“The Global Sense of Disaster was Synchronized With my Own Disaster”: Implications of the COVID-19 Crisis on the Wellbeing of Survivors of Sexual Violence

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Abstract
The present study is designed to improve our understanding of the impact of the COVID-19 pandemic, as collective trauma, on the wellbeing of survivors of sexual violence (SV). The data are based on an online qualitative survey about the experiences of 39 survivors and a thematic analysis of ten in-depth interviews with service providers in Israel. The findings reveal that the pandemic and restrictive measures are associated with increased risk for participants’ wellbeing, caused directly by pandemic characteristics, as well as indirectly through the denial of access to coping resources. Paradoxically, the pandemic also offers relief, given the widespread restrictions imposed on the entire population and the general crisis atmosphere. The service providers’ perspective indicates an increased demand for services as well as for their adjustment. These findings highlight the vulnerability of individuals with a history of SV and the need for accommodation of frontline SV services for health crises.

Keywords
COVID-19; sexual violence; rape crisis centers; qualitative; collective trauma; focused ethnography

Introduction
Worldwide, the outbreak of the COVID-19 pandemic and associated social distancing measures introduced novel health risks and economic insecurity, leading to a global health, humanitarian, and socioeconomic crisis with real and immediate impact on daily life (Thompson & Rasmussen, 2020). Many countries declared national emergencies and employed preventive measures such as lockdowns (Nay, 2020). Both the disease itself and the associated response measures heightened psychosocial risk factors in already vulnerable populations (Desai, 2020; Wang et al., 2020).

However, the specific ways in which post-trauma has shaped psychosocial wellbeing during the COVID-19 outbreak still represent an uncharted territory. In particular, there is a need for studies to examine the effects of the pandemic on individuals with sexual violence (SV) background (Tsur & Abu-Raiya, 2020). Moreover, public and third-sector service providers offering helpline and emergency services for SV survivors have struggled to adapt programs and adequately meet the emerging needs of this population during the pandemic. Consequently, the service providers may have a unique perspective regarding the impact of the pandemic on SV survivors as well as recommendations for policymakers on future disaster preparedness and response that can complement the survivors’ perspectives. Thus, the goal of this exploratory study is to better understand the impact of COVID-19 and the associated response measures on survivors of SV and to provide bottom-up recommendations for policymakers.

The Impact of COVID-19 on Sexual Violence Survivors
Starting at the turn of 2020, the outbreak of the COVID-19 pandemic has affected the lives of most human beings around the globe in numerous ways (World Health Organization, 2020). As COVID-19 poses a real threat to both physical and emotional health, people have found
themselves forced to cope with new emotional challenges and particularly with feelings of stress, uncertainty, and fear (Qiu et al., 2020). From a psychosocial perspective, the implications of COVID-19 have been theoretically linked to the concept of collective trauma (Stanley et al., 2021; Watson et al., 2020), defined as a stressful event that universally affects a geographical area and/or social group and fundamentally disrupts the structures of and relationships within communities. Collective trauma harms individuals’ view of the world, challenging notions about safety, autonomy, and meaning of the human experience (Hirschberger, 2018).

Despite the homogeneity inherent to the concept of collective trauma, research and theory acknowledge the diversity of responses to it based on individual differences such as resilience and preexisting exposure to trauma (Bonanno & Diminich, 2013). Furthermore, exposure to collective trauma can shape the delivery of health services due to a patients’ varying ability to access supportive services as well their challenges in providing services during emergencies given elevated distress, tension, and dysregulation (Hirschberger, 2018). In addition, collective traumas pose challenges for mental health professionals striving to provide effective client services while addressing the same issue in their personal lives, defined as shared trauma (Tosone, 2011).

As a collective trauma, COVID-19 can lead to the emergence of various sorts of psychosocial distress (Lima et al., 2020; Pappa et al., 2020; Shapiro, et al., 2020; Torales et al., 2020; Zhang et al., 2020), referred to as the “second tsunami” of the pandemic (Dutheil et al., 2020). Emerging findings document the psychosocial toll of the pandemic, reflected in elevated levels of fear (Lee et al., 2020), stress (Lai et al., 2020), as well as health-related and economic anxiety (Bareket-Bojmel et al., 2020). Other findings document acute stress symptoms in response to the outbreak among self-isolated adults (Xiao et al., 2020), healthcare workers (Shechter et al., 2020), and school-age children (Zhang et al., 2020). For example, an Israeli study with 639 participants found that gender, sociodemographic status, chronic illness, belonging to a risk group, and having a family member who had died of COVID-19 were all positively associated with fear of COVID-19, and that fear levels were associated with anxiety, stress, and depression (Bitan et al., 2020). Furthermore, qualitative research indicted the threatening effect of measures to contain the spread of the virus. For example, in a study among women who live alone, some participants interpreted movement restrictions as a secret way of establishing an authoritarian regime (Kamin et al., 2020).

