A QUALITATIVE DESCRIPTIVE STUDY OF THERAPISTS AND THEIR WORK WITH SOCIALLY ISOLATED FEMALE VICTIMS OF SEXUAL VIOLENCE AMID THE COVID-19 PANDEMIC

by

Iris Lazette Saldivar

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Philosophy

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APPROVED BY:

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ABSTRACT

The purpose of this qualitative descriptive study was to assess the experiences of therapists and the descriptions of their navigation processes while working with female victims of sexual violence who were socially isolated during the COVID-19 pandemic in the state of Texas. The theory that guided this study was the theoretical framework of loneliness, social isolation, and associated health outcomes. The research study focuses on two research questions that sought to examine the experiences and navigation of virtual treatment of therapists who provided counseling during the COVID-19 pandemic from March 2020 to March 2022. This study sought to find a straightforward description of an occurrence; the goal was to examine how therapists who work with victims of sexual violence describe their work with isolated female victims of sexual violence during the COVID-19 pandemic and how they navigated throughout. Data was collected via semi-structured interviews with 20 therapists. The setting of the interviews was completely virtual and conducted via Zoom. Findings suggest that therapists who treat socially isolated female victims of sexual violence during the COVID-19 pandemic will experience high levels of strain and will utilize effective problem-resolution solving to overcome barriers brought forth by the pandemic.

Keywords: therapists, sexual violence, pandemic, experiences, navigation

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Dedication

This dissertation is for my family. My entire educational journey has been filed with mixed emotions and without their support, success would not have been possible. To my parents, thank you for believing in me and not allowing me to stop when I wanted to, reminding me of the greatness that exists. To my son, thank you for being the light in my life; you graced me with your existence in the midst of my doctoral journey and have lifted me during the darkest times. I hope to only be the best role model and mother to you for all of eternity. To the love of my life, thank you for supporting me, loving me and reminding me of my potential. To my sisters, thank you for providing me with happiness and laughter during the stressful times. And of course, to those who portrayed continuous doubt, who did not believe I could accomplish such an achievement, thank you for giving me every reason not to stop. I am eternally thankful and blessed. This journey would not have been possible without you all. I love you.

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CHAPTER ONE: INTRODUCTION

Overview

This qualitative descriptive study examines how therapists describe their work and navigation processes with socially isolated, female victims of sexual violence during the global COVID-19 pandemic. In the United States, sexual violence (SV) is a major public health concern and a profound human rights violation that occurs in all societies and across all social classes (Dartnall & Jewkes, 2013). Acts of SV occur in a wide range of various circumstances and settings, ultimately rooted in gender inequality and discrimination. According to Anderson & Overby, it is estimated that 1 in 3 women will experience sexual violence in their lifetime in the United States (2020). Furthermore, according to Dartnall & Jewkes, approximately 6% to 59% of women will experience SV from a husband or boyfriend in their lifetime (2013). Over the last three decades, the United States has seen an increase in the number of acts of sexual violence and their intensity (Levinson, 2002). This substantial increase has led to greater discussions concerning sexual violence, including its treatment and its long-term effects. As a result, this study focuses on therapists who work with victims of sexual violence and the description of their work and how they have navigated treating patients experiencing its effects during the COVID-19 pandemic.

Background of the Problem

COVID-19 brought forth challenges to public health worldwide, causing a dramatic loss to human life while also causing a disruption to the American economy. As the focus of the pandemic has remained on resolving the challenges caused by the pandemic, other severe consequences, specifically sexual violence, became less of a priority to many while silently increasing substantially. The topic of sexual violence has gained a great amount of focus during

the pandemic. Viero et al. (2021) reported a higher perceived risk of domestic and sexual violence against women during the COVID-19 pandemic. Domestic and sexual violence is prevalent, and consequently, victims are projected to seek aid and guidance through rehabilitation and treatment; however, as the United States found itself in a bind with several operation challenges amid the pandemic, it became questionable as to how the healthcare sector can operate and provide services without placing more people at risk of acquiring other sicknesses like COVID-19. As individuals experience sexual violence, however, the need for treatment and rehabilitation becomes essential for survivors. This leads to a greater need of information that can be used to expand the knowledge on how to develop effective methods for therapists to consider while working with the trauma population of sexual violence survivors.

Worldwide, sexual violence has become increasingly more intense and more common over the last three decades. Sexual violence is a combination of sexual pleasure and aggression and has become a major public health concern (Levinson, 2002). Researchers such as Almas & Pirelli Benestad (2017); Bennet et al. (2021); and Cornejo et al. (2019) have previously discussed basic types of standards of sexual behavior that are presumed to be normal. These normal standards of sexual behavior derive from statistical, religious, cultural, and personal beliefs and customs. According to Dartnall & Jewkes (2013), sexually violent acts can take place in many different circumstances and settings. Included in these circumstances that have been identified by Dartnall & Jewkes (2013) are : rape in marriage or dating relationships; rape of non-romantic acquaintances; sexual abuse by those in positions of trust; rape by strangers; multiple perpetrator rape; sexual contact involving trickery, deception; rape during armed conflict; sexual harassment, unwanted sexual touching; rape of men in prisons; unwanted exposure to pornography; sexual abuse of mentally or physically disabled people; and sexual abuse of boys

and girls. As a result of these sexual crimes, therapists and their ongoing practices have become vital in healing and supporting the victims.

Female Victims of Sexual Violence

Sexual violence (SV) is a public health and human rights problem that has been found to have profound effects on the health and wellbeing of individuals, families, and communities (Stewart & Chandra, 2017). SV is likely to occur amongst both men and women; however, the most serious forms of sexual violence happen to women by men. Perpetrators of sexual violence are most commonly men who are known by the victims or an intimate partner. According to the Rape, Abuse, and Incest National Network (RAINN), (2022), every 68 seconds, an American is sexually assaulted, and individuals aged 18 to 34 have a higher risk of becoming a victim at 54%. However, most victims of sexual violence are female, as 1 out of every 6 American women has been a victim of either an attempted or completed assault in her lifetime (RAINN, 2022). RAINN (2022) also states that following sexual violence, women are likely to experience suicidal or depressive thoughts. 94% of women who have been raped experience symptoms of post-traumatic stress disorder (PTSD) during the two weeks following the rape (RAINN, 2022). 30% of women report symptoms of PTSD 9 months after the rape (RAINN, 2022). 33% of women who are raped contemplate suicide. 13% of women who are raped attempt suicide. Approximately 70% of rape or sexual assault victims experience moderate to severe distress, a larger percentage than for any other violent crime (RAINN, 2022). Precise and accurate measures of sexual violence can be challenging to reach due to the stigma placed on sexual violence. Sexual violence, including rape, is commonly regarded as defiling; therefore, victims find it difficult to share their stories and experiences (Dartnall & Jewkes, 2013). Despite these

challenges, sexual violence remains a major public health problem for women in the United States.

The COVID-19 Pandemic

COVID-19 (or SARS-CoV-2) was discovered in December 2019 in Wuhan, China. Being extremely contagious, the disease began to spread rapidly around the world. Three months later, on March 11, 2020, a global pandemic was declared by the World Health Organization (WHO), resulting from the spread of COVID-19 (Centers for Disease Control and Prevention, n.d.). Immediate efforts were taken in an attempt to contain the spread of the disease using social distancing, personal protective equipment, and hand hygiene. The COVID-19 pandemic caused a dramatic loss of human life and brought forth challenges to public health worldwide. In March 2020, the United States and its territories began to implement community mitigation policies to help control the spread of the virus. A widely implemented strategy was the issuance of an order that required individuals to stay at home. According to the CDC, each stay-at-home order was analyzed and coded into one of five mutually exclusive categories: 1) mandatory for all persons; 2) mandatory only for persons in certain areas of the jurisdiction; 3) mandatory only for persons at increased risk in the jurisdiction; 4) mandatory only for persons at increased risk in certain areas of the jurisdiction; or 5) advisory or recommendation (i.e., nonmandatory) (Centers for Disease Control and Prevention, n.d.). The order caused various changes to the lives of every individual. People began to fear for their lives as the virus began to spread, and those around them began to die.

Sexual Violence Trauma Therapy

According to Alberta (2004), it becomes both rewarding and challenging for professionals to provide psychological services. It has been suggested that those professionals

who work with trauma survivors have been identified as being at risk of receiving negative effects from their work (Albert, 2004). The act of sexual violence can cause negative health outcomes to occur, such as posttraumatic stress disorder (PTSD), depression, obesity, poor body image, and pain-related disability (Pebole et al., 2020). Previous research has shown how various interventions can provide aid to a sexual violence survivor. Peoble et al. (2020), suggest that the use of exercise can positively impact both mental and physical outcomes in women sexual violence survivors that suffer from posttraumatic stress disorder. According to these researchers, exercise is used as a form of therapy for those women from trauma-affected populations (Peoble et al., 2020).

Scholars such as Au et al. (2017) and Cowan et al. (2020) have found that women who suffer from PTSD also suffer from the concept of shame. Shame has been suggested to contribute to the development and maintenance of PTSD (Au et al., 2017). Shame is referred to as the affective experience of feeling intrinsically defective, socially undesirable, and inadequate. These feelings can place women in a negative state of mind and can be challenging to treat using a form of trauma-based therapy (Au et al., 2017). Because sexual assault can result in severe physical and emotional trauma, it is highly important for other interventions to be facilitated, including targeted, individualized psychotherapeutic treatment. This individualized treatment allows professionals to gradually acquire levels of achievement in patient outcomes (Cowan et al., 2020).

Highly associated with sexual violence therapy is the development of vicarious trauma. Vicarious trauma is the profound and permanent change in the ways therapists think, feel, and behave as a direct result of their work (Kadami et al., 2004). Because of its common occurrence, it is considered a standard consequence in a therapist's line of work (Wheeler & McElvaney,

2017). Therapists experience various negative effects much like vicarious trauma because of their work, including secondary traumatic stress and burnout. According to Samios et al. (2013), therapists who work with trauma survivors can also experience compassion satisfaction, a more positive effect, while experiencing negative effects of trauma work. Above all, sexual violence is prevalent, and consequently, trauma survivors seek aid and guidance through therapy. Therefore, the work of therapists remains vital and crucial. Although there are previous studies assessing the demand for treatment of sexual violence survivors, there is a gap in the research that fails to assess how professionals explore, navigate, and understand working with these survivors during natural disasters such as the COVID-19 pandemic. The sole purpose then becomes to explain the work of the therapists who work with victims of sexual violence during natural disasters and how to best navigate treatment during challenging times, specifically the COVID-19 pandemic.

Problem Statement

The safety concerns COVID-19 brought forth caused the world to operate differently to protect against illness and death. For example, individuals in the workforce either began to work remotely, remained in their work environment, or were laid off. The pandemic transformed the way therapists provided treatment. According to Patterson et al. (2021), the importance of physical and emotional closeness with vulnerable patients is often guided by clinicians' personal mission and values; however, with the changes brought forth by the COVID-19 pandemic, various challenges were presented to clinicians' identities and sense of mission while working with clients (Patterson et al., 2021). Researchers claim a huge increase in the number of calls from women victims began in March 2020 (Davis et al., 2020). Because the occurrence of a global pandemic was uncommon, health professionals were not equipped or prepared in the light of pandemic procedures.

One problem to prioritize is that it is unknown how therapists who work with victims of sexual violence effectively work during the COVID-19 pandemic without considering what effects may occur on the therapists and their treatment plans. It is important to take into deliberation the possibilities of each victim's situation that may be based on the effects of the pandemic and the guidelines and orders that were proposed to help contain the spread of the virus. There is a gap in the literature regarding therapists and their work with victims and clients amid a natural disaster, including a pandemic. This gap includes the experiences of therapists and how they navigate working with female victims of sexual violence during the COVID-19 pandemic in the United States. This gap in research is important to address because the United States remained operating within the effects of a global pandemic for 3 years, and the findings can aid trauma therapists who work with victims of sexual violence during future possible pandemics or natural disasters.

Purpose Statement

The purpose of this qualitative descriptive study is to examine therapists who work with victims of sexual violence and the descriptions of their navigation processes while working with female victims of sexual violence who were socially isolated during the COVID-19 pandemic in the state of Texas. At this stage in the research, sexual abuse will be generally defined as the use of sexual actions and words that are uninvited and harmful to another individual; refers to crimes like sexual assault, rape, sexual abuse, sexual harassment, sexual exploitation, intimate partner sexual violence, incest, drug-facilitated sexual assault, and alcohol facilitated sexual assault (RAINN, n.d.). While social isolation involves having only little to no interaction with individuals on a regular basis (Rockowitz et al., 2020). The concept guiding this study was

developed by the Committee on the Health and Medical Dimensions of Social Isolation and Loneliness in Older Adults, the theoretical framework of loneliness, social isolation,

Sexual violence can occur in the lives of any given human being. However, because sexual violence is never-ending, preventative measures taken are not as likely to be 100% effective. According to Samios et al. (2013), therapists who work with trauma survivors can vary in experiences, including the occurrence of compassion satisfaction and negative effects such as burnout and vicarious trauma. These effects are likely to include vicarious trauma, secondary traumatic stress, and burnout (Helpingstine et al., 2021; Kadami et al., 2004; Moulden & Firestone, 2007; Way et al., 2004). However, despite the need for detailed research and time, the reality is that sexual violence is becoming increasingly prevalent.

The COVID-19 pandemic was still ongoing in early 2023, and while restrictions and guidelines imposed in 2023 may not have been as severe as those imposed in 2020, the population still had to adjust to certain new lifestyles and norms in the aftermath of the pandemic. Regardless, the occurrence of sexual violence remains highly possible and those who endure the traumatic acts are left with nothing but the memory and the pain from the event. Thus, the missions of therapists are to help survivors cope and heal from their pain. However, because of the COVID-19 pandemic, therapists were forced to operate differently, providing services in alternative ways, including remote sessions. The possibility of victims of sexual violence remaining in unsafe environments became highly likely because of imposed COVID-19 policies and guidelines. Thus, it becomes vital to examine how therapists work with specific sexual violence victims while, at the same time, facing challenges and obstacles presented by a global pandemic. Although a study has never been conducted before regarding these specific elements, this study offers an opportunity to research and explore different effects the COVID-19 global

pandemic has had on the population and how professionals have adjusted. The completion of this study will allow therapists to receive assistance, guidance, and information on working with trauma victims during natural disasters such as a global pandemic.

Significance of the Study

The global pandemic provided great damage to the country, and the resolutions and attempts at mitigating those damages provide important data. As COVID-19 continues to demonstrate to the world population the importance of value, welfare, and adaptability, professionals also gain insight into situations that provide significant opportunities to expand their knowledge on their work with trauma-related clients and how to overcome unforeseen circumstances and significant discomfort. Insight into various methods and practices are a few positives that derive from the unfortunate circumstances the COVID-19 pandemic presented. These positives may be lost if the research fails to take advantage of unforeseen and unfortunate circumstances.

In the challenging situations the global pandemic has placed on the general population, an opportunity is presented for therapists who provide services to victims of sexual violence. The findings of this study can be pertinent and of significant interest to therapists who provide services to victims of sexual violence. Trauma narratives are critical to the understanding of trauma-focused therapy (Frank et al., 2021). Great amounts of literature focus on therapists and the effects trauma therapy can leave on therapists, including vicarious trauma, burnout, secondary traumatic stress, and compassion satisfaction (Helpingstine et al., 2021; Kadami et al., 2004; Moulden & Firestone, 2007; Way et al., 2004). Assessing the experiences, navigations, and understandings of therapists during the COVID-19 pandemic will add to the existing literature providing possible alterations and advancements in therapy and treatment while

adapting to a new lifestyle brought upon by a global pandemic. The likelihood of a global pandemic occurring has increased over the past century due to global travel and integration, urbanization, changes in land use, and greater exploitation of the natural environment (Madhav et al., 2017). This literature advancement can help to develop methods and practices for assisting victims of sexual violence who are both female and socially isolated, leading to better services and outcomes in trauma therapy.

Research Questions

In formulating this study, the following research questions guide the work:

RQ1: How do therapists who provide services to socially isolated, female victims of sexual violence describe their work experiences during the global COVID-19 pandemic?

RQ2: How do therapists who provide services to socially isolated, female victims of sexual violence navigate through online therapy sessions during the global COVID-19 pandemic?

Definitions

COVID-19: an infectious disease caused by the SARS-CoV-2 virus that causes severe respiratory syndrome; an acute respiratory illness in humans that produces severe symptoms and possible death, especially in older people and individuals with underlying health conditions (Centers for Disease Control and Prevention, n.d.).

Licensed Therapists: counselor who earned a bachelor's degree from an accredited school, completed a graduate program from an accredited institution, and passing scores on the National Counselor Examination for Licensure and Certification (NCE) and the Texas Jurisprudence Exam

Online Sessions: the use of integrated audio or video chat tools including Zoom and telephone

Pandemic: an outbreak of a disease that is considered infectious and has spread across a large area (Rockowitz et al., 2020).

Sexual abuse: the use of sexual actions and words that are uninvited and harmful to another individual; refers to crimes like sexual assault, rape, sexual abuse, sexual harassment, sexual exploitation, intimate partner sexual violence, incest, drug-facilitated sexual assault, and alcohol facilitated sexual assault (RAINN, n.d.).

Social Isolation: in relation to the COVID-19 pandemic; the absence of social contracts, having only little to no individuals to interact with regularly (Rockowitz et al., 2020).

Socially Isolated Female Victims: females who have fallen victim to sexual assault/violence, that sought online therapy treatment; but remained within their households having few people to interact with regularly due to the COVID-19 pandemic.

Therapist: a trained individual in psychotherapy that treats illnesses without the use of surgery or drugs; active in providing assistance to those who struggle or challenged with mental or emotional problems (Patterson et al., 2021).

Vicarious Trauma: The emotional residue of exposure to traumatic stories and experiences of others through work; witnessing fear, pain, and terror that others have experienced; a pre-occupation with horrific stories told to the professional (American Counseling Association, 2016).

Victims of sexual violence: an individual who is harmed, injured, or killed resulting from a crime, accident, or other events (Samios et al., 2013).

Assumptions, Limitations and Delimitations

Assumptions

Assumptions are beliefs that are accepted as true by the researcher (University of Louisville, 2021). This project has identified the following assumptions:

Assumption One: It is assumed that the participants will be honest and truthful in their responses. That means that the therapists who work with victims of sexual violence will be honest in describing their experiences with the global COVID-19 pandemic. To provide assurance that this will occur, the researcher will preserve the anonymity and confidentiality of the identities of the participants to maximize truthfulness.

Assumption Two: The second assumption that the researcher has is that predisposed biases and prejudices can influence the data collection and data analysis. To control for this assumption, the researcher will utilize several methods of maintaining truthfulness, including the use of member checking, peer debriefing, and field notes. These methods of truthfulness will help to control for any potential influences of bias and prejudice that bleed into the research process.

Limitations

Limitations in research are potential weaknesses in a study that are mostly out of the researcher's control (College of William & Mary School of Education, 2022). This project has identified the following limitations:

Limitation One: A limitation of qualitative research is that it is difficult to verify the results of the study. In this study, the research is asking individual therapists who work with victims of sexual violence to describe their experiences during the global COVID-19 pandemic. Essentially this research is looking at a very small segment of the therapeutic population during a very brief period of time, limiting its scope.

Limitation Two: Due to the small sample size and lack of statistical data, replication of this study might be difficult. This is because of the narrow scope of the problem this research is

investigating. To address this limitation, this researcher will provide clear research steps so that others might try to replicate the study if they desire.

Delimitations

Delimitations are the boundaries and limitations the researcher sets for their own study (College of William & Mary School of Education, 2022). The following delimitations have been identified by the researcher:

Delimitation One: The first delimitation is that the study excludes therapists who work with male victims of sexual violence and will only focus on therapists who work with female victims that have been isolated because of COVID-19. To establish this, the researcher will utilize a screening instrument to determine which potential participants work with socially isolated female victims of sexual violence during the global COVID-19 pandemic. This delimitation was made because the study is only focusing on isolated female victims of sexual violence.

Delimitation Two: The semi-structured interviews will be conducted via a telecommunication system, the Zoom platform. Because of this, it might be difficult for the researcher to read body language as questions are being answered. To control for this, the researcher will insist that the video device stay on so the researcher can observe the participant as they are answering questions. This delimitation was made because of the researcher's choice to conduct interviews via online. It can be more difficult to hide natural body language in person versus online, where the face is only seen.

Delimitation Three: The sample size for this study will be 20 therapists who work with victims of sexual violence pulled from the State of Texas, from the San Antonio and Dallas areas. A consequence of this is that limited sample sizes and scopes can influence the generalizability of research findings. This delimitation was made because the researcher is only using 10

participants per city, San Antonio and Dallas. The population of each of these cities are estimated to be more than 1 million each.

Chapter Summary

The problem is that it is unknown how therapists who work with victims of sexual violence work with the specific circumstances during the COVID-19 pandemic without regard to what effects may be put on therapists and their treatment plans. Because there are no current qualitative studies conducted to explore this exact focus, as previous studies have focused on why there was an increased occurrence of sexual violence doing the pandemic (Banerjee & Pati, 2020; Koenig et al., 2020l; & Wood et al., 2020) the present study aims to explain how therapists who work with victims of sexual violence describe their work and how they navigate through amid the COVID-19 pandemic. The following chapter will review the existing literature related to sexual violence, COVID-19, and therapy for sexual violence. In addition, a theoretical framework will be provided for the study.

