trauma, making it imperative for counselling psychologists to continuously evaluate their client's progress.

Roepke (2015) found that cognitive behavioural therapies like prolonged exposure and cognitive restructuring increased PTG for trauma survivors. Specifically, cognitive-behavioural stress management (CBSM)- a manualized therapy that identifies sources and indicators of stress- was found to benefit trauma survivors by addressing negative thought patterns, teaching relaxation techniques, and encouraging the utilization of social support systems. In addition, Roepke (2015) found several approaches designed specifically for PTG that range from 8-10 weeks and focus on psychoeducation, cognitive restructuring, personal responsibility, social support, existential and spiritual concerns, emotional regulation, narrative creation, and self-disclosure. Xu et al. (2016) also found success in a preliminary study on a novel PTG treatment program tailored to Chinese primary healthcare workers. The program incorporated elements of traditional Chinese medicine and participants received psychoeducation on how stress, anxiety, and depression impact physical, behavioural, and cognitive symptoms, learned effective coping strategies (meditation, relaxation, etc.), and were given the space to discuss and reflect upon growth experiences. While the study featured a small sample size and there was no control group, Xu et al. (2016) found a positive relationship between PTG, personal accomplishment and both intrinsic and extrinsic satisfaction levels. Overall, more research is needed to provide substantial evidence on the efficacy of treatment programs specifically designed to foster PTG. Calhoun and Tedeschi (2006) promote caution when utilizing programs solely intended to foster

growth as some trauma survivors do not experience PTG, thus highlighting whether it is fair to have such expectations. Further discussion on this can be found in Chapter 3.

Gender Differences in Posttraumatic Growth

Research suggests that gender is a key predictor of trauma and PTG. An earlier meta-analysis on self-reported measures found that women had consistently higher PTG scores than men (Vishnevsky et al., 2010). Vishmevsky et al. (2010) reviewed 77 studies that had a combined sample of 16,076 participants with various traumatic experiences; the most common experiences were cancer, bereavement, and natural disasters. The authors identified and analyzed common moderating variables including age, assessment measure (PTG-I, SRGS, or both), trauma event type, the language of the measure, and sample type (college, community, or mixed). Researchers found an overall small to moderate but reliable gender difference (.28) with women scoring higher than men. Moreover, effect sizes were positive across all moderating variables and did not vary across community, college, and mixed samples. Other studies on survivors of natural disasters (Akbar & Witruk, 2016; Jin et al., 2014), adult children caregiving a parent diagnosed with cancer (Teixeira & Pereira, 2013), and studies about trauma in general (Tedeschi & Calhoun, 1996; Swickert & Hittner, 2009) demonstrated that women experience significantly higher levels of PTG than men. When exploring the relationship between PTSD and PTG, Jin et al. (2014) utilized a large sample size (n = 2,300) of hurricane survivors and found a significant gender difference in growth scores wherein 39.4 % of women but only 11.7 % of men reported PTG when controlled for PTSD levels.

Several studies across cultures regarding PTG after the recent COVID-19 pandemic have also found women report higher levels of PTG than men (Adjorlolo et al., 2022; Kalaitzaki, 2021). Cohen-Louck (2022) collected data from a large sample (1,310) and explored the

relationship between gender, quarantine duration (short, medium, and long), and PTG. They found that women reported higher PTG at each duration, but the largest mean difference between women and men was during long-term quarantine, with women reporting a mean score of 2.84 compared to men's mean score of 2.43. Adjorlolo et al. (2022) hypothesized socialized gender roles enable women to be vulnerable, and women often seek emotional support and resources that are essential to PTG. In contrast, men are expected to remain strong and not outwardly display emotional distress.

While the aforementioned studies provide significant data on gender differences in PTG, it is important to note that many use cross-sectional designs and either do not categorize trauma by type of trauma event or solely focus on one specific trauma event, making the results compelling but difficult to generalize. Additionally, some studies suggest women are more likely to experience PTG than men (Adjorlolo et al., 2022; Kalaitzaki, 2021), but there are a few that found gender did not affect overall PTG scores (Alamdar & Zhang, 2019; Barlow & Hetzel-Riggin, 2018; Cundiff et al., 2023; Shigemoto et al., 2020). Additionally, of the nine articles Alamdar and Zhang (2019) included in their literature review on help-seeking behaviour and PTG in the aftermath of natural disasters, three found women had higher PTG scores compared to men, five found no significant gender difference, and one found men had higher PTG scores compared to women. However, Alamdar and Zhang's (2019) review was narrow in scope, and none of the studies were designed to specifically explore gender differences. Additionally, Shigemoto et al. (2020) convenience sampled from Hurricane Harvey recovery groups on Facebook, which demonstrates that participants already exhibit help-seeking behaviours. Even with such limitations, it brings into question what contributes to gender differences in PTG. Several of these studies included additional standardized measures that revealed significant

differences in the process of PTG, such as perceived social support measures (Cundiff et al., 2023) or how specific gender traits associated with traditional masculinity and femininity positively predict PTG (Barlow & Hetzel-Riggin, 2018).

Some researchers hypothesize that biological and cognitive differences between men and women contribute to higher rates of PTSD symptomology and diagnosis in women compared to men. For instance, women have a more sensitive hypothalamus–pituitary axis than men, and PTSD has been observed to correlate with a hyperactive amygdala, hypoactive prefrontal cortex, and suppressed communication between the two in an excessive fear response (Olff, 2017). Thus, it has been hypothesized that due to cognitive differences, women may have elevated PTSD symptoms due to higher threat perception and perceived loss of control (Jin et al., 2014). However, behaviour does not exist in a vacuum and both Tedeschi and Calhoun (1996) and Schaefer and Moos (1992) acknowledge that there are proximal and distal elements of PTG. Additionally, the APA (2018b) recognizes that the biological basis of psychopathology and diagnostic criteria does not adequately factor in cultural expectations, lived experiences, and contexts of distress. It is clear that there are a number of social and cultural factors that must be explored to better understand how everyone, regardless of gender, has the opportunity to grow after trauma.

Socialized Gender and Posttraumatic Growth

Beginning in the 1970s, sociologists began to differentiate *sex* from *gender* (Eagly & Wood, 2012; West & Zimmerman, 1987). Sex refers to the genitalia and sex chromosomes an individual is born with; depending upon biological makeup individuals are assigned female or male at birth. Alternatively, gender is a binary socially constructed concept that provides social scripts consisting of attitudes, activities, and behaviours for boys, girls, men, and women to follow.

Gender Schema Theory suggests that these scripts are internalized through gender-based schematic processing (Bem, 1981). According to Bem (1981), self-identity is linked to gender schemas, so when children learn attributes associated with their gender, these become part of who they are. Further, children learn how to self-evaluate their place in the world through their gender schema, influencing their preferences, attitudes, and behaviours.

While gender schemas are the internal processing of common narratives, *gender roles* are the external performance of them. West and Zimmerman (1987) believe that gender is "… a routine, methodical, and recurring accomplishment… a complex of socially guided perceptual, interactional, and micropolitical activities that cast particular pursuits as expressions of masculine and feminine 'natures'" (p. 4). Similarly, Social Role Theory suggests that differences and similarities in behaviour reflect gender role beliefs that, in turn, represent people's perceptions of men's and women's social roles in society (Eagly & Wood, 2012). For instance, women are expected to be caring and compassionate, which may be why many women are oriented toward nurturing activities. This may explain why teaching, nursing, and social work are female-dominated occupations. Social structures in society often reinforce these beliefs starting in early childhood. For instance, attitudes about masculinity and femininity influence what is considered to be appropriate behaviour for pre-schoolers; boys are encouraged to play physical or mechanical games (e.g. building blocks, sports, etc.) whereas girls are encouraged to engage in literacy or fine motor activities (reading, drawing, etc.) (Aprilianti et al., 2021). From these perspectives, individuals *display* their gender by adopting masculine or feminine traits and *performing* behaviours associated with them. These performances are then reinforced both internally and through interpersonal interactions, and individuals are held personally and socially accountable for their behaviour (Bem; 1987; West & Zimmerman, 1987).

Since gender roles are shared constructs, people are more approving of behaviour that aligns with the gender an individual is performing. This leads to *gender stereotypes* which include physical and psychological beliefs about what boys, girls, men, and women typically do as well as what they should do (Koenig, 2018). Individuals are held accountable by being rewarded for conforming to gender norms or penalized for deviating (Eagly & Wood, 2012). For instance, O'Beaglaoich et al. (2015) examined narrative experiences of gender role conflict experienced by Irish schoolboys and found that many did not talk about their emotions for fear of being teased by their peers. Evidently, people are aware of this; therefore, they are less likely to express masculine behaviour as a woman or feminine behaviour as a man unless the benefits outweigh the costs. Similarly, early childhood educators and parents reinforce gendered behaviours by awarding boys with gifts in the form of Legos and trucks whereas girls are given dolls and kitchen appliances (Aprilianti et al., 2021). While "doing" gender does not necessarily mean individuals always live up to gender norms, their behaviour is at risk of gender assessment and they are often rewarded when they conform to gender norms (West & Zimmerman, 1987).