Although COVID-19 may have a severely adverse impact on the psychosocial wellbeing of all individuals, those who are vulnerable or marginalized may be particularly impacted (Kamin et al., 2020; Petrowski et al., 2021; Philpot et al., 2021)—specifically those with pre-pandemic trauma experiences such as SV. SV is a significant and severe trauma, causing multiple, long-term negative outcomes, such as PTSD, depression, substance abuse, suicidality, repeated victimization, and chronic physical health problems (Amado et al., 2015; Campbell et al., 2009; Fergusson et al., 2013). Given its impact on their psychological status, relationships, and perception of the world, SV makes survivors particularly vulnerable in catastrophes (Herman, 2015), experiencing imminent threats such as COVID-19 as overwhelming. Like the “invasion of subjectivity” that is an inherent constituent of SV (Herman, 2015), COVID-19 may be perceived as a potential invader (Tsr, et al., 2017). Indeed, pre-pandemic maltreatment experiences such as childhood abuse and neglect have been found to exacerbate the impact of exposure to COVID-19 on mental health (Guo et al., 2020).

As in other collective traumas (Tosone, 2011), this elevated risk was exacerbated by the reduced access to welfare and justice services due to lockdowns and the tendency of government authorities to shift care resources to the public health crisis. In March 2020, the UN Inter-Agency Standing Committee (2020) published a paper on how to include marginalized and vulnerable people during the pandemic. The section on gender-based violence survivors raised the possibility of disruption of care and support that could affect services in one-stop crisis centers in tertiary level hospitals. Further, survivors’ ability to access formal and informal services might also be reduced by perpetrators taking advantage of social distancing restrictions to exercise power and control over their partner (Kaukinen 2020; World Health Organization, 2020). Finally, emerging research on the pandemic as collective trauma illustrated that given the shared trauma experienced by their patients and the need to maintain their own emotional balance mental health practitioners were struggling to provide service (Ventouris et al., 2020).

However, even though exposure to past SV could be a risk factor for elevated levels of distress, an Israeli study conducted by Tsur and Abu-Raiya (2020) revealed a complex set of patterns regarding COVID-19 distress. The first pattern, reflecting a “negative route,” revealed that childhood abuse survivors tended to experience elevated levels of COVID-19-related distress. The second, “positive route,” showed that when controlling for the media effect of trauma symptoms, some childhood abuse survivors expressed lower levels of COVID-19 distress compared to individuals without childhood abuse background. The authors suggested that such reduced distress could be explained by the potential “shielding” effect of exposure to childhood abuse in the face of subsequent acute stressors, as these might be perceived as representing a relatively minor threat. Another explanation was related to cognitive processes of a repressive coping style...
related to attention to the threat that could act as a buffer. The authors suggested the need for further research to explain their complex findings and pinpoint their underlying mechanisms (Tsur & Abu-Raiya, 2020).

The dual route of the implications of COVID-19 for SV survivors was also documented in a study on implicit collective emotions related to the pandemic. In that study, a metaphor analysis demonstrated how implicit emotional experiences of COVID-19 converged around several negative emotions such as grief, disgust, anger, and fear, but in a few cases, participants metaphorically described the pandemic as an opportunity for positivity, happiness, and community-building (Stanley et al., 2021). These findings further highlighted the need for an additional study of an apparently complex phenomenon.

**The Israeli Context**

The first case of COVID-19 in Israel was diagnosed in February 2020. Like other countries, Israel implemented various containment measures, including quarantines and lockdowns (Stein-Zamir et al., 2020). In mid-March, the government decided to close the education system and to prohibit gatherings of more than 10 people. Entertainment and other public venues were closed, including restaurants, movie theatres, gyms, shopping centers, places of worship, beaches, and parks (Ministry of Health, 2020). All social services, except emergency medical services, were shut down, and social workers were initially declared “non-essential” (Katz & Cohen, 2020). This was obviously counterproductive in terms of mitigating the additional risks that COVID-19 could pose for vulnerable populations such as SV survivors (Bradbury-Jones & Isham, 2020).

The Israeli sociocultural setting may have had a unique impact on the wellbeing of SV survivors during the pandemic. This is in part because the Israeli gender context is a complex one. Women have equal rights by law and occupy important positions in the labor market, but everyday life is still dominated by patriarchal norms, due to the central role played by religion and the country’s continual state of conflict (Fogiel-Bijaoui & Rutlinger-Reiner, 2013). It is estimated that one of three Israeli women are sexually assaulted at least once in their lifetime (Regev et al., 2014), an SV prevalence similar to that of other Western countries (Garcia-Moreno et al., 2013). However, the country’s intractable conflict results in a certain marginalization of SV phenomena in the media and public agenda in favor of issues of national security (AUTHORS; Shoham, 2012).

