Psychosocial Support for Women Survivors of Cyberviolence

A manual for service providers responding to digital gender-based violence

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Acronyms

CBT: Cognitive Behavioral Therapy
FGM: Female Genital Cutting
GBV: Gender Based Violence
ICT: Information and Communication Technology
PFA: Psychological first aid
PTSD: Post-traumatic stress disorder
TFV: Technology Facilitated Violence
VAW: Violence Against Women

Definitions and Concepts:

Cognitive Behavioral Therapy (CBT): A form of goal-oriented psychotherapy that addresses negative emotions and unhealthy behaviors through understanding and changing unhealthy thought patterns. This form of psychotherapy takes a practical approach to problem solving and stress management.

Female Genital Cutting: Also referred to as female genital mutilation (FGM), refers to "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for cultural or other non-medical reasons."[1]

Psycho-education: Psycho-education is a process used in psychotherapy that aims to educate clients and their support systems (e.g., family) by providing information and resources about mental health issues to promote coping strategies and resilience.

Online Gender-Based Violence (GBV) / Violence Against Women (VAW) / and Cyberviolence:

The Office of the United Nations High Commissioner for Human Rights defines online violence against women as "Any act of gender-based violence that is committed, assisted or aggravated (in part or fully) by the use of ICT (examples: using mobile phones, smartphones, internet, social media, email) against a woman because she is a woman or affects women disproportionately." [2]

In this document, both terms "victim" and "survivor" will be used to refer to someone who was subjected to violence. For years, humanitarian workers have been advocating for the use of the term "survivor" (considered a more empowering term), referring to someone who has been able to overcome an incident of abuse despite being victimized, giving them some power over their life events. However, in recent years, many victims have been reclaiming the term "victim", arguing that the humanitarian aid community cannot dictate how victims should feel, as some people do feel victimized and have not yet been able to overcome the violence incident. In addition, the term "client" will be used to refer to individuals who access community services or psychosocial support. Depending on specific contexts and examples, the manual uses the terms technology-facilitated violence (TFV), online Gender-Based Violence (GBV) and online Violence Against Women (VAW) interchangeably.

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[1] UNFPA. (2020). Female Genital Mutilation. https://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions#:~:text=elimination%20of%20FGM%3F-,What%20is%20female%20genital%20mutilation%20(FGM)%3F,or%20other%20non%2Dmedical%20reasons .

[2] https://www.ohchr.org/sites/default/files/HRBodies/HRC/RegularSessions/Session38/Documents/A_HRC_38_47_EN.docx

Chapter 1- Introduction

This chapter introduces the objectives of the *Psychosocial Support for Women Survivors of Cyberviolence* manual and its target audience. The section will also give an overview of the Salam@ project, which contributed to the data used to develop this manual.

THE SALAM@ PROJECT

Women, youth, and civil society organizations are increasingly the target of threats and attacks online. Yet, there is a serious lack of knowledge and capacity to effectively address this issue in the MENA region. Salam@, the Digital Safety for Women and Youth in the MENA Region program aims to change perceptions and behaviors, increase public awareness of digital safety, and build the lasting capacity of women, youth and civil society organizations to operate safely online. Working closely with local partners in Jordan, Morocco, Algeria, Tunisia, Kuwait, Libya, and Bahrain, the program adopts a "public health" approach to addressing online risk and violence, from running public awareness campaigns through to hands-on-training and support in digital safety best practice. Salam@ is implemented by the SecDev Foundation, which has been at the forefront of digital safety globally, identifying and responding to digital needs, with significant presence in Asia, Eurasia and the Middle East. The Foundation develops creative and culturally sensitive approaches to engage the general public on digital safety matters.

Digital safety is not only a technical or legal issue; it is a public health issue as it affects most families and individuals in the society. A holistic approach that views digital safety dynamics with a public health lens enables the Salam@ program to explore and unpack multiple dimensions of gender relations and power dynamics. Current Salam@ efforts in the region include:

- Raise broad-based awareness on digital skills and best practices for women and girls.
- Build local capacities for digital resilience, through targeted digital safety basics training and the development of female digital advocates.
- Provide emergency response/impact mitigation for women and civil society organizations supporting women who have been attacked online.
- Provide cases of online GBV with rapid response support and mitigation, and/or referrals to reputable local support services providers, as needed.
- Enhance evidence-based knowledge and practice for women digital resilience through case studies research and identification of needs, gaps, resources, potential interventions and opportunities.
- Nurture a local digital safety network for stakeholders to advocate at a national level.

PURPOSE OF THE MANUAL

The *Psychosocial Support for Women Survivors of Cyberviolence* manual is evidence-based guidance for service providers, project managers, and frontline workers who address issues related to online GBV and TFV. The manual outlines how to establish a remote or in-person case management and psychosocial services provision system and is intended to:

- Unpack and discuss the consequences of cyberviolence on women's lives in the MENA region.
- Provide guidance on effective case management and psychosocial support to women and girls survivors of cyberviolence.
- Suggest a referral pathway for case managers.
- Outline basic psychological first aid.
- Advise on how to provide effective and secure remote and online services.
- Provide guidance on how to prevent burnout and other psychological consequences that can result from working with survivors of GBV.