CHAPTER TWO: LITERATURE REVIEW

Overview

This chapter will thoroughly discuss the related literature for the current study. The literature included will focus on the different areas relevant to the study such as, the experiences of therapists, the understandings of therapists, and the navigation of sexual violence therapy. This discussion will also include the theoretical framework that will help to guide the study.

Introduction

The following chapter will address the previous literature in context with the proposed study. A thorough review of research has been conducted to identify studies that explore the navigation, understanding, and experiences of therapists who work with victims of sexual violence. A background discussion will be provided on sexual violence, trauma therapy, and social isolation as it relates to the COVID-19 pandemic. The literature found and assessed for this section was pulled from Liberty University's online Jerry Falwell Library using keywords *"COVID-19," "sexual violence," "therapy," "trauma," "sexual violence victims," "sexual violence rehabilitation," "sexual violence treatment," "therapists," "COVID-19 effects," social isolation,"* and *"therapist experiences."* Various journals were used to access published scholarly articles including the *Journal of Consulting and Clinical, Journal of Aggression, Maltreatment & Trauma, Counselling Psychology Quarterly*, and *Journal of Traumatic Stress.*

Theoretical Framework

The central focus of this study examines therapists who work with sexual abuse victims and their description of their experiences and navigation while working with female victims of sexual violence who were socially isolated during the COVID-19 pandemic. Therapists who work with sexual abuse victims are trained individuals in psychotherapy that treat sexual abuse

victims without the use of surgery or drugs and are active in providing assistance to those who struggle or are challenged with mental or emotional problems. Sexual assault victims are individuals who were harmed or injured resulting from a sexual act or behavior forced upon a woman, man, or child without their consent. Social isolation in relation to the COVID-19 pandemic involves the absence of social contact and/or have only little to no individuals to interact with on a regular basis.

The theory guiding this study is the theoretical framework of loneliness, social isolation, and associated health outcomes. According to Barnes et al. (2021), the theoretical framework demonstrates that there is a bidirectional relationship between loneliness and social isolation under social connection, as well as a relationship with pre-existing risk factors, and specific health outcomes. Barnes et al. (2021), previous studies show that loneliness and social isolation are both independently associated with similar negative physical and mental health outcomes. These include higher rates of mortality, depression, and cognitive decline (Barnes et al., 2021). This bidirectional relationship is shown in figure 1.

Figure 1.

The theoretical framework of loneliness, social isolation, and associated health outcomes.

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Note: The theoretical framework of loneliness, social isolation, and associated health outcomes model was produced by the Committee on the Health and Medical Dimensions of Social Isolation and Loneliness in Older Adults in 2020, summarizing the bidirectional relationship

between loneliness and social isolation under the social connection and the relationship with pre-existing risk-factors, and specific health outcomes. From Barnes, T. L., MacLeod, S., Tkatch, R., Ahuja, M., Albright, L., Schaeffer, J. A., & Yeh, C. S. (2022). The cumulative effect of loneliness and social isolation on health outcomes among older adults. Aging & Mental Health, 26(7), 1327-1334. https://doi.org/10.1080/13607863.2021.1940096.

As shown in figure 1, risk factors and health outcomes are both shown to have independent associations with loneliness and social isolation. For example, depression, poor sleep, hypertension, and cognitive decline have been shown to have independent associations with loneliness (Barnes et al., 2021). Meanwhile, cardiovascular disease, inflammatory processes, increased dementia risk, disability, cognitive decline, mortality, and reduced quality of life have been shown to have independent associations with social isolation (Barnes et al., 2021). The 2020 consensus report of the National Academies of Science, Engineering, and Medicine (NASEM) highlights many risk factors associated with both loneliness and social isolation that include social, cultural, and environmental factors; psychological and cognitive factors; and physical health factors (Barnes et al., 2021). They also highlight the many health outcomes associated with both social isolation and loneliness, including cardiovascular disease, stroke, dementia, and mortality.

According to Barnes et al. (2021), interventions that promote social connectedness and eliminate social barriers can be extremely important in improving the outcomes of therapy interventions. During the COVID-19 pandemic, social ties with the community and the public were placed on pause. The effect of online therapy interventions is currently unknown due to the recent development of the pandemic. This theoretical framework will allow the researcher to look at how the online sessions of therapy either helped or struggled to improve the social

connectedness of victims of sexual violence during the pandemic. This will be accomplished through the conduction of interviews with therapists who work with victims of sexual violence and provide online therapy services to sexual violence victims. Therapists who work with victims of sexual violence will provide feedback on their experiences and the navigation of the therapy sessions providing insight into the effectiveness of their services. Additionally, the theoretical framework will aid in demonstrating how social isolation may play a role in whether online therapy sessions are beneficial or more challenging. This will be accomplished through the completion of coding based on the audio-recorded interviews. The coding of the data will be determined by the described experiences of working with the victims, how the therapists felt providing services, in what ways the therapists guided or directed the victims, and the insights gained from the administration of their services.

Loneliness, Social Isolation, & Associated Health Outcomes with Sexual Assault

The central focus of this study examines the descriptions of therapists' experiences, including their navigation of online therapy sessions with socially isolated female victims of sexual violence during the COVID-19 pandemic. According to the guiding theoretical framework for the current study, there is a greater need for interventions to address loneliness and social isolation among vulnerable adults (Barnes et al., 2021). During the COVID-19 pandemic, guidelines were formed to help the population avoid the risk of serious illness; and while these recommendations are warranted, it is likely for the impacts of physical and social distancing on the population's mental health to be lasting and significant, including loneliness and social isolation (Barnes et al., 2021). That said, therapy interventions that promote improving social connectedness and eliminating social barriers could be extremely important in improving outcomes for socially isolated victims of sexual violence (Barnes et al., 2021).

Sex-Crime Victimization

Sex offender notification laws have been established with the sole purpose of allowing at-risk individuals where previously convicted, registered sex offenders (RSOs) reside. These laws assume that (1) the risk of being victimized is positively correlated with geographic proximity to a registered sex offender, (2) potential victims can use RSO identifying information effectively to reduce their risk of victimization, and (3) notification reduces overall victimization risk near RSOs (Agan et al., 2014). Criminal victimization is the most common traumatic event to which the general population is exposed (Guay et al., 2018). Victims of violent crimes, such as domestic and sexual violence, are at elevated risk of developing severe psychological distress (Guay et al., 2018). It is quite often for victims to suffer from negative mental health outcomes; these negative outcomes may be exacerbated by certain aspects of victimization, including, but not limited to, the experience of a threat to one's life or physical integrity, stigma related to the crime, loss of interpersonal trust, and involvement in the judicial process (Guay et al., 2018). As noted by Guay et al. (2018), previous studies have indicated that between 19% and 33% of exposed individuals develop acute stress disorder (ASD). Thus, an ASD diagnosis, research, and clinical experience have shown that this diagnosis is a powerful risk factor for the development of post-traumatic stress disorder (PTSD), leaving victims with an overall 89% chance of developing PTSD after ASD (Guay et al., 2018).

Sexual assault (SA) is a common and deleterious form of trauma (Dworkin et al., 2017). 17-25% of women and 1-3% of men will be sexually assaulted in their lifetime (Dworkin et al., 2017). Due to the high prevalence of sexual assault, it is particularly concerning considering its significant psychological consequences for survivors. SA is a major public health concern because it appears to have a more substantial impact on mental health than other forms of trauma

(Dworkin et al., 2017). Beginning as early as the 1970s, increasing attention to SA as a feminist issue as well as growing interest in the impact of traumatic life experiences, manifested in several seminal academic works on the psychological impact of SA (Dworkin et al., 2017). In a study conducted by Sutherland and Scherl in 1970 (as cited in (Dworkin et al., 2017) thirteen female sexual assault survivors were assessed; these women were described as a condition involving an early period of anxiety and fear, followed by a depressive phase. In a study conducted by Burgess and Holmstrom in 1974 (as cited in (Dworkin et al., 2017), 146 women who were interviewed were admitted to a hospital with a presenting complaint of SA. Their observed condition was categorized as "rape trauma syndrome," and it involved a spectrum of acute symptoms, including somatic reactions like muscle tension and stomach pain. Also included were emotional reactions like fear and self-blame. Researchers noted these women entered a "reorganization" phase that included nightmares, phobic reactions to trauma reminders, and increase in motor activity. These findings set the groundwork for an explosion of research on the impact and treatment of SA (Dworkin et al., 2017).

It is evident that SA is a life-altering experience for many survivors, but not all who are assaulted develop psychological problems (Dworkin et al., 2017). The characteristics of individuals, such as demographics and prior assault history, may cause the impact of SA to vary. Assaults vary in terms of characteristics that could also affect the psychopathology of each victim; these characteristics include the presence of physical injury, the weapon used by the perpetrator, and the relationship of the victim to the offender. In a study conducted by Campbell et al., in 2009, among the relationships between these SA characteristics, physical injury was found to be the only characteristic associated with psychopathology (Dworkin et al., 2017). In a meta-analysis of the association between distress and interpersonal violence, time since stressor

was negatively associated with effect sizes (Weaver & Clum, 1995), and a review of the impact of intimate partner violence on psychopathology found that rates of depression decline over time (Golding, 1999). In a qualitative review of associations between SA and multiple forms of trauma, identified mixed findings regarding the importance of current age in post-SA psychopathology were found. Most studies identified no relationship between age and distress, and several identified either positive or negative associations between age and specific forms of psychopathology (Campbell et al., 2009). In terms of gender, results also are mixed (Dworkin et al., 2017).

Therapy Interventions

There are several psychological treatments for disorders such as post-traumatic stress disorder (PTSD) and acute stress disorder (ASD) (Watkins et al., 2018). These treatments include trauma-focused interventions and non-trauma-focused interventions. Trauma-focused treatments directly address memories of the traumatic event or thoughts and feeling related to the traumatic event (Watkins et al., 2018). Both Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT) are trauma-focused treatments. Non-trauma-focused treatments aim to reduce PTSD symptoms, but not by directly targeting thoughts, memories, and feelings related to the traumatic event. These treatments include relaxation, stress inoculation training (SIT), and interpersonal therapy (Watkins et al., 2018).

The use of internet-delivered, online interventions provides many advantages for the prevention and treatment of psychological problems and mental health disorders including depression, anxiety, and functional limitation (Lippke et al., 2021). According to Lippke et al. (2021), previous studies have consistently found that online treatments can save therapists' time and support relapse prevention of psychological problems. Additional strengths of online

interventions over face-to-face (F2F) are that they were deliverable from remote locations, need less commitment, and provide more flexibility for therapists and patients. It is also likely for reduction in the risk of stigma that comes from mental disorders and treatment seeking to occur (Lippke et al., 2021). Moreover, patients in psychotherapeutic interventions may miss their F2F sessions or drop out of therapy because it is possible for patients to feel as if the location of the therapy is too far away. Thus, online mental health interventions can bridge the gap between patients and therapists when the patient cannot travel to the intervention site or both are limited in their mobility (Lippke et al., 2021).

Online therapies may harbor weaknesses like the requirement of knowledge and skills such as computer and internet health literacy and general literacy (Lippke et al., 2021). It is not possible for every patient to benefit from online psychotherapy or blended therapy forms (i.e., a combination of F2F psychotherapy with online interventions modes) due to limited introspection capabilities or the nature of their disorder (i.e., , severe disorders, chronic syndromes, or personality disorders (Lippke et al., 2021). A personalized tool may be needed to consider individual patient characteristics. Traditional F2F therapy settings can help patients with self-reflection, especially if they are not well experienced with expressing their cognitions and emotions. Additionally, online therapies may prevent counselors from reacting to emergency situations like acute psychic decompensation or acute psychosis as adequately as they could in an analog situation (Lippke et al., 2021). Negative experiences with digital psychotherapeutic interventions could have the consequence in patients feeling less motivated, feeling unsure, or even avoiding trying F2F therapy. Conversely, relative to F2F interventions, online interventions might have limitations such as higher dropout.

Social Connectedness and Social Barriers

As previously discussed, the theoretical framework of loneliness, social isolation, and associated health outcomes model was produced by the Committee on the Health and Medical Dimensions of Social Isolation and Loneliness in Older Adults in 2020. The theory states that loneliness and social isolation are both independently associated with similar negative physical and mental health outcomes later in life, including higher rates of mortality, depression, and cognitive decline Barnes et al., (2021). For the current study, the researcher is essentially looking at how online therapy interventions may have assisted or further challenged socially isolated sexual assault victims in developing their social connectedness during the COVID-19 pandemic.

The researcher will attempt to find if online therapy sessions provide support for socially isolated victims of sexual violence and if there is a removal of social connectedness. The use of social networks shapes many aspects of social and economic activity (Bailey et al., 2018). Those who live in developed nations, digital technology has become an integral aspect of their culture, their education, and their life. Social connectedness forms the basis for creating strong, long-lasting interpersonal bonds (Bailey et al., 2018). The importance of meaningful relationships has been incorporated into a variety of other theories, such as frameworks on social capital, self-presentation, and self-determination theory. The use of social connections is a central feature of the normative developmental trajectory of adolescence to adulthood (Bailey et al., 2018). They contribute to elements of adolescents' psychosocial wellbeing, such as anxiety, loneliness, and depression.

Related Literature

Throughout the COVID-19 pandemic, emerging data and reports have shown that all types of violence have intensified, specifically sexual violence (Rockowitz et al., 2021). Sexual

violence is prevalent, and consequently, trauma survivors seek aid and guidance through therapy. Overall, it is estimated that one in three women will experience sexual violence in their lifetime in the United States (Anderson & Overby, 2020). While amid the COVID-19 pandemic, there is a need for greater information to expand the knowledge on how to develop effective methods to consider while working with the trauma population. The purpose of this qualitative descriptive study is to examine therapists who work with victims of sexual violence and their descriptions of their experiences and navigations while working with female victims of sexual violence who were socially isolated during the COVID-19 pandemic in the state of Texas. This issue is unique to the field because the COVID-19 pandemic was still ongoing up until 2023, with no certain end in sight. The pandemic transformed healthcare for both clinicians and patients, and with the changes brought forth by the COVID-19 pandemic, challenges were presented to clinicians' identities and sense of mission. According to Samios et al. (2013), therapists who work with trauma survivors can experience compassion and satisfaction while experiencing the negative effects of trauma work. The following sections will discuss the COVID-19 pandemic in relation to sexual violence in depth. The researcher will discuss the experiences of therapists including the possibilities of vicarious trauma, secondary traumatic stress, burnout, and compassion satisfaction. Concluding the chapter, the researcher will also provide a discussion of the understandings of therapists, including self-deception and social capital, and the navigation of therapists and how they work with trauma victims.

The COVID-19 Pandemic and Sexual Violence

Accompanied by emergencies and disasters, extreme stress, uncertainty, and fear dramatically raised concerns about potential increases in gender-based violence. Throughout the global pandemic, physical and social distancing guidelines became mandated to slow the spread

of the virus until vaccination became available (Munro-Kramer et al., 2021). Previous pandemics and emergencies identified the most common factors that increase the risk of violence. These factors include economic insecurity, poverty-related stress, job loss or reduced working hours, quarantine, and social isolation. According to Muldoon et al. (2021), during the SARS and H1N1 pandemics, it was found that isolation caused psychological distress, loneliness, depression, stress, post-traumatic stress disorder, anger, sleep disorders, problematic substance use. These resulting factors led to an increased risk of violence in the United States.

The COVID-19 pandemic rapidly transformed how and whether individuals worked. A significant number of individuals remained in their homes, avoiding the outbreak of the disease and under the commands of shelter-in-place orders. Working remotely brought forth consequences ranging from psychological to physical effects. According to Banerjee & Pati (2020), working remotely caused great consequences for women. Women were found to have a greater increased risk of domestic and sexual violence and online harassment. According to Wood et al. (2020) hotlines across the nation saw a surge in use from individuals stuck at home in unsafe situations, with a lack of formal and informal support. The pandemic caused great risks of occupational stress from low pay, work conditions, burnout, and secondary traumatic stress causing IPV and sexual assault to navigate the challenges of providing safety for those at home (Wood et al., 2020). Koenig et al. (2020) discussed that individuals who were affected by shelter-in-place mandates became more vulnerable to the risk of intimate partner violence, including domestic and sexual violence; however, psychological factors such as elevated stress from losing a job and loss of financial security were likely to exacerbate these risks. According to Viero et al. (2021), intimate partner violence is likely to increase after disasters and outbreaks for three reasons. First, reduced marital satisfaction may occur and reinforce aggressive

behaviors to manage relational conflicts between intimate partners. Second, stressors that derive from post-disasters, including economic disruption, may trigger increased aggressive behaviors. Lastly, important supports for women, like family, friends, and professional services, that aid women victims of violence have the potential to become limited.

People began to fear for their lives as the virus began to spread, and those around them began to die. Many chose to socially isolate themselves to protect not only themselves, but their loved ones. David et al. (2021) suggests how social distancing measures and stay-at-home orders contribute to the increase in intimate partner violence for domestic and sexual violence in the home. Van Rensburg & Smith (2020), claim the social effects of the pandemic placed women at an increased risk of violence; further suggesting social isolation is a risk factor for sexual violence, as well as other forms of violence. The stay-at-home mandates affected the opportunities for women to physically engage with others, causing the ability of others to observe and inquire about warning signs of abuse to reduce (van Rensburg & Smith, 2020). It is likely that women may have found it difficult to reach out to support networks, including friends, family members, and crisis lines.

In a literature review conducted by the World Health Organization (WHO), it is discussed that, in the United States, social distancing and social isolation measures increase the likelihood of individuals becoming at risk of violence. According to Davis et al. (2021), previous research conducted on social support suggests that the presence of adequate social support can decrease the likelihood of victimization and re-victimization. Although social isolation has caused sexual violence victims to not seek treatment, it has also resulted in a reduction in health services staff and has led to reduced access (Dosdale & Skarparis, 2020). It is possible that during the pandemic, those who needed urgent health care following sexual violence may have experienced

increased anxiety about seeking services due to the increased potential of acquiring COVID-19, leaving themselves untreated (van Rensburg & Smith, 2020). Sorenson et al. (2021) state isolation is considered a hallmark of violence in relationships that heightened during stay-at home mandates. In the United States, domestic and sexual violence reports increased by 32-36% following social isolation and quarantine (Gebrewahd et al., 2020). The movement restrictions ignored the needs of women who were abused and assaulted and left these women in the presence of an abusive partner.

Changes in service provision from shelters, support hotlines, community-based agencies, and emergency departments all occurred due to the pandemic (Muldoon et al., 2021). Those who required health services changed the way they sought help. Davis et al. (2021) noted that physical and psychological stressors, isolation, the closure of schools and businesses, and job losses increased the context of the pandemic have become linked to intimate partner violence and sexual violence. John et al. (2021) claimed that quarantine and closure of businesses and schools exacerbated gender-based inequalities and increased exposure of women and girls to gender-based violence. As the COVID-19 pandemic hit, surges in government imposed restrictive policies arose, diminishing access to comprehensive gender-based violence services (John et al., 2021). Some community agencies and service providers saw a spike in the volume of individuals who visited health professionals for violence related trauma, while others saw a decrease since social distancing policies became implemented (Muldoon et al., (2021). However, the challenge was when most nonessential businesses began to close, community agencies and service providers began to modify their options for domestic and sexual violence services, thus reducing the options for individuals to receive support on a walk-in basis. Because of the developed confusion of whether businesses were open or closed, those who may have been affected by

domestic and sexual violence became unaware of what services remained open, thus not seeking help or assistance (Muldoon et al., (2021).

Viero et al. (2021) revealed that there is a greater risk of domestic and sexual violence against women when restriction policies are established due to the COVID-19 pandemic. While conducting a literature review, Verio et al. (2021) found a significant increase in the number of calls from women victims beginning in March 2020. After conducting a cross-sectional study with data collected via an internet-based survey, Davis et al. (2020) found that individuals who tested positive for COVID-19 were 2 to 3 times more likely to experience or perpetrate violence against an intimate partner. Kaswa (2021) assessed the COVID-19 pandemic and its effect on health services for individuals who live with HIV. It was found that the COVID-19 pandemic caused a disruption in services and severely impacted access to healthcare and services. Wood et al. (2020) assessed the gap between the experiences of the workforce providing support to survivors, as well as the evolving service delivery methods, shifting safety planning approaches, and occupational stress of frontline workers during the COVID-19 pandemic. Researchers suggested that the pandemic caused a decrease in client safety, and the lack of resources needed to help sexual assault survivors provided an increase in intimate partner violence. Bennet et al. (2021) claimed COVID-19 has had negative implications for dating and sexual violence among student victims. Services for victims of sexual violence have been disrupted by the pandemic, and it is vital for healthcare professionals to adapt and find effective and efficient methods to administer their services. Bayzar et al. (2021) claim COVID-19 caused an increase in domestic violence while reducing the likelihood of sexual function amongst the population. Using a survey method, Jetelina et al. (2020) found that the worsening of victimization among physical and sexual violence was significantly higher during the pandemic than it was pre-COVID.