Israel is also a multicultural society composed of diverse ethnic groups, some of which are traditional, patriarchal, and separatist, with deep mistrust in government enforcement and welfare services, creating barriers to reporting abuse and thus denying SV survivors the opportunity to receive professional treatment (Tener et al., 2017). More broadly, Israel is also a family-centered society, which affects SV survivors in engaging in treatment services and shapes their wellbeing (AUTHORS).

A recent study conducted from the perspective of professionals in Israel and the US found that COVID-19 had implications for intrafamilial child sexual abuse, including increased risk related to family stress, barriers to detecting and reporting intrafamilial child sexual abuse, and changes to the therapeutic process (Tener et al., 2021). In addition, professionals raised concerns about the potential ripple effect of economic stressors on the mental health and wellbeing of the caregivers and children, resulting in increased rates of depression, suicide, aggression, and drug abuse. More specifically, most of the Israeli and some US professionals described how the focus of their intervention shifted from coping with the abuse itself to family maintenance and stabilization.

Another key contextual factor is access to healthcare. Israeli law allows all citizens equal access to healthcare facilities with all medical expenses covered. In practice, however, SV survivors may not always benefit from this access, for various reasons. For example, a recent study by Razi et al., (2021) examined the association between self-reported history of sexual violence and health behaviors, focusing on routine gynecological care and mental wellbeing. More than a quarter of the female participants (26.3%) reported a history of SV, and a significant association was found between SV history and neglected gynecological care, as well as with the risk of postpartum depression.

One pivotal actor in the Israeli context that provides crisis and therapeutic support to SV survivors is the Association of Rape Crisis Centers—the umbrella organization of nine regional rape crisis centers (RCCs). The RCCs provide a wide range of services to survivors of SV and their families, including a 24-hour crisis intervention helpline, face-to-face counseling, and accompanying the survivors to the hospital and during the process of pressing charges at police stations, confronting perpetrators, and testifying in court. The centers also provide group therapy and referrals to private therapists (Rizkalla et al., 2021).

**The Current Study**

The present exploratory study was designed to better understand the impact of the COVID-19 pandemic as a collective trauma and the associated response measures on SV survivors and to provide bottom-up recommendations for policymakers. Specifically, given previous research that indicated a mixed impact on survivors, we aimed to explore the factors and mechanisms underlying SV experiences from the perspective of survivors and
service providers during the first COVID-19 outbreak in Israel. Accordingly, a qualitative approach was employed aiming not only to shed light on the “what” but also on “how” and “why” regarding responses to COVID-19 outbreaks (Vindrola-Padros et al., 2020).

Accordingly, the research questions were as follows: (1) What is the perceived impact of COVID-19 on the survivors’ psychosocial wellbeing? (2) What are survivors’ perspectives on how to better adjust SV services and policies in response to a global crisis? (3) How do RCC service providers perceive the impact of the pandemic on SV survivors in terms of the demand for and nature of services? (4) What are the service providers’ perspectives on how to better adjust SV services and policies in response to a global crisis?

**Method**

We adopted a qualitative naturalistic approach that emphasizes a holistic understanding of phenomena in the context in which they take place (Lincoln & Guba, 1985). This inductive approach is particularly suitable for studying experiences that carry multiple and often shifting meanings in order to develop, through mutual dialogue with the research participants, a body of practical knowledge that will lead to effective social change (Frost et al., 2020). It is complemented by quantitative data analysis, providing a broader perspective on the topic, and offering a higher level of validation and reliability, which unites an aspect of human interpretation with a quantitative one (Johnson et al., 2007).

A focused ethnography design was employed in the current study. A focused ethnography is an applied form of ethnography that gathers data from multiple sources on a specific social phenomenon or institution in a specific cultural landscape and timeframe (Cruz & Higginbottom, 2013; Richards & Morse, 2012). This research design was selected because it is ideal for collecting specific data within a narrower scope of inquiry, from specific perspectives (Cruz & Higginbottom, 2013; Richards & Morse, 2012)—in this case, data on the wellbeing of SV survivors during the first COVID-19 outbreak from the perspectives of survivors and service providers. A focused ethnography design also involves data collection that targets key informants so that relevant results can be obtained within a relatively short time. Short-term and targeted data collection enable timely sharing of findings (Cruz & Higginbottom, 2013), necessary in the fast-moving context of a global pandemic. Finally, given the current study’s aim to provide bottom-up recommendations for policymakers, focused ethnography, a design that is increasingly being used in health services research (Cordisco Tsai et al., 2022; Ohuere et al., 2021), is particularly well-suited for informing healthcare settings and practice (Cruz & Higginbottom, 2013).

**Participants and Procedures**

We used a convenience/volunteer sample with participants recruited primarily online using the Facebook or WhatsApp pages of the Association of Rape Crisis Centers in Israel and online sites devoted to issues of SV. The link to the electronic survey was distributed for 2 weeks in May 2020. The following inclusion criteria were applied: age over 18 years and self-identification as SV survivor. The online questionnaire asked about the survivors’ experience and what could have helped them during the first outbreak (March-May 2020). This period was selected as it included the initial responses to COVID-19, mainly nationwide lockdown and restriction of “non-essential” social services (Katz & Cohen, 2020).