INTENDED AUDIENCE

The manual is a tool for groups and individuals providing services to people affected by online GBV, including frontline workers, social workers and case workers, community workers, health care providers, counsellors and therapists, among others.

METHODOLOGY

In developing the manual, the Community Hub team first conducted a desk review of best practices in case management and psychosocial service provision to women and girls survivors of cyberviolence. The team then interviewed frontline workers associated with the Salam@ program in the 7 countries of operation, as well as with psychosocial service providers in Yemen, Tunisia, Jordan, and Egypt. Interviews focused on capturing the experiences of project coordinators and service providers. These formal discussions identified the type of violence they dealt with and their main challenges in understanding and responding to online GBV. Based on the interviews, the team was able to identify priorities and gaps in knowledge and capacity for service providers to prevent and respond to cyberviolence against women.

CYBERVIOLENCE AGAINST WOMEN IN THE MENA REGION

Cyberviolence is enabled by existing structures of inequality for women around the world. The gender power imbalance that exists at all levels of society is detrimental to women in many ways,

and disguises, justifies, normalizes and perpetuates VAW. Women in MENA also suffer from legal and cultural norms of inequality, with policies and practices that include male guardianship, Female Genital Cutting (FGC), early marriage and honor killing. While in many ways the digital sphere has created opportunities and spaces for women, the unfortunate reality is that gender power dynamic is already highly integrated into digital access and activities.

Cases throughout the manual demonstrate how abusers inflict physical or emotional abuse on women and girls in response to their online activity. At the same time, violence is inflicted using digital platforms and communications.

Digital technologies and online spaces are considered to be the 'public sphere', and accordingly, gender power imbalances and male guardianship are extended to women and girls' online activities; heavy surveillance and a set of conditions are often enforced by parents or male guardians. Girls are commonly instructed by their 'guardian' to use fake names or accounts, avoid use of personal pictures, share passwords with parents or male guardians and limit online interaction with specific circles. As a result, women and girls are forced to practice self-censorship.

Beyond the restriction of women and girls' activities online, there also has been an increase in violence against women related to digital technologies; a concerning trend is present of women facing harassment, violence, or attack because of their online activities, as well as technology-facilitated attacks against women, including cyberbullying, cyberstalking, spying, blackmail, doxxing, creation of deepfakes, etc. In one extreme case in 2019, a young Palestinian woman, Israa, became the victim of a suspected honor killing in the occupied West Bank. Israa was abused and ultimately killed by her brother after posting a video of herself on an outing with her fiancé ahead of the wedding. Brutal attacks against women who share digital content that their family members deem inappropriate are devastating and further reinforce a restriction on women and girls' activities through trauma and fear.

Male guardianship was institutionalized in Saudi Arabia until 2018. Women also still require permission from male relatives to issue a passport, study abroad or get married. Female Genital Mutilation is still brutally practiced on girls in many countries like Egypt, although officially banned by law. It is estimated that 37% of women in Arab countries have experienced domestic violence[3]. Comparison within countries shows that domestic violence is relatively high in

[3] UN Women. (n.d.). Facts and Figures. Retrieved October 25, 2020, from https://arabstates.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures

Morocco (over 50% percent)[4], Egypt (30 percent)[5], and Algeria (1 in 6 women). Egypt has exceedingly high rates of sexual harassment, with around 99% of women being subjected to sexual harassment in the public and private spheres, and several incidents of mass sexual assaults have been reported since 2005 including some cases of politically-motivated violence.[6]

Like all forms of VAW, cyberviolence is normalized in both law and society. Several penal codes in the region-- including in Jordan, Egypt, Syria, and Lebanon-- give a reduced sentence to a perpetrator when the crime is motivated by protection honor. Furthermore, victim-blaming is strongly reinforced by society and in some cases even by service providers, and internalized by women and girls themselves.

The nature of the internet exacerbates these issues and further reinforces the unequal gender power dynamics involved in VAW; users can be disguised, violators can fall outside the boundaries of legal systems, information can be quickly disseminated, and personal data and information is more vulnerable to hacks and theft. All of these factors make women's online experience extremely risky and the violence they experience highly dangerous. Yet, resources to address the issue are scarce. Furthermore, the nature of online violence is still not understood and rationalized by service providers, and therefore women are not receiving the psychosocial support they need.

GUIDING PRINCIPLES

A set of principles and values should guide the work of individuals working with a survivor of any form of violence, in order to ensure the autonomy and safety of the individual. Any violation to these principles can put the survivor in danger. It is essential for service providers to develop skills, education and self-awareness to have insight into any biases, stereotypes, and perceptions that impact their work with survivors of violence. In addition, it is important to be aware of one's personal traumas and triggers to ensure the safety and the well-being of the service provider and by extension, the survivor. Ideally, service providers work with supervision and professional collaboration, in order to process, discuss, and reflect on skills, responses, actions, and feelings with an experienced psychologist or social worker.