Current research on gender stereotypes reflects our attitudes regarding gendered behaviour. Common narratives suggest that school-aged girls should be wholesome and sociable, but not dominant (Koenig, 2018). As adults, women are held accountable for having a feminine appearance, an interest in languages/arts, and a communal nature. Further, women are expected to show concern about others, be sociable, and have higher emotional sensitivity than men (Hentschel et al., 2019). Alternatively, boys should be agentic and active, but not shy, weak, or emotional (Koenig, 2018). Boys often act tough and conform to heterosexual norms to preserve their masculine appearance, because "… boys who did not satisfy the standards of general competence, strength, and toughness reported experiencing negative consequences. These

repercussions included: devaluation of status or hierarchical standing… perceived or real negative judgments from others… and negative self-judgments" (O'Beaglaoich et al., 2015, p. 322). Masculinity is more restrictive than femininity, and masculine preservation prompts boys to restrict their emotions for fear of non-reciprocity (Koenig, 2018). Later in adulthood men should appear masculine, be sexually active, avoid being shy and acting feminine, have emotional toughness, and provide for their families (Koenig, 2018; Wong et al., 2020). Although a lot of gender discussions are exclusive to masculine and feminine constructs, it is important to note that gender is not binary. Many cultures acknowledge that gender exists on a spectrum, and some even recognize a third sex, including the Kathoey in Thailand and Hijras in India (Mareck et al., 2004). However, much of the literature reflects Western constructs; therefore, research that includes gender-diverse communities is sparse. This will be further discussed under limitations of the current literature in this chapter.

Men are more likely to endorse traditional gender roles, masculine norms have more personal relevance, and men are more concerned with others' perception of their gender performance (Barlow & Hetzel-Riggin; Juvrud & Rennels, 2017). Additionally, concern with others' beliefs about gender-specific behaviour matters more to men than their personal beliefs (Juvrud & Rennels, 2017). Easton et al. (2013) hypothesize that hegemonic or "toxic" masculine values (dominance, emotional and physical toughness, and hyper-independence) may impact men's ability to engage in important PTG processes such as cognitive appraisal, effectively blocking their opportunity to review and understand their trauma. This aligns with Barlow and Hetzel-Riggin's (2018) research on Intimate Partner Violence (IPA), gender role adherence, and PTG. Barlow and Hetzel-Riggin (2018) found that gender role adherence positively predicted PTG, particularly for women who align with traditional femininity and men who adhere to less

hegemonic masculine norms. Essentially, men who did not have high scores on scale items of the Male Role Norms Inventory and Bem Sex Roles Inventory aligned with "toxic masculinity" (e.g. dominance, forcefulness, and aggression) and had high scores on scale items associated with "healthy masculinity" (e.g. leadership, ambition, and respect) had stronger associations with PTG. While causal conclusions cannot be drawn from cross-sectional data, results from this study highlight how the socialization of gender impacts an individual's ability to engage with vital aspects of the PTG process.

The Relationship Between Gender and Trauma

To better understand how socialized gender roles predict PTG, it is important to consider how gender norms impact how an individual expresses their trauma, the likelihood of experiencing or being exposed to trauma, and cultural responses to traumatized individuals. Although boys and men are more likely to experience a traumatic event, they typically report what researchers consider to be "low-impact trauma", which includes nonsexual violence perpetrated by a stranger, and no interpersonal trauma, including accidental injury, serious illness, war trauma, and witnessing injury (Barlow & Hetzel-Riggin, 2018; Carlson & Slovak, 2008; Kimerling et al., 2018; Olff, 2017). In contrast, women and girls are more likely to be exposed to interpersonal violence, receive threats of bodily harm, and experience "high-impact trauma" such as intimate partner violence, sexual assault, stalking, and childhood maltreatment (Carlson & Slovak, 2008; Cundiff et al., 2023; Kimerling et al., 2018; Olff, 2017). In Canada, the prevalence of sexual assault is 15.4% among women compared to 4.4% among men. Other unwanted sexual experiences are 23.4% among women compared to 6.4% among men (Government of Canada, 2021). Women also report higher rates of victimization compared to men who have been through similar trauma events. As an example, Cundiff et al. (2023) found

that despite comparable rates of IPV between genders in the sample, women reported significantly higher levels of physical abuse, emotional abuse, and severe combined abuse. Similarly, Rzeszutek et al. (2016) found that HIV-positive women had higher posttraumatic stress symptoms (PTSS) than men.

Because women in social environments that endorse traditional gender roles have higher rates of high-impact trauma, it could be possible that this level of trauma severity may account for women having higher rates of PTSD diagnosis and PTG outcomes compared to men (Kimerling et al., 2018). Further, while some studies have found a negative relationship between PTSS and PTG, Rzeszetek et al. (2016) and Schubert et al.'s (2016) meta-analyses of the relationship between PTSD and PTG found that of the 19 studies included, the majority found that PTSD positively predicted PTG; PTG was higher in participants with PTSD compared to non-PTSD subgroups. Similarly, in their sample of hurricane survivors, Jin et al. (2014) found that 45% of participants who met the criteria for PTSD reported PTG. Considering PTG occurs when trauma events challenge an individual's cognitive schema, and women are more exposed to high-impact trauma, one potential hypothesis for gender differences is that women's trauma is severe enough to challenge their assumptive world and redirect their life's purpose (Calhoun & Tedeschi, 2006; Schubert et al., 2016).

In addition to the relationship between socialized gender roles, trauma type, and mental health outcomes, gender scripts guide emotional expression. In the immediate aftermath of suffering, women are more likely to experience both emotional and dissociative responses to trauma such as anxiety, fear, and avoidance, and to report higher rates of depression and PTSD (Carlson & Slovak, 2008; Olff, 2017). Furthermore, women are more likely to report re-experiencing traumatic events through flashbacks, whereas men are more likely to experience

physiological symptoms and endorse reckless, aggressive, and self-destructive behaviours (Carlson & Slovak, 2008; Farhood et al., 2018; Jin et al., 2014; Kimerling et al., 2018). Per assumed gender characteristics, women are more sensitive; therefore, they can express their emotions without social consequences. Conversely, men are more stoic; emotional expression does not align with masculine constructs with the exception of anger, one of the few emotions men can show without social repercussions (Farhood et al., 2018; Hentschel et al., 2019; Koenig, 2018; Wong et al., 2020). Farhood et al. (2018) surmise that men's expression of trauma symptoms may not reflect current diagnostic criteria because it is more socially acceptable for them to express anger than to appear weak. While research on gender bias in diagnostic materials is mixed, emotion-focused and expressive coping help with cognitive processing and contribute to PTG (Calhoun & Tedeschi, 2006). Thus social norms that allow emotional expression for women yet restrain it for men may also contribute to gender differences in PTG (Alamdar & Zhang, 2019).

Gender norms dictate differences in emotional and behavioural responses, and gender constructs influence values that can impact traumatic experiences or our perception of traumatic events. For instance, Cohen-Louck (2022) found that during the COVID-19 pandemic, Israeli women reported higher overall levels of growth, and PTG scores increased with time spent in quarantine. However, it was the inverse relationship for Israeli men. Cohen-Louck (2022) surmises that gender socialization increases the value that women place on their families and encourages men to engage in activities outside of the household such as work, sports, etc. Comparably, Social Role Theory suggests that women's nurturing enables them to fulfill the social roles of parent, caregiver, or homemaker, and men's leadership qualities suit social roles that revolve around work (Eagly & Wood, 2012). Through a social constructionist lens, it could

be hypothesized that women who spent more time in quarantine may have had access to more support and resources that aligned with their values and/or socialized gendered responsibilities, whereas men were unable to fulfill their social duties and may have found it difficult to adapt. This notion is supported by previous research on gender differences in PTG wherein researchers found women had higher scores on enhanced family closeness compared to men (Swickert & Hittner, 2009).

Coping

Much like perception, experience, and expression of trauma, gender roles influence coping strategies. According to the literature, possible mediators for gender differences in PTG are women's ability to engage in ruminative thoughts and emotion-focused coping strategies (Alamdar & Zhang, 2019; Cholankeril et al., 2023; Konaszewski et al., 2021). While passive forms of emotion-focused coping such as self-blame, denial, self-distraction, and behavioural disengagement can lead to anxiety and depression, they are also common reactions to trauma and align with intrusive rumination (Calhoun & Tedeschi, 2006). Alternatively, some studies found that women also tend to use more positive reframing and self-talk than men and are more expressive with their coping strategies (Park et al., 1996; Tamres, Janicki, & Helgeson, 2002). These positive forms of emotional-focused coping mirror the process of deliberate rumination and motivate individuals to seek information and/or emotional support (Calhoun & Tedeschi, 2006).