Social Isolation and Victims of Sexual Violence

Social isolation is a deprivation of social connectedness. Social connectedness is described as a crucial aspect of society; it is a core impediment to achieving well-being (Zavaleta et al., 2017). Social isolation has a significant number of effects. In ontogeny and phylogeny, the basic fact is that humans need others to survive and prosper. Animal studies have been found to be useful and significantly important to the study of social isolation (Zavaleta et al., 2017). This is because human studies of social isolation are limited in intensity and duration due to the risk of deleteriousness (Zavaleta et al., 2017). Longitudinal studies in population-based samples with statistical control for potential confounding variables have identified potential behavioral, neural, hormonal, cellular, and genetic effects of isolation in humans (Zavaleta et al., 2017). These studies have provided the following findings: (1) perceived social isolation is a more important determinant of deleterious outcomes than is the variation in objective social isolation that is seen in population-based studies, and (2) the effects of perceived isolation in these longitudinal studies share much in common with the effects of experimental manipulations of isolation in nonhuman social species: increased sympathetic tonus HPA activation, decreased inflammatory control, expression of genes regulating glucocorticoid resistance (Zavaleta et al., 2017).

Humans are capable of deception, betrayal, exploitation, murder, empathy, compassion, loyalty, and prosocial behavior (Zavaleta et al., 2017). And it is possible for a social threat to occur at any given moment due to shifting alliances, malleable social hierarchies, and the presence of others. According to Peitrabissa and Simspon (2020), mental health consequences deriving from the negative consequences of the COVID-19 pandemic lockdown are likely to outlive the pandemic. The most common psychological disorders that have emerged from the pandemic include anxiety and panic, obsessive-compulsive symptoms, insomnia, digestive

problems, depressive symptoms, and post-traumatic stress (Peitrabissa and Simspon, 2020). Although these disorders are not a direct consequence of the pandemic, they are considered to be largely driven by the effects of prolonged social isolation.

Isolation paired with psychological and economic stressors accompanying the pandemic, as well as protentional increases in negative coping mechanisms, create a perfect storm. This perfect storm allows for an unprecedented wave of violence to occur inside of the home. In relevance to the current study, there is a considerable amount of growing evidence on the relationship between social isolation and sexual abuse. According to Young et al. (2001), women who have been sexually abused are more likely to report being socially isolated than women who have not been sexually abused. Additionally, social isolation is found to be more common among women who have been sexually abused by a family member, who were abused when they were young, and who have been abused for a long period of time (Young et al., 2001). The pandemic considerably increased the risk of online and offline harm to children and young adults by increasing vulnerabilities and reducing protection (Harris, 2021). For many children and young people who were physically and socially isolated from friends and trusted adults, their emotional and mental health became compromised, with confinement at home and changes to their routines being common features (Harris, 2021).

Much of the population began to experience anxiety due to living with high levels of stress among parents and careers from illness, job loss, and economic uncertainty. As a result, a great amount of these experiences of parental stress contributed to neglect and other kinds of maltreatment (Harris, 2021). A considerable amount of sexual abuse is opportunistic rather than carefully planned and tends to follow a path of least resistance (Harris, 2021). The majority of survivors of sexual abuse suffer from symptoms like those of post-traumatic stress disorder,

including anxiety, nightmares, and intrusive thoughts (Young et al., 2001). Many survivors also experience long-term effects that are interpersonal in nature. Survivors tend to have more difficulty forming secure attachments with others, tend to have lower interpersonal competence, and often report problems with their interpersonal relationships, including those with parents, romantic partners, friends, and children (Young et al., 2001).

Other existing research based on social isolation and sexual assault revolves around the use of substances, including alcohol and crack cocaine. Many women who abuse substances report feeling socially isolated due to past experiences of sexual trauma (Young et al., 2001). In previous studies (Rhoads, 1983; Schilit & Gomberg, 1987; Tucker, 1981), it has been found that women who abuse alcohol and illicit drugs are likely to have limited social networks and friends. Tucker (1981) found that women who use heroin and have same-sex best friends were more likely to report having no friends and describe themselves as lonelier compared to women without addictions. These same findings were found in a study that assessed alcoholic and nonalcoholic women (Schilit & Gomberg, 1987). In a study conducted by Boyd and Mieczkowski (1990), it was found that greater social isolation exists among female crack cocaine users who characterized their lives as alienated, with damaged social support networks.

During the pandemic, social isolation formed intense and unrelieved contact in the homes of many families, as well as depleted existing support networks through extended family members, and social and community-based support networks (Usher et al., 2020). While social isolation is an effective measure of infection control, it can lead to significant social, economic, and psychological consequences, which can be the catalyst for stress that can lead to violence (Usher et al., 2020). According to Usher et al., (2020), COVID-19 was used as a coercive control mechanism whereby perpetrators exert further control in an abusive relationship; more

specifically, in the use of containment, fear, and the threat of contagion as a mechanism of abuse. In the United States, as quarantine measures became extended, individual states reported similar increases in domestic abuse incidents ranging from 21% to 35% (Usher et al., 2020). In a study conducted in Australia, it became highlighted that people had intimate partners who used COVID-19 as a form of abuse (Usher et al., 2020). Further explaining that those experiencing domestic abuse may have been too fearful of going to the hospital for fear of contracting COVID-19.

Clinical Service Disruptions

The empirical research on the disruptions of clinical services during the COVID-19 pandemic is very limited. Examples of disruptions include the rapid transition to telehealth, reduced caseloads, and clinic closures (Davenport et al., 2020). Although certain disruptions may be temporary, prudent, and likely in the best interests of both patients and providers, there are various negative and positive consequences. Research displays a considerable number of findings discussing the application of remote communications as well as the implications for telemedicine and telehealth.

The COVID-19 pandemic disrupted healthcare delivery in more ways than the population can count (Rose & Ellen, 2020). There were many changes in the way services and treatment were delivered. As noted by James et al. (2022), the COVID-19 pandemic had major changes on the provision of therapy, with organizations recommending therapy be provided via remote platforms, such as telephone or videoconferencing. There has been a considerable amount of research that has been found in favor of remote platforms being used for therapy (Fleuty & Almond, 2020; Simpson & Reid, 2014). These studies suggest that the use of remote platforms allows for therapy to be more accessible and flexible with timings. According to Davenport et al.

(2020), it is possible for patients to not receive the appropriate care that is needed and for those patients who are seen in person, there is an increased risk of COVID-19 exposure for themselves and their provider. Davenport et al. (2020) strongly suggests that with the many health conditions that exist, the impacts of clinical service disruptions are not experienced similarly across patients, clients, providers, regions, and countries. The existing structural inequities in health and health care result in these negative consequences varying by income, race, education, availability of transportation, and geographic location, among other social determinants of health (Davenport et al., 2020).

Due to COVID-19, clinicians faced several challenges. Of specific interest should be continuity of care and clinician well-being. The COVID-19 pandemic forced psychotherapists to abruptly adopt telemental health modalities with little to no training (Bell et al., 2021). These effects on clients and clinicians merit examination. According to Bell et al. (2021), these potential areas include effects on client-clinician relationships, the effectiveness of most suited for telemental health services, altered safety of the shared therapy room, fluctuation of crises on clinicians' caseloads and therapeutic modalities appropriate for telemental health services. The use of telehealth has increased exponentially throughout the last decade, and with the occurrence of the COVID-19 pandemic, there has been an increase in the demand for empirical literature on the transition to teletherapy and its effects (Morgan et al., 2021). Prior to the pandemic, a nationally representative consumer survey found that for mental and physical health services, remote communications rates rose from 6.6% to 21.6% between 2013 and 2016. Additionally, it was found that almost two-thirds of the participants reported the willingness to use video calling to discuss health concerns. The increased availability and lower cost of teletherapy platforms are suggested to have made the delivery of mental health interventions more viable.

Various studies have found that teletherapy has been effective in addressing anxiety, autism spectrum disorders, chronic pain, depression, eating disorders, post-traumatic stress disorder, substance use disorders, and pediatric traumatic brain injury (Boisvert et al., 2010; Bouchard et al., 2004; Godleski et al., 2012; Herbert et al., 2017; Hilty et al., 2013; King et al., 2014; Mitchell et al., 2008; Rees & Maclaine, 2015; Sánchez-Ortiz et al., 2011; Wade et al., 2019). It has been found that there is a presence of willingness from clients to engage in teletherapy due to familiarity with teletherapy applications, perceiving teletherapy as beneficial, and lack of barriers such as transportation and provider availability. According to Gagnon et al. (2004), females are found more likely to use teletherapy and be satisfied with services.

Crises have been suggested to increase the severity of clients' symptoms. This increase causes a demand for more clinicians. During the pandemic, clients required more of a clinician's time, attention, and energy (Bell et al., 2021). And while caring for others can be challenging itself, during crises, it can become more difficult for clinicians to treat patients while coping with the overall effects of a crisis. Therapists, clinicians, and providers have not only been exposed to the effects of the pandemic but also experienced adversity.

The Experiences of Therapists

Sexual violence is an unfortunate and extremely common event to occur in the United States. Because of the common occurrence, licensed professionals become highly associated with victims of sexual violence in their work. The experiences of the professionals who provide psychological services to victims of sexual violence vary by case. These professionals, or therapists, are either positively or negatively affected by their work. Although research is sparse on the positive effects (Wheeler & McElvaney, 2017), it has been suggested by scholars (Helpingstine et al., 2021; Kadami et al., 2004; Moulden & Firestone, 2007; Way et al., 2004)

that professionals are more likely to be at a higher risk for being negatively affected by their work. These negative effects associated with the work of therapists include vicarious trauma, secondary traumatic stress, and burnout. These collective effects define and describe the experiences of therapists who work with trauma clients, including victims of sexual violence.

Vicarious Trauma

Vicarious trauma was first explained and used by McCann and Pearlman in 1990 (Way et al., 2004). According to Kadami et al. (2004) vicarious trauma describes profound and permanent alterations in the ways therapists think, feel, and behave because of their work with traumatic material from their clients. These alterations include changes in the therapists' sense of self, spirituality, worldview, interpersonal relationships, and behavior (Way et al., 2004). Vicarious traumatization of therapists is considered a standard consequence that derives from the engagement with trauma victims or clients, including sexual-related victims and mental health-related victims (Wheeler & McElvaney, 2017). Early studies (Figley, 1993; Figley, 2002; McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995) explain the use of protective factors to aid in reducing the possibility of negative impacts from occurring (Wheeler & McElvaney, 2017). These protective factors include supervision, personal therapy, self-care strategies, social supports, and organizational supports. Other studies (Hernández, Gangsei, & Engstrom, 2007; Arnold et al., 2005; Stamm, 2005) consider the possibility of the occurrence of positive impacts, including various post-traumatic growth, vicarious resilience, and compassion satisfaction (Wheeler & McElvaney, 2017).

A study conducted by Wheeler & McElvaney, (2017) explored the positive impacts on therapists who work with children who have been sexually abused in Ireland. Using unstructured interviews, researchers found that although thoughts of negative impacts linger throughout their

work time, the therapists claimed their experiences provided an enhancement in their own attitudes and lives. Although positive impacts may be likely, it has become more frequent for negative consequences to become present in a therapist's work (Wheeler & McElvaney, 2017). Therapists who also work with traumatized clients in various sexual-related cases, including commercial sexual exploitation, similarly face the possibility of the occurrence of vicarious traumatization. This is because sexual abuse treatment includes services like listening empathically to survivors as they share graphic details of their victimization experiences and the intensity of their pain (Way et al., 2004).

The traumatic experiences that occur during an individual's life may cause trust and relationship building especially difficult, and those that have faced continuous violence and sexual abuse risk the likelihood of living with long-term traumatic effects (Helpingstine et al., 2021). Thus, causing these effects to impede living a healthy, safe, and productive lifestyle. Studies (VanDeusen & Way, 2006; McCann & Pearlman, 1990) have shown that when the work of therapists is trauma-intensive, a decrease in empathy, motivation, and efficacy will occur among the therapists (Helpingstine et al., 2021). According to Way et al. (2004), negative effects that result from working with traumatized clients may also include compassion fatigue or secondary traumatic stress, countertransference, and burnout. It has been considered by scholars (Figley, 1995) that compassion fatigue is the most appropriate term to describe secondary traumatic stress effects resulting from vicarious trauma (Way et al., 2004). Especially in cases related to sexual abuse and violence, vicarious traumatization in therapists requires self-assessment and monitoring, prevention, and intervention (Way et al., 2004). However, the experiences and consequences of therapists will vary case by case.

Secondary Traumatic Stress

According to Hensel et al. (2015), secondary traumatic stress (STS) occurs as a reaction to secondary or indirect exposure to traumatic events that have been experienced by another individual. Professionals develop STS after working therapeutically with trauma victims. Sexual violence is a common traumatic event that occurs in the lives of individuals. According to Samios et al. (2012), sexual violence is not only prevalent, but it is linked to higher rates of stress, including STS and posttraumatic stress disorder (PTSD), compared to other traumas. Therapists that are exposed to the traumatic events disclosed by their clients are at high risk of experiencing secondary traumatic stress (Samios et al., 2012).

Because sexual violence is a common traumatic event, throughout their careers, therapists frequently work with sexual violence survivors. This frequent engagement places therapists at risk of negative outcomes that derive from secondary traumatic stress; these negative outcomes include fear, sleeping difficulties, intrusive images, and avoiding reminders of the client's traumatic experiences (Samios et al., 2012). Therapists have also been shown to report great emotional exhaustion (Samios et al., 2012). In a study conducted in the United Kingdom (Wall et al., 1997), employees of the National Health Service reported great stress and minor psychiatric disturbances more than other job groups (Moulden & Firestone, 2007). These employees worked directly with victims of trauma. In a study completed by Kadami & Truscott (2004), scholars found there were no differences between the levels of vicarious trauma, traumatic stress symptoms, and levels of burnout among therapists who provide services to different client populations, including trauma victims. However, researchers suggested that therapists do not suffer from significant emotional or phycological concerns, but instead, they are found to cope well with their challenging work (Kadami & Truscott, 2004).

According to Baird & Jenkins (2003), a growing number of clinical and research evidence claims that therapists who work with traumatized clients may develop reactions specific to the traumatic nature of the clients' material. These reactions can include re-experiencing a survivor's traumatic event, avoidance, becoming numb, and persistent arousal (Baird & Jenkins, 2003). Although these are nearly identical to the symptoms of PTSD, therapists may develop STS instead. Baird & Jenkins (2003), assessed the presence and correlates of secondary traumatic stress, vicarious trauma, burnout, and general distress, comparing volunteer and paid staff working with sexual assault and/or domestic violence survivors. In relation to STS, researchers found that STS should be more common among counselors or therapists who see more severely traumatized clients. Therapists who develop PTSD and STS may experience similar symptoms; however, the difference is that while PTSD originates from direct exposition to a traumatic event, STS is a consequence of indirect exposure to trauma due to close personal contact with a trauma victim (Rzeszutek et al., 2015).

There are various studies (Baird & Jenkins, 2003; Bride, 2007; Meadors et al., 2009; Moran & Britton, 1994) that have observed the symptoms of STS in helping professionals, including social workers, emergency workers, sexual assault counselors, and health care providers (Rzeszutek et al., 2015). These symptoms of STS have also been identified and reported in trauma therapists. In a study conducted by Pearlman and Maclan in 1995, there were reported significant levels of STS symptoms in nearly 62% of examined trauma therapists (Rzeszutek et al., 2015). Adams and Riggs in 2008, found that 31% of trauma therapy trainees exceeded the clinical cut-off score in the STS inventory (Rzeszutek et al., 2015). Within these studies, it can be suggested that STS symptoms are not only related to performance at work, increasing absenteeism among employees, and decreasing job satisfaction, but are also found to

be linked to various mental and somatic problems, including depression, anxiety, and alcohol and drug abuse (Rzeszutek et al., 2015).

Burnout

Service providers, including therapists, remain critical to ensuring victims of trauma receive the necessary treatment for their trauma (Helpingstine et al., 2021). While working with individuals dealing with trauma, professionals may experience negative effects on their own mental and physical health; alongside vicarious trauma and secondary traumatic stress, burnout may also be experienced. According to Hebert Freudenberger (1974), the term burnout is used to describe the consequences of severe stress in professions (Helpingstine et al., 2021). He defined burnout as a feeling of exhaustion and fatigue. According to Maslach (1982), burnout can be described as a body's process in response to the chronic emotional strain of dealing extensively with other human beings, particularly when they are in trouble or having problems (Helpingstine et al., 2021).

There are existing studies that have provided evidence suggesting that a therapist's regular exposure to traumatic patient information is highly linked to mental health outcomes, especially burnout (Helpingstine et al., 2021). In a study conducted by Helpingstine et al. (2021), researchers found that professionals expect burnout to most likely occur while working with trauma victims. At the conclusion of the study, it became evident to scholars that professionals felt that burnout was an unavoidable aspect of their careers. In a study conducted by Devilly et al. (2009), trauma therapy professionals were examined to assess vicarious trauma, secondary traumatic stress, and burnout among trauma victims with mental health challenges. Researchers found that both vicarious trauma and burnout contribute to the prediction of affective distress, with burnout being the strongest predictor (Devilly et al., 2009). Baird & Jenkins (2003) suggest

that burnout amongst trauma therapists varies based on several different circumstances. Such as, the likelihood of burnout occurring is highly predicted amongst more trauma-experienced workers. These experienced professionals reported more emotional exhaustion and greater feelings of personal accomplishment. In addition, burnout was also found to be associated with the number of clients seen by professionals.

Survivors of sexual abuse present many personal and professional challenges to therapists (Lee et al., 2010). As early as 1995, there have been several early studies (Ellerby, 1997; Jacksonet al., 1997; Layton, 1988; Polson & McCullom, 1995) that have reported sexual offender and abuse survivor therapists being significantly influenced by their work. This influence produces multiple emotional and physical ailments that affect both the well-being and treatment efficacy of the therapist (Lee et al., 2010). According to Lee et al. (2010), burnout among trauma therapists was originally perceived as an individual problem and less as an organizational problem. During the 1980s, burnout scales, including Staff Burnout Scale for Health Professionals and Maslach Burnout Inventory-Human Services Survey, assumed and measured burnout as an individual syndrome. More recently, scholars have expanded the theoretical framework of burnout, discussing the problem as part of an organization and not only as a personal matter (Lee et al., 2010).

The probability of therapists experiencing burnout consequently from their trauma work varies between individuals, as well as the presence of possible protective and risk factors (Sodeke-Gregson et al., 2013). These variables include age, gender, and engagement in therapy. Organizational variables may include the provision of supervision, perceived workplace support, provision of trauma-specific training, urban versus rural workplace setting, remuneration, and working for public versus private organizations. In a study conducted by Craig and Sprang

(2010), the following variables predicting the probability of therapist burnout were found: younger age, having no special trauma training, having an increased percentage of individuals on the caseload with PTSD, being an inpatient practitioner, and not using evidence-based practices. The experiences of therapists differ from each other due to specific variables. However, it can be confirmed that therapists who work with trauma clients will be negatively affected in ways such as burnout but also positively affected in ways such as compassion satisfaction (Sodeke-Gregson et al., 2013).

Compassion Satisfaction

Sodeke-Gregson et al. (2013), discuss compassion satisfaction (CS) as a positive impact of therapist trauma work. Compassion satisfaction is defined as the sense of fulfillment or pleasure that therapists derive from doing their work well (Sodeke-Gregson et al., 2013). There are three elements that compose compassion satisfaction: "(1) the level of satisfaction that a person derives from their job; (2) how well a person feels they are doing in their job, related to the levels of competency and control that therapists feel they have over the traumatic material they are exposed to; and (3) the level of positive collegiate support that a person has, with aspects of structural and functional social support being particularly important." (Sodeke-Gregson et al., 2013, p.2).

Therapists consider compassion satisfaction to be a unique experience, as it focuses on the powerful involvement of emotional engagement necessary for successful therapeutic work (Samios et al., 2013). According to Craig and Sprang (2010), there is a growing body of literature that suggests therapists have a sense of personal growth from their work with trauma clients. In 2007, Sprang found that specialized trauma training of therapists significantly increased compassion satisfaction and decreased compassion fatigue and burnout (Craig &

Sprang, 2010). Craig and Sprang (2010) found that evidence-based practices and an increase in the number of years of clinical experience reduce burnout and compassion fatigue and increase compassion satisfaction. In 2006, preliminary research by Conrad and Keller-Guenther brought forth support for compassion satisfaction. Research suggests CS can play a role in mitigating the negative effects of trauma work (Samios et al., 2013). In attempting to assess if CS can reduce negative effects for trauma therapists, various studies have been conducted. According to Samios et al. (2013), therapists who work with trauma survivors, including survivors of sexual violence, can experience compassion satisfaction while also experiencing the effects of trauma work. While examining the potential protective role of CS, Samios et al. (2013) found that although secondary traumatic stress is related to greater depression, factors of anxiety and support were found to buffer the role of CS on the negative effects of secondary traumatic stress on anxiety. Therapists who reported higher high levels of CS were found to be protected from the negative effects of secondary traumatic stress on anxiety (Samios et al., 2013).

It has been argued that therapists can be influenced by trauma clients in positive ways while experiencing personal growth (Hunter, 2012). Hunter (2012) explored the experiences of therapists and their therapeutic bond, finding that compassion satisfaction counterbalances with vicarious resilience. This brought forth the results of the reduced intensity of bearing witness to traumatic experiences and developing vicarious traumatization. Although great compassion satisfaction can result from working with trauma clients, including victims of sexual violence, posed risks are still very probable.