An online survey is ideal for studying new and sensitive research topics because it provides a high degree of anonymity with easy access to large and geographically diverse samples that can facilitate participation and disclosure (Braun et al., 2020). Similar to other health-related research conducted during COVID-19 (Yter et al., 2021), and in line with recommendations for rapid qualitative research in that context (Vindrola-Padros et al., 2020), we decided to use online surveys as the most efficient way to capture rich data. Under the circumstances of the pandemic, this is a risk-free method that is flexible in terms of speed, feasibility, cost-effectiveness, and widespread coverage, allowing us to obtain meaningful data to inform public health response (Vindrola-Padros et al., 2020), without compromising on the quality of data collection (Braun et al., 2020).

In the present study, the online qualitative survey was comprised of eight questions, including informative questions about gender and age and questions regarding different aspects of the impact of the pandemic. Thirty-nine participants (38 women) completed the survey; their ages ranged from 19 to 70 (M = 32).

In addition, the sample consisted of 10 service providers from various RCCs across Israel. They were recruited by purposive sampling through the Association of Rape Crisis Centers in Israel. All had five to 10 years of professional experience with SV survivors, and all were employed as high-level executives. The interviews with them were conducted by the second author who solicited their comments about the impact of the pandemic on SV survivors, their work during the abovementioned period, the accommodation of services, and recommendations for policymakers. The interviews lasted about 1 hour and were transcribed verbatim and translated into English professionally, in line with recommendations for cross-language qualitative research (Squires, 2009).

Another data source was used for quantitative evaluation of demand for services: all nine RCCs in Israel provided us with the numbers of contacts made from March 1
to June 30, 2019 and the same period in 2020. This comparison sample consisted of all the helpline services that the centers provided, including phone calls, online anonymous chats, WhatsApp chats, and emails. The contacts were classified as either first or repeat contacts (calling back for further information or guidance), enabling to assess changes in the number and characteristics of helpline beneficiaries (Petrowski et al., 2021).

Data Analysis and Quality Criteria

A coding team of all the authors, all involved in research in the field of SV, conducted a thematic analysis of the data-informed by the critical realist ontology perspective (Braun & Clarke, 2006). First, the transcribed interviews and answers to the online survey separately were read and reread independently by the authors, to gain greater familiarity with the data and identify initial themes for each participant’s experience. Then the research team grouped these themes into emergent descriptive categories. Next, the themes were refined and labeled, and interrelationships between them were proposed. In addition, the data provided by the RCCs were analyzed using simple descriptive statistics. The final stage involved an iterative process of cross-case analysis, to find consistent patterns across the answers to the online survey and the interviews.

By the sixth interview and by the 27th answer to the online survey, code saturation was achieved, as fewer new issues in relation to the implications of COVID-19 in various domains of life were identified. However, more interviews and answers to the online survey were needed to fully understand the mechanism underlying those issues and to reach meaning saturation. Thus, data collection was continued until complete saturation was achieved, when no new issues and meanings were identified (Hennink et al., 2017).

Lincoln and Guba and’s (1985) four constructs—credibility, transferability, dependability, and confirmability—were used to establish trustworthiness. Credibility was established through data source and site triangulation, and member checking. Triangulation consisted of using two main data sources and interviewing participants from multiple organizations representing different organizational cultures. Credibility was also enhanced by creating a pleasant atmosphere during the interview that permitted participants to express themselves openly and freely, by ensuring accurate and complete transcription of the interviews and their interpretation through the detailed explanation of all the stages of the research process and the grounding of the analysis in extracts, enabling the readers to judge the quality of the findings, the relationship between them, and the context of their generation. The transferability of the findings was supported by a detailed description of the methodology and by thick descriptions of the participants’ points of view within their lived context.

Data analysis resulted in four focused themes related to our research questions. The first was related to the wellbeing implications of COVID-19 from the survivors’ perspective. The second was related to survivors’ recommendations on how to better adjust SV services and policies in response to a global crisis. The third theme addressed the pandemic’s implications for SV survivors from the service providers’ perspective. Finally, the fourth theme captured service providers’ recommendations for adjusting SV services and policies in response to a global crisis.

Ethical Considerations

The study was approved by the departmental Research Ethics Committee of the authors’ University [deleted for review]. Given the COVID-19 crisis and the vulnerability of the participants, special ethical measures were taken (Vindrola-Padros et al., 2020). All participants signed an online informed consent form. They were assured that they could skip any question that they preferred not to answer and stop the survey at any point. They answered the questions in their own words and their preferred level of detail. In addition, they were guaranteed free professional support via various channels such as telephone and online chat after completing the questionnaire. In addition, the participants were given the option to contact the authors directly by phone and email and were encouraged to do so in case of concerns they might have about the survey topics or in order to receive immediate support if needed. Finally, they were offered to complete the survey together with the second author.