Interestingly, there is a significant relationship between rumination and spirituality (Eames & O'Connor, 2022). Spirituality may be the catalyst for deliberate rumination as it provides a framework that can help integrate new meaning into existing belief systems. As is the case with rumination, there are gender differences in the use of spiritual and religious coping in the face of

trauma. Adjorlolo et al. (2022) found women enduring the COVID-19 pandemic were more committed to spiritual and religious practices compared to men. Similarly, Rzeszutek et al.'s (2016) study of PTSS and PTG with individuals diagnosed with HIV and Prati and Pietrantoni's (2009) research on optimism, social support, and PTG, found that women reported more spiritual-related growth.

Help-Seeking

Healing from trauma can be an all-consuming task. As individuals are left to pick up the pieces they may not know where to start. Although individuals can experience PTG without professional treatment, research suggests that those who do seek help are better equipped to process their emotions, deal with denial, and accept change, helping them to reinvest in themselves (Mutisya & Owuor, 2018). Some researchers found gender to be insignificant in terms of its influence on help-seeking behaviours (Shigemoto et al., 2020). Socialization suggests that people who personally endorse masculine stereotypes are less likely to seek help compared to those who endorse traditional femininity, regardless of biological sex (Juvrud & Rennels, 2017). Neilson et al. (2020) believe that cultures that endorse the concept of traditional masculinity and stigmatize men's emotions foster the belief that trauma is emasculating. This is reflected in Silvestrini and Chen's (2023) qualitative study on help-seeking among veterans. They found former male military members were reluctant to seek mental health services to due internalized stigma, fear of reliving their trauma, and preference for emotional repression. Barnett et al. (2020) had similar findings regarding IPV, and they surmised that men were less likely to seek both formal (police, counselling psychologists, etc.) and informal (friends, family, etc.) support than women due to social context. Growth and acceptance require vulnerability, which can lead to intense emotions that do not align with masculine values (Easton et al., 2013).

Men also seem to be more affected by others' attitudes toward gender stereotypes. Therefore, it is plausible that men weigh this risk and decide that gender role adherence is more important, thus impeding growth. However, Barrett et al. (2020) surmised that, since socialized femininity assumes women are responsible for childrearing, gender differences in IPV may be attributed to women's increased need for instrumental assistance (lawyers, financial aid, etc.) in addition to emotional support.

When examining gender role adherence, it is important to understand how the intersection of race, culture, and gender roles impacts help-seeking. For instance, Caucasian women in Western cultures are more likely to seek mental health services compared to individuals from different ethnic and cultural backgrounds (Shigemoto et al., 2020). I hypothesize there are a number of reasons why this might be, such as the recent shift in social discourse with millennials and Generation Z regarding seeking mental or having the socioeconomic resources to access treatment. In contrast, Western society has a history of mistreating and oppressing African American women, and their experiences with rejection, anticipatory stigma, racism, and racial discrimination from the healthcare system and healthcare professionals impact their willingness to seek help (Waller et al., 2021). Additionally, African American women experience internalized stereotypes such as "the strong black woman" who is expected to be resilient, which decreases their willingness to seek help. However, PTG has multiple pathways, and these individuals often seek help through more culturally acceptable and accessible resources. For instance, African American women who have experienced IPV commonly report engaging in self-care or seeking comfort and support from the Black Church to address their trauma (Waller et al., 2021). Similarly, in the aftermath of Hurricane Harvey, connecting with community resources had a significant effect on PTG for men who did not want

to seek mental health treatment (Shigemoto et al., 2020). Although it is important to acknowledge these alternative pathways to PTG, the level of growth was consistently higher for both men and women who sought professional help. Additionally, a number of studies have observed that therapeutic intervention is effective in facilitating PTG (Mutisya & Owuor, 2018; Roepke, 2015; Xu et al., 2016). In their social justice efforts, therapists must contribute to removing barriers to treatment and take an intersectional approach, acknowledging cultural differences and identifying additional resources e.g. church communities, that encourage transformational growth.

Social Support and Disclosure

Although Tedeschi & Calhoun (1995) believe that there is a positive correlation between social support and PTG, the research is divided on whether there are significant gender differences in perceptions of support and whether perceived support predicts PTG for both genders. For instance, Cundiff et al. (2023) found similar overall scores of perceived support from family, friends, and significant others. Still, when examining each subscale individually, men who reported higher levels of IPV felt less acceptance and support from their significant others whereas women's experiences of abuse did not alter their perception. In contrast, Pinzon and Rotol (2022) found that women struggling with infertility perceived higher rates of overall support compared to men. When examining each subscale, researchers found that men perceived the most support from their significant others compared to family and friends, contradicting Cundiff et al. (2023). Beginning around the age of three, young girls are given baby dolls to nurture and care for (Marecek et al., 2004). Thus, researchers surmised that women had a higher mean average because infertility may cause them more distress, and therefore increase their desire to seek support.

In general, women benefit more from social support than men. Cundiff et al. (2023) found a positive correlation between perceived support and PTG for women, but not for men. Further, Lee et al. (2022) found that high levels of stress with low levels of support had a greater impact on women than men. This may be attributed to gender differences in socialization as women are taught to value and emphasize social relationships at a young age (Merecek et al., 2004). Even so, the interconnected nature of disclosure, interpersonal relationships, and finding meaning after trauma suggest that social support systems contribute to the PTG process, regardless of gender (Tedeschi & Calhoun, 1995). Therefore, differences in benefits and perceptions may be due to how individuals utilize their interpersonal relationships during times of distress.

In addition to the perception of social support, socialization also impacts the specific social networks people turn to and how they utilize them. For instance, Martínez-Hernáez et al. (2016) found that the young men in their study used their friends to normalize their avoidance behaviours by going out and “partying”, and self-control- a trait typically associated with masculinity- preceded awareness of the problem. They were more likely to avoid emotional distress, and if they did disclose waited to do so until they could maintain self-control. Alternatively, young women's awareness of the problem was seen as a necessary step to achieving self-control, and disclosure helped them reflect on their experiences. As per Tedeschi and Calhoun (1996), deliberate rumination is a critical step in accepting change. It also helps create new narratives and life wisdom, regardless of gender.

Gender differences also emerge in the likelihood of turning to support networks in times of distress. Swickert and Hittner (2009) found that both men and women who utilized social support coping reported greater levels of PTG than those who did not. However, men were less likely to seek social support compared to women, therefore reporting significantly lower levels

of growth. This may be because socialized masculinity discourages outward displays of emotion; boys and men are taught to avoid disclosure to maintain the status quo (O'Beaglaoich et al., 2015). If men disclose they may be met with negative reactions (confusion, victim blaming, teasing, etc.), which often reinforces self-blame and symptoms of distress (Bonnan-White et al., 2015; Cundiff et al., 2023). Thus, going against gender norms and expressing distress can negatively impact how men view themselves (O'Beaglaoich et al., 2015). In fact, Lewis et al. (2022) found that men who survived childhood sexual abuse had to reconcile with the shame and confusion they felt because they believed men were unable to be victims of abuse.

In contrast, individuals who are met with empathy, acceptance, and reciprocity have better mental health outcomes, and these positive experiences with disclosure increase PTG rates (Taku et al., 2009). Women often report more positive receptions to their disclosures compared to men, perhaps due to the fact they are allowed to express distress without impacting how they view themselves (Bonnan-White et al., 2015). Therefore, they are more likely to attract social support or seek it out when they need it. Further, the type of trauma experienced can impact assumptions about how they may be received. For example, traditional ideologies assume that masculine men are fertile men. Pinzon and Rotol (2022) hypothesized that men's shame regarding their struggles with infertility could have prevented them from reaching out to their friends and family, a reason why they may mainly rely on their significant others for support. In contrast, the physical and psychological nature of IPV may supersede gender role adherence for men who have experienced IPV (Barrett et al., 2020). This aligns with Cundiff et al.'s (2023) data that showed men had similar perceptions of overall social support compared to women. Barrett et al. (2020) also found that even though men were less likely to seek formal support, they reached out to at least one source of social support.

When examining gender differences through a social constructionist lens, it is important to consider the fact that masculinity and femininity exist on a spectrum. McKenzie et al. (2018) highlight that research on masculinity is often generalized. However, their qualitative examination of men's narratives regarding interpersonal relationships and social support shows that masculinity is not monolithic or static. Participants mainly compartmentalized their relationships by engaging in socially masculine activities with men and personal disclosure with women. Some participants endorsed hegemonic masculinity, which made it difficult to confide in their male friends and impacted their mental well-being. Participants normalized the lack of emotional reciprocity as inherently masculine, and they avoided emotional dialogue with other men due to past experiences that left them feeling shame and rejection. Alternatively, men with previous trauma explained that through positive experiences of disclosure, they learned the benefits of close emotional relationships from other men who demonstrated openness and encouraged it in return. These narratives align with Lewis et al.'s (2022) qualitative study that found traditional masculinity was counterproductive to PTG for men with histories of childhood sexual abuse. These men reconstructed what masculinity meant to them, which included an increased appreciation for their relationships, openness and vulnerability, and empathy.