The following are key principles for regulating the psychosocial support work to ensure the safety and security of the service provider and survivor.

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[4] Kasraoui, S. (2019, May 15). New Survey Shows High Rates of Violence Against Women in Morocco. Retrieved October 25, 2020, from https://www.moroccoworldnews.com/2019/05/273120/survey-high-rates-violence-women-morocco/

[5] Wassef, N. H. (2018). Domestic and Social Violence against Women during the Egyptian Uprising. *Mediterranean Journal of Social Studies*. Retrieved from http://archive.sciendo.com/MJSS/mjss.2018.9.issue-1/mjss-2018-0020/mjss-2018-0020.pdf

[6] Abdelmonem, A., & S. G. (2017). Action-Oriented Responses to Sexual Harassment in Egypt: The Cases of HarassMap and WenDo. *Journal of Middle East Women's Studies, 13*(1). Retrieved from https://harassmap.org/storage/app/media/uploaded-files/project_muse_648034.pdf

Survivor-Centered Approach

Client-centered or survivor-centered care fosters a supportive and empowering environment, offline or online, for the survivor to ensure that they are understood, their needs are met and that their choices are respected. This approach emphasizes the importance of acknowledging that each person's experiences and reactions are unique to them. Some people will choose to report an incident and others will not, depending on how supportive and safe their environment is; emotional responses to abuse may look very different from person-to-person. A survivor-centered approach also emphasizes the right for all survivors to be educated about options and resources available to them. This is often a challenge in most communities in the MENA region as stigma surrounds victims of harassment and violence and may inhibit their access to proper support.

Initiatives launched by development organizations and governments that encourage women and girls to "speak up" and report violence must also pay close attention to social and legal outcomes for victims. Rates of prosecuting perpetrators of violent crimes are statistically low; at the same time, confidentiality of the victim's identity is not reliably protected, which puts victims at further risk of threats and retaliation. Overall, there remains a culture of "blaming the victim" for violence and harassment, and with a long and expensive road to justice, it is unsurprising that women and girls would be hesitant to report on crimes. This becomes even more complicated in cases involving TFV because offenders are sometimes in other jurisdictions and therefore a careful consideration of the consequences for reporting should be considered.

A survivor-centered approach can address some of these challenges for women and girls to report abuse, however there are challenges to implementing it in collectivist societies that tend to put more weight on social harmony than the individual wellbeing. It is important for service providers to center the priorities and wishes of their client when providing psychosocial support. In some jurisdictions, service providers are instructed by the state to take reconciliation steps in cases of domestic violence, before taking any legal action against the abuser or assisting the woman to leave the situation. In small communities that suffer from lack of resources, it is not unusual for psychosocial and VAW services to be provided by community members who are not properly trained or regulated; while the community member may have good intentions, it is essential that a service provider have appropriate training on GBV support and victim protection.

Survivor-centered care is stressed throughout the manual to reinforce that service providers must maintain objectivity and respect the experiences, values, and priorities of the victim/survivor. The role of the provider is to facilitate an informed decision by making resources easy-to-understand and evidence-based information accessible.

Right to Confidentiality

The right to confidentiality means that information disclosed by the survivor is not available, accessible, or sharable to anyone without the survivor's explicit consent.[7] Consent in this context is the process of agreeing to share information or participate in the process of case management or receiving support. A client should be informed on the scope of support services and how their personal information and related documentation will be stored, treated, analyzed, and shared by the service provider.

The definition and application of client confidentiality differs across the MENA region; considerations such as the role of the family may interfere with client confidentiality. Service providers and people accessing services have reported that boundaries of confidentiality can be blurred in the local context; in cultures where the societal good and family ties are prioritized, informing a victim's family or spouse may not be viewed as a confidentiality breach. Furthermore, service providers sometimes focus on the role of providing mediation between women or girls survivors of violence and perpetrators, especially in cases where the perpetrator is a family member.

In one example from the region, a young girl was referred to a community center by her PSS service provider, who disclosed to the local center that the girl had been a victim of rape by an older man who targeted and groomed her online. The client had not consented to the details of her assault being shared. The PSS provider's intention was to support the young girl, however the breech in privacy and confidentiality put her at risk of discrimination, victimization, and stigma. It is critical that the client consents to any details of their personal information being shared, even for the purpose of support services referral. This is particularly important for service providers that receive cases and deal with victims through online platforms. It is important for the victim to understand who can access her information.

Client confidentiality when working with victims of cyberviolence goes hand-in-hand with the survivor-centered approach to service provision and is essential to client safety and healing. Individuals should be in control of how their cases proceed, and the service provider must prioritize the needs and preferences of the survivor. In this sense, the service provider should not, in any circumstance, reveal information about the violence to the victim's family, even if they deem it necessary for their wellbeing. An exception would be if the individual is at risk of inflicting harm on themself or others, in which case proper channels for mandatory reporting

[7] USAID, GBV IMS, Primero, IRC, International Medical Corps, UNHCR, . . . UNICEF. (2017). Interagency Gender Based Violence Case Management Guidelines. Retrieved from http://www.gbvims.com/wp/wp-content/uploads/Interagency-GBV-Case-Management-Guidelines_Final_2017.pdf

should be followed. More in-depth details of confidentiality and how consent should be handled and given online are provided in Chapter 3.