Therapists' Understandings of Working with Victims of Sexual Violence

Inside every individual is an innate knowledge that the time spent alive is limited and that death is a natural phenomenon (Boniello, 1990). The research field has discussed processes and

reactions that follow a loss. In research dated back to 1985, Jansen examined the differences between pathological and healthy grieving, suggesting an individual will vacillate between various stages of grief before a loss is finally resolved (Boniello, 1990). Early work has led to the emergence of three central factors that help therapists, professionals, and helpers understand the loss and grief that is experienced by their clients. These factors are: "1) there appears to be a cycle of resistance, exhaustion, acceptance, and renewal involved in a natural grieving process, 2) the intensity and time limit of one's grief is influenced by past experiences, the degree to which the loss affects one's daily life, one's personality and the support one receives from external sources when a loss is experienced, and 3) losses can remain unresolved for extended periods of time with dramatic consequences to one's ability to function effectively in future endeavors." (Boniello, 1990, p. 368).

Losses that occur due to sexual victimization are immeasurable to researchers (Boniello, 1990). Individuals who suffer from sexual abuse enter treatment at various stages of the grief process. Victims can experience rage or depression if they are conscious of their victimization or "will present a generalized picture of malaise due to the symptoms that have developed but will have no real insight into the source of their difficulties (Boniello, 1990, p.368). To assist victims of sexual violence with a loss, therapists must become a part of the therapeutic process in ways that may challenge their own belief systems and values. While treating highly traumatized people, therapist work can be challenging and demanding while requiring well-developed skills and psychological strength (Danylchuk, 2015). According to Danylchuk (2015), there is an ever-increasing amount of knowledge that is available to professionals pertaining to their trauma work; this includes the nature of trauma, the immediate and long-term impact on the person, and the endless number of elements that are put into successful trauma treatment. Because trauma

therapists are at great risk of developing negative consequences from trauma work, it becomes demanding for professionals to find effective ways to deal with the trauma and a deep satisfaction in their ability to help others (Danylchuk, 2015). According to Danylchuk (2015), qualities including tolerance for ambiguity, emotional intensity, and holding on to the reality that life includes both good and evil can help therapists remain in a healthy state of mind while treating trauma clients. However, therapists must also be willing to feel inadequate and have a willingness to learn about trauma, their client, and themselves (Danylchuk, 2015).

There is an ongoing journey endured by trauma therapists that consists of an ongoing goal of remaining conspicuous of one's own self-history, patterns, emotional triggers and reactions, and levels of comfort or discomfort with emotions (Danylchuk, 2015). Creating an understanding of the trauma client helps the therapists become fully aware of their situations. When a therapist is knowledgeable about oneself, it becomes possible for the therapist to feel a difference within their body and mind that comes as a result of forming a relationship with their client (Danylchuk, 2015). Once they begin to recognize their own selves, therapists become aware of their personal feelings, the emotions of the client, and whether their personal feelings are ones transmitted by the client or a combination of the two. The developed relationship between a therapist and a client plays an important role in successful treatment. During their work, therapists develop understanding of the impact of their clients' or victims' traumatic experiences, specifically sexual violence, and the connection between the experience and the victim's response (Westland & Shinebourne, 2009). These understandings can also include awareness of specific challenges the victim faces, including self-deception and social capital.

Self-Deception

Self-deception is used to describe the maladaptive attitudes and behaviors of clients or victims, including denial, evasion, contradiction, avoidance, withholding, and lack of self-understanding (Westland & Shinebourne, 2009). Previous literature discusses self-deception and how it can allow an individual to falsely believe pieces of information even though strong evidence is provided. Individuals can lead themselves to believe their spouses are not having affairs, their children are not using illicit drugs, and often, that they are not being abused (Westland & Shinebourne, 2009). On the contrary, twisted self-deception causes self-deceived individuals to believe in something they want to be false, such as a husband who believes his wife is having an affair, only based on his flimsy evidence and minor details, despite not wanting it to be true (Westland & Shinebourne, 2009). Furthermore, memories of sexual abuse are recovered during psychotherapy. According to Nachson (2001), it has been debated whether the recovered memories are undistorted representations or false beliefs. When an individual recognizes but does not acknowledge their abuse self-deception occurs. The mind can simultaneously hold two contradictory beliefs without being aware and determining which mental state or belief is subject to awareness. According to Nachson (2001), this selection is unconsciously driven by biasing information and reasoning, selective attention, development of unrealistic optimistic approaches, and denial of contradictory evidence. The presence of self-deception can be extremely challenging for therapists, making it difficult to understand the situation of the victim and find a proper approach to provide treatment.

Social Capital

Because sexual violence has been suggested to be linked to severe psychological sequelae, professional help is required for recovery; therefore, therapists must gain knowledge of

each situation to help gain understanding of the impact and how to treat its effects. According to Hall et al. (2014), women who fall victim to sexual violence have an increased risk of mental health problems. Mental health problems may include but are not limited to post-traumatic stress disorder (PTSD), depression, anxiety, and social maladjustment. Because sexual violence can lead to high numbers of physical and mental health sequelae, it has become required for healthcare professionals to know the risk factors of how to assist disclosure and respond safely (Stewart & Chandra, 2017). In a study that was conducted in the Democratic Republic of the Congo (DRC), it was found that nearly 40% of women experience sexual violence (Hall et al., 2014). However, these female victims encounter negative consequences following their attacks. According to Hall et al. (2014), communities within the DRC have existing dynamics of gender inequality and harmful gender attitudes; it is these dynamics that place blame on sexual violence survivors for the occurrence of the incident. Following their attacks, many female victims become rejected by their husbands and family, begin to experience poor standing within their communities, and become excluded from social and community life. In communities like those located within the DRC, interpersonal trauma rates may be high due to specific, systemic dynamics; therefore, it is in these locations where healing must involve social factors (Hall et al., 2014).

The ability of women to function socially within their communities can be affected by the negative reactions that are received. Women who develop mental health problems begin to experience social drift (Hall et al., 2014). It is the social drift that leads to decreased social resources. To understand a victim of sexual violence or any trauma victim, a therapist must gain insight into their client; this includes items like social structure. When aspects of a woman's social structure are overall affected, women then develop high levels of distress, causing the

development of other challenges, including distrust, shame, and loss of self-esteem (Hall et al., 2014). Because trauma therapists focus on the treatment and healing of their clients, it is vital to understand the social structure that surrounds their clients and the resources that are available to them. Social capital is a multidimensional concept that is useful when one is investigating attributes of the social environment that may positively contribute to mental health. (Hall et al., 2014, p.1680). Hall et al. (2014) state that individuals who endow great social capital are more likely to have better health and mental outcomes. These individuals who have greater social capital are also likely to have greater access to social support. However, it is usual for survivors of sexual violence to avoid people, places, and situations that remind them of their trauma (Hall et al., 2014). Previously, survivors have reported having unhelpful beliefs about trust, the dangerousness of individuals and the world, power, esteem, safety, and intimacy. The understanding of a situation and acknowledgment of difficulties can help increase social capital and allow clients to regain comfort in seeking different types of relationships.

The Navigation of Sexual Violence Therapy

Mahase, (2021) states, “The World Health Organization has said that physical and sexual violence against women should be treated as a public health problem” and called for healthcare workers to be trained in “responding to the needs of survivors holistically and empathetically.” (p. 1). In 2013, Sohal and James-Hanman discussed intimate partner and sexual violence against women and how the act is a major public health problem that requires a compassionate and effective response. In a study based on data from 70 countries, it was found that the key catalyst for action from the government was public support and media attention (Sohal & James-Hanman, 2013). Although characteristics within these 70 countries differed amongst one another, such as religions, levels of income, and political systems, results remained the same. It has also

been suggested by Sohal and James-Hanman (2013) that the best clinical guidance for female sexual violence survivors includes recommendations for using emergency contraceptives, post-exposure prophylaxis for HIV and sexually transmitted diseases, safe and legal abortions, and psychological interventions. Specific recommendations made by professionals may be available for specific victims of sexual violence; however, it can be possible for sexual health services to not be available for all (Sohal & James-Hanman, 2013). It is then that it becomes necessary for therapists to focus on the approach and structure of available treatment that is customized for each client based on their circumstances and their severity.

A therapist's navigation through treatment for victims of sexual violence widely varies by the circumstances of each victim and the traumatic event. A trauma therapist's focus on treatment and healing can be complex. Sensitive topics, much like the discussion of sexual violence, can be difficult to navigate because of the painful and emotional experiences that an individual has endured (Cornejo et al., 2019). However, just as the topic of sexual violence is difficult for the victim to discuss, therapists are challenged too.

Conversations of sensitive contents and meanings of the victims' experiences can affect a therapist and cause the reoccurrence of pain in a victim. Those who seek treatment and guidance following an incident of sexual violence or abuse often experience a lack of ownership to their sexuality (Almas & Benestad, 2017). It is likely that victims of sexual violence will experience general problems after trauma that cause effects on their sexuality. These problems may include (but are not limited to) loss of own personal history, reduced psychological functions (anxiety, depression, and self-mutilation), eating disorders, low self-esteem, powerlessness, negative memories, defense strategies, and loss of awareness of boundaries (Almas & Benestad, 2017). Because of the endless challenges that sexual violence survivors face following their assault, it is

vital for therapists to structure their treatment plans accordingly based on the client. Structure allows therapists to navigate through treatment with a survivor of sexual violence; it creates an agenda and guides to providing effective and successful methods to support and rebuild.

The organization of a treatment plan can be helpful when there is a better understanding of the victim; this includes a gathering of the individual's background history. It has been previously reported by professionals about the inadequate understanding of cultural features that create problems in effective service delivery (Gill & Harrison, 2013). Because just as there are differences in the experiences of abuse and assault of each woman, there are also differences in the influence of both their responses and the responses of their service providers (Gill & Harrison, 2019). Using an individual's background on their lifestyle can help to navigate discussions and find ways for the individuals to become comfortable and feel safe with their therapists. However, the background of individuals differs in various ways; this includes religions, cultures, and sexualities.

A challenge that has been experienced by therapists during their navigation of treatment is the concept of race and ethnicity. According to Gill & Harrison (2019), it is possible for black and minority ethnic women to suffer abuse from their partners and multiple family members. It is also likely that these women will experience "inappropriate professional responses from statutory and voluntary agencies, including a lack of coordination, failures in multi-agency co-operation, high levels of stereotyping and racism, and even a reluctance to engage for fear of appearing racist" (Gill & Harrison, 2013, p. 511). According to Gómez (2014), there is an increased risk for sexual violence on college campuses for not only women but for all ethnic minorities. On college campuses, sexual violence disproportionately affects those with lower societal status due to oppression, including racism and sexism. Much like Gill & Harrison

(2019), Gómez (2014) also suggests that cultural differences can affect the likelihood of sexual violence occurring. Sexual violence survivors endure great trauma and need the perfect guidance and assistance from the correct licensed professional. A therapist can help to discuss the challenges and consequences that derive. During therapy sessions, it is when therapists will decide on a structural base for treatment and how each survivor should be approached and treated. Gill & Harrison, (2019), Gómez (2014) discusses the heightened risks of the occurrence of sexual violence occurring amongst ethnic and racial minorities. The different circumstances of each sexual violence victim will determine how therapists will choose to navigate through treatment plans.

Chapter Summary

The literature is undoubtedly extensively related to therapists and their circumstances with trauma victims. Therapists who provide services to victims of sexual violence undergo a considerable number of experiences that develop their understandings and transform their navigations of treatment. Alongside the ongoing practice of therapists consists of a continuing goal of remaining conscientious of one's own self-history, patterns, emotional triggers and reactions, and levels of comfort or discomfort with emotions that creates a therapist's understanding (Danylchuk, 2015). These understandings help therapists navigate through building and customizing appropriate treatment plans and programs for victims, as well as allowing therapists to receive the necessary information to help get through the given therapy. It is, without a doubt, that the COVID-19 pandemic transformed healthcare for both therapists and patients. However, the need for research examining the experiences, understandings, and navigations of therapists working with female victims of sexual violence, who have been socially isolated during the COVID-19 pandemic, comes from the fact that the pandemic was still

ongoing up until 2023. The pandemic has brought the rarest of circumstances for research to be attained to assess therapists and their work with victims of sexual violence. Traditionally, therapists have been found to use methods of psychotherapy to treat patients, including psychodynamic psychotherapy, trauma-focused cognitive–behavioral therapy (TF-CBT), and eye movement desensitization and reprocessing therapy (EMDR) (Cowan et al., 2020). However, it is likely that a change may have occurred during the COVID-19 pandemic. Undoubtedly, the experiences of therapists have been found to be either positive or negative (Wheeler & McElvaney, 2017). Scholars (Helpingstine et al., 2021; Kadami et al., 2004; Moulden & Firestone, 2007; and Way et al., 2004) suggest that professionals are more likely to be at a higher risk for negative effects such as vicarious trauma, secondary traumatic stress, and burnout rather than positive effects like compassion satisfaction. Nonetheless, the research is clear that the work of therapists is a great deal of time consumption when it consists of victims of sexual violence. However, alongside a global pandemic, the work of therapists may just be a little more complex.

CHAPTER THREE: METHODS

Overview

As previously mentioned, the purpose of this qualitative descriptive study is to examine therapists who work with victims of sexual violence and their descriptions of their experiences and navigations while working with female victims of sexual violence who were socially isolated during the COVID-19 pandemic in the state of Texas. This chapter will examine the methods portion of this qualitative descriptive study. The chapter will adequately describe and justify the research design while defending relationships between the problem, research questions, designs, and methods. Also included will is a population narrative and selection measures for the sample and participants. This will allow a demonstration of how the data processing and analysis procedures are appropriate considering the study's design and research questions.

Research Method and Design

Lambert and Lambert (2012) describe the goal of qualitative descriptive studies as to comprehensively summarize, in everyday terms, specific events experienced by individuals or groups of individuals. The decision to use a qualitative descriptive approach comes from the fact that the current study seeks to find a straightforward description of an occurrence. The goal of this study is to examine how therapists who work with victims of sexual violence describe their work with isolated female victims of sexual violence during the COVID-19 pandemic and how they navigated throughout. Because the current study is non-experimental, the interview will administer interviews with twenty therapists located in two major cities of Texas, San Antonio, and Dallas. The researcher will seek to find an explanation with no pre-selection of study variables and no manipulation of variables.

This study will address two objectives: The first objective will be to provide an explanation of how therapists who work with victims of sexual violence describe their work with socially isolated female victims of sexual violence during the pandemic. This will include the experiences and understandings they have gained from their work. The second objective is to provide an explanation of how therapists who work with victims of sexual violence navigate through their work with socially isolated female victims of sexual violence during the pandemic. The navigation of therapists who work with victims of sexual violence may include boundaries used to improve work-life balance and avoid burnout, arrangement of workday schedule, and methods used to practice self-care. Sexual violence is a topic of sensitivity, and therapists that actively engage in this area are more prone to negative effects such as vicarious trauma, secondary traumatic stress, and burnout (Helpingstine et al., 2021; Kadami et al., 2004; Moulden & Firestone, 2007; Way et al., 2004).

Research Questions

In formulating this study, the following research questions guide the work:

RQ1: How do therapists who work with victims of sexual violence describe their experiences during the global COVID-19 pandemic?

RQ2: How do therapists who work with victims of sexual violence navigate through working during the global COVID-19 pandemic?

Population and Sample Selection

As of 2019, there have been 4,775 active licensed therapists practicing in the state of Texas (Texas Department of State Health Services, 2019). Over the past 10 years, this number has increased by 9.1%; however, more specifically, since 2014 there has been an increase in therapists by 12.6% and a reported 29.2% increase since 2009 (Texas Department of State Health

Services, 2019). The participants (therapists who work with sexual abuse victims) are to be practicing only in the state of Texas at the time of the study. The administration of interviews will be carried out via the Zoom platform. The interviews will be conducted in a location of participants' choosing, out of the range of hearing from others due to topic sensitivity.

A sample frame of sixty potential therapists who work with victims of sexual violence will be purposely chosen throughout the San Antonio and Dallas regions. The researcher will identify therapists who work with victims of sexual violence within the regions and attempt to recruit potential participants via e-mail. Each potential individual will be sent an invitation to participate (see Appendix A). From these potential participants, a total of twenty Texas therapists who work with victims of sexual violence from San Antonio and Dallas will be selected using nonprobability sampling. The researcher will draw a purposive sample, selecting participants from a sampling frame that is designed to contain the characteristics desired. These requirements are that they: must be licensed, must practice in either San Antonio or Dallas, must specialize in sexual abuse and trauma therapy, must have remained employed during the Covid-19 Pandemic (2020-2022), must have worked with sexual violence victims, and must have offered online therapy sessions to victims. Each participant that agrees to participate in the study will be screened to determine if they are qualified for the study (see Appendix C).

Data Collection Procedure and Management

Prior to obtaining data, the researcher will complete the University's Institutional Review Board (IRB) application process. Once IRB approval has been granted, the researcher will begin to draw a purposive sample. The key form of recruitment will be done by contacting organizations located in San Antonio and Dallas that offer support for sexual violence to their clients. An additional form of recruitment will be the use of snowball sampling; a therapist will

be asked for recommendations or knowledge of other therapists who specialize in sexual trauma. The selection of participants must contain the characteristics desired. These characteristics include must be licensed; must practice in either San Antonio or Dallas; must specialize in sexual abuse and trauma therapy; must have remained employed during the Covid-19 Pandemic (2020-2022); must have worked with sexual violence victims; and must have offered online therapy sessions to victims.

The time frame to complete the individual, semi-structured interviews will be approximately 45 to 60 minutes. The first few minutes will be used to describe the purpose of the study, the rights of the participant and to answer any questions. The remaining time will be used to collect the interviews from the participants. The raw data obtained from the seven open-ended and semi-structured in-depth interview questions will guide this study. These questions will be centered on the research questions of how therapists who work with victims of sexual violence describe their work, with socially isolated female victims of sexual violence, during an ongoing global pandemic and how they navigated through their work. The decision to use open-ended, semi-structured and in-depth questions allows the responses from the therapists to have a broad range and provides an opportunity for these professionals to discuss and describe the undertakings of their work with these specific victims.

All interviews will be audio-recorded and are estimated to last approximately 45 minutes to one hour. Due to topic sensitivity, the researcher is aware that some interview questions may be sensitive and challenging for participants to discuss. It is also important for the researcher to remember to protect the participants' well-being during the interviews. The researcher will allow the participants to take breaks as needed, decline to answer any questions, and have the right to withdraw from the study. It important to note that participants will be given adequate time to

answer each question and contribute as much information as possible. At the conclusion of the interview, the researcher will ask the participants if there is any additional information, they may feel can contribute to the study that was not discussed during the interview.

Trustworthiness

The trustworthiness of qualitative content analysis is presented through credibility, dependability, conformability, and transferability (Elo et al., 2014). For the current study, trustworthiness will be achieved through feedback and recommendations provided by the committee chair member. With the guidance and assistance of the committee chair, this study will allow trustworthiness to be present, improving the quality and validity of the study.

Credibility

Credibility is defined as confidence in the truth of the findings (Elo et al., 2014). The researcher will achieve credibility using member checking and thick description. Member checking occurs when the data or results obtained from the study are returned to the participants to check for accuracy and resonance with their experiences (Birt et al., 2016). The researcher will send a copy of the data to each participant so they can review the document to ensure participants are given the opportunity to review what they discussed during the interview. Although this is a simple technique, it can be difficult to accomplish if some participants do not respond to an e-mail with their transcript (Birt et al., 2016). The second method is thick description. Thick description is the process of paying attention to contextual detail in observing and interpreting social meaning when conducting qualitative research (Drew, 2019). According to Drew (2019), thick description involves more than recording and describing. The researcher must also obtain background information that is necessary for understanding the relevance, meanings, and intention of the information that is obtained during the research.

Dependability

Dependability refers to the stability of data over time and under different circumstances (Elo et al., 2014). The researcher will achieve dependability using member checking, sampling sufficiency, and peer debriefing. Like credibility, using member checking, the researcher will provide a review of the transcript obtained from each interview conducted. The second method is sampling sufficiency. Sample sufficiency is known as the minimum number of participants required to identify a statistically significant difference if a difference truly exists (Cope, 2014). The current study's target sample is 60 therapists who work with victims of sexual violence within the San Antonio and Dallas regions. Within the sample, the researcher will select 20 participants (10 from each city) that fit the study's criteria. Although the sample size of 10 per city may seem relevantly small, the participants will be representing only those therapists who specialize in sexual violence and who continued to provide services during the COVID-19 pandemic.

The third method that will be used is peer debriefing. Peer debriefing is the process of working with peers who have no personal interest in a project but will assist in providing feedback and will review and assess transcripts, methodology, and findings (Cope, 2014). The researcher will seek assistance from external experts who will provide a thorough review of the themes and findings of the current study.

The first peer, or external expert, has received a Ph.D. in Criminology and Criminal Justice at Texas State University, a M.S. in Criminal Justice at the University of the Texas at San Antonio, and a B.S. the University of the Texas at San Antonio. Peer debriefer 1 currently serves as a Vice Principal for Dallas ISD. His research interests include process and outcome

evaluations, and correlates of prosecutorial and judicial decision making. He will be serving as a professor at the University of Texas at Dallas beginning in the Fall of 2024.