Criticisms of Posttraumatic Growth

The literature mentions several valid criticisms regarding assessment measures of PTG. A highly cited study by Fraizer et al. (2009) suggests that the PTG-I does not accurately measure the five domains of PTG. Whether it is intentional or unintentional, people may misrepresent themselves on self-report measures. To combat this, Fraizer et al. (2009) used a prospective design to measure whether self-report data from the PTG-I resulted in true growth. They found that PTG-I scores and growth in PTG-related domains were unrelated. In fact, perceptions of

growth were related to increased distress levels whereas actual growth was related to decreased distress. The authors also found a relationship between perceived growth and positive reinterpretation coping, and they hypothesized that perceptions of growth may be a form of avoidance coping. Similarly, Boals and Schuler (2019) highlighted the weak correlation between the scale items on the PTG-I and SRGS and measures of mental health such as anxiety, depression, PTSD, etc. While these findings are often cited when referencing the validity of the PTG-I, Johnson and Boals (2015) note several flaws within the study; Fraizer et al. (2009) used the C-PTGI, which is a modified version that only measures four out of the five PTG-related domains. The authors also used another non-standardized test (The Religious Commitment Inventory), which Johnson and Boals (2015) note reflects organized religion rather than spirituality.

Fraizer et al.'s (2009) study highlights critical flaws in the PTG-I. To address these flaws, several researchers have recommended changes to methodology to ensure accurate results. For instance, Johnson and Boals (2015) suggest including additional measures. To demonstrate, they utilized the PTG-I in concert with The Centrality of Events, which measures the degree to which the traumatic event impacted the individual. They found weak correlations between PTG-I scores and low event centrality, but correlations between PTG-I and high event centrality were strong. Therefore, the authors hypothesized that PTG *is* a valid measure, and quantifiable change can be observed when trauma is truly central to an individual's life.

Another recommendation to improve the accuracy of measures is to address what some researchers have found to be the illusory side of PTG. Critics of the PTG-I question the validity of self-reported measures as they may have an element of illusion. Researchers agree that most measures of self-reporting can be influenced by factors such as social desirability (Fraizer et al.,

2009). Participants may feel obligated to follow social scripts and report increased growth because they think they are *supposed* to grow after trauma. Similar to Fraizer et al. (2009), Zoellner and Maerckerf (2006) surmise that self-perceptions of growth in the aftermath of trauma could be a form of avoidance coping, wherein individuals are not truthful with themselves about their current distress levels, or they may be more self-deprecative of who they were before the traumatic experience. An individual's perception of change may not accurately predict prospective data of actual change (Fraizer et al., 2009). With this knowledge, most authors have concluded that the measurement of true change cannot solely rely on recalled experience.

Addressing the illusionary side of PTG, Zoellner and Maerckerf (2004) developed the Janus-Face Model, a two-component model of PTG that addresses the constructive side of adaptive functioning, resulting in PTG as an outcome (cognitive restructuring) and the illusionary side, resulting in PTG as a method of coping (avoidance, denial, and wishful thinking). These illusions have been observed to increase self-perceptions, naïve optimism, and the belief that external circumstances are better than they are. Zoellner and Maerckerf (2004) posit that in the short-term proximal phase, PTG is more of a coping method than an outcome. However, in the long-term distal phase, survivors will be more constructive and show an increase in adaptive functioning and a decrease in illusionary coping strategies. To address both sides of PTG, researchers suggest including measures that assess post-traumatic stress symptoms, optimism, and openness to new experiences.

In addition to the potential illusionary side of PTG, critics also point out that research regarding PTG only accounts for positive transformation and neglects any negative changes. Given that Tedeschi & Calhoun (1996) endorse the relationship between PTG and PTSD, and

research has shown that distress and growth can happen simultaneously (e.g. Ogińska-Bulik, 2018), theorists and researchers would be remiss to ignore negative and neutral life changes. To address some of these criticisms, Boals and Schuler (2019) revised existing measures to develop and test the SRGS-Revised (SRGS-R). The authors neutralized the language for items on the SRGS scale and added questions regarding negative changes after trauma. Researchers found that the SRGS-R has strong internal reliability and convergent validity. Additionally, the SRGS-R had significantly stronger correlations with mental health measures, including depression, anxiety, global distress, and PTSD symptoms. Furthermore, in contrast to the PTG-I, SRGS-R scores were associated with decreased use of avoidance coping such as self-blame, disengagement, and substance misuse. As such, Boals and Schuler (2019) hypothesize that the SRGS-R is less prone to illusory growth.

Researchers note that PTG-I scores may be difficult to interpret as they do not account for environmental, intrapersonal, and interpersonal characteristics and stressors such as financial strain, previous pathologies, or relationships (Calhoun & Tedeschi, 2006). Further, measures only focus on personal benefit so positive changes within communities, families, and nations are not evaluated. Expanding on these limited domains could help provide insight into how communities change after experiencing a natural disaster, how family units adapt when one of the members has a terminal illness, or how marginalized cultural groups recover from shared trauma.

Another notable criticism of the SRGS and PTG-I is that cultural differences may impact the interpretation of domains like spirituality and life wisdom. Although the PTG-I has been translated into multiple languages and some researchers have claimed it is a universal measure, there is some evidence to suggest that PTG is experienced differently in different cultures (Jozefiaková et al., 2022). Kashyap and Hussain (2018) point out there is no universal definition

of trauma, nor is there a universal script for how people respond to it. They also note that most studies that validate cross-cultural adaptations of the PTG-I have been conducted by researchers who are not immersed in the culture. These etic (outside) perspectives lack nuance. Furthermore, Kashyap and Hussain (2018) note that assessment tools like the PTG-I are Western methods of measurement that use Western definitions of growth, and certain foundational concepts such as self-actualization present differently in individualistic vs. collectivist cultures. For instance, some of the items being measured, such as changes in self-reliance, only apply to individualistic cultures as in these contexts there is an assumption that the self is separate.

Mirzaee et al. (2021) highlight the importance of socialized gender and culture when interpreting scale items in PTG measures. Utilizing a sample of Iranian students, they found cultural and gender differences in scale-item interpretations when assessing for both positive change (PTG) and negative change, otherwise defined as Posttraumatic Depreciation (PTD). While most were able to correctly pair positive items with the PTG-I and negative items with the PTD-Inventory (PTDI), women were more likely to consider "Changing the Priorities" as a positive change and less likely to evaluate "Clarifying Priorities about What is Important in Life" as a negative change. They surmise that women are socialized to be flexible, whereas rigidity is associated with masculinity. They also found differences in cultural understandings of spirituality, suggesting that cultural adaptation of scales is needed to ensure accurate results.

Limitations to the Current Literature

There are a number of common limitations in the literature. First, most studies were cross-sectional, meaning that causal relationships could not be determined, only hypothesized. Furthermore, both Schubert et al. (2016) and Alamdar & Zhang (2019) highlight the inconsistency of measures being used and the use of non-standardized assessment tools. Certain

studies were qualitative and thus used open-ended questions that are difficult to generalize (e.g. Taku et al., 2009). Other quantitative studies admitted that measures had poor internal reliability (e.g. Shigimoto et al., 2020). Many studies collected data from university students (e.g. Barlow & Hetzel-Riggin, 2018; Cundiff et al., 2023; Mirzaee et al. 2021) which may cause a sampling bias and make it difficult to generalize findings. For example, Barlow & Hetzel-Riggin (2018) speculated that the lack of gender differences was because the gender role adherence measurements they employed may not suit younger populations. Additionally, even if it is culturally diverse, samples of university students are not necessarily representative of broader populations. Similarly, some researchers sampled from online trauma forums and social media support groups (e.g. Easton et al., 2013; Schaer, 2020; Shigimoto et al., 2020). Again, this may cause sampling bias and could potentially skew results. For instance, Shigemoto et al. (2021) acknowledge that participation in the Hurricane Harvey recovery groups on Facebook from which they sampled alludes to already possessing help-seeking behaviours.

Even if studies had the perfect sample to reflect the general population and used gold standard measurements, trauma is an extremely broad concept with multiple factors making it difficult to study. For instance, type of trauma (e.g. interpersonal vs. non-interpersonal), duration of the trauma itself (e.g. abuse throughout childhood vs. experiencing a car accident), the time since it was experienced, and age of trauma (e.g. early development vs. late) influences the trajectory of symptoms and impact. In the literature, a few studies did not specify the type or severity of the trauma experienced (e.g. Slade et al., 2019) while others solely focused on one specific seismic event (e.g. Silvestrini & Chen, 2023). Moreover, researchers (e.g. Schubert et al., 2016) noted that many studies do not include measures for both PTSD and PTG making it difficult to determine how the severity of symptoms correlates to PTG outcomes. Although it is

important to study particular populations and life events, it is difficult to compare the PTG scores of adults caretaking a severely ill parent with the PTG scores of individuals who survived IPV. It is also challenging to compare the PTG scores of individuals who experienced physical abuse versus individuals who experienced emotional abuse.