"Do No Harm"

The "Do No Harm" principle requires humanitarian actors and service providers to ensure that their interventions do not put survivors of violence at further risk of harm and trauma. Clear reporting mechanisms and a code of conduct for frontline workers and service providers can prevent further harm from happening.

The ''Do No Harm" principle starts with a strong sense of cultural sensitivity by the service providers, as well as a solid foundation, training, and competency in the services being offered. In addition, the principle requires a great deal of self-restraint to separate one's values and beliefs from the provision of care and services. Particularly in the case of digital violence, it is important for service providers and first responders to have a solid grasp on the aspects of women's rights and experiences that intersect with their online activities. For instance, a common digital safety guidance is to "never share your password". However, sharing a password to online accounts with male guardians may be a condition for women to access the internet or their device, and refusing to do so may raise suspicion or prevent the individual from using the accounts at all. As in this case, understanding the cultural and personal context of the community/individual being supported is essential to providing appropriate care and avoiding causing further harm.

Empathy

Empathy is one of the most important qualities that a service provider or anyone working with survivors of violence can have. Empathy is defined as the ability to understand what others are experiencing while considering their thoughts, feelings, environment and world view and accepting them.

Empathy is different from sympathy-- the feeling pity or sorrow towards the survivor, which can increase victimization and potentially cause further emotional harm. Empathy is usually reflected through body gestures, facial expressions and tone of voice. Calm voice, being engaged, active listening, appropriate eye contact, and allowing and being comfortable with silence while providing a service are all characteristics of an empathetic service provider. Looking at a notebook or asking too many or too detailed questions could reflect a non-empathetic attitude. While victim blaming is a global problem, it is very widely normalized and accepted in the MENA region, often even by the victims themselves. It is therefore crucial that service providers do not ask questions that may suggest victims should blame themselves for their actions or decisions. Both the content of the question and the manner in which it is asked can affect how the victim

interprets it. Common problematic questions include: Were you alone? What were you wearing? What time did this happen? Did you have a strong reaction to the violence? Victim-blaming in digital violence extends to questions like “how come you had such a weak password?” or statements like “You should have never clicked on a link” and “you shouldn’t send personal pictures to anyone on the phone”, and “you shouldn’t even store them on your phone”

It is also important that a service provider not have a sympathetic reaction. Crying or reacting intensely to the story of the survivor would reflect a sympathetic attitude and lack of experience, which would make the survivor feel victimized, and feel like they are losing control and power. This, in the long run, would have negative consequences. It may create a relationship where the survivor is dependent on the service provider may deepen feelings of victimization, making it hard for the survivor to recover from the violence they were subjected to, or it may discourage the individual from accessing support in the future.

Empathy can also be demonstrated when providing virtual or remote services. Service providers can validate and acknowledge the survivors’ feelings and experiences by ensuring they feel heard, allowing them to tell their story without interrupting for unnecessary or excessive details, and allowing them the space to talk and express themselves.

In societies where women’s conduct is linked to their “honor”, it can be the case that empathy is expressed only towards those who are perceived to be worthy. Service providers must be able to separate personal bias and should not assess the stories of the survivors based on their own personal beliefs. All victims are worthy of empathetic care that is free of judgement. A person who experienced physical abuse is not more or less worthy of support than someone experiencing emotional or financial abuse; similarly, violence committed by a family member/spouse should be treated with as much seriousness as an attack by a stranger. Selective empathy with digital violence is a big problem as well, especially blackmail cases: a victim who is blackmailed with stolen pictures is much more likely to get sympathy than a victim who has been blackmailed by pictures that she has willingly shared.

Chapter 2: Cyberviolence

This chapter will define the different forms of cyberviolence and provide examples of how women and girls in the MENA region experience abuse in the digital space.

Information and Communication Technology (ICT) has had an immense, positive impact on the status of women and marginalized communities. It has created platforms for individuals and communities to express themselves, make their voices heard, organize political and social movements, and gain access to virtual public and private spaces. At the same time, digital platforms and spaces have also proven to embody the gender power dynamics that harm women and subject them to violence.

TFV, including online gender-based violence can take many forms: perpetrators can be trusted family members, acquaintances, or strangers. Consent-- whether with regard to sharing personal information and photos or to online advances and interactions-- is not widely practiced or respected in online spaces. In addition, the online sphere affords protection to abusers, not only protecting their identities, but also protecting them from legal repercussions depending on their physical location. Finally, the speed and efficiency of data transfer on the online sphere combined with reduced control over data (e.g., inability to delete trails of information and pictures) compromise users' privacy and safety. In the MENA context, personal privacy, especially for women and girls, is a sensitive issue. Public exposure of a woman's photos, communications, or information can have serious consequences. This section outlines several forms of digital violence that threaten the ability of women and girls to operate safely and freely online.