Findings

The analysis indicated multiple implications for the psychosocial wellbeing of survivors of SV in various domains of life, as suggested by both survivors and service providers.

“A lot of really bad flashbacks”.

The Implications of COVID-19 from the Survivors’ Perspective

Negative implications. The participants described multiple negative implications of COVID-19 in various domains of life. Specifically, these implications were related directly to the harm associated with the pandemic (e.g., uncertainty) and indirectly to the preventive measures employed to reduce the risk of contagion, as these disrupted the survivors’ coping mechanisms.
**Mental Dimension**

The sense of uncertainty affecting all Israeli society and its effects on the individual participants given their vulnerability as SV survivors were described by many as emotionally devastating, leading to anxiety that was often even more significant than the actual threat of the pandemic. For example, one participant described this as follows:

> What I was most afraid of from the beginning was the loneliness and the mental state – that the therapeutic services would be taken away or that I would have to go into quarantine. That I won’t meet anyone and that my mental state would deteriorate. I was not afraid of the virus itself. These were the main difficulties. It was very difficult.

Furthermore, the SV background limited some of the participants’ coping strategies such as social support, making the above-mentioned fears materialize for some participants:

> I felt I was unable to cope anymore. A lot of my friends that are my age went back to their parent’s home and I couldn’t because it was related to the trauma. I experienced quite a lot of suffering during this period.

The loss of control due to the pandemic amplified the participants’ stress. For example, one participant described the impact of the pandemic on her emotional wellbeing as a “huge uncertainty, with ongoing changes. How long will it take? I feel that I don’t know what would happen next, and how I should cope with this.” Another described the combined effect of uncertainty and loss of control on her self-efficacy: “I think that the uncertainty and loss of control during this period affect the ability of victims to cope with sexual abuse and their efforts to regain control over their lives.”

Indeed, the participants described rapid mental deterioration. The disruption of their daily schedule, the lack of welcome distractions, and the demand to remain shut in overwhelmed many of them—the began thinking repeatedly about their trauma, with flashbacks and panic attacks. As noted, some reported great solitude, and this added to the frequency of dissociative spells: “I had too much time with myself alone. The flashbacks came up all the time, no distractions and financial uncertainty – hard time.”

The mechanism causing the deterioration in the participants’ mental health operated by limiting their abilities to cope with the implications of the pandemic. First, the closure of some therapeutic services and the provision of others online led some participants to stop their psychological therapy or experience it as a distant interaction. The participants felt that their difficulties became “invisible”: “I had to stop my therapy, precisely at the time I needed it so much.” In addition, the switch to online therapy was described as inadequate since it demonstrated and intensified their loneliness: “I see the therapist inside a small square on the computer and not in front of me in the room; there are technical interruptions [. . .]. I had that feeling again, the loneliness and the need to cope alone.”

Furthermore, some participants acknowledged the risk to their wellbeing and their ongoing coping with the SV trauma and, as a precaution, chose to isolate themselves: “Because for part of the coronavirus period, my therapist was absent, I felt that my life and my struggle were on ‘hold’. To keep myself safe without support, I disconnected from everything.”

**Interpersonal Dimension**

The participants described social isolation that was both self-induced and imposed because of the nationwide lockdown. This social isolation affected the participants' wellbeing, among other things by creating a void that was filled with posttraumatic invasive thoughts, as described by one participant: “I had a lot of time alone [. . .]. I had a lot of negative thoughts. I felt lonely, I thought of the rape all the time, I couldn’t stop.” For other participants, social isolation affected their wellbeing indirectly by depriving them of their coping mechanisms. For example, one interviewee described how the “lockdown forced me into solitude, it disconnected me from all the things that are helping me to deal with my condition during ordinary times.”

As we have seen, for some participants, social isolation was self-induced as a protective mechanism. However, this resulted in several cases of flashbacks and even suicidal ideation and attempts. In the following quote, a participant elaborated in the survey on the effects of her imposed isolation:

> It made me consider many times to go back to my parents' house even if it means going back to where I was hurt because I could not deal with it. In the end, I managed not to travel. This caused a setback in the treatment process and uncertainty – instead of coping with the abuse I had to engage in survival with the corona. I immersed myself in the most difficult thoughts about the past because there were no other issues in my life. I hurt myself, which did not happen for a long time.

**Functional Dimension**

The lockdown, isolation, and changes in the daily routine disrupted the participants’ lifestyle, with negative effects on their day-to-day functioning. Specifically, feeling lonely, empty, and meaningless disrupted their functioning led to sleeping disorders. One participant described it as follows: “Everything was a mess, no daily schedule. I woke up at noon, I felt useless, I had no meaning at all.”
Participants also described a sense of “imprisonment” due to the movement restrictions that made them feel like they were losing control: “All this time I felt imprisoned with no option to go outside and get some fresh air.” Furthermore, the sense of “imprisonment” was experienced as a reenactment of the SV experience given the similar feeling of not being able to escape or control your own life: “I felt imprisoned. It took me back to the times I couldn’t run away and had no control over my life. The fact that other people can decide what will happen to me was unbearable.”