Similar to quantifying broad concepts like trauma, researchers only design studies that include males and females. Research that interchangeably uses gender terms like men and women with biological terms like male and female not only conflates sex with gender but also excludes nonbinary and transgender individuals (e.g. Silvestrini & Chen, 2023) or lump them into one category (Nadal et al., 2016; as cited in Counselman-Carpenter & Redcay, 2023). Although there is limited research that explores intergroup differences among individuals who identify as gender diverse, Counselman-Carpenter & Redcay (2023) found variance in certain domains of PTG. For instance non-binary individuals reported higher levels of social support from non-binary communities, whereas transgender individuals had significantly lower socialization with other transgender people. In addition, Barr et al. (2022) found a significant relationship between internalized transphobia and PTSD; transgender individuals who reported higher rates of anti-transgender bias and non-affirmation experiences had worse PTSD symptoms. The authors surmised that shame prevents trauma processing and may cause transgender individuals to distance themselves from their own communities. However, Strauss et al. (2020) point out that many of the risk factors for poor mental health outcomes are external, evident in the fact that half the participants in their study claimed they lacked familial and social support, felt isolated from the transgender community, and were repeatedly discriminated against. These risks are obstacles to the common factors of PTG, thus future research should focus on the impact of socialized gender norms on PTG for gender-diverse individuals.

There remains a large gap in research on non-binary and transgender individuals' experiences with PTG. This is concerning as members of these communities experience higher rates of trauma when compared to their cis-gendered peers. Strauss et al. (2020) discovered that self-harm and suicidal behaviour in their sample of Australian transgender youth were fourteen times greater than the general population. Barr et al. (2022) found that their adult sample of non-binary and transgender individuals had concerningly high rates of clinically significant PTSD symptoms, high rates of trauma, numerous experiences with discrimination, rejection, and violence because of who they are (anti-transgender bias), and often feel invalidated in their gender by not being seen for who they are (gender non-affirmation). They suggest that with repeated non-affirming and anti-trans experiences, gender-diverse individuals are likely to internalize shame for their identity. However, few studies acknowledge the nuances of gender-diverse communities.

Future Directions

It is difficult to effectively evaluate and validate PTG measures when the theoretical constructs are broad and difficult to define. Considering the aforementioned limitations of the current literature, theorists need to further develop models of PTG and solidify definitions of concepts (such as social support) and outcomes (including relationships with others). Although initial research on changed perspectives of trauma survivors indicated that current PTG domains were the most common, re-visiting or expanding on these domains would provide valuable insight into growth in different areas of life (Calhoun & Tedeschi, 2006; Zoellner & Maercker, 2006). Moreover, researchers should evaluate the individualistic nature of growth and consider investigating PTG on a larger scale for communities impacted by natural disasters or racial, ethnic, and culturally oppressed groups (Shigemoto et al., 2020). Shigemoto et al. (2020) suggest

exploring alternative avenues to PTG such as community resources. This would allow for valuable insight into recovery after large-scale scale trauma events and could ensure communities have the resources they need to heal.

Although the literature suggests that there are gender differences in PTG (Cohen-Louck, 2022), Vishmevesky et al.'s (2010) meta-analysis highlights the lack of variables that help to explain why. Several authors observed gender differences in coping (Akbar & Witruk, 2016; Alamdar & Zhang, 2019; Cholankeril et al., 2023) and surmised these strategies impact PTG. For instance, Akbar and Witruk (2016) and Alamdar and Zhang (2019) found women were more likely to engage in deliberate rumination, and Akbar and Witruk (2016) and Cholankeril et al. (2023) observed that women were more likely than men to use emotion-focused and expressive coping strategies. As such, these authors surmised that coping mediated the relationship between gender and PTG. However, more empirical research is needed, and Vishmevesky et al. (2010) recommend that future research investigate cognitive processes men and women experience in the aftermath of trauma to better understand whether coping style and rumination contribute to gender differences in PTG.

In terms of methodology, future research should increase the scope of focus to include negative life changes as well as positive life changes. Mirzaee et al. (2021) suggest including standardized measures to assess posttraumatic depreciation (PTDI), and Boals and Schuler (2019) suggest including standardized measures that have been created to reduce the potential for illusory growth (such SRGS-R). This would give counselling psychologists valuable insights into changes that may occur after trauma, both good and bad. Additionally, it would benefit researchers to gather additional observational data from third parties such mental health professionals, caregivers, etc. rather than solely relying on participants' self-report measures.

Barlow & Hetzel-Riggin (2018) recommend future research include face-to-face methods such as interviews. Barlow and Hetzel-Riggin (2018), Mirzaee et al. (2021) and Teixeira et al. (2013) suggest following up initial exploratory research with longitudinal research to explore whether PTG increases or decreases over time and to further investigate causal variables.

Another consideration for future research is to explore is the concept of socialized gender. Rzeszutek et al. (2016) recommend that research explore how masculinity and femininity are associated with the process of adjustment. This includes gender identities outside of the binary, meaning researchers must include gender-diverse and transgender individuals in studies. Barr et al. (2022) and Stauss et al. (2020) surmise that this may provide more insight into whether gender differences in PTG experiences are a result of cognitive/biological differences or socialized gender (or both). Similarly, Barlow and Hetzel-Riggin (2018) noted that participants in their study may have been too young for measures used when assessing gender role adherence, and their sample of college-aged students was rather homogenous. Since socialized gender constructs are socioculturally influenced, the authors recommend that future research include participants of various ages, cultures, and sexualities and replicate findings using clinical and community-based samples.

Summary of the Literature

In summary, posttraumatic growth is a phenomenon that some individuals experience in the aftermath of life-changing traumatic events. While there are multiple growth models, Tedeschi and Calhoun (1995) rose to prominence within mental health research, and many studies are based on the domains outlined in their PTG process to measure outcomes. Much of the research focuses on growth without the assistance of therapy, but there are a number of novel interventions that focus on PTG that have shown preliminary success. However, some theorists

hypothesize that placing the expectation of growth on survivors could impact true growth (Calhoun & Tedeschi, 2006). Instead, they suggest applying an integrative framework to psychotherapy that helps with cognitive processing, narrative development, interpersonal relationships, and meaning-making.

PTG theorists recognize that trauma and growth exist within cultural and social systems that influence change mechanisms that lead to personal transformational growth. Social constructions of gender create social roles that account for differences and similarities between men and women. According to Social Role Theory and Gender Schema Theory, these attitudes, beliefs, and values about how girls, boys, men, and women should look and behave are internalized, self-regulated, and socially reinforced, leading to socialized gender roles (Bem, 1981; Eagly & Wood, 2012; Mareck et al., 2004). Socialized gender directs behaviour and influences how men and women experience and express trauma. For men, these attitudes and beliefs motivate them to restrict emotional behaviour that does not align with idealized masculine norms. In contrast, women are expected to be emotional so they face fewer repercussions for expressing distress as doing so does not deviate from social norms. In the following chapter, I will apply the literature to provide counsellors with insight into how they can integrate a PTG framework into their current practices and provide a number of recommendations for gender-sensitive therapy. The goal is to help elevate trauma-informed practices and potentially reduce gender barriers to PTG.

Chapter 3: Application and Recommendations

This capstone answers the following questions: how does gender role socialization impact posttraumatic growth? And how can counselling psychologists apply a PTG framework to trauma-informed practices? In Chapter 2, the literature reviewed highlighted several key themes regarding gender differences in both PTSD and PTG that influence different aspects of the process of growth after trauma. Regarding trauma and PTSD, there is a higher prevalence of PTSD among women (10.2%) than men (5.7%) (Government of Canada, 2021). Additionally, while men are seemingly more likely to experience a traumatic event, women have been found to experience more "high-impact trauma" (such as intimate partner violence, sexual assault, etc.). Further, several studies found a significant relationship between PTSD and PTG (Schubert et al., 2016; Teixeira & Pereira, 2013), supporting Tedeschi and Calhoun's (1996) hypothesis that higher distress levels increase PTG.

There is evidence to suggest that women report higher overall levels of PTG than men (Adjorlolo et al., 2022; Vishnevsky et al., 2010). More specifically, several empirical studies found gender differences in coping (Alamdar & Zhang, 2019; Cholankeril et al., 2023), help-seeking (Barrett et al., 2020; Neilson et al., 2020), and disclosure and social support (Swickert & Hittner, 2009). Western ideologies suggest that women are more emotional than men; thus, women can be expressive without social repercussions (Hentschel et al., 2019). Through this lens, some researchers surmised that these beliefs enable women to utilize emotion-focused coping strategies in response to intrusive rumination and emotional distress (e.g. Alamdar & Zhang, 2019; Cholankeril et al., 2023; Cohen-Louck, 2022), which can lead to deliberately reflecting on the event, re-evaluating their relationships, and creating new goals. Additionally, women are assumed to be communal and are socialized to value their social relationships

(Koenig, 2018). Several studies found that women are more likely to utilize social support than men (e.g. Barrett et al., 2020; Pinzon & Rotoli, 2022; Swickert & Hittner, 2009). Thus women may be more willing to seek help and disclose their distress to professionals or social support systems (e.g. Swickert & Hittner, 2009) which helps to create a new life narrative. Moreover, women reported higher growth in PTG domains related to spirituality, thus women are seemingly more committed and open to spiritual engagement; spiritual or religious practices help individuals find meaning moving forward (e.g. Adjorlolo et al., 2022; Rzeszutek et al., 2016; Swickert & Hittner, 2009).