The second peer, or external expert, received her bachelor's and master's degrees from Stephen F. Austin State University. She earned her doctoral degree from the University of Texas at San Antonio. Her research focus is on the training and induction of school counselors.

The third peer, or external expert, is an assistant professor of counseling in the Department of Counseling at the University of Texas at San Antonio. She graduated with a Ph.D. in Counselor Education and Supervision from Ohio University, Athens, Ohio. The overarching focus of her research is to augment counselor competence in the promotion of mental health and well-being by leveraging a strengths-based positive psychological lens, spanning three interrelated research pathways: (a) group interventions, (b) training programs and leadership development, and (c) creative and innovative practices.

Confirmability

For the researcher to achieve conformability, the researcher must demonstrate that the study's results are clearly linked to the conclusions and can be followed and replicated (Moon et al., 2016). Coding will be used to achieve confirmability. Based on the feedback given by all participants, codes will be established. These codes will be based on patterns that are found during the open-ended interviews. The researcher will use inductive coding, which is a ground-up approach that allows the narrative to emerge from the raw data (Cope, 2014). The researcher will start with the raw data, then group into emerging themes found within, then develop codes based on the data and the themes. Once codes have been established and formed, they will be listed in a table that will be provided in the appendix of the current study.

The researcher's role in the current study is to retrieve information from each participant regarding their thoughts, feelings, and experiences. The present topic focuses on sexual violence against women. As a researcher, it is vital to acknowledge any personal beliefs or assumptions that may possibly influence the research process (Cope, 2014). The researcher is a young woman who may not have had a prior history of sexual violence but may know of family or friends who have. It is vital for the research to remove her personal beliefs toward the operation of therapy services for sexual violence victims. This includes whether the researcher believes online sessions are beneficial or unmanageable. The researcher will not make assumptions but instead will ask participants for clarification if a response appears vague or deceiving (Cope, 2014). Also, because participants (therapists) may have a difficult time discussing their experiences and navigation with sexual violence victims, the researcher will need to ensure the protection of their information and identity.

Transferability

Transferability is considered a type of external validity (Moon et al., 2016). It refers to the degree to which the findings described in the study are applicable or useful to theory, practice, and future research (Moon et al., 2016). To achieve transferability, the researcher will also use sampling sufficiency and thick description. The current study will assess a total of twenty therapists who work with victims of sexual violence in hopes the sample size will produce thorough and meaningful findings while minimizing the unnecessary burden on participants and expenditure of resources (Young & Casey, 2018). A sample size of twenty may provide insight to a new and current matter that has yet to be explored. In addition, a thick description of the background data will allow readers to understand and compare the operations of therapists with the impact of the pandemic (Dell, 2019).

Data Analysis Procedures

To analyze the data of the current study, the researcher will use a six-step thematic analysis. The decision to perform a thematic analysis derives from the fact that the researcher will focus on concepts, experiences, and opinions found during the research process (Scharp & Sanders, 2019). Once all data has been collected through interviews via Zoom, the researcher will extract meaning from the data using the six steps. The overall goal is to provide an explanation of the work of the therapists and their navigation processes, and to do so, the researcher must identify common themes and patterns across the data set (Scharp & Sanders, 2019).

Step 1: Familiarizing: To begin, the researcher will familiarize oneself with the data, taking a look at it as a whole. The researcher will transcribe the audio-recorded interviews, looking for any patterns or common themes within. The researcher will conduct the transcription of interviews through an online software application that will be later identified. It is vital for the researcher to continuously revisit the first stage of the process to develop a thorough grasp of all the data (Scharp & Sanders, 2019).

Step 2: Generating initial codes: Once common patterns have been found, the researcher will develop codes for the data. The codes will be based on the feedback given by each participant and their experiences and navigation with sexual violence clients. It is vital for the researcher to complete multiple rounds of analysis to allow for the opportunity to generate new codes each time (Scharp & Sanders, 2019). The researcher must be thorough and exhaustive during this stage.

Step 3: Generating themes: Once the researcher has generated codes from the transcriptions, she will thoroughly examine the codes to identify code patterns that will be used to generate

themes. Themes allow the researcher to bundle codes together as one (Scharp & Sanders, 2019). During this stage, the researcher may eliminate codes if they appear to be too broad.

Step 4: Reviewing themes: Once the researcher has generated themes based on the developed codes, she will begin a review. This review will ensure that all themes generated are accurate and relevant to the data it should represent (Scharp & Sanders, 2019).

Step 5: Defining and naming themes: The researcher will next apply a straightforward name to each theme. This will allow the reader to make sense of the data (Scharp & Sanders, 2019).

Step 6: Creating the report: Finally, to wrap up the analysis, the researcher will type out all findings onto a word document (Scharp & Sanders, 2019). The findings will all be included in chapter 4 of the current study. Tables will be created to explain coding and will be put into the appendix of the study. The researcher will also summarize all findings in the conclusion section of the paper. All biases and opinions of the researcher will be avoided and excluded.

Back Up Plan

To reach the targeted sample for this research, the researcher will reach out to local organizations throughout the San Antonio and Dallas areas that provide counseling for sexual violence. The researcher will identify therapists from various organizations who work with victims of sexual violence within the regions and attempt to recruit potential participants via e-mail. Before IRB permission is obtained, the researcher will reach out to selected organizations to obtain written permission for future participation in the current study. Should the researcher find it difficult to obtain permission from the organizations, the researcher will reach out to different therapists by obtaining their names and telephone numbers using the Google search engine. These possible participants will be contacted individually and not as part of their organizations.

Ethical Considerations

It is ethically challenging to conduct research on human subjects (Bracken-Rochse et al., 2017). Because society allows researchers to invite individuals to participate and engage in research, it is required for researchers to meet certain conditions, including the permission of a research ethics board, also known as an Institutional Review Board (IRB). The IRB determines whether the risk and benefits are balanced, whether there is fair recruitment, and whether voluntary, informed consent is sought (Bracken-Rochse et al., 2017). The three fundamental ethical principles of the Belmont Report will drive the current study, these principles being (1) respect for persons, (2) beneficence, and (3) justice (Bracken-Rochse et al., 2017).

Per the United States Belmont Report of 1979, the concept of vulnerability plays a central role in research ethics (Bracken-Rochse et al., 2017). Therapists who work with victims of sexual violence are exposed to an extremely vulnerable population. Those who are considered vulnerable are individuals who have the questionable capacity to consent. Victims of sexual violence are susceptible, along with the information given to their therapists. Because the discussion of sexual violence holds a great amount of sensitivity, the researcher must ensure their study does not provide disrespect, change, or harm to the participants (therapists) throughout the administration of the survey questions. It is important for the therapists to remain in the same state as they were when the interview began.

To begin, the researcher will ensure informed consent is given by each participant (see Appendix B). Because participant interviews will be taken via Zoom, each participant will be informed of their rights of participate in a document via email which will be read prior to surveying. The informed consent process will include adequate information about the study, an opportunity for the participant to consider their options of participation, and the obtainment of

the participant's voluntary agreement, while ensuring the participant understands the purpose and goal of the study. Other information included in the document will be why the participant was selected, the expected duration of the survey, that participant withdrawal may occur at any time with no penalty, and an invitation for the participant to ask questions. However, the researcher will inform each participant withdrawal cannot occur once interviews have been transcribed and pseudonyms have been created. Each participant will be asked twice via Zoom if they agree to participate in the study: once at the beginning of the process and again before administering the survey questions. They will also be informed of their right to withdraw from the study at any time. The researcher will also seek to ensure that the participants' confidentiality will be protected. Their identity will not be released as their names will be replaced with pseudonyms. All data collected throughout the current study will be secured and protected on a password lock laptop. This raw data will only be accessible by the researcher and the researcher's committee chair member. Because the researcher intends to obtain permission to audio record all participant interviews, all audio recordings, and transcripts will also be kept on a password lock computer, which only the researcher will have access to. Lastly, any biases or opinions of the researcher will be excluded from the research. All information received will be thoroughly analyzed by the researcher and will be kept for 7 years on a password secured laptop.

Chapter Summary

The purpose of this qualitative descriptive study is to gain more insight into how therapists who work with victims of sexual violence describe their work and navigation processes with socially isolated female victims of sexual violence during the global COVID-19 pandemic. Chapter three discusses the methodology that will be used to conduct the proposed

research study. The proposed research design will consist of a purposive sample of therapists who specialize in trauma and sexual violence therapy. The selection of participants will be based on a required set of characteristics. The researcher will collect data using open-ended and semi-structured interviews via a Zoom platform to study and assess the proposed research questions. The gathered data will be coded and analyzed based on common themes and patterns found in the therapists' answers. The researcher will present and ensure trustworthiness throughout the research process. Any biases or opinions of the researcher will be excluded. In the following chapter, the researcher will present the results of the data collection process.

CHAPTER FOUR: RESULTS

Overview

The purpose of this qualitative study was to examine therapists and their descriptions of work experiences and navigation during the COVID-19 pandemic in the state of Texas. Data was collected via semi-structured interviews with 20 therapists who work with victims of sexual violence. The researcher's back up plan, as noted in Chapter 3, was used to obtain participants. To begin, the researcher reached out to local organizations throughout the San Antonio and Dallas areas that provide counseling for sexual violence. The researcher found it difficult to gain permission from local organizations to recruit potential participants; therefore, the researcher obtained contact information for local therapists using the Google search engine, then applied the use of snowball sampling.

To be eligible for the study, participants must be licensed, must practice in either San Antonio or Dallas, must specialize in sexual abuse and trauma therapy, must have remained employed during the Covid-19 Pandemic (2020-2022), must have worked with sexual violence victims, and must have offered online therapy sessions to victims. A total of 113 emails were sent to potential therapists who work with victims of sexual violence. The researcher was able to obtain permission from 3 therapists, who fit the study's criteria. Because of the low response rate, the researcher asked each participant for recommendations or knowledge of other therapists who specialize in sexual trauma. This resulted in a total of 20 participants used for this study. It is important to note all 20 therapists included in this study originally provided therapy face-to-face; due to disruptions delivered by COVID-19, these therapists began to provide alternative options in services by implementing virtual treatment to both existing and new clients. Interview data was transcribed and analyzed using a sex-step thematic analysis. The decision to perform a

thematic analysis derives from the fact that the researcher focused on concepts, experiences, and opinions found during the research process (Scharp & Sanders, 2019). The analyzed data was initially coded using common patterns and themes; once established, the researcher thoroughly examined all codes to ensure trustworthiness. These codes and themes have been charted and further discussed in this chapter.

Participants

The following section briefly describes each of the twenty participants interviewed for the current study. Each participant was assigned a "P" then included with a number; for example, P4 was used for participant #4. All details that were given to the researcher that may have disclosed the individual's identity has been changed to ensure the privacy and confidentiality of each participant. The data that has been collected was to be only in relevance to the researcher's requested specific time frame for the current study, March 2020 to March 2022. This was an important indicator as the goal of the current was to analyze the descriptions of the therapists' experiences and navigations while working with female victims of sexual violence who were socially isolated specifically during the COVID-19 pandemic. There were no incidents of participant dropouts reported.

The following table, Table 1, presents participant overview for the current study. Within the table, participant demographics are presented including geographical location, age, race, gender, education level and work location of each participant.

Table 1

Participation Overview

Participant	Location	Age	Race	Gender	Education Level	Treatment Settings
P1	San Antonio	47	Hispanic	F	H.S/B.S./M.S./Ph.D	Private
P2	Dallas	45	White	F	H.S/B.A./M.S	Private
P3	Dallas	46	White	F	H.S/B.S./M.S.	Private
P4	San Antonio	34	White	F	H.S/B.A./M.S./Ph.D	Private
P5	San Antonio	44	White	F	H.S/B.A/M.S.	Public Organization
P6	San Antonio	33	White	M	H.S/B.A./M.S./Ph.D	School/Public Organization
P7	San Antonio	36	Hispanic	F	H.S/B.A/M.S.	Private
P8	Dallas	35	White	F	H.S/B.A/M.S.	Private
P9	Dallas	33	White	F	H.S/B.A/M.S.	Public Organization
P10	Dallas	37	Black	M	H.S/B.A/M.S.	School/Public Organization
P11	San Antonio	34	White	F	H.S/B.A./M.S./Ph.D	Private
P12	Dallas	36	White	F	H.S/B.A/M.S.	Hospital/Public Organization
P13	San Antonio	48	Hispanic	F	H.S/B.A/M.S.	School/Public Organization
P14	Dallas	34	White	M	H.S/B.S./M.S.	Private
P15	Dallas	38	White	F	H.S/B.S./M.S.	Private
P16	San Antonio	41	Hispanic	F	H.S/B.S./M.A.	Private
P17	San Antonio	37	White	M	H.S/B.S./M.S./Ph.D	Private
P18	Dallas	32	Hispanic	F	H.S/B.A/M.A/M.S.	School/Public Organization
P19	San Antonio	47	Hispanic	F	H.S/B.A./M.A.	School/Public Organization
P20	Dallas	36	White	F	H.S/B.A./M.S.	Private

Participant Description

Participant 1 (P1)

P1 identifies as a 47-year-old Hispanic female. P1 holds a high school diploma, Bachelor of Science in Psychology, Master of Science in Psychology and a Doctorate in Psychology. She privately treats patients in San Antonio.

Participant 2 (P2)

P2 identifies as a 45-year-old White female. P2 holds a high school diploma, Bachelor of Arts in Social Work and a Master of Science in Social Work. She privately treats patients in Dallas, Texas.

Participant 3 (P3)

P3 identifies as 46-year-old White female. P3 holds a high school diploma, Bachelor of Science in Psychology and a Master of Science in Psychology. She privately treats patients in Dallas, Texas.

Participant 4 (P4)

P4 identifies as a 34-year-old White female. P4 holds a high school diploma, Bachelor of Arts in Social Work, Master of Science in Social Work, and a Doctorate in Social Work. She privately treats patients in San Antonio, Texas.

Participant 5 (P5)

P5 identifies as a 44-years-old White female. P5 holds a high school diploma, Bachelor of Arts in Social Work, Bachelor of Arts in Psychology, and a Master of Science in Social Work. She treats patients at a family counseling center located in San Antonio, Texas.

Participant 6 (P6)

P6 identifies as a 33-year-old White male. P6 holds a high school diploma, Bachelor of Arts in Sociology, Master of Science in Sociology, and a Doctorate in Sociology. He treats patients at a local high school and family counseling center both located in San Antonio, Texas.

Participant 7 (P7)

P7 identifies as a 36-year-old Hispanic female. P7 holds a high school diploma, Bachelor of Arts in Marriage and Family, Bachelor of Arts in Social Work, and a Master of Science in Social Work. She privately treats patients in San Antonio, Texas.

Participant 8 (P8)

P8 identifies as a 35-year-old White female. P8 holds a high school diploma, Bachelor of Arts in Sociology, and Master of Science in Sociology. She privately treats patients in Dallas, Texas.

Participant 9 (P9)

P9 identifies as a 33-year-old White female. P9 holds a high school diploma, Bachelor of Arts in Marriage and Family, and a Master of Science in Marriage and Family. She treats patients at a local women's shelter located in Dallas, Texas.

Participant 10 (P10)

P10 identifies as a 37-year-old Black male. P10 holds a high school diploma, Bachelor of Science in Psychology, and a Master of Science in Psychology. He treats patients at two local high schools, both located in Dallas, Texas.

Participant 11 (P11)

P11 identifies as a 34-year-old White female. P11 holds a high school diploma, Bachelor of Arts in Social Work, Master of Science in Social Work and a Doctorate in Social Work. She privately treats patients in San Antonio, Texas.

Participant 12 (P12)

P12 identifies as a 36-year-old White female. P12 holds a high school diploma, Bachelor of Arts in Marriage and Family, and a Master of Science in Marriage and Family. She treats patients at a major hospital in Dallas, Texas, as well as a local women's shelter also located in Dallas, Texas.

Participant 13 (P13)

P13 identifies as a 48-year-old Hispanic female. P13 holds a high school diploma, Bachelor of Arts in Sociology, and a Master of Science in Sociology. She treats patients at a local high school and a family counseling center, both located in San Antonio, Texas.

Participant 14 (P14)

P14 identifies as a 34-year-old White male. P14 holds a high school diploma, Bachelor of Science in Psychology, Master of Science in Psychology, and a Doctorate in Psychology. He privately treats patients in Dallas, Texas.

Participant 15 (P15)

P15 identifies as a 38-year-old White female. P15 holds a high school diploma, Bachelor of Science in Psychology, and a Master of Science in Clinical Mental Health Counseling. She privately treats patients in Dallas, Texas.

Participant 16 (P16)

P16 identifies as a 41-year-old Hispanic female. P16 holds a high school diploma, Bachelor of Science in Human Services and a Master of Arts in Human Services Counseling. She privately treats patients in Dallas, Texas.

Participant 17 (P17)

P17 identifies as a 37-year-old White male. P17 holds a high school diploma, Bachelor of Science in Psychology, Master of Science in Psychology, and a Doctorate in Psychology. He privately treats patients in San Antonio, Texas.

Participant 18 (P18)

P18 identifies as a 32-year-old Hispanic female. P18 holds a high school diploma, Bachelor of Arts in Social Work, Bachelor of Arts in Marriage and Family and a Master of Science in Social Work. She treats patients at a local university in Dallas, Texas.

Participant 19 (P19)

P19 identifies as a 47-year-old Hispanic female. P19 holds a high school diploma, Bachelor of Arts in Social Work and a Master of Education in School Counseling. She treats patients at a local high school and community college in San Antonio, Texas.

Participant 20 (P20)

P20 identifies as a 36-year-old White female. P20 holds a high school diploma, Bachelor of Arts in Criminal Justice, Bachelor of Arts in Social Work, and a Master of Science in Social Work. She privately treats patients in Dallas, Texas.

Narrative Summary

For the current study, 50% of the interviewed therapists were located in San Antonio, Texas and the other 50% were located in Dallas, Texas. Only 20% of the interviewed therapists

were male while the other 80% were female. The ages of the participants ranged from 32 to 48 with 38 being the average. 65% of the participants were White, 30% were Hispanic/Latino, and 5% were Black. 25% of the participants hold a PhD as their highest level of education while the other 75% hold a master's as their highest. 60% of the participants worked for private companies and the other 40% worked for the public including shelters, high schools, universities and hospitals.

Interview Lengths

The following table provides a detailed look at each session for interviews. For each corresponding participant, the date of when the interview took place is presented. Also included is the duration of each interview. The first ten participants are displayed below and the remaining ten are displayed on page 78. The average length of an interview was 52 minutes and 30 seconds.

Table 2

Interview Lengths

Participant	Date	Time
P1	8/23/23	47 min. 52 sec.
P2	9/6/23	55 min. 23 sec.
P3	9/20/23	52 min. 33 sec.
P4	10/9/23	45 min. 43 sec.
P5	10/27/23	50 min. 2 sec.
P6	11/3/23	55 min. 14 sec.
P7	11/15/23	58 min. 10 sec.
P8	11/28/23	49 min. 55 sec.
P9	12/11/23	54 min. 3 sec.
P10	1/5/24	52 min. 16 sec.

Participant	Date	Time
P11	1/10/24	47 min. 29 sec.
P12	1/16/24	50 min. 35 sec.
P13	1/17/24	49 min. 1 sec.
P14	1/26/24	62 min. 34 sec.
P15	2/1/24	56 min. 40 sec.
P16	2/9/24	53 min. 22 sec.
P17	2/13/24	60 min. 20 sec.
P18	2/15/24	51 min. 9 sec.
P19	2/19/24	48 min. 33 sec.
P20	2/22/24	44 min. 57 sec.

Data Analysis

Transcribing

All interviews were conducted via Zoom. Using a digital voice recorder, that was purchased from Amazon, the researcher voice recorded each interview. Each interview was transcribed using a transcription tool, Notta. Immediately following transcription, the transcripts were printed, and the researcher begun the six-step thematic analysis.

Thematic Analysis

To analyze the data of the current study, the researcher used a six-step thematic analysis. The decision to perform a thematic analysis came from the fact that the researcher focused on concepts, experiences, and opinions found during the research process. Once all data was collected through interviews via Zoom, the researcher extracted meaning from the data using six steps. The overall goal was to provide an explanation of the work of the therapists and their

navigation processes; therefore, the researcher identified common themes and patterns across the data set.

Step 1: Familiarizing: To begin, the researcher familiarized herself with the data, looking at it as a whole. The researcher transcribed all audio-recorded interviews using Notta, printed and broke down each interview looking for patterns. Each transcript was revisited approximately 3-4 times allowing the researcher to develop a thorough grasp of all the data. Due to the length of time between each interview, the researcher was able to thoroughly analyze each transcript.

Step 2: Generating Initial Codes: After reading through each transcript multiple time, common patterns were founded by the researcher. Common patterns founded included the frequent discussion of stress and the discussion of feeling overstimulated made by a mass majority of participants. Other patterns included the frequent presence of anxiety and exhaustion discussed by participants. The researcher developed codes from these patterns using an inductive approach. These codes were based solely on the feedback given by each participant and their experiences and work navigation. Similar patterns were grouped together to form a code. For example, statements made about feeling overwhelmed and overworked, were grouped into the code overstimulation. It was vital for the researcher to complete multiple rounds of this analysis to allow for the opportunity to generate new codes each time. The researcher was thorough and exhaustive during this stage.