BLACKMAIL

One of the most common forms of online GBV seen in the MENA region is blackmail**.** When a perpetrator uses information, photos, or communications (whether legitimate or fabricated) about an individual and threatens to release the information, it is considered blackmail. Commonly, an abuser will threaten to expose personal photos or online relationships/communications with a woman's family members or on public forums. In some cases, the information/documentation is obtained when the woman shares it voluntarily, under a pretense of privacy, and sometimes the information is obtained through hacking or scams; in both cases threatening the release of these materials is considered blackmail and should be taken seriously. The consequences for women whose personal information and files are exposed can be severe- including blame and punishment from their families, social stigma, personal and professional impacts, alienation, and in extreme cases physical violence or murder.

According to interviews with service providers in Jordan, Egypt and Tunisia, this form of cyberviolence seems to be the most common form they see among their clients. Perpetrators count on the intense fear of women from dishonoring family members, social shame, and the consequences of breaking gender norms. Many examples exist of intimate partner violence and the use of blackmail, in which a partner or former partner will threaten exposure of information or documentation about a woman or girl to gain leverage or control over, or as retaliation in the case of disagreements or breakups. Blackmail is often driven by a desire to seek revenge, humiliate the victim, or in return for sexual favors. In some cases, perpetrators have blackmailed women for money, and because of the extreme fear and shame victims live in, a victim may continue to finance the perpetrators for months and years.

While blackmail predates the internet as a form of violence against women, the ease of communication through the online sphere, and the digital footprints have made it easier for perpetrators to reach and violate women, and to threaten them more fiercely. According to a psychologist from Jordan, "several girls under the age of 18 don't know that they are being subjected to violence although they are being subjected to manipulation, abuse and sometimes sexual assault. They come to complain about the lack of emotional engagement from their partner (online)." These girls usually have to keep the abuse a secret and feel trapped in the relationship because they don't know how to disentangle from the abuser.

In recent years, online resistance and social movements have materialized in response to cyber blackmail. In Syria, for example, several initiatives launched to allow women and girls to discuss and report cyberviolence. In an article by Deutsche Welle, women discuss experiences with blackmail from ex- partners who demanded non-consensual acts, using the threat of exposing intimate photos to their families. Other initiatives, like Gardenia (2019), have responded to around 1100 women who have shared their stories with different forms of violence, especially cyberviolence. For instance, one initiative that was founded at the start of the pandemic to combat digital violence in Syria is called "No to Cyberviolence", and was a successful campaign on Facebook. This group was founded as a response to the founders' recurrent experiences with online GBV. The aim of the group is to act fast to report and block perpetrators from social media.

Blackmail is also used in conjunction with smear campaigns to target high profile women leaders, including politicians, journalists, and activists. There are several cases of women from MENA countries who were targeted with online attacks and blackmailed with private photos to force them to quit their elections campaigns, jobs, or retract from a political position. Ghada Oueiss and Ola Al- Fares, journalists at Al Jazeera, were targeted after covering new findings about the murder of Jamal Khashoggi in 2020. Private and photoshopped pictures were used to blackmail them into quitting their jobs. The hashtags #Ghada_Jacuzzi and #Ola_Sauna were trending on Facebook and Twitter in a smear campaign that claimed that the women obtained their

professional positions through sexual favors. In Palestine, the journalist Hagar Harb, has been subjected to bullying, trolling, and death threats for covering controversial social and political issues and investigative reports about the corruption happening in the Palestinian government. These campaigns aim to intimidate, discredit the work of women leaders, and ruin their reputations; such coordinated efforts are rarely seen targeting men in the same public roles. As a result, many women shy away from participating in the public sphere to avoid such violence.

NON-CONSENSUAL SHARING OF PHOTOS

A recent campaign was launched in Egypt (2020) against a male 'fraternity' group at the American University in Cairo (AUC). Screenshots on social media showed that the group shared over 700 naked and sexual photos of women and girls, in some cases along with identifiable information. In addition to having their personal photos exposure, the victims were also harassed by people who accessed their information via the group. This non-consensual pornography case demonstrates how the digital footprint, and online communications can strongly exacerbate violence against women online with faster and broader exchange of information.

DOXING

Doxing is the act of publicly revealing private personal information about someone, such as their address, place or work, private contact information (of the person, or a family member), etc. Doxing sometimes happens simultaneously with sharing non-consensual distribution of personal Images. Doxing is often exercised for public shaming or to invite further harassment or threat of violence to the targeted individual

SEXTORTION

Sextortion is a type of blackmail in which someone pressures another person to send them content of a sexual nature, money, sexual favors or other, by threatening to distribute their private and sensitive material. A Tunisian psychologist who works with service providers on provision of psychosocial services to survivors of cyberviolence, gave an example of a group of women who were controlled and abused by a perpetrator for years, asking them to send content of sexual nature, tattoo certain messages on their bodies, and send large amounts of money to the perpetrator's account by threatening to share intimate photos of the women; it was later revealed the account was fake and run by an acquaintance who was targeting the women.