In addition, the crisis had an indirect effect on the participants’ daily functions by disrupting healthy habits that served as coping strategies. For example, some began eating compulsively while others lost weight drastically. They linked these changes to the feeling of losing control and attempting to regain control within the chaos: “I started eating a lot because the rest of my coping mechanisms were taken away from me.”

Positive Implications
Concurrently with the negative implications, some of the participants also reported positive implications of COVID-19, primarily a sense of relief. Note that the relief and other positive implications are relative and temporary given the difficulties survivors faced every day—definitely not absolute relief or improvement and often part of a complex set of implications that included negative ones. The first positive implication was the relief derived from the social distancing measures, which enabled some participants to reduce their efforts to function normally on a daily basis, including having to leave the house. For example, one participant described the shifts in her wellbeing: “From existential anxiety to a sense of comfort that I would not have to leave the house.”

Second, some participants described how the lockdown allowed them to remain secluded in their homes and shield themselves from the outside world. The restrictions of movement freed them of the daily assignments and interpersonal contacts that were usually challenging for them: “I felt relieved, the restrictions on being close to other people helped me, I felt safe, maybe for the first time in my life.” Specifically, the restriction on bodily contact was identified as protective: “The restriction helped me a lot, suddenly no one tries to hug, no one touches you, no fear to sleep at night, no fear to ride the bus because if somebody would sit next to me, I can pretend I have a cough.”

Another mechanism through with the pandemic paradoxically benefitted the participants was related to the global apocalyptic situation that was in line with their feelings, as indicated by one participant: “I experienced the corona period as good. The global sense of disaster was synchronized with my private sense of disaster.” Specifically, this paradoxical effect was related to a sense of normalization given the overall limited functionality, as described by one interviewee: “Until the corona I was afraid to leave the house and since then there is a feeling of alignment with the world because everyone had to stay hidden in their homes.” Some participants even felt that the SV they had experienced and its consequences for their lives, such as isolation, trained them to better cope with the pandemic: “I feel I was better prepared than others for the lockdown. I kind of got used to it after being locked up at home for almost 2 years. Kind of back to my safe place.”

Another aspect where COVID-19 benefitted the participants was that being alert to their vulnerability made them a more agentic position in coping with the risk to their wellbeing associated with the pandemic. For example, one participant indicated how the acknowledgment of the risk she might be in, given her SV background, led her to fill her day with activities: “Surprisingly, out of fear, I urged myself to do a lot of things.” Another participant reported being already equipped with coping tools: “I had the tools to deal with the triggers that floated. So you could say I coped well.”

For still others, the deterioration in their wellbeing because of the pandemic was a trigger for engagement in therapy and social support that benefitted their wellbeing:

The time at home flooded me with a lot of really bad flashbacks. The good part is that I started talking about it more with friends and with my therapist, and I even managed, for the first time, to define what happened as rape and assault, and even sometimes blame myself a little less.

“Someone to Correspond with Anonymously”:
Participants’ Recommendations

Given the realization that coping with the pandemic would be long-term, the participants were asked about measures that could help them and other survivors through this crisis. The main recommendation was related to accessing coping resources. Many pointed out the need for financial support that will allow them to subsist, continue therapy, and even buy a computer that has become such a necessity nowadays. To meet the heightened need for psychological support, participants suggested the option of correspondence: “I would be happy if there was [. . .] someone to correspond with anonymously just to sometimes unburden the feelings and not get into a situation that I cut myself for a relief.”

The second type of suggestion was related to the need to adjust the government’s preventive measures to SV vulnerabilities. First, the need for face-to-face
therapeutic and supportive meetings was pointed out as critical for many participants. For example, one participant indicated: “A clear and unquestionable exception [to the social distancing rules] to [enable] joining a frontal support group.” Second, some participates indicated the need to adjust other preventive measures such as wearing a mask:

If there were more exceptions concerning wearing the mask, which is very unpleasant and reminiscent of bad things. The exceptions for those with a disability certificate were expanded—that is, I traveled longer distances and went to nature. It is important to keep the exceptions and maybe even add a few more tailor-made ones.

“Misery Loves Company”: the Implication for SV Survivors from the Service Providers’ Perspective

Implications Based on the Demand for Services. According to data provided by the RCCs regarding calls received in the first month of the outbreak (March 2020) compared to the same period in 2019, there was a slight reduction in the total number of calls. However, starting April 2020, there was a substantial increase in new and particularly repeat calls (from 20% to 40%; see Table 1).