Step 3: Generating themes: Once the researcher generated codes from the transcriptions, she thoroughly examined the codes to identify patterns in the codes to generate themes. The use of themes identified allowed the researcher to bundle codes together as one. As the researcher developed codes and grouped similar ones together, she found two main themes that emerged.

Step 4: Reviewing themes: Once the researcher generated the two themes based on the developed codes, she began the review. This review ensured that all themes generated were accurate and relevant to the data it represents. Within the review, the researcher identified a total of 8 associated categories to be factors of the two themes. These categories were found to be sources that could best define the two themes.

Step 5: Defining and naming themes: The researcher then applied a straightforward name to each theme: *strain* and *effective problem-resolution solving*.

Step 6: Creating the report: Finally, to wrap up the analysis, the researcher typed out all findings onto a word document. The findings will all be thoroughly discussed in this next section of this chapter. Tables were created to explain coding and are also found in the appendix of this study. All biases and opinions of the researcher were avoided and excluded.

Results

Of the current study, all themes were developed through an in-depth investigation of data and further organized based on the related research questions. These common themes are outlined in corresponding tables. Participants' experiences and descriptions are found throughout the thematic detail to provide better clarification of the subject matter. It is important to note all 20 therapists included in this study originally provided therapy face-to-face; due to disruptions delivered by COVID-19, these therapists began to provide alternative options in services by implementing virtual treatment to both existing and new clients.

Table 4 provides a look at the two themes *strain,* and *effective problem-resolution solving* that were generated using the codes found within the data. Four categories appeared to be the sources of most *strain*: overstimulation, constant adjustment, discomfort, and demanding. Four categories appeared to be associated with *effective problem-resolution solving* regarding the

navigation of their processes. These themes and their emerging categories will be discussed based on their relevance to each research question for the current study in this chapter.

Table 4

Central Themes and Sub Themes

RQ1: Strain	RQ2: Effective Problem-Resolution Solving
1) Overstimulation	1) Routines
2) Constant Adjustment	2) Specific Conflict Resolution
3) Discomfort	3) Goal Setting
4) Demand	

Research Question One *(How do therapists who provide services to socially isolated, female victims of sexual violence describe their work experiences during the global COVID-19 pandemic?)*

Between the years of 2020 and 2023, COVID-19 had a destructive impact on people's lives and healthcare services (Abdulkareem et al., 2022). The rapid spread of the pandemic imposed high pressure on society, impacting work-related processes and placing strain upon all personnel (Abdulkareem et al., 2022). When taking into considerations the pressures from the pandemic, it can be assumed that individuals will experience higher levels of strain when restrictions are in order, affecting different processes including those at work. Changes that occurred during the pandemic, resulted in the establishment of modifications in models of care. Strain is most likely to increase when there is a presence of disruption or changes in services. Participants in the current study were asked to describe their work experiences when providing

treatment virtually to socially isolated female victims of sexual violence during the COVID-19 pandemic. One main theme, *strain*, and four sub themes emerged from the data collection process. In regard to RQ1, participants described their experiences with online treatment to be heavy in strain.

The following table (Table 5) provides shows the first central theme *strain* to develop from the data analysis. The table displays the corresponding research question for the central theme and its related sub themes.

Table 5

Research Question One: Common Theme and Associated Categories

RQ1: How do therapists who provide services to socially isolated, female victims of sexual abuse describe their work experiences during the global COVID-19 pandemic?
Central Theme: Strain
1) Overstimulation
2) Constant Adjustment
3) Discomfort
4) Demand

Central Theme: Strain

Each therapist that was interviewed expressed feelings of immense stress and the feeling of being under pressure while providing online services during the COVID-19 pandemic. Participant 16 (P16) stated, "…there was always something that needed to be done or changed…keeping up was challenging.". Participants were asked a series of open-ended questions pertaining to the description of their work experience. Participant 15 (P15) said, "…providing services to any particular sexual assault victim is greatly challenging regardless of

the circumstances of anything…specifically during the pandemic, the pressure intensified causing this sense of panic and high levels of stress".

Work-related stress can occur when work demands and pressures do not correspond to the individual's knowledge and abilities, that in turn challenge their ability to cope. It can occur in a wide range of work circumstances but mostly occurs when individuals feel as if they have little control over work processes. More broadly, stress in the workplace may be the result of exposure to a range of work stressors and appears to arise when people attempt to manage their responsibilities, tasks or other forms of pressure related to their jobs, and encounter difficulty, strain, anxiety or worry in this attempt (Bhui et al., 2016). Work stressors can take different forms depending on the characteristics of the workplace and may be unique to an organization. In relevance to the current study, job strain is one of the most commons forms of stress. Regarding RQ1, participants described their work experiences to be heavy in strain. Overall, strain was found to be associated with four other categories (*overstimulation*, *constant adjustment*, *discomfort* and *demand*) thus suggesting these four to be considered the main sources.

Overstimulation. Overstimulation is best described as when an individual's senses are completely overloaded with information making it difficult to fully process the information they are receiving (Harvard Medical School, 2022). Those who experience overstimulation, may need time to recharge, process, and collect themselves after a stressful period (Harvard Medical School, 2022). P17 and P18 both mentioned the presence of overstimulation during virtual sessions that consisted of too many distractions and interruptions. P16 stated during interview question #2A, "one of the main difficulties was maintaining their engagement and attention throughout the sessions with the distractions of online learning social media and other digital

temptations it was sometimes tough to keep them focused on the therapy process". During interview question #5, P18 stated it can become stressful trying to maintain client engagement when the remote location of the client is too disturbed.

> Attempting to maintain control became challenging when there was too much commotion happening around the client… the presence of all these extra noises counteracted my entire thought process and it became difficult to navigate through… especially with the client's attention not intact.

P8's explanation of overstimulation mainly derived from her describing the beginning process of implementing online therapy. She stated, when discussing interview question #1, "in a state of panic, even the littlest of tasks seem big and overbearing." P8 also described the presence of overstimulation when discussing the challenges of virtual sessions with clients who had disruptions like young children in the home during sessions.

> I faced extreme challenges with was distractions from my end…but also distraction on behalf of the client and their home situation and how they joined in on our sessions…distractions can be a real challenge working from home means that there can be all sorts of interruptions and background noise that can disrupt the therapy session…it became extremely overpowering some days.

While answering interview question #1, P10 described how she each felt experienced overstimulation after increasing her caseload due to the increased demand of virtual during the pandemic.

> My caseload exploded as more and more students were seeking support for anxiety depression even suicidal thoughts…I had to get really intentional about self-care just to

> keep my head above water but honestly there were days I wasn't sure how I was going to make it through.

Becoming overwhelmed can lead to feelings of anxiety, frustration, and fatigue (Harvard Medical School, 2022). This experience can occur in anyone at any time; a seemingly harmless day-to-day routine can impact an individual's sense and strain the body (Harvard Medical School, 2022). Individuals are constantly bombarded from the physical environment around them, and this demands attention, leaving the individual feeling exhausted. P7 described her overstimulation senses while working long hours from home when answering interview question #2A.

> it took a heavy emotional toll at times…the boundaries between work and home life blurred… lack of separation between work and personal life made it difficult to detach at the end of the day without that physical transition it was easy for the emotional weight of sessions to linger working from home during the pandemic… there were days where I had immense feelings of being overwhelmed

P11 discussed throughout her interview the many pros that came from online therapy including remote access and conveniency for those individuals who are short on time alongside the cons that derived such as becoming overwhelmed with client volume thus leading to forms of stress.

> Attending these online sessions in the comfort of your own home is one of the pros that most take into consideration…convenient for those who use a work-life balance lifestyle allowing these individuals to schedule their sessions that are most suitable...but taking on an excessive number of virtual clients can become overwhelming and lead to job burnout very quickly.

P1 described overstimulation when it came to her work life and personal life coming together during the pandemic during interview question #1.

> Remote work is only convenient and easygoing when there aren't interruptions stopping you from workin… balancing my kids, their schoolwork, my job, household chores were impossible…

P3 & P14 also both discussed overstimulation when working from home and having extra outliers. During interview question #1, P3 explained how working remotely made it harder to focus and remain strongminded. "The pandemic having us cooped up in our homes was dreadful... some days I felt the main focus shift from work to family…I found it was easy to fall behind and become overwhelmed," stated by P3. P14 discussed the inability to find a work life balance throughout the pandemic that led to her experience of overstimulation during interview question #2A.

> I experienced overstimulation for a vast majority of the lockdown…it was difficult trying to establish a routine or set schedule considering my specific employment and its workload…working hours varied majority of the time.

Constant Adjustment. Participants described constant work adjustment as another source of strain when describing their work with socially isolated female victims of sexual violence. Work adjustment is best described as the continuous and dynamic process by which the individual seeks to achieve and maintain correspondence with his or her work environment (Dawis & Lofquist, 1976, p. 55). Adding to the presence of strain, some of the therapists described overall changes brought forth by COVID to be overwhelming. "Honestly, if something bad were to occur in this world again, and we had to relive a time like 2020, my mental state might not be as resilient as it was the first time around," this statement was made by P4 when

discussing her overall experience with virtual therapy and its significant changes it brought upon her during the pandemic for interview question #2A. P16 too discussed his toughest battle he has had with his professional career because of change during the pandemic for interview question #7.

> There were too many changes that had to happen, it was difficult keeping up…learning new tech platforms troubleshooting issues all while trying to provide quality care remotely some days the weight of clients' heightened struggles.

For interview questions #2A P5 described the presence of work adjustments and how it became essential for her to act quickly implementing changes in her method of therapy as the pandemic quickly developed.

> When the effects of COVID started to trickle in, it was then when I realized there were going to be so many changes that had to be made, not only in my personal life, but for this job… I had to respond and act quick due to the spread of COVID-19…I made changes in routines and treatment plans…the challenging part was it wasn't a one-time change…changes were constant as the pandemic progressed as well as the pandemic diminished.

P12 explained to the researcher the continuous changes she had to make throughout the pandemic and how she found pros to virtual therapy while implementing different strategies during interview question #2. She explained how the constant change in treatment plans allowed her to establish relationships with all different types of clients regardless of their situations, past experiences and reasons for being in therapy. "The changes in therapy had opened up possibilities for therapists like myself…I found such great effectiveness in altering the way I as a

therapist interact with clients and vice versa." P15 also expressed positivity while describing constant changes found within therapy for interview question #7.

> The stress was intense in the first 6-8 months from all the changes…it became easier to manage once I was able to establish plans and routines…being virtual did cause great strain but overall, the pandemic and teletherapy created new ways for individuals to receive treatment and get the help they need.

During interview question #2A, P10 discussed how constant work adjustment resulted in immense feelings of stress while treating female clients from two local high schools.

> It was a total nightmare trying to get a plan in place to continue sessions with some of the students… the most difficult part was with treatments plans and how vital it was for them to change continuously throughout the pandemic… there was no way that same plan would work months down the road when factors of the pandemic would change.

P2 conveyed her work adjustment when discussing her overall experience during the pandemic with virtual therapy

> The pandemic introduced new challenges that were not as prevalent prior to its onset restrictions on in-person interactions and the shift to virtual platforms created barriers that were not as prominent before

Discomfort. Participants described discomfort as another source of strain when describing their work with socially isolated, female victims of sexual violence. For the current study, discomfort is best described as the mental uneasiness or annoyance. According to Schmidt (2022), change can be an important, exhilarating, and rewarding part of business; however, it can also be the most stressful. Schmidt (2022) states that change is one of the life's biggest stressors that causes discomfort in any work environment. P20 described the discomfort that came from

adjusting to virtual sessions and adapting to a different workstyle when asked interview question #1. "Implementing trauma-focused treatment plans virtually felt uneasy…changing any type of routine or schedule or whatever the case may be change can be a nuisance", stated by P20.

During interview question #2A, P1 discussed the mental discomfort that came from learning how to adjust to online therapy sessions and manage treatment plans.

> Change is always uncomfortable but that's because we are human… the heavy workload and tasks that came with providing online therapy was overall tedious and time consuming…treatment plans targeted at specific trauma that has occurred in one's life, in my professional opinion, is easier to navigate when they are done face-to-face, reason being is it can be easier for trauma clients to express emotions and cognitions or thoughts in person rather than over a device.

According to Markman (2023), when facing new or difficult situations, individuals often feel a combination of stress and discomfort. The stress reflects the potential for something to go wrong when you're unsure of an outcome. The discomfort can include stress, but also the amount of hard work you need when faced with an outcome that hangs in the balance. When answering interview question #1, P10 discussed his employment with two local high schools during the pandemic describing his uncomfortableness between virtual sessions and his high school female clients. "Change is never easy and exerting change on young trauma victims who have already been excruciating levels of emotional, mental or physical pain feels criminal," stated by P10.

P5 & P11 similarly discussed the uneasiness with possible privacy issues, considering the worst that could possibly happen during virtual sessions. "I was worried about my clients and their comfortability with meeting online…then I was worried about privacy concerns and the

possibility of my clients not having that private area or room to talk… sexual violence is an extremely sensitive topic it can take countless numbers of tries to have a trauma victim become comfortable enough to even begin speaking," stated by P5 for interview question #3. P11 mentioned that she was able to work from her own office, but without clients on site. She said that although she was not a work-from-home individual, the remote experience from her office was at first uncomfortable and hard to adjust to. She stated how beforehand she was not used to being dependent on her laptop but went to always having it on hand no matter where she went. The only concern she had with virtual therapy after slowly adapting to it was concerns of privacy for her clients. "In a room, I have control over factors like privacy and being able to read body language to tell when an individual is uncomfortable, through a webcam I could not and it drove me mad," said P11. Other participants who worked remotely from their offices included P16 and P20. "Working from my office helped alleviate some of the distress that came from having to make these changes," stated P20.

Participants displayed great discomfort when speaking on the initial transition from in-person sessions to online sessions. "During the pandemic this barrier was much more complex to break through just because of that social isolation," stated P4. It should be noted that feelings of discomfort diminished as months moved forward within the years of 2020-2022 during the pandemic.

Demand. Participants portrayed demand as another source of strain when describing their work with socially isolated, female victims of sexual violence. Demand can be best defined as requiring more time, effort, and attention, with very high standards. According to Bakker and Demerouti (2007), job demands are defined as physical, psychological, social, or organizational aspects of the job that require sustained physical and psychological effort or skills and are

therefore associated with certain physiological or psychological costs. Pressure in a workplace is unavoidable due to the demands; it is perceived as acceptable by an individual. However, when that pressure becomes excessive and unmanageable, stress occurs (Bakker and Demerouti, 2007). During interview question #7, P6 described the work to be demanding, requiring more time and effort to treat female victims of sexual violence due to mandatory social isolation.

> Above all, treating trauma clients is a challenging profession to take on…once you collectively consider the effects of the pandemic like social isolation, this field became much more difficult to navigate…social isolation is already common amongst sexual assault victims so when they're forced to actually engage in social isolation instead of by natural selection the work becomes 15 times more demanding trying to find ways around it.

P5 described the presence of demand when discussing her position at a local family counseling center and the significant increase in virtual treatment requests when answering interview question #3.

> Between October of 2020 and June of 2021 there was a significant increase in the demand for online therapy for our center…although you can assume remote work would be much more convenient with great adaptability odds, this demand caused an increase in the amount of effort and work overflowed consuming majority of my time throughout the entire pandemic…there were challenges trying to meet the demand of online therapy treatment.

Other participants like P2 & P15 illustrated the presence of demand when discussing noticeable increases in the demand for therapy specifically during the COVID-19 pandemic

lockdown. During interview question #6, P2 mentioned the increase in referrals she received during the lockdown.

> The surge in calls for national hotlines was astounding. It was unbelievable. Reports of intimate partner violence both domestic and sexual were being made way too frequently… my job became overwhelming with the number of referrals and requests I was receiving for virtual treatment… I spent countless hours and exhausted all efforts researching and trying to find options for those individuals who were sheltering in place at home where acts of sexual assault occurred.

P15 described feelings of stress that occurred when the demand for therapy increased with the disruption of services during interview question #6.

> A considerable number of all new clients I took on during the pandemic were clients that were already receiving treatment prior to the pandemic and the disruption of services…I had an increase in caseloads that required a tremendous amount of time and effort to manage…constant efforts and perseverance helped me while trying to establish new relationships virtually, but it also caused me loads of stress.

Research Question Two ***(****How do therapists who provide services to socially isolated, female victims of sexual violence navigate through online therapy sessions during the global COVID-19 pandemic?)*

For the current study, each therapist interviewed described their treatment processes and concerns they had with using virtual therapy during the COVID-19 pandemic. Participants were asked a series of open-ended questions pertaining to the description of these processes to explain their form of treatment navigation upon socially isolated, female victims of sexual violence. Regarding RQ2, participants described effective problem-resolution solving when describing

their navigation processes of online therapy sessions. Effective problem-resolution solving was found to be associated with four components (*routines, specific conflict resolution, and goal setting)* thus suggesting these four to be at the basis of navigating through online therapy sessions during the COVID-19 pandemic.

Table 6

Research Question Two: Common Theme and Associated Categories

RQ2: How do therapists who provide services to socially isolated, female victims of sexual abuse navigate through online therapy sessions during the global COVID-19 pandemic?
Central Theme: Effective Problem-Resolution Solving
1) Routines
2) Specific Conflict Resolution
3) Goal Setting

Central Theme: Effective Problem-Resolution Solving

It was found that participants portrayed effective problem-resolution solving when navigating through online therapy. According to P5, "virtual treatments during the global pandemic were perplexing considering every client's situation was unique when taking into terms the pandemic at large and its effects it had on society," also emphasizing how important it became to digest each client's situation completely to determine online treatment plans, availability and potential conflicts. P2 also emphasized the importance considering circumstances regarding work-from-home jobs, related school matters, and living circumstances so when issues or conflicts arose, she was equipped with the appropriate measures to take. However, in some cases of uncontrollable situations or unforeseen circumstances, participants like P13 portrayed effective problem-resolution solving using routines, specific conflict resolution, the establishment of goals and the use of support. "When problems occur and barriers

are presented, it is essential for us counselors to act upon these issues fairly quickly exhausting all efforts and resources as necessary", stated by P13.

Routines. Participants discussed the use of routine-based therapy when discussing their navigation through online therapy treatments. Therapists that treated younger female clients were found to have used routine-based sessions more often than those with older female clients. In response to interview question #2, P19 discussed the use of routines when explaining her navigation process with female clients who attended high school during the pandemic. "The use of routines was beneficial for our those particular sessions…it allowed for each of them to receive consistency in which many desperately needed… it also allowed for some to feel more at ease knowing what to expect".

P6 and P13 similarly discussed the use of implementing routine-based sessions with their younger clientele that conveniently helped them save time in planning. "Getting into the routine of scheduled sessions allowed me to spend less time planning for each one…when we began each session, we were able to jump right in," stated by P13 during interview question #2. P6 mentioned how using routines helped him alleviate some of the stress he had while transitioning to virtual sessions during interview question #4.

> My workload was high…a great amount of tasks that needed to be done…establishing routines with a specific set of clients, based on a variety of factors did help my stress levels when it came to session planning for each week.

Despite feelings of strain that were expressed by participants and their virtual transition, participants continued to describe methods like the use of routines that helped overcome certain barriers of online treatment including routines. In some sort of fashion, each participant was found to have discussed routines for being the backbone of treatment navigation during the

pandemic. They were also found to be widely associated with the construction of relationships between therapists and clients during the pandemic. Participants like P10 and P17 both discussed how the use of routines helped establish new relationships with virtual female clients during the pandemic. During interview question #2, P10 discussed a routine of some sessions beginning a discussion of clients and their current state of emotion. “Session begun with a feelings ‘check-in’… I would ask how they were and if it was totally different than last session, I would then lead into questions relating to what they were up to since we last talked to get a gist of the shift in their emotional stance…it became the usual”. Also during interview question #2, P17 discussed how her treatment plans varied by client and their specific situation, mentioning how the factors of their well-being would decide what tasks and course of action to take. “Ultimately we would establish a set routine based on goals and particular things we wished to work on.” “It helped in maintaining close relationships virtually”.

P5 was employed with a family counseling center that treated female clients located at a major university in San Antonio. She described the use of routines for female clients who suffered from emotional triggers associated with their post-traumatic stress disorder (PTSD) when discussing interview question #5. P5 stated the concerns she had with the pandemic and sexual trauma is the common factor of social isolation. “We work to get individuals comfortable enough to remove themselves from isolation and the pandemic worked to keep individuals in isolation.” P5 described that the use of routines and how they allowed her individuals to develop a sense of comfortability with things that may trigger them. “Implementing minor daily tasks something as simple as writing in a journal each day was something I worked to enable clients to get into the habit of doing.” “Whether the darkness was a trigger, or a food smell, or even the

sensation of touch, we developed these small to-do tasks for them to do on a daily basis that may gradually allow them to overcome specific fears and triggers.

Participants like P2 and P4 both mentioned how establishing routine-based sessions helped female clients with the fear of leaving their homes, following a traumatic experience. During interview question #5, P2 described how the operation of virtual therapy brought more female trauma clients with the fear of society and the preference for social isolation. She discussed the pandemic alongside the mandate of social isolation (or stay-at-home orders) and female clients who already proceeded to self-isolate due to trauma. She mentioned that establishing daily routines for these specific set of clients helped to build up the confidence for these women to be part of society again. “Routines that included stepping outside each day for 1 minute and building up to being able to stay outside of the home for 10 minutes were just some of the assignments that I instructed these women to do on their own.” “Eventually it became a part of their daily routines…they began to set goals for themselves.” P4 discussed routines applied during sessions for clients who preferred to socially isolate to protect themselves. “Clients with the fear of leaving their homes, incorporating a routine for daily ‘outside’ exercise was the basis of our treatment plan… the pandemic limited our options, so we stuck with activities such as going for a walk or bike riding.”