CYBERSTALKING

Many ICT tools and applications are used by perpetrators, including intimate partners, to facilitate stalking, abuse and coercive control by following an individual's activities and movements using their digital footprint, and/or by hacking their personal devices and accounts. ICT and social media have greatly facilitated stalking and harassment of women and girls. Snapchat, for example, has a map feature that abusers use to track their victims in great detail. Hacking phones, using hidden digital cameras, and GPS tracking of vehicles are also used to stalk victims. Previous experience and research have shown that stalking by intimate partners can be highly dangerous. According to a study by Woodlock (2016), cases involving intimate partners lasted 2.2 years on average, compared with 1.1 years for stalking by others. Stalking and cyberstalking are also strongly associated with homicides and attempted homicides.[8]

In a recent case, an Egyptian man was cyberstalking women and using social media and other ICT tools to track and blackmail them, in return for sexual favors. As a result, an Instagram page called Assault Police started a campaign specifically to collect anonymous testimonies from girls and women who were harassed and assaulted by this man. The effort collected more than a hundred testimonies of sexual assault, sexual harassment, extortion, and blackmailing from the same individual. In another case, a young student shared her story of being blackmailed for years after sending a picture of herself to a peer. Her peer blackmailed her with this picture and asked her for sexual favors at school in return. She experienced shame, depression, self-harm and suicidal ideation, and was cut out of her social circles, forcing her to change schools. Years later the pictures were shared on the AUC campus group, taking her back to how she felt when she was 14. She explains "that's it, the life I built for myself was over. For months after the incident, everywhere I walked on campus I felt like everyone was looking at me. I started wearing oversized sweatshirts with the hood up and sunglasses every time I went to my classes."

GENDER TROLLING

Trolling is another form of violence, sometimes targeting women in the public sphere, and aims to provoke, irritate and insult. Trolling is undertaken by a group of social media users who wage a brutal war of violent and abusive comments, blackmail, and threats against the targeted woman. The anonymity provided by social media provides a sense of safety for the perpetrator to act however they want, thinking they will not be held accountable, a phenomenon referred to by psychologists as the online disinhibition effect. The MENA region is full of examples of women politicians and journalists who have been forced out of public work by online trolls. According to

[8] Council of Europe. (2018). Mapping study on cyberviolence. https://rm.coe.int/t-cy-mapping-study-on-cyberviolence-final/1680a1307c

the International Federation of Journalists, one in two women journalists experience sexual harassment, psychological abuse, online trolling and others forms of GBV that targets their professional life. Similar to the cases of Ghada Oueiss and Ola Al-Fares, Dima Sadek, a former reporter and show host at LBC TV Channel, was subjected to trolling in 2019 after supporting protests against the Lebanese government. Photoshopped and faked photos sexually objectifying her were spread on the internet and sent to her family members. Rachel Karam, Nancy Sabeh, Halima Tabiaa, and Layal Saad are also other Lebanese journalists who have been targeted by online defamation campaigns of a misogynistic nature. Tawakkol Karman, the Yemeni human rights activist and Nobel Peace Prize winner was also subjected to a smear campaign online by Saudi media accusing her of having ties with the Muslim Brotherhoods after she was appointed to a position on Facebook's Oversight Board.

The problem with trolling and the online disinhibition effect is not only how it is reflected in the behavior of the troll, but also those who are referred to as "witnesses" or observers around the victim-- other men and women approving, liking and supporting abusive and misogynist comments and attitudes. This creates an overwhelming sense of lack of safety and extreme danger to the victim and has serious psychological impact.

PSYCHOLOGICAL IMPACT OF CYBERVIOLENCE

Online GBV is specific in nature and has serious, negative psychosocial impact on its victims. A study published by Cambridge University Press in 2018 studying 100 victims of cyberstalking showed that all except 6 made major changes in their social and professional life as a direct impact of the cyberviolence: 39% moved from their homes, 53% quit their jobs, 55% experiences nightmares, disturbances in appetite and sleep, 83% suffered from anxiety, 37% fit the diagnosis of PTSD and 24% experienced suicidal ideation.[9] Women, and especially young women and girls, who experience cyber sexual harassment are not aware of available resources for them and they usually suffer from shame and loneliness resulting in a higher probability of self-harm. Unfortunately, there has been little research and data on the psychosocial impact of cyberviolence on women in the MENA region. Through the work of the Salam@ program, some patterns have been observed and documented on the impacts of online GBV. Similar to global trends, women survivors of cyberviolence do experience increased anxiety, disturbances in appetite or sleep, and some examples have shown suicidal ideations, self-harm, and in some cases death by suicide. Yet, some of the most significant patterns amongst survivors of cyberviolence are increasing self-blame and believing that their activities and choices caused the violence to happen. In many cases, victims experience changes in self-image and self-perception which can impact their actions and choices in their lives moving forward.