While women seem to be socialized to engage with vital elements of the PTG process, current research on masculine gender norms suggests that hegemonic masculinity may restrict men from transformation. According to the literature, subjective masculinity encourages dominance and emotional toughness and discourages femininity (e.g. O'Beaglaoich et al., 2015; Wong et al., 2022), and men seemingly value traditional gender norms and are more impacted by others' perceptions of their masculinity (Barlow and Hetzel-Riggin, 2018). Although there is conflicting evidence on whether there are gender differences in the perception of support and if social support is more vital for women to experience PTG (e.g. Cundiff et al., 2023), perceived support has been shown to impact an individual's mental health and self-view and increase the risk for self-blame (e.g. Bonnan-White et al., 2015). Some studies suggest that certain types of traumatic experiences can make a man feel emasculated (e.g. Pinzon & Rotoli, 2022). Thus, men's increased risk of social repercussions for emotional expression may explain lower help-seeking behaviours. However, Shigemoto et al. (2020) highlighted multiple pathways to PTG (e.g. community resources) for men who did not pursue formal support.

Overall, the literature within this review suggests that traditional concepts of masculinity restrict pathways to posttraumatic growth. A few qualitative studies provided rich insight into men's narratives and experiences of growth after trauma, finding that reconceptualizing masculinity was part of the turning point for some men (e.g. Lewis et al., 2020). In contrast, none of the research on women's narratives of PTG mentioned re-evaluating relationships with femininity. One study suggested that moving away from hegemonic masculinity and endorsing "healthy" masculine characteristics can positively predict PTG (e.g. Barlow & Hetzel-Riggin). Thus, there is evidence to support the hypothesis that conforming to traditional masculinity can decrease an individual's opportunity to transform, heal, and grow.

Practice Recommendations for Gender-Sensitive Therapy

Given the insights derived from the literature it is of utmost importance that counselling psychologists understand the nuances of socialized gender and how they impact an individual's attitudes, beliefs, emotions, behaviours, interpersonal relationships, trauma experiences and expressions of distress. The following recommendations are provided for the consideration of psychologists but are not intended to substitute for the clinical judgment and expertise of the provider acting within their authorized scope of practice and within their own personal competencies when working with any individual client. They are not prescriptive treatments but rather an integrative framework for consideration. The overall combination of suggestions is intended to help psychologists elevate their trauma-informed practices and increase the potential for PTG for all genders.

The literature suggests that it would be beneficial for psychologists to explore each client's unique gender identity and move away from generalized gender-sensitive frameworks to an approach tailored specifically to their client's gender identity (Seidler et al., 2018). In 2018, The

American Psychological Association (APA) published ethical guidelines for working with masculine identities, feminine identities, and transgender and non-binary identities to provide a framework for psychologists to improve treatment efficacy (APA; 2018b; APA, 2018c; APA, 2015). While the Canadian Psychological Association (CPA) has not provided frameworks for ethical practice for masculine, transgender, and non-binary identities, they did publish guidelines for feminine identities (CPA, 2007). However, these guidelines have not been updated in over a decade.

The recommendations formulated herein take inspiration from the aforementioned APA documents, as well as research on gender-based preferences in psychotherapy and gender-sensitive strategies, to engage and retain clients while encouraging gender sensitivity in the work of psychologists. However, it is recommended that the CPA take inspiration from the APA and generate guidelines that inform psychologists on how to enhance their practice with clients who identify as boys and men. Consistent with guidelines and procedures regarding revisions to ethical practice documents, it is also recommended that the CPA update existing guidelines for women to better reflect changes in social contexts, current research, and practice changes within the past 5-10 years (APAb, 2018; CCPA, 2020). Further, guidelines for working with gender-diverse populations should also be considered.

Recommendation 1: Counselling psychologists have a foundational knowledge of gender identities and related terms and recognize that gender is socially constructed based on cultural and contextual norms

Gender refers to socially constructed identities that reflect the attitudes, beliefs, and behaviours associated with biological sex characteristics of males and females (APA, 2015; APA, 2018b; West & Zimmerman, 1987). Gender identity is a felt sense of *being* a girl, woman,

boy, or man, a blend of the aforementioned identities, or another culturally recognized gender. Cis-gendered individuals' gender identity aligns with their biological sex, transgender individuals' gender identity does not align with their biological sex, and non-binary individuals do not conform to one specific gender identity. When working with trauma survivors, counselling psychologists should consider the above terms to better understand how their clients' gender is constructed within their cultures and explore how such identities impact their lived experiences. For instance, transgender and non-binary individuals express that an understanding of these populations' issues associated with their identities is crucial.

Recommendation 2: Counselling psychologists understand how sociocultural identities influence behaviours and experiences and reflect on their own identities and biases regarding gender norms

Women have higher exposure to violence, are socialized to be more submissive, are more likely to internalize behaviours, and have higher rates of PTSD; counselling psychologists should use caution to reduce the likelihood of pathologizing trauma responses (CPA, 2007; Olff, 2017). In contrast, men face negative social consequences when they express their emotions, which impacts their ability to show vulnerability and form deep relationships (APA, 2018b). Additionally, since the literature suggests men are not taught to express their emotions, they are more likely to externalize trauma responses which can lead to misdiagnoses. Transgender and non-binary individuals often experience trauma due to higher rates of discrimination, violence, and psychological distress and lower rates of social support due to stigma associated with their gender identities; they face higher rates of discrimination in every domain of the healthcare system (APA, 2015; Counselman-Carpenter & Redcay, 2023).

To benefit their clients, psychologists should reflect on their own sociocultural upbringings and understand how their personal experiences may impact the efficacy of therapy with certain clients (CPA, 2007). Similarly, it would benefit them to recognize that their client's culture, ethnicity, race, age, gender identity, socioeconomic status, sexual orientation, cognitive and physical ability, and religious and spiritual beliefs shape their experiences and behaviours (APA, 2015; APA, 2018b; APA, 2018c; CPA, 2007; Levenson et al., 2023). To maintain integrity, psychologists should consider the outcomes of socialization and reflect on their own socialized attitudes and beliefs that may influence reactions and interpretations in therapy. They should also take a non-judgemental stance and recognize that a broad range of gender variation is healthy and normal.

Recommendation 3: Recognize and acknowledge the intersection and impact of power and privilege on gender identities

Gender identities grant access to institutional power and privilege which can influence overall well-being. For instance, in patriarchal societies (such as Western culture), boys and men are given more social and economic power than other gender identities (CPA, 2007). Moreover, power is awarded to Caucasian men who align with traditional masculine norms such as dominance and heterosexuality. Thus, the cost of these privileges increases adherence to hegemonic masculine norms. The consequences of doing so can lead to an inability to express emotions and form deep relationships as well as increased violent behaviour and sexist attitudes (APA, 2018b). Counselling psychologists can help by providing psychoeducation on socialized masculinity and bringing awareness to its harmful effects.

Gender identities are not the only context for discrimination and oppression when addressing inequality. Counsellors should explore their clients' sociocultural identities beyond

gender as well as the clients' proximity to power their identities grant access to. When working with women, psychologists (especially men) must take every precaution to reduce power imbalances in the therapist-client relationship through collaboration and allowing the client to be the expert of their own lives (CPA, 2007). They could also help women work through personal experiences of oppression, discrimination, and trauma due to social beliefs about their gender identities and validate difficulties in juggling multiple demanding roles (mother, wife, etc.) (APA, 2018c). Research demonstrates that environments that validate women's issues and make space for them to explore different versions of womanhood counteract negative psychological effects. Thus, providers could also identify strengths and successes that have helped clients navigate contradictory messages about what it means to be a woman and empower them to seek help.

Colonization has decreased the visibility and acceptance of transgender and non-binary individuals. Many transgender and non-binary individuals experience internalized transphobia and are often the target of violent hate crimes (Jones et al., 2022; APA, 2015). Additionally, those from non-dominant cultures experience racism, discrimination, and oppression beyond their gender identities, which impacts their mental well-being and transformational growth (Jones et al., 2022; Oh et al., 2022). Further, social scripts within Western cultures are heteronormative and cis-gendered, which contributes to the marginalization of transgender and non-binary communities (Levenson et al., 2023). Counselling psychologists working with these populations should provide a safe space to explore these identities and the trauma endured because of society's view of these individuals. Similarly, they should normalize and validate anger and distress from being marginalized. However, research suggests negative expectations for the future increase distressing symptoms and reduce PTG (Jones et al., 2022). Thus,

counselling psychologists should be cautious and not assume these identities cause psychological distress.