Specific Conflict Resolution. Participants discussed the presence of specific conflict resolution when discussing their navigation through virtual sessions. For the current study, specific conflict resolution is defined as the process of ending a setback with a specific approach or plan directed precisely to that problem. P1 portrayed specific conflict resolution when explaining how she overcame barriers with female clients and privacy concerns while discussing interview question #4.

> Initially discussing the possibility of virtual sessions, many expressed concerns of privacy as in not having an ideal area or place where they feel is private enough…after several discussions the idea of Zoom arose…majority of my clients sat in cars in their driveways…audio calls and video calls were both listed as available options… it was about privacy and comfortability.

During interview question #4, P10 discussed privacy issues with his high school female clients and how he worked through those situations and concerns using their everyday cellular devices.

> A vast majority of high schoolers have cell phones…Zoom became our solution… I conducted both video and audio calls based on preference… students went into their backyards, sat in cars, sat out on their front curbs, wherever they felt most secure and safe they went.

Participants like P14 & P20 both described similar barriers to online treatment in which they applied specific conflict resolution. While answering interview question #3, P14 stated, "financial difficulties are the worst types of problems to face". P14 went on to explain how she continued virtual treatment with female clients who could not provide payment for sessions during the pandemic in interview question #4. "It is often unforeseen…we had enough to deal with with the disease itself… it was not something I could easily resolve… I made the decision to temporary wave all payments for a short term for exclusive clients". P20 too discussed conflicts with clients and payment options explaining her decision to wave fees and dues during the pandemic for those who faced financial difficulties and hard times during interview question #4.

When answering interview question #3, P9 discussed the issues she faced with female clients from the local women's shelter who had no access to technology for future potential virtual sessions and how she overcame using specific conflict resolution.

> Depending on the circumstances is how I went about handling each dilemma I faced.… I helped quite a handful gain the access to prepaid cell phones so once they established the means that allowed them to leave the shelter, sessions could continue on.

P8 discussed how she resolved work-life related conflicts for female clients who were mothers of young children when answering interview question #4.

> Meeting times became based off several factors incorporating nap times, lunch hours, potential free time, when their spouse was home…the client and I would draw out what a day-to-day schedule looks like for them and go straight from there…often times I offered weekend sessions or if necessary 30-minute sessions… schedules always fluctuated greatly.

According to P13, a few conflicts he worked to resolve quickly and appropriately pertained to the issue of female clients who were either not engaging in sessions or were not interested in therapy.

> Reaching out from time to time was all I could do truly… sending positive emails with resources and those important phone numbers…with clients who did not genuinely engage I worked to find topics of their interest to incorporate into our sessions and work up from there...there were times I had to facilitate crucial conversations when needed.

Goal Setting. Participants discussed the presence of goal setting when discussing their navigation through virtual sessions. For the current study, goal setting is defined as the process of defining specific, measurable, achievable, relevant, and time bound objectives that an

individual aims to achieve (Locke & Latham, 2006). P10 described goal setting and its importance in treatment plans specifically during the COVID-19 pandemic during interview question #5. He said establishing goals with his young female clients "illustrated a bigger picture" allowing clients to look forward to their healed future self without the negative effects of the pandemic weighing down on them. "Goals, goals, goals, they're more crucial than we as individuals want to believe." He also went on to explain the relationship between goals and clients and how they provided guidance when working around barriers of social isolation. "The issue with social isolation and sexual assault victims is it's natural for them to want to be socially isolated from the rest of the world." P10 also stated, "establishing set goals helped these women gain the confidence to look forward to connecting with others again outside of the pandemic."

P13 discussed goal setting when explaining treatment plans with high school female clients during interview question #2. She explained the use of short-term and long-term goals and how they allowed for her clients to become motivated and determined to work through their trauma. "Goals are so so so important in trauma therapy because they help these trauma victims gain the motivation and determination to overcome trauma." "Setting short-term and long-term goals helps clients be like ok 'this is where I want to be in a few months and this is where I plan to be years from now' and it pushes them forward from that trauma, not backwards while they're on this journey of healing."

The use of goal setting was found to be crucial in treatment plans for P5 who treated female clients that developed unhealthy habits in response to the severe trauma they endured. P5 discussed with the researcher the presence of clients who developed eating disorders during the pandemic while trying to cope with their trauma. "One young woman struggled with her body image after the assault and what had happened was that during the pandemic, she gained over 50

pounds." "She used eating as a way to cope and disturb her body image because her idea behind it was another being would not be physically attracted to her and would not want to harm her if she was 'bigger'." P5 said how establishing short-term goals for specific troubles helped clients to heal in a healthier way. She also explained how the combination of crucial conversations and the discussion of goals became beneficial for her and her female clients during the pandemic.

P8 spoke about her clients and their troubles with insomnia during the pandemic as a response to their sexual trauma. "The development of disorders as a response to trauma is extremely common whether it's a sleeping disorder or often times eating disorders." P8 stated that sleeping disorders like insomnia are often to be considered delayed responses that are associated with trauma. She described how the use of goals and routines both helped female clients establish effective and appropriate coping strategies that worked for them, not against them during interview question #5.

> The effects of trauma widely range for trauma victims that's why treatment plans vary based on numerous factors…those that struggle with physical symptoms may have trouble sleeping, breathing or even issues like the development of acne… those that struggle emotional symptoms will have trouble regulating their own emotions of anger or sadness or anxiety…whatever the case may be setting goals to work on that specific problem is the first step to take.

Other participants like P3 & P20 discussed the use of goals for female clients who faced emotional troubles of dissociation. P3 explained the feeling of being "numb" and how it is more of a biological emotion rather than physical. She mentioned how participants who dissociate themselves from society and their own self became challenging to work through during the pandemic. "Individuals who detach themselves from their thoughts, emotions, their societal

network in response to their trauma is common." "Some will say they don't care what happened or they don't believe their trauma experiences affected their life and more than usual will say therapy isn't something that can help them because they're fine and don't expect much from life anyways." P3 said while working with female clients with this specific mindset during the pandemic, she found that a combination of crucial discussions, routines and goal establishment helped to steer individuals towards healing instead of running away from their trauma.

P20 stated that setting short-term goals for those who have disassociated from themselves, and society was the beginning of her treatment process for interview question #2. She explained the use of journaling and how she instructed clients to write down daily thoughts, feelings, and goals between each therapy session. "Journaling was the first task I would give to those who were so emotionally detached…it was a rough start as pages remained blank, but eventually it evolved into a daily routine and emotions slowly crept their way back onto the pages." P20 then explained how the use of daily goals guided these clients pushing them to step out of their comfort zone they had no awareness of being in.

Peer Debriefing

Peer debriefing is the process of working with peers who have no personal interest in a project but will assist in providing feedback and will review and assess transcripts, methodology, and findings (Cope, 2014). The researcher spoke with her external experts who provided a thorough review of the themes and findings of the current study.

Peer debriefer 1 suggested the use of the associated four categories to best describe the sources of strain. He stated in an email to the researcher, "because you found strain to be a main theme for your first research question, list the associated sources of strain, such as why does strain mostly occur, what are the most common reasons." Because of his suggestion, four

components were used to explain the first central theme, *strain,* and an additional three components were used to explain the second central theme, *effective problem-resolution solving*. Peer debriefer 2 helped the researcher rename the second central theme. Initially the researcher listed "Workload Management" as the second theme, but after a brief discussion, the researcher and peer debriefer both agreed "Effective problem-resolution solving" would be a better fit. Lastly, peer debriefer 3 discussed with the researcher about the layout of her themes. She advised the researcher to explain each theme found with its corresponding research question, explaining how it would provide a better and easier read for the reader. She found no issues with the commonality between the researcher's codes and theme.

Member Checking

Member checking occurs when the data or results obtained from the study are returned to the participants to check for accuracy and resonance with their experiences (Birt et al., 2016). Each participant received a copy of the data that was retracted from the interview. The following message was sent via email to each participant immediately following the completion of each interview transcription.

> Good morning, I am following up as promised! Attached is the transcript for your interview. Should you have any questions or concerns please reach out to me. Thank you for your participation and most of all, your time.

Of the participants, 65% acknowledged the researcher confirming delivery of the transcript and had no additional information or concerns. 35% of participants did not reach back out or confirm they had received the transcript.

Chapter Summary

In this study, conducted interviews were utilized to describe the experiences and navigation processes of therapists who virtually treated socially isolated, female victims of sexual violence, during the global COVID-19 pandemic. Twenty therapists were involved in the research study which was composed of five demographic questions for categorical purposes and seven additional main interview questions. The seven interview questions explored the participant's experiences while providing services, description of their treatment processes, barriers to providing online therapy, overcoming barriers, maintaining active participation, negative experiences, and the overall impact from their work.

All interviews were audio recorded and lasted from 44 minutes to 62 minutes providing ample time for each participant. Each audio recording was transcribed almost immediately and then analyzed to capture and discuss themes that emerged from these interviews. This entailed using the information gathered during the interviews and reducing it to the prevalent themes that informed and responded to the provided research questions. Robust interpretations from all participants illustrated the experiences and navigation processes related to strain and effective problem-resolution solving. Within these two main themes, 8 associated categories were subsequently derived.

In regard to RQ1, participants described their work experiences to be heavy in strain. Four associated categories that appeared to be great sources of the strain included being overstimulated, having to adapt, being uncomfortable with change, and the work becoming demanding. In regard to RQ2, participants discussed that they navigated through online therapy using effective problem-resolution solving. Four associated categories emerged from these discussions with great relations, and they include the use of routines, specific conflict resolution,

and goal setting. The final chapter will discuss conclusions, implications and recommendations for future research.

CHAPTER FIVE: SUMMARY

Introduction

The purpose of this qualitative descriptive study was to assess the experiences of therapists and the descriptions of their navigation processes while working with female victims of sexual violence who were socially isolated during the COVID-19 pandemic in the state of Texas. The research study focused on two research questions that sought the experiences and navigation of virtual treatment of therapists who provided counseling during the COVID-19 pandemic from March 2020 to March 2022. It is important to note all 20 therapists included in this study originally provided therapy face-to-face; due to disruptions delivered by COVID-19, these therapists began to provide alternative options in services by implementing virtual treatment to both existing and new clients. This chapter brings a conclusion to the research by summarizing and providing a discussion of the findings along with delimitations and limitations, implications and recommendations for future research.

Summary of Findings

The data that was obtained through interviews via Zoom was gathered over the course of six months. Seven interview questions explored the participant's feelings while providing services, description of their treatment processes, barriers to providing online therapy, overcoming barriers, maintaining active participation, negative experiences, and the overall impact from their work. All data was interpreted and analyzing using a six-step thematic analysis. Two main themes and seven associated categories were revealed after a thorough analysis. The research questions with corresponding central themes and subthemes are as follows.

Findings for Research Question 1

Description of Experiences: Main Theme and Categories for Research Question 1

1. Strain
    a. Overstimulation
    b. Constant Adjustment
    c. Discomfort
    d. Demand

The first theme that emerged during the analysis, relating to RQ1, was the description of strain. Every therapist expressed feelings of immense strain that served as the commonality of all four associated categories. According to Lippke et al. (2021), it is highly possible for therapists to harbor weakness like the requirement of knowledge and skills such as computer and internet health literacy and general literacy resulting in mixed negative emotions. Therapists portrayed the occurrence of *overstimulation* when describing their initial transitions from face-to-face treatment to virtual therapy and as they continued to adjust to the changes to treatment implementation brought forth by the COVID-19 pandemic. With the emergence of technology, media, and modern lifestyles, it can often become difficult for individual to manage how they react to overwhelming situations; thus, being overwhelmed can lead to feelings of anxiety, frustration, and fatigue (Harvard Medical School, 2022). Individuals are constantly bombarded from the physical environment around them, and this demands attention ensuring the proper techniques and methods to survival, leaving them feeling exhausted.

While discussing the *constant adjustments* that had to be made during the pandemic, strain was existent. Participants explained how their continuous and dynamic processes used to achieve and maintain correspondence with their work environment resulted in great strain. Work

adjustment is a term that is used to describe a desired state of correspondence or fit between an individual's capabilities and wants and the commensurate requirements and rewards or opportunities provide within an organization (Hesketh, 2004). Technological change, globalization, mergers, takeovers, and other external events have increased the requirement for ongoing work adjustment and adaptive performance (Hesketh, 2004). Individuals respond to the demand for adaptation across the life span with varying degrees of adaptiveness. Adaptiveness is determined by individual uniqueness and the nature of interaction with the environment (Ikiugu, 2007).

According to Schmidt (2022), change is one of the life's biggest stressors that causes discomfort in any work environment. Participants exposed *discomfort* as the third main source of strain while discussing their transitions from face-to-face treatment plans to virtual treatment plans. Mentioned earlier in the current study, the experiences of the professionals who provide psychological services to victims of sexual violence vary by case. These professionals, or therapists, can be positively and or negatively affected by their work. The participants for the current study showed great discomfort while adjusting to implementing virtual therapy and trying to maintain control and manage new perceived issues with online therapy including privacy concerns and learning new routines and work schedules. According to Abrams (2002), the pandemic not only made planning for the future feel impossible, but it caused levels of stress to increase with the most basic decisions.

Lastly, participants discoursed job *demand* to be associated with strain when discussing their experiences with online therapy treatment. Karasek (1979) established the Job Demand-Control model that is based on the idea that high job demands impair health particularly when employees possess only limited job control (Angerer & Mueller, 2015). Participants found their

jobs to require more time and effort treating female victims of sexual violence virtually. Pressure in a workplace is unavoidable due to the demands; it is perceived as acceptable by an individual. The main factor of social isolation increased demand in the jobs of the participants when learning how to manage virtual sessions and how to control for social isolation itself when associated with delayed responses to sexual assault. Participants also discussed the noticeable increases in the demand for virtual therapy thus resulting in high client volume and long work hours.

Findings for Research Question 2

Description of Navigation: Main Theme and Categories for Research Question 2

1. Effective Problem-Resolution Solving
    a. Routines
    b. Specific Conflict Resolution
    c. Goal Setting

The second theme to emerge during the analysis, relating to RQ2, was effective problem-resolution solving. Every therapist discussed effective problem-resolution solving that served as the commonality of three associated categories. According to Cornejo et al. (2019), a therapist's navigation through treatment for victims of sexual violence widely varies by the circumstances of each victim and the traumatic event. The discussion of sexual violence can be difficult to navigate because of the painful and emotional experiences that an individual has endured (Cornejo et al., 2019). Therapists defined the use of *routines* when describing their navigation through virtual therapy. Collectively, participants considered routines to be the backbone of treatment plans. They were also considered to be crucial in establishing new relationships between therapists and clients specifically during the pandemic. Majority of participants noted

that the use of routines was more useful and common amongst young female victims of sexual violence. Throughout interviews participants portrayed the wide range of treatment ideas and plans to navigate through the factor of social isolation. Due to the endless challenges that sexual violence survivors face following assault, it is vital for therapists to structure their treatment plans accordingly based on the client. Structure allows therapists to navigate through treatment with a survivor of sexual violence; it creates an agenda and guides to providing effective and successful methods to support and rebuild.

The second category associated with effective problem-resolution solving was found to be *specific conflict resolution*. According to Almas & Benestad (2017), individuals who seek treatment and guidance following an incident of sexual violence or abuse often experience a lack of ownership to their sexuality. It is likely that victims of sexual violence will experience general problems after trauma that cause effects on their sexuality that include but are not limited to: loss of own personal history, reduced psychological functions (anxiety, depression, and self-mutilation), eating disorders, low self-esteem, powerlessness, negative memories, defense strategies, and loss of awareness of boundaries (Almas & Benestad, 2017). Sexual violence survivors endure great trauma and need the perfect guidance and assistance from the correct therapist; they can help to discuss the challenges and consequences that derive (Gomez, 2014). During therapy sessions is when therapists will decide on a structural base for treatment and how each survivor should be approached and treated. It is when conflicts and barriers arise during treatment when therapists will use specific conflict resolution to overcome said problems.

The last category found to be associated with effective problem-resolution solving was *goal setting*. Participants utilized goals for female clients to help maintain and establish determination and motivation during treatment. It was also used to help overcome specific

conflicts that arose during their time in therapy. According to Danylchuk (2015), there is an ever-increasing amount of knowledge that is available to professionals pertaining to their trauma work; this includes the nature of trauma, the immediate and long-term impact on the person, and the endless number of elements that are put into successful trauma treatment. Participants discussed the use of goal setting as an element for controlling the outcome of trauma therapy during the COVID-19 pandemic. Allowing their clients to place focus more into the future and not so much on the current negative impacts that the pandemic placed on all of society.

Limitations

There were several limitations to this study. The first limitation was due to sample size and lack of statistical data. The study assessed 20 therapists to represent the experiences and navigation of online treatment for the State of Texas. As of 2019, there have been 4,775 active licensed therapists practicing in the state of Texas (Texas Department of State Health Services, 2019). As previously mentioned, over the past 10 years, this number has increased by 9.1%; however, more specifically, since 2014 there has been an increase in therapists by 12.6% and a reported 29.2% increase since 2009 (Texas Department of State Health Services, 2019). Replication of this study will be difficult because of the narrow scope. However, this limitation can be overcome if future researchers replicate the study with a larger sample size and population. This may allow for a greater chance for generalizability to exist.

Second, the current study is qualitative. It is difficult to verify the results of the study. In this study, the researcher asked individual therapists who work with victims of sexual violence to describe their experiences during the COVID-19 pandemic. The study only looked at a very small segment of the therapeutic population during a very brief period, limiting its scope. Because this study focused on virtual therapy from March 2020 to March 2022, it is likely that

the data gathered from interviews from this specific time frame, may differ from the responses that would be given if the study was conducted outside of this time frame. This limitation may be overcome if future researchers precisely follow the research steps, considering all factors of the current study.

After the conduction of research, the researcher decided upon an additional limitation, namely the geographical constraints of the participant pool. During the pandemic, lockdown and shelter-in-place orders varied by state in the U.S; states like Arkansas and Nebraska did not mandate lockdown orders (Kettl, 2020). This circumstance was identified as a limitation due to the factor of social isolation. Social isolation is a deprivation of social connectedness, while social connectedness is described as a crucial aspect of society (Zavaleta et al., 2017). It is a core impediment to achieving well-being. The absence of lockdown orders does not diminish the presence of social connectedness, instead it allows it to remain in place. Therefore, those states that did not participate in mandatory lockdown orders, female victims of sexual violence may have continued to receive face-to-face treatment instead of engaging in virtual therapy. And if they did receive virtual therapy treatment, the presence of social isolation would only be present due to self-decision and not the effects of the COVID-19 pandemic. Therefore, this study cannot generalize its findings back to the United States. If replication of this study occurred in states where there is an absence of social isolation (as a result from the pandemic) results may be misleading. This limitation can be overcome in the future if future researchers who choose to replicate this study ensure the use of screening tools to ensure generalizability.

Delimitations

There were a few delimitations to the current study. First, the study excluded the experiences and navigations of virtual therapy with male victims of sexual violence. The current

study only focuses on the administration of virtual therapy amongst female victims of sexual violence. Findings reflect the words of therapists when specifically treating socially isolated female victims of sexual violence. Any therapy experiences or navigation with any other population were not used or documented for this study. This delimitation was established by the researcher when the decision was made to use a screening tool to determine which participants worked with the specific set of clients. Because of this delimitation, generalizability is constrained. It would be difficult to generalize all virtual therapy experiences and navigation of therapists who work with victims of sexual violence are similar; it is possible for experiences and navigations to vary with male victims of sexual violence.

Second, semi-structured interviews were conducted via Zoom. All interviews conducted displayed the neck and face areas only on camera and because of this it was difficult for the researcher to read body language throughout the interview process. When conducting face-to-face interviews body language is easier to read by the interviewer. The researcher did allow the interviewee a choice of preference for video or audio Zoom calls and 100% of participants were interviewed with the camera on. The researcher attempted to control for this delimitation by keeping the video device on, however with only the neck and face area on display, this delimitation remained present. The researcher attempted to control for this in other ways such as ensuring the interviewee was comfortable during the interview by asking if it was acceptable to move on to the next question, giving the participant the choice to withdrawal from the study at any point of the interview process and following up after the completion of the interview. Generalizability is not constrained but also not guaranteed due to this delimitation. It is unknown whether participants were truthful or said certain things to allow the researcher to believe they were comfortable and in perfect standing.

Lastly, the limited sample sizes and scopes may have influenced the overall generalizability of research findings. The sample size for this study was only 20 therapists and those 20 were to represent the State of Texas. Each city is estimated over 1 million in population, while the researcher only assessed 10 therapists from San Antonio and 10 therapists from Dallas (United States Census Bureau, 2023). It may be unlikely to generalize these findings to a great portion of each Texas city when the participants only represent .001%.

Implications

This study was implemented to fill the gap in the literature that fails to assess how professionals experience and navigate working with sexual assault victims during natural disasters such as the COVID-19 pandemic. Although current studies have previously focused on virtual therapy itself, (Bailey et al., 2018; Lippke et al., 2021; and Watkins et al., 2018) none have been conducted specifically in relevance to virtual therapy for sexual assault during natural disasters like the COVID-19 pandemic. The findings of the current study can empower other trauma therapists to broaden their knowledge on the process of virtual therapy treatment including what to expect and how to overcome any negative impacts that inhibit individuals from receiving treatment. The importance of the current study focusing on virtual therapy specifically during the COVID-19 pandemic cannot be minimized. It demonstrated that it is vital for therapists to extend their familiarity with virtual treatment to be more equipped for any possible occurrence of natural disasters. In addition to natural disasters, it would be more beneficial to understand the effects and impacts of virtual therapy and how it can allow for therapists to broaden the scope of available treatment tactics.

Theoretical Implications

This qualitative research study incorporated the theoretical framework of Barnes et al. (2021), Loneliness, Social isolation, and Associated health outcomes. The work of Barnes et al. (2021), was essential in this research study because of its descriptive bidirectional relationship between loneliness and social isolation under social connection. Barnes et al. (2021) states that interventions that promote social connectedness and eliminate social barriers can be extremely important in improving the outcomes of therapy interventions. Interviews conducted were used to look at how therapists experienced and navigated through virtual therapy, illustrating the nature of social connectedness of victims of sexual violence during the pandemic. During the COVID-19 pandemic, guidelines were developed to help society avoid the risk of serious illness; and while these recommendations were warranted, it became likely for the impacts of physical and social distancing on the population's mental health to be lasting and significant, including loneliness and social isolation (Barnes et al., 2021).

The themes gathered provided an insight into the value of virtual services showing that virtual therapy may be challenging, but suitable when necessary. The use of social networks shapes many aspects of social and economic activity and when social connectedness is present, strong interpersonal bonds develop contributing to an individual's wellbeing like anxiety, loneliness and depression. Suggesting, therapy interventions that promote improving social connectedness and eliminating social barriers could be extremely important in improving outcomes for socially isolated victims of sexual violence (Barnes et al., 2021).

Practical Implications

Current literature aptly demonstrates that the use of internet-delivered, online interventions can provide many advantages for the prevention and treatment of psychological

problems and mental health disorders including depression, anxiety, and functional limitation (Lippke et al., 2021). Studies by Lippke et al. (2021) and Watkins et al. (2018) suggest that online treatments can save therapists' time and support relapse prevention of psychological problems. Some researchers also state there is possibility of reduction in risk of stigma that comes from mental disorders and treatment seeking to occur (Lippke et al., 2021). There are practical considerations to add to the literature pertaining to the use of virtual therapy. To begin, it is vitally important to completely understand an individual's situation at the commencement of therapy, assessing all aspects. It can be likely for online therapists to harbor weaknesses like the requirement of knowledge and skills. It is also possible for some individuals to not benefit form online therapy or mixed therapy forms due to limited introspection capabilities and the nature of their disorder. A personalized tool used to consider individual client characteristics may be useful. Implemented methods and techniques should be developed and applied specifically for online therapy when in times of natural disasters like a pandemic where disruption of services occurs. Training and exclusive processes may provide therapists some guidance to implementing online therapy when they are not familiar.

Strengths and Weaknesses

The current study recognizes strengths and weaknesses that derive from its literature. First, this study was able to provide an in-depth view of virtual therapy amongst female sexual assault victims during the COVID-19 pandemic. The use of qualitative research has allowed for the audience to see how therapists and virtual therapy work in natural environments. However, there is no possibility for a cause-and-effect relationship to be determined. Therapists describing the implementation of virtual therapy and providing an in-depth discussion of how and why it may have helped or challenged them, and their clients does not allow for the researcher to

conclude virtual therapy accurately helped or challenged them. Because this study based its research methods on semi-structured interviews, it could be likely that reactivity may have occurred, and the researcher did not know. Participants providing responses that are more in line with social norms is highly possible and almost impossible to prevent or perceive. Lastly, generalizability is not likely with this study.

Recommendations for Future Research

The current study found that therapists, who provided online treatment to socially isolated female victims of sexual violence during the COVID-19 pandemic, describe their work experiences to be high in strain and will use effective problem-resolution solving to overcome barriers and issues that arise. Although research is sparse on the positive effects (Wheeler & McElvaney, 2017), it has been suggested by scholars (Helpingstine et al., 2021; Kadami et al., 2004; Moulden & Firestone, 2007; Way et al., 2004) that professionals are more likely to be at a higher risk for being negatively affected by their work.

This gap in research was important to address because the United States remained operating within the effects of a global pandemic for 3 years, and the findings can aid trauma therapists who work with victims of sexual violence during future possible pandemics or natural disasters. However, it is possible for virtual therapists and the community might benefit from future research that includes a mirrored qualitative study utilizing a population of therapists that includes the description of experiences and navigation of virtual therapy amongst male victims of sexual violence. It also may be beneficial for future studies to be conducted in a different geographical location where COVID-19 pandemic lockdowns were not mandatory or did not occur. This would provide in-depth experiences and treatment navigation of trauma therapists to compare and contrast to the one presented in this study.

Because generalizability of this study is constrained by the delimitations and limitations, another suggestion would be to implement a similar qualitative study utilizing a larger population of therapists considering the same factors presented in this study. This may provide a higher chance for generalizability to exist. The current delimitations and limitations helped to frame this study but future developments in this related field may provide guidance and can be pertinent and of significant interest to therapists who provide services to victims of sexual violence. Future studies in the related field may help other therapists and the barriers they face with implementing virtual therapy amongst victims of sexual violence during future natural disasters where remote access is key. It could also aid outside of natural disasters like a pandemic, such as individuals who have limited mobility.

Potential future studies should focus on a quantitative method that can help to improve scope and generalizability with this specific population size while considering the same factors as the current study. Using a correlational research design, future researchers can assess the relationship between virtual therapy and socially isolated, female victims of sexual violence. The focus of the study should be placed on whether virtual therapy treatments are effective and efficient when used for socially isolated female victims of sexual violence. The potential study can investigate these two variables to determine if there is any correlation.

Summary

This qualitative descriptive study examined how therapists describe their work and navigation processes with socially isolated, female victims of sexual violence during the global COVID-19 pandemic. The study sought to bring a greater understanding and add to literature by taking advantage of unforeseen and unfortunate circumstances brought on by natural disasters

like the COVID-19 pandemic. Insight into various methods and practices are a few positives that derive from the unfortunate circumstances.

Trauma narratives are critical to the understanding of trauma-focused therapy (Frank et al., 2021). Assessing the experiences and treatment navigation of therapists during the COVID-19 pandemic will add to the existing literature providing possible alterations and advancements in therapy while adapting to a new lifestyle brought upon by a global pandemic. It is possible for this literature advancement to help develop methods and practices for assisting victims of sexual violence who are both female and socially isolated, leading to better services and outcomes in trauma therapy.

According to Lippke et al. (2021), online mental health interventions can bridge the gap between patients and therapists when the patient cannot travel to the intervention site, or both are limited in their mobility. However, there is a gap in the research fails to assess how professionals experience and navigate working with sexual assault victims during natural disasters such as the COVID-19 pandemic. In relevance to the current study, therapists, virtual treatment and social isolation due to a natural disaster like the pandemic has not been well-studied to date. This study attempted to fill a portion of that gap. Upon completion of the analysis, it was found that therapists who treat socially isolated female victims of sexual violence during the COVID-19 pandemic will experience high levels of strain and will utilize effective problem-resolution solving to overcome barriers brought forth by the pandemic like social isolation. While all studies have limitations, the results of this literature indicate future exploration into potential correlations between virtual therapy and natural disasters will aid in providing therapists additional resources and implementation strategies to strengthen the use of virtual treatment during natural disasters much like the COVID-19 pandemic.

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Appendix A

IRB Approval

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

July 26, 2023

Iris Saldivar
Vincent Giordano

Re: IRB Exemption - IRB-FY22-23-1754 A QUALITATIVE DESCRIPTIVE STUDY OF THERAPISTS AND THEIR WORK WITH SOCIALLY ISOLATED FEMALE VICTIMS OF SEXUAL VIOLENCE AMID THE COVID-19 PANDEMIC

Dear Iris Saldivar, Vincent Giordano,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2.(iii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

For the final versions of your documents, click on your study number in the My Studies card on your Cayuse dashboard. Next, click the Submissions bar beside the Study Details bar on the Study details page. Finally, click Initial under Submission Type and choose the Letters tab toward the bottom of the Submission Details page. Your information sheet and final versions of your study documents can also be found on the same page under the Attachments tab.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,
G. Michele Baker, PhD, CIP
Administrative Chair
Research Ethics Office

Appendix B

E-mail Invitation

Greetings,
As a doctoral student in the Helms School of Government at Liberty University, I am conducting research as part of a doctoral degree requirement. I would like to invite you to participate in my study which will seek to describe the experiences and navigation of therapists who worked with sexual violence victims during the COVID-19 Pandemic (March 2020 – March 2022).
Participants must be licensed, practice in the city limits of San Antonio and Dallas, specialize in sexual abuse and trauma therapy, have remained employed and practicing during the COVID-19 pandemic (March 2020 – March 2022), worked with sexual violence victims, and have provided online therapy sessions during the pandemic.
Should you agree to participate, you can expect to volunteer 45-60 minutes of your time. This time will be spent online via Zoom with me. The data garnered from this study will be utilized for subsequent publication; at that time, all sensitive details will either be removed or modified to protect your identity. A consent document is attached to this email. The consent document contains additional information about my research. If you choose to participate, please sign and date the form and email it to me prior to participating in the interview.
Sincerely,
Iris Saldivar

Appendix C

Information Sheet

Title of the Project: A QUALITATIVE DESCRIPTIVE STUDY OF THERAPISTS AND THEIR WORK WITH SOCIALLY ISOLATED FEMALE VICTIMS OF SEXUAL VIOLENCE AMID THE COVID-19 PANDEMIC
Principal Investigator: Iris Saldivar, Doctoral Candidate, Helms School of Government, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be a licensed therapist in Texas, practice in either San Antonio or Dallas, must specialize in sexual abuse and trauma therapy, must have remained employed during the Covid-19 Pandemic (2020-2022), must have worked with sexual violence victims, and must have offered online therapy sessions to victims. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of this qualitative descriptive study is to gain more insight into how therapists who work with victims of sexual violence describe their work and navigation processes with socially isolated female victims of sexual violence during the global COVID-19 pandemic.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following:

1. First task: Answer a few demographic questions on paper (5 minutes).
2. Second task: Participate in an in-person, audio-recorded interview that may take anywhere from 45-60 minutes. Interviews will be conducted via Zoom. Interviews will consist of semi-structured questions asked by the researcher.
3. Third task: Member-checking. Participants will review their transcribed interview 24-48 hours after the completion of the interview. This will allow time for any possible questions the participant may have.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include a better understanding and hopefully push those who may need help to reach out despite the conflicting events going on in the world around them.

What risks might you experience from being in this study?

The expected risks from participating in this study are minimal, which means they are equal to the risks you would encounter in everyday life. The risks involved in this study include the possibility of psychological stress from being asked to recall and discuss prior trauma. To reduce

risk, I will monitor each participant and discontinue the interview if needed based on behavior and moods.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential by replacing names with pseudonyms.
- Interviews will be conducted in a location where others will not easily overhear the conversation.
- Data collected from you may be used in future research studies or shared with other researchers. If data collected from you is reused or shared, any information that could identify you will be removed beforehand.
- Data will be stored on a password-locked computer, in a locked desk drawer. After seven years, all electronic records will be deleted, and all hardcopy records will be shredded.
- Recordings will be stored on a password locked computer for seven years and then erased. The researcher and members of her doctoral committee will have access to these recordings.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Iris Saldivar. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at You may also contact the researcher's faculty sponsor, Dr. Vincent Giordano, at

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the IRB. Our physical address is Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA, 24515; our phone number is 434-592-5530, and our email address is irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Appendix D

Consent

Title of the Project: A QUALITATIVE DESCRIPTIVE STUDY OF THERAPISTS AND THEIR WORK WITH SOCIALLY ISOLATED FEMALE VICTIMS OF SEXUAL VIOLENCE AMID THE COVID-19 PANDEMIC

Principal Investigator: Iris Saldivar, Doctoral Candidate, Helms School of Government, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be licensed, must practice in either San Antonio or Dallas, must specialize in sexual abuse and trauma therapy, must have remained employed during the Covid-19 Pandemic (2020-2022), must have worked with sexual violence victims, and must have offered online therapy sessions to victims. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of this qualitative descriptive study is to gain more insight into how therapists who work with victims of sexual violence describe their work and navigation processes with socially isolated female victims of sexual violence during the global COVID-19 pandemic.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following:

4. First task: Participate in an in-person, audio-recorded interview that may take anywhere from 45-60 minutes. Interviews will be conducted via Zoom. Interviews will consist of semi-structured questions asked by the researcher.
5. Second task: Member checking. Participant will review their transcribed interview 24-28 hours after the completion of the interview. This will allow time for any possible questions the participant may have.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include a better understanding and hopefully push those who may need help to reach out despite the conflicting events going on in the world around them.

What risks might you experience from being in this study?

The expected risks from participating in this study are minimal, which means they are equal to the risks you would encounter in everyday life. The risks involved in this study include the possibility of psychological stress from being asked to recall and discuss prior trauma. To reduce risk, I will monitor each participant and discontinue the interview if needed based on behavior and moods.

How will personal information be protected?

The records of this study will be kept private. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential by replacing names with pseudonyms.
- Interviews will be conducted in a location where others will not easily overhear the conversation.
- Data collected from you may be used in future research studies or shared with other researchers. If data collected from you is reused or shared, any information that could identify you will be removed beforehand.
- Data will be stored on a password-locked computer, in a locked desk drawer. After seven years, all electronic records will be deleted, and all hardcopy records will be shredded.
- Recordings will be stored on a password locked computer for seven years and then erased. The researcher and members of her doctoral committee will have access to these recordings.

Is the researcher in a position of authority over participants, or does the researcher have a financial conflict of interest?

The researcher serves as student at Liberty University. To limit potential or perceived conflicts, data collection will be anonymous, so the researcher will not know who participated. This disclosure is made so that you can decide if this relationship will affect your willingness to participate in this study. No action will be taken against an individual based on his or her decision to participate or not participate in this study.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Iris Saldivar. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at You may also contact the researcher's faculty sponsor, Dr. Vincent Giordano at

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the IRB. Our physical address is Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA, 24515; our phone number is 434-592-5530, and our email address is irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to [audio-record] me as part of my participation in this study.

_____
Printed Subject Name

_____
Signature & Date

Appendix E

Interview Guide

The purpose of this qualitative study is to examine therapists and their description of their experiences and navigation while working with female victims of sexual violence, who were socially isolated during the COVID-19 pandemic in the state of Texas. Volunteer participants must be licensed, practice in the city limits of San Antonio and Dallas, specialize in sexual abuse and trauma therapy, have remained employed and practicing during the COVID-19 pandemic (March 2020 – March 2022), worked with sexual violence victims, and have provided online therapy sessions during the pandemic.
By conducting this research, I will be able to provide an insight on the experiences and navigation of therapy services during natural disasters, such as the COVID-19 pandemic. Previous studies have assessed the demand for treatment of sexual violence survivors and the effects on therapists. However, there is a literature gap failing to assess how these professionals explore, navigate, and describe working with trauma survivors during natural disasters like the pandemic. This gap in research is important to address because the United States is still in the middle of a global pandemic, and the findings can provide assistance to trauma therapists during the pandemic and for future natural disasters.

Your participation in this research is entirely voluntary and will involve no risk to your physical or mental health beyond those encountered in everyday life. You may refuse to participate or withdraw from my study at any time without consequence. You may also decline to answer any specific question asked.

As a participant, you should expect to volunteer a minimal of 45 minutes of your time. This time will be spent online via Zoom with me where I will conduct an audio-recorded open-ended, semi-structure interview. The data garnered from this study will be utilized for subsequent publication; at that time, all sensitive details will either be removed or modified to protect your identity. All information will be kept and protected on a password required computer and will be disposed in 7 years from the end of the study. Your confidentiality will be maintained to the degree permitted by the technology used.

Appendix F

Screening Instrument

1. Are you a licensed therapist?
2. Do your practice in the city of San Antonio, TX or Dallas, TX?
3. Do you specialize in sexual abuse or trauma therapy?
4. Did you remain employed and practicing during the COVID-19 Pandemic from March 2020 to March 2022?
5. During this time frame of March 2020 to March 2022, did you work with victims of sexual violence?
6. Did you provide online therapy services to victims during this time frame?

Appendix G

Demographic Instrument

1. What is your race?
2. What is your gender?
3. What is your age?
4. Please list all degrees you have achieved.
5. Please list all settings where you have provided treatment. This may include hospitals, schools, private practices, and public organizations.

Appendix H

Semi-Structured Interview Questions

1. Can you explain to me about how you felt providing treatment via online sessions to socially isolated, female victims of sexual violence during the COVID-19 pandemic?
2. Can you describe to me your process in providing clinical services to socially isolated, female clients for sexual violence?
    a. In any way did you find it challenging to adapt to the specific circumstances?
    b. In your professional opinion, do you believe the pandemic may have further challenged clients in obtaining the proper services for their trauma due to social isolation?
3. During the pandemic, what types of barriers were presented in providing online services?
    a. Were there any barriers that became more challenging to manage during the pandemic compared to pre-pandemic times?
4. Can you explain what methods you found to be the most beneficial in overcoming barriers?
    a. Were there any barriers that were not possible to overcome due to the status of the pandemic?
5. How do you get socially isolated clients to maintain engagement in their clinical services?
    a. Did you find this process challenging in any way particularly during the COVID-19 pandemic?

   b. What was the most successful method you used to help socially isolated clients remain engaged in services?
   c. During the pandemic, were there any specific situations that you were not successful in when attempting to maintain client engagement?

6. Were there any specific stressful experiences that may have affected or influenced you or your job performance during the pandemic?
   a. How did you alleviate any negative feelings?
   b. Are there any lingering feelings from these stressful experiences?
7. Considering social isolation and the pandemic, how would you describe the overall impact of your work with this specific group of clients?
   a. Should a pandemic reoccur, do you believe you would be (more or less) prepared to provide services as opposed to now?

Appendix I

Codes and Themes

Table 3

Common Codes

1) Feelings while providing services		2) Description of treatment process		3) Barriers to providing online services		4) Overcoming of barriers		5) Maintaining patient engagement		6) Negative therapist experiences		7) Overall impact	
Stressed	18/20	Virtual ONLY	13/20	Privay & Confidentiality	13/20	Appt. Confirmations	11/20	Establishing Goals	17/20	Death	17/20	Stressful	18/20
Under pressure	17/20	Progress-Based Sessions	15/20	Life Conflicts	14/20	Specific Conflict Resolution	17/20	Time Availabilty Requests	13/20	Illness	15/20	More Demanding	16/20
Exhaustion	16/20	Routine-Based Sessions	16/20	Lack of Technology	15/20	Persistency	12/20	Structured Routines	16/20	Uncontrollable Situations	18/20	Overstimulated	16/20
Discomfort	17/20	**2a) Challenges of process**		Lack of Determination	6/20	**4a) Not possible to overcome**		**5a) Challenges during pandemic only**		Processing Overall Change	14/20	Constant Adjustments	15/20
Overwhelmed	16/20	Longer Work Hours	16/20	**3a) More challenging barriers**		Scheduling conflicts	5/20	Limitations	11/20	**6a) Alleviating negative feelings**		**7a) More/less prepared now**	
		Overwhelming Tasks Amount	15/20	Work-life Conflicts	13/20	No interest from clients	7/20	**5b) Most successful method**		Rest/relax	14/20	Yes	18/20
		Distractions	16/20	Work-life Demands	14/20	Ghost Clients	10/20	Structured Routines	16/20	Family Support	17/20	No	2/20
		Changes in Work Enviroment	18/20	Work-life Schedules	13/20			**5c) Not successful**		Personal Hobbies	14/20		
		2b) Further challenges of pandemic						Emails vs Calls	12/20	**6b) Lingering feelings**			
		Yes	16/20							No/relief	15/20		
		No	4/20							Yes	5/20		

Appendix J

Researcher Reflexivity Statement

As a young female college student, many of the women I have crossed paths with throughout my life, at one point in their life, have suffered at the hands of an abuser. Many of these women have previously shared their experiences with me, illustrating their trauma and pain. The topic of sexual assault is an extremely sensitive topic and while looking back at the conversations I held with these women, I realized how hard it could be to speak on the topic with an actual victim. I decided to place the focus on therapists for this project for three reasons. 1) Sexual assault is prevalent. 2) Discussions with victims of sexual violence could negatively affect the individual by recalling pain from the traumatic experiences they have unfortunately endured. 3) Therapists could possibly benefit from this study by using the gathered data to develop adequate treatment plans for victims during natural disasters that inhibit victims from getting the help they need. While engaging in conversations with therapists during interviews, previous conversations I had with women and their traumatic experiences were never recalled. During the pandemic, I did not experience an absence of health services. I also had no experience or knowledge about therapy or the profession prior to this study. This project was a learning experience for me in hopes it could provide guidance for therapists during future unforeseen natural disasters.