[9] Pathé M, Mullen PE. The impact of stalkers on their victims. *Br J Psychiatry*. 1997; 170:12-17. doi:10.1192/bjp.170.1.12

Internalizing Blame

Another significant pattern in work with survivors of cyberviolence is internalized blame and shame. This was highlighted from the interviews and clearly described by one of the service providers supporting women of online violence in Jordan: “They tend to experience more guilt and shame in being subjected to online violence, because they feel like they are part of the problem and should be blamed for it since they used the internet insecurely.” According to Dr. Garbouj, when working with women survivors of online violence “the first step is to work on building their confidence, the second step is making sure that they recognize that they are victims and do not feel responsible for the violence and working on the shame and guilt they feel.” She tells the story of a focus group she conducted with a group of women who were subjected to sexual harassment while using public transportation. When asked how they feel when subjected to sexual harassment in transportation, the majority expressed feelings of guilt. When Dr. Garbouj questioned the reason behind the guilt, some of the women explained that by being in public transportation, they intruded on a male sphere or domain and that their existence enticed men to harass them. This sentient of shame, guilt, and taking blame for attacks or harassment is not uncommon among women victims of cyberviolence.
This is also reinforced by some digital safety advice available to women. Instead of teaching women about safe internet tools and tips on account protection, some digital safety advice focuses on restriction, urging women to stop using or sharing pictures and information online, and to limit their online activities. This advice does not only affect women’s gains from the online sphere, but it also puts a burden on women for any violation they experience. It echoes the common advice that women are responsible for preventing sexual harassment in the streets: ‘do not go out often, do not go out at night, do not go out alone’ as well as putting restrictions on women’s behavior in the public sphere. These responses inhibit women’s participation online and reinforce victim blaming, and as a result increase the tendency of women to self-censor themselves.

Uncertainty and Fear from Perpetrator and Defamation

Another common characteristic that has been exhibited by women victims/survivors of cyberviolence is extreme fear and uncertainty. Following online abuse or attacks, women may experience extreme fear and psychological and social isolation that could lead them to withdraw from the online sphere, self-sensor their online engagement, and/or close down social media accounts. In some cases of trolling, harassment, or smear campaigns, the targeted woman continues to receive harassment, including threats of violence, for weeks, months, and sometimes years. The persistence of the abuse has severe implications for the individual’s health and wellbeing and in some instances, online violence does evolve into physical harassment and violence. In Morocco, there was one devastating case in which a 16-year-old girl who survived

sexual assault received relentless online harassment and blackmail with photos from the incident, demanding that she drop charges against the men who raped her; the young girl died by suicide as a result of the abuse.

As stated by Dr. Garbouj "the perpetrator lives under the illusion of being more powerful and less likely to be punished behind the screen. He/ she also thinks that the victim is less powerful and more vulnerable behind the screen." In a research study done by Amnesty International in 2017 on the experiences of women online in a number of Western countries, one high profile woman received around 200 abusive messages a day and said:

> *"The psychological impact of reading through someone's really graphic thoughts about raping and murdering you is not necessarily acknowledged. You could be sitting at home in your living room, outside of working hours, and suddenly someone is able to send you an incredibly graphic rape threat right into the palm of your hand."*[10]

In fact, there are several examples in which online violence, blackmail, and threats lead to offline violence. Many women have been forced to leave their jobs; especially public positions, some were forced to hire private security, others were murdered. In Iraq, a 22-year-old Instagram influencer named Tara Fares was shot in her car and died. Fares received death threats from unknown men who thought of her content as indecent and inappropriate. During that time, other influencers received the same threats. Ms. Iraq, Shaimaa Qasim, reported that she received messages from unknown men warning her that she "would be next."[11]

Impact on Sense of Self

Cyberviolence impacts every aspect of women's wellbeing, not only causing psychological symptoms but also affecting their self-image and sense of self. Research has shown that cyberbullying is associated with a series of personal problems such as excessive worrying and a lower sense of self-worth.

Through the interviews, it was clear that the shock women experience when betrayed by someone they know and trust deeply affects their self-esteem and confidence. A service provider working with survivors of violence in Egypt stated that most of the cyberviolence survivors are blackmailed by their partners or ex-partners for revenge, money or custody of the children. In many cases, the women are in complete denial of the situation and unable to process how a person they love would intentionally harm them, their reputation, and their family. In some cases, it is apparent that the crime is premeditated, with photos or videos taken by the partner

[10] Amnesty International. (n.d.). *Amnesty reveals the alarming impact of online abuse against women*. Amnesty International. https://www.amnesty.org/en/latest/news/2017/11/amnesty-reveals-alarming-impact-of-online-abuse-against-women/ .
[11] Tarawnah, Naseem. (2020). Sextortion, harassment, and deep fakes: How digital weapons are being used to silence women. Ifex. https://ifex.org/sextortion-harassment-and-deepfakes-how-digital-weapons-are-being-used-to-silence-women/

with the intention of using it for harm or leverage later on. The interviews from Tunisia and Jordan echoed the same concern; Dr. Garbouj also talked about how women and girls express self-contempt which later affects their trust in their own decisions and judgements.