Recommendation 4: Psychologists strive to implement gender-sensitive therapeutic services

Psychologists should explore their clients' attitudes and beliefs regarding gender and the impact these have on their current functioning (Seidler et al., 2018). They must also recognize that masculinity and femininity exist on a spectrum and give clients space to define their own identities (APA, 2018b). In terms of effective therapy for men, Seidler et al. (2018) and Liddon et al. (2017) did meta-analyses on strategies to engage men in psychotherapy and to outline gender-specific preferences. Based on their findings, Seidler et al. (2018) recommend clearly communicating the structure, process, and expected timelines of therapy to reduce mistrust. Recommendations include: validating feelings of shame and uncertainty and recognizing difficulties in communicating emotions; demonstrating self-disclosure to model skills and remove perceived power differentials; adapting language and interventions to be more action-oriented (reframing symptoms as problem-solving opportunities and letter writing in place of verbal emotional disclosure); and using common terms, slang, and humour, and swearing (client dependent). Additionally, psychologists could explore different paths to healing as there is evidence to suggest community resources and support groups increase men's help-seeking behaviours. Adolescent boys may benefit from shorter sessions, psycho-educational groups, and non-traditional environments (outdoors) (APA, 2018b; Liddon et al., 2017). While the literature has proven these strategies to be successful, psychologists should maintain caution and ensure they do not reinforce strengths associated with hegemonic masculinity and reinforce power differentials in relationships (Seidler et al., 2018).

In contrast, Liddon et al. (2017) found that women prefer individual psychotherapies and are more likely to have an awareness of their problems than men. Women are also more likely to engage in emotion-focused coping strategies and to talk about their feelings. However, research also suggests that girls and women benefit from group settings and community resources such as women's support groups, psychoeducational groups, and faith-based communities as well as non-traditional psychotherapies, such as wilderness therapy, art therapy, prayer, meditation, and mindfulness. (APA, 2018c).

Transgender and non-binary individuals often feel unsafe, struggle with emotional regulation, suffer loss, and have negative expectations for the future (Levenson et al., 2023). Given the history of discrimination and pathologization of transgender and non-binary identities, these populations may be mistrustful of healthcare professionals (Levenson et al., 2023). In their trauma-informed affirmative LBGTQ+ practices, Levenson et al. (2023) recommend psychologists create spaces of emotional and physical safety by respecting and using preferred pronouns and gender-neutral language in sessions, on signage, and within documents, having gender-neutral bathrooms, and trauma-training all staff. Additionally, to reduce isolation and increase social connection, counsellors must be aware of resources such as peer support groups and community organizations that enhance therapeutic services (APA, 2015). Waldron et al. (2023) clustered evidence-based and alternative approaches into broad categories: program, interpersonal, insight, and meaning-making. The literature suggests that gender-affirming CBT, creative arts therapy groups, Interpersonal Psychotherapy (IPT) psychodynamic approaches, and Narrative Therapy can increase positive outcomes by providing corrective relational experiences, exploring personal narratives, increasing autonomy over their thoughts, feelings, and behaviours, and increasing self-efficacy (Waldron et al., 2023).

Although these modalities offer techniques, language, and frameworks that have proven to be effective, psychologists must use them with caution and educate themselves on common criticisms. For instance, the individualistic emphasis of CBT neglects contextual stressors that contribute to an individual's problem, which might reinforce internalized stigma when the problem is rooted in marginalization. Psychologists are encouraged to utilize gender-affirming resources and explore the use of peer workers in tandem with psychotherapy (Levenson et al., 2018; Waldron et al., 2023).

Recommendation 5: Counselling psychologists address cultural and systemic gender-based issues through advocacy and education

Institutional and systemic injustice continues to impact the well-being of all genders in various ways. For instance, men are more likely to experience and perpetrate violence, and racial stereotypes contribute to the over-incarceration of black, Latino, and Indigenous men (APA, 2018b). However, the association of violence with masculine identities creates barriers for the majority of men who are not violent. Due to such stereotypes, men who experience IPV or sexual assault are less likely to seek help, and if they do struggle to find help due to the emphasis on battered women While most men do not perpetuate violence, women, transgender and non-binary individuals are often the target of violent behaviours and hate crimes (APA, 2018c). Additionally, marginalization creates barriers to healthcare and housing for transgender and non-binary individuals, causing an increased risk for homelessness, addiction, risky sexual behaviours, poor physical and mental health, and suicide (APA, 2015; APA, 2018b). To combat the negative impact socialized gender norms have on well-being, counselling psychologists should advocate for change.

Advocacy can occur on local, provincial, or national levels depending on the ability of counselling psychologists to personally commit and their level of expertise or area of focus (APA, 2018c). For instance, school psychologists could work with teachers to raise awareness of sexual harassment, racial injustice, and gender-based violence, and educate students on socialized gender identities. Alternatively, counsellors might join social justice groups outside of work to create change and work to address biases in their personal lives.

Professionally, counsellors must recognize historical injustices within the field. For instance, psychological research, clinical practices (such as assessment), frameworks, and theories have minimized and pathologized women's experiences as well as transgender and non-binary identities (APA, 2015; CPA, 2007). Moreover, Waldron et al. (2023) encourage counsellors to collaborate with gender-affirming organizations (including healthcare) to connect transgender and non-binary clients with appropriate resources outside of therapy. Additionally, counsellors might address power imbalances through actions like endorsing equal leadership opportunities and addressing biases experienced by their colleagues or clients (APA, 2018c).

Recommendations for an Integrative PTG Framework

To promote PTG outcomes including relating to others, personal strength, appreciation for life, new possibilities, and spiritual and existential changes survivors must examine their core beliefs, learn to manage emotional distress, learn constructive disclosure, move from intrusive rumination to deliberate rumination, and strengthen interpersonal skills (Tedeschi & Moore, 2021). This will help survivors rebuild their understanding of themselves, their lives, and the world around them, develop new goals, and find meaning in what happened to them.

While a few pilot studies included in the literature review have shown some success, theorists are apprehensive about designing a PTG modality (Calhoun & Tedeschi, 2006). Despite

clients' and clinicians' best efforts, it is normal that some trauma survivors do not experience PTG, making it important to consider whether counselling psychologists should place that expectation on their clients. Wortman (2004) highlights the risk of joining clients' friends and family who expect trauma survivors to recover quickly (as cited in Tedeschi & Calhoun, 2006). Instead of creating a specific framework for PTG, counselling psychologists might benefit from applying a growth perspective and PTG framework to trauma-informed practice. The following PTG-informed framework is rooted in the PTG process outlined by Tedeschi and Calhoun's (1996) model. The framework outlines the clinician's roles and responsibilities in facilitating PTG. It also provides recommendations on interventions and modalities that incorporate emotional regulation and distress tolerance skills as well as narrative, cognitive, existential, and interpersonal techniques. Again, these recommendations are offered for the consideration of duly qualified providers acting within their authorized scopes of practice and specific personal competencies and are not intended to substitute for the clinical expertise, experience, and professional judgment of any provider when providing services to any specific client.

The Counsellor's Roles and Responsibilities

Calhoun and Tedeschi (2006) suggest that counsellors wishing to integrate a growth perspective take the roles of *facilitators of change* and *expert companions* and approach their clients with *openness* and *humility*. Stepping into these roles helps reframe the expectation that counsellors are responsible for creating change, which can inadvertently put pressure on the client or increase blind spots to small changes that have already been made, both positive and negative. For instance, a client may express a small appreciation for an existing relationship but also exhibit symptoms of distress. It is normal for survivors to experience both growth and distress simultaneously, but if a clinician were only looking for obvious, positive changes or

interpreted distress as being stagnant, they would miss the opportunity to explore new narratives, identify signs of strength, and recognize cognitive shifts.

Given the impact that gender socialization has on trauma and the PTG process, it is also the clinician's responsibility to have a foundational understanding of how cultural and social norms shape survivors' behaviour to align with gender roles and stereotypes and contribute to counsellors' gender biases (APA, 2018b). The APA (2018b) suggests that, despite higher rates of suicide, men are less likely to exhibit symptoms of internalized disorders or be diagnosed with depression as men are socialized to externalize their distress. Thus, without foundational knowledge of gender socialization, psychologists may not recognize or misinterpret signs of distress which could lead to misdiagnosis and ineffective treatment planning. Further, they may have a negative reaction when a man emotionally discloses or misinterpret reluctance as resistance, impacting emotional regulation, rumination, and cognitive processing (Calhoun & Tedeschi, 2006).

Safety and Emotional Regulation

The sole goal for survivors after trauma is simply to survive (Calhoun & Tedeschi, 2006). With this understanding, psychologists applying a PTG-informed framework must ensure they provide their clients with a safe environment. Physically, the environment should be well-lit (including parking areas and hallways), have welcoming and inclusive language in documentation, include security measures (e.g. monitoring who comes and goes), and be mindful of noise levels (Menschner et al., 2016). To ensure emotional safety, counselling psychologists should be non-judgmental, be consistent (e.g. scheduling), maintain healthy boundaries, and reflect on how an individual's sociocultural identity (e.g. gender, race, culture, etc.) impacts trauma responses.