This quantitative pattern was also reflected in the RCC service providers’ qualitative accounts. According to their description, upon the outbreak of the pandemic and the public realization of its consequences, there was a sense of shock, which reduced the preoccupation with SV in favor of the existential threat: “A form of reduction of the private trauma against the background of the general danger and trauma.” However, with time, the calls multiplied up to the point of total overflow with the removal of the restrictions and the return to normality, when private conversations became possible again. Specifically, and in line with the quantitative data regarding the rise in repeated calls, the service providers described many calls to the helplines by “ordinary callers,” who call the helpline routinely given the unavailability of other services: “There were a lot of calls from regular callers during the period because they were cut off from any source of support they had and turned to the helpline because it is a source of support that they know.”

This rise created a huge burden on service providers who were themselves facing a pandemic crisis and needed to take care of their families. This work burden affected both the service providers’ wellbeing and their ability to provide adequate service: “I answer phone calls from my car or with my kids in the back.”

Implications Based on the Nature of RCC Work. Regarding the nature of services, RCC staff identified three main changes. First, in contrast to pre-pandemic calls and referrals, some of the calls dealt with general violence issues rather than being focused on sexual violence:

A lot of calls were about violence in general, physical violence, for example, or someone who looked for a safe place to leave her abusive husband. The shelters were closed due to the pandemic, and I guess our helplines are quite famous, so everything drained in our direction.

Moreover, the nature of the calls was described as more severe, with more critical complaints than usual, a higher level of distress, and more issues related to financial hardship, housing, and nutrition, alongside triggers for loss of control. For example, the staff workers described that the use of masks, disinfectants, etc. triggered a sense of danger among the survivors. The RCC staff attributed this change to the sense of crisis and the closing of many therapeutic resources, leading in extreme cases to people remaining untreated. Specifically, the staff indicated on the existential nature of the crisis highlighted the ineffectiveness of available services:

Quite a few victims talked about the fact that the whole world was aligning with their loneliness. This sense of existential fear, “no one will understand me”, dovetails with the overall social situation. Some were comforted by it while others were even more distressed by it. Misery loves company: suddenly there is no life outside . . . so they approached us.

A second change in the nature of services was related to the preferred time of service. RCC staff reported a dramatic increase in nighttime calls and linked it to the daily schedule disruption: “We got a lot of calls during the night. [When] a call [expressed] real distress, it seems that the victims felt more comfortable to make it and talk to us at night. It was a big change for us.”

| Month       | Change in New Calls | Change in Repeat Calls | Overall Change |
|-------------|---------------------|------------------------|----------------|
| March 2020  | 18%-                | 3%+                    | 2%-            |
| April 2020  | 20%+                | 36%+                   | 32%-           |
| May 2020    | 23%+                | 36%+                   | 33%-           |
| June 2020   | 43%+                | 43%+                   | 43%+           |
**Service Providers’ Recommendations**

During the first outbreak, the RCC staff had to make significant accommodations to meet the survivors’ needs. Those accommodations were recommended by the managers for future disaster preparedness and response. For example, one of the RCCs allowed survivors to come and stay for several hours in the center while staff members were around so that they have a temporary safe haven:

> We understood the need of many victims for a place to be in, physically, for a few hours. To go out from their four walls and talk to someone in person. So we created this possibility – to come to the center and stay in our meeting room, to drink coffee or tea with a biscuit, rest a little bit and go back home.

In addition to helplines, the crisis required expanding online assistance services: anonymous chats, WhatsApp, and email contacts. This accommodation came in response to the significant increase in the number of online services use during the first outbreak. It was described as deriving from the younger population’s tendency to prefer online media on a phone call. This trend was also linked by the service providers to the difficulty of finding a private place to talk on the phone, given the work overload.

In addition, the crisis centers for minorities, which mainly serve the Arab community, provided services via email and even via the crisis center’s Facebook to protect some callers from their abusers. The urgent need resulted in the development of a chat in Arabic: “During this period, we understood the emerging need for an online service. Victims connected us through Facebook because they couldn’t talk safety. Now we are preparing to develop an online chat in Arabic.”

**Discussion**

The findings of this study provide initial insights into the perceived impacts of the COVID-19 pandemic as a collective trauma on survivors of sexual violence (SV), based on their experiences during the first outbreak in Israel. The findings portray a perplexing combination of both positive and negative implications. In that, they echo the complex pattern found by Tsur and Abu-Raiya (2020), according to which individuals with a history of childhood abuse may experience both elevated and reduced levels of COVID-related distress.

Our findings further add to the literature by suggesting underlying mechanisms of both the harmful and beneficial impacts of the pandemic on survivors of SV that are both grounded in the characteristics of the COVID-19 crisis as a collective trauma. Regarding the negative implications, the pandemic poses an elevated risk for the wellbeing of SV survivors—directly via the pandemic characteristics such as uncertainty, and indirectly via the denial of their coping resources. The result may be a significant deterioration in their wellbeing that is not easily reparable by removing social distancing restrictions. Specifically, the findings indicate the implications of the perception of the crisis as unpredictable and as infringing on their control for negotiating health experiences and their wellbeing (Missel et al., 2020; Stanley et al., 2021). Perceiving the crisis as unpredictable affects SV survivors’ well-being by limiting their perceived self-efficacy and producing more maladaptive forms of social coping such as self-induced isolation that further adds to their distress.