CHALLENGES IN DEALING WITH CYBERVIOLENCE AGAINST WOMEN

Social And Legal Challenges

There are social and legal factors that challenge the process of reporting and charging people who commit acts of GBV. In cases of TFV, the challenges are even greater. First, the social practice of 'blaming the victim' strongly discourages women from coming forward in fear of being blamed for harassment or violence. Women and girls are often perceived as at-fault if they break social and cultural traditions before or during the abuse, or for "unsafe" use of the internet. Further, victims are often hesitant to come forward to report a crime out of fear of retaliation from their abuser, or other repercussions. A number of the individuals interviewed felt that they allowed the violence to happen, for example by responding to blackmail out of fear. The interviews with service providers made it clear that reporting incidents of cyberviolence is highly dependent on the cultural background of the victims and the availability of a trusted support system. A service provider from Egypt talked about women from an area with families from conservative backgrounds. She notes that a woman or girl might not come forward at all to report violence or abuse, and if she does, the outcome rarely works out in her favor. There have been instances where a woman being blackmailed by her ex-partner is advised by family to give up her marital and child custody rights in exchange for keeping photos/information private. In addition, girls who have been groomed and abused by men online may be pressured to marry the abuser. Reporting is even rarer in TFV cases because of anonymity and jurisdiction. Oftentimes, the offender is anonymous and this may discourage authorities from investigating the case. Also, if the offender lives in another legal jurisdiction (country), the process to charge the offender would be long and complicated. The screenshot below shows the journey of a father who tried to report an incident where his Egypt-bound daughter was blackmailed by a man living in Dubai. Even though he was adamant to report the incident, the involvement of two law enforcement systems and the necessity of their cooperation essentially hinders the process.

Policing Women's Online Activities

Women's online behavior is strongly policed by society, and often by authorities, which also contributes to women's fear of report. In societies where women's bodies and behavior is constantly policed and under control by men in authority, women are often punished for actions that others deem inappropriate. Acknowledging how inter-sectionalities play a role in controlling and policing women's bodies in MENA societies is also important. For example, women who wear a headscarf feel they are targeted with harassment and claims of "indecency" when they post videos or content on social media platforms. It is also common for women and girls to have their online activities controlled and regulated by family members. Dr. Malak of Jordan discussed how

families may feel they are protecting young women and girls by searching their phones daily, restricting internet access at night, and confiscating phones each evening. Through this discussion, Dr. Malak reflected on whether this behavior is considered protecting or policing and how it impacts the participation of these girls and young women in the public sphere.

Lack Of Experienced Service Providers

Preliminary research from Salam@ program and interviews conducted for this manual have shown that service providers and civil society organizations in the MENA region do not have a full understanding of TFV, its different forms, and how it impacts women and girls. Even service providers who have been trained and have experience working with survivors of TFV, may not appreciate the seriousness of online-GBV, with reports of comments such as "at least the violence only happened online". The perception that cyberviolence is not as serious as physical abuse was observed with almost all groups that participated in Salam@ training. This is a reflection of gaps in understanding and awareness among service providers in the region on the specificity of cyberviolence and its psychosocial impact on its victims. Addressing these gaps will be essential to ensuring women and girls have access to quality support services. Secondary to a lack of understanding or knowledge about TFV, many service providers demonstrate negative attitudes towards survivors of cyberviolence. While conducting the literature review for this manual, the team noticed that many research studies, articles and discussions, including those from mental health professionals, focus on the personality of the victim rather than the abuse waged against them. Victims were frequently labeled as having a personality disorder; analysis focused on why people seek out interactions on the internet, as opposed to investigating the root of the online harassment and attacks. In some texts, victims were also described as having gaps in their emotional intelligence and relations with those around them. These attitudes highly reinforce victim blaming and are disconnected from the experiences of the victims. In the worst scenarios, untrained service providers communicate to the victims that they deserve the consequences they are facing. In one case, a woman sought a service provider after being blackmailed with content by a man she had an affair with. The service provider promised to help them and file a lawsuit to stop the sharing of the pictures but also made it clear that the court would file an adultery case against the client. This is one clear example of how service providers could hurt victims and contribute to their fear and suffering rather than provide survivor-centered care.

Through the Salam@ team interactions with service providers during training, workshops, and individual discussions, it was clear that there was a demand for capacity strengthening for dealing with cyberviolence. Providers identified the need for more knowledge and training on different forms of therapy that would respond to the needs of cyberviolence survivors, including basic counseling and cognitive behavioral therapy (CBT). Dr. Malak expressed that not enough training is available on this kind of violence: "those are clients who were living in the virtual world and

now are back in real life- they have a different experience and we are not trained on how to deal with them". She continues, "when it comes to services, the focus is more on the security forces dealing with cybercrimes, as they are the first step in the process of reporting (formally or informally), and us (social workers and psychologists) are not seen as important service providers for these kinds of cases….several of those cases come back after a few years because they get subjected to a similar form of violence, because they do get the security or legal intervention but they do not get rehabilitation". It was clear that in Jordan, the security forces and police are on the frontline to respond to cyberviolence, not psychosocial workers. As a result, capacity-building efforts and resources are not meeting the psychosocial support needs of victims.

CONCLUSION

While ICT has brought many advantages and