Once the clinician has established a safe environment, they can provide psychoeducation on trauma responses and incorporate emotional regulation strategies. Additionally, psychologists should assess whether their client aligns with traditional gender roles and, if needed, address inner conflict if trauma responses do not align with traditional gender roles. This will help validate the client's emotions and provide them with a safe space to experience them. Psychologists should consider teaching clients emotional regulation and distress tolerance skills *before* engaging in any interventions that may cause distress while ensuring they are capable of tolerating distress in themselves. Techniques that help with emotional regulation include deep breathing, grounding, and mindfulness.

Cognitive-Behavioural

In addition to emotional regulation, cognitive processing is an integral aspect of the PTG process. Since cognitive processing and disclosure are closely related, psychologists should be open-minded and continue cultivating spaces where survivors feel safe to disclose. This requires psychologists to examine their biases and personal triggers that may motivate them to avoid difficult topics or unintentionally encourage survivors to suppress their discomfort. For instance, psychologists whose attitudes, beliefs, and values align with Western culture's ideologies of traditional masculinity may look, act, and feel uncomfortable or judgemental if/when a man cries during a session. Additionally, psychologists may overlook the impact of traditional femininity on IPV survivors' submissive behaviours, thus missing the opportunity for understanding, validation, and strengths-seeking to promote personal strengths outcomes (CPA, 2007).

Cognitive processing also requires psychologists to help survivors move through this process of intrusive rumination to deliberate reflection (Calhoun & Tedeschi, 2006). Similar to existential elements, this involves meaning-making as survivors often attempt to find reasons

why the trauma event occurred. As the process of rebuilding schemas is cognitive in nature Tedeschi and Moore (2021) suggest utilizing cognitive behavioural strategies to help facilitate this process. Additionally, Roepke's (2015) meta-analysis of PTG in psychotherapy found that interventions rooted in a cognitive-behavioural framework have successfully promoted PTG outcomes. There are a number of evidence-based treatments and techniques rooted in this framework that are strongly recommended for trauma therapy, including Prolonged Exposure (PE) and Trauma-Based Cognitive-Behavioural Therapy (TB-CBT) (Menschner et al., 2016). Additionally, meta-analyses of Eye Movement Desensitization and Reprocessing (EMDR) show similar outcomes to exposure therapies. However, the APA (2018) has identified non-inclusive elements and subtle bias in CBT, so psychologists must use caution when implementing interventions to reduce the risk of ineffective practices. Additionally, manualized treatment (e.g. EMDR) requires additional competencies and certified training, so counselling psychologists must ensure they are only engaging in modalities that they are authorized and competent to practice.

Narrative Expression

Roepke (2015) also found that narrative interventions encouraged PTG. Trauma survivors need to develop a narrative that incorporates their traumatic experience with positive outcomes so they can revise their goals and life's purpose. Research has found that feminist narrative therapy helped facilitate growth for Cambodian women post-migration by examining social and cultural beliefs which shaped trauma narratives and developing new versions of their stories (Uy & Okubo, 2018). Additionally, different forms of narrative expression have helped bereaved individuals process their trauma and demonstrate growth (Calhoun & Tedeschi, 2006). Narrative interventions like expressive writing, talking, and praying have helped survivors organize

thoughts, feelings, and beliefs, which helped them progress toward transformation (Uy & Okubo, 2018).

Existential

Traumatic experiences that alter core beliefs are often associated with various types of loss. Whether it is the loss of a loved one, cognitive or physical abilities, or dreams and goals, survivors often lose their former life purpose (Tedeschi & Moore, 2021). Thus, a necessary element of PTG is the ability to find meaning and purpose in life in the aftermath of trauma. To do so, psychologists must help survivors as they question why they experienced what they did, the fairness of life, and whether their trauma had a purpose, which ultimately leads to finding meaning. There are a number of existing modalities that focus on this, including logotherapy and existential therapy. For instance, Frankl's Logotherapy helps to facilitate two levels of meaning: the present and ultimate meaning (Zoellner & Maercker, 2006). The foundations of treatment assume that all lives have meaning, and people have free will and are motivated to find it. In logotherapy, patients are encouraged not to focus on what has been lost, but to seek meaning in the future despite grief or despair. Similarly, Zoellner and Maercker (2006) state Yalom's Existential Therapy helps survivors work through topics like death, freedom, and meaning.

Interpersonal

Transformational growth is a shared experience. Interpersonal relationships can be the source of strife but can also help survivors explore meaning in their trauma narratives. Several evidence-based therapies have been shown to enhance interpersonal skills and encourage clients to incorporate social circles in their healing, including Interpersonal Psychotherapy (IPT) and Emotionally Focused Therapy (EFT). IPT helps survivors identify who in their social circles they would feel comfortable disclosing to and would support them in the search for new meaning

(Tedeschi & Moore, 2021). EFT has significantly helped veterans with PTSD reduce relationship distress and individual symptoms of depression (Ganz et al., 2022).

While the client-therapist relationship accounts for much of the change in individual therapy, group therapy and community resources are interpersonal in nature (Tedeschi & Moore, 2021). As mentioned in the gender-sensitive guidelines, research suggests that boys and men prefer group over individual sessions (Levenson et al., 2023). While women prefer individual therapy more than men, research has shown that they also benefit from group therapy as they learn from others' experiences, expand perspectives, and teach critical skills that enable them to make positive changes in their lives (APA, 2018c). Additionally, social support and family acceptance significantly improve the quality of life for transgender and non-binary individuals (APA, 2015). With these considerations, psychologists working with these populations should incorporate interpersonal elements by connecting clients to group therapies, peer support groups, and community resources.

Reflections on Personal Learning

At the beginning of this capstone project, my interest in post-modern frameworks and feminist values largely focused on the oppression and discrimination toward women and gender-diverse populations. While I recognized that social scripts and patriarchal societies negatively impact men, the literature demonstrated how restrictive traditional masculinity can be. I feel more empathetic and understanding about the difficulties of deviating from gender norms. Even when boys and men define their own version of masculinity, it can be a stressful experience, especially if it is done alone. Additionally, this work enabled me to understand the fact that empathy, emotional expression, and interpersonal connections are learned skills, so simply asking an individual who was actively told not to engage in "feminine" behaviour for the

majority of their life to talk about their feelings or confide in their friends often sets them up for failure. I intend to apply this insight to my own therapeutic practice and maintain a sense of patience and understanding with my clients.

Further, during this capstone process, my learning was informed by my own experiences witnessing clients experience PTG. I also witnessed how gender socialization had both positive and negative influences on the work done in therapy. Thus, through both the literature and lived experience, I have learned that clients who intentionally reflect on their experiences, reappraise their ability to control the situation, incorporate friends, family, and community in their healing, and feel comfortable sharing their thoughts, feelings, and behaviours demonstrate growth in some aspect of their lives. While this capstone only provides a small window into the nuance and complexity of trauma, it is my greatest hope that it showcases how vital it is for psychologists to understand the impact of gender socialization on how survivors experience and heal from it.

Capstone Limitations

In addition to the research limitations outlined in Chapter 2, this capstone project has several limitations. To start, this capstone relies on published research and is limited to the inclusion criteria outlined in Chapter 1. As few studies directly address the impact of gender socialization on PTG, the recommended gender-sensitive guidelines and application of a PTG framework are inferred based on ethical practice documents (APA, 2015; APA, 2018b; APA, 2018c; CPA, 2007), qualitative and quantitative research regarding gender-sensitive practices to engage and retain clients (Levenson et al., 2023; Liddon et al., 2017; Seidler et al., 2018), and an integrated PTG framework based on the theoretical model of PTG (Tedeschi & Calhoun, 1996; Tedeschi & Moore, 2021; Zoellner & Maercker, 2006). Additionally, much of the research is from Western perspectives and rooted within gender binaries; transgender and non-binary

individuals remain under-studied. Moreover, these perspectives inform my worldview, and while I continue to reflect on my sociocultural identities, certain interpretations may be biased. Much of this project urges counselling psychologists to explore their own experiences of gender socialization to better understand how it may impact perceptions and interpretations, and I implore all readers to do the same while reading this capstone.

Capstone Summary

This capstone explored the impact of gender on PTG within a social constructivism framework. While trauma experiences negatively impact overall well-being, survivors can also experience transformational growth in multiple life domains. Through rumination, self-disclosure, and social support, survivors can reduce emotional distress, change cognitive schemas, develop narratives, endure distress, and gain life wisdom (Tedeschi & Calhoun, 1996). However, socialized gender scripts regarding masculine and feminine identities influence experiences and symptoms of trauma and help or hinder the process and likelihood of PTG. Counselling psychologists are encouraged to educate themselves on gender identities, recognize the contexts in which they are created and the impact of power and privilege, reduce biases, and advocate for social change. Instead of creating gender-specific program approaches with PTG as an expected outcome, psychologists are encouraged to integrate a PTG framework and incorporate cognitive, narrative, interpersonal, and existential elements into trauma-informed practices. This is in hopes of increasing engagement and retention in psychotherapy and giving everyone, regardless of gender, the opportunity to transform their lives.

Resources

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