Furthermore, the findings reveal the special meaning attached by SV survivors to measures employed to tackle the pandemic (Kamin et al., 2020). These induce an imprisonment-like experience perceived as a reenactment of the SV experience given the similar feeling of not being able to escape or to control your own life. Accordingly, despite the usefulness of understanding COVID-19 as a collective trauma, we need to adopt the critical awareness that COVID-19 disproportionately affects vulnerable populations such as SV survivors in multiple ways.

In contrast, the relative benefits to the participants’ wellbeing are related to the mitigation of their sense of otherness and exclusion from society, because the global crisis created a situation of equal restrictions for all—“misery loves company,” as one service provider put it. This relative relief may reveal more about the hardship and the sense of otherness that the victims feel and deal with on a daily basis (Campbell et al., 2009; Herman, 2015). This is because it “takes” a global collective trauma that connects people through experiences of helplessness, uncertainty, and grief (Watson et al., 2020) to normalize and ease their own adversity. Thus, beyond the knowledge that the study provides regarding the impact of the COVID-19 on victims, it also teaches us how survivors feel routinely as “other” and isolated. Finally, for some participants, the SV they had experienced and its consequences for life such as isolation trained them to better cope with the pandemic. This finding is in line with previous findings regarding the link between physical abuse and neglect and improved coping (Sudbrack et al., 2015).

Concerning the implications of the pandemic from the point of view of rape crisis center staff, we found that the reliance on the centers grew significantly as indicated by the number of calls and referrals. The nature of the calls also changed, with a higher number of urgent calls due to the closure of therapeutic services. These changes may reflect a change in the social perspective, with the public gaze focused on the urgent health crisis to the detriment of populations at risk (Katz & Cohen, 2020). This is especially alarming.
because even in ordinary times, Israeli media and the public agenda downplay the issue of SV in favor of other threats, such as threats to national security (Gueta et al., 2020).

Finally, the findings also point to another aspect of COVID-19 as a collective trauma by highlighting the implications of the shared trauma on service providers’ wellbeing and ability to provide services. Specifically, the rise in calls has created a huge burden for the service providers, who were themselves facing a crisis and needed to take care of their families. This issue may be particularly important since previous research conducted during routine periods has already indicated the secondary traumatic stress among counselors and volunteers working with SV survivors (Gueta et al., 2021).

Limitations and Future Directions
Given the main qualitative nature of the present study and its aim to describe how people make sense of their lived experiences, we did not examine whether the participants’ self-reported perceptions of harms or benefits were indicative of their psychosocial well-being. Further quantitative research is needed to assess the implication of the COVID-19 crisis on the wellbeing of survivors of SV. Another caveat is that most of the present study’s participants self-selected to take part. Although qualitative surveys are positive for inclusion and participants in many ways, this methodological limitation risks excluding participants with limited literacy skills and those without computers or access to the internet, thus excluding some of the least privileged and most vulnerable groups in society (Braun, et al., 2020). Future studies, therefore, should be directed at gaining a more representative picture of the impact of the pandemic on SV survivors. Last, attention should be paid to the specific Israeli cultural setting of the study, even though the findings may heuristically and tentatively be transferred to other relevant contexts (Lincoln & Guba, 1985).

Recommendations for Policy and Practice
The results of the present study have implications for policy and practice in terms of accommodation of existing SV frontline services for collective trauma preparedness and response. First, given the exacerbated risk and the denial of other coping measures revealed in this study, it is necessary to both increase access and adapt services by advocates, therapists, and helpline practitioners. A wide array of services need to be made available, including independent advocacy and peer support, and mentoring services, and new ways need to be developed to reach out to survivors to enable the beneficial implications for their mental health to be related to a sense of community belonging (Philpot at al., 2021). Accordingly, it is critical that services remain available despite social distance restrictions to prevent deterioration in the condition of survivors as well as secondary traumatic stress and burnout among counselors and volunteers working with them, given the shared trauma (Gueta et al., 2021).

Another recommendation is service adjustment. This may include accommodating hours of service to ensure that survivors can contact services discreetly without alerting their abuser (Bradbury-Jones & Isham, 2020). It is also recommended to scale up and leverage existing online short and sufficient psychosocial interventions for survivors, accessible in times of lockdown. Several online interventions for individuals who suffer from interpersonal violence have been proposed and tested for effectiveness (e.g., Nguyen-Feng et al., 2016). However, the current findings also indicate the need to allow face-to-face support and establish a safe haven for survivors.

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The authors of this manuscript have complied with APA ethical principles in their treatment of individuals participating in the research, program, or policy described in the manuscript. The research has been approved by the ethical board committee of Department of Criminology Bar-Ilan university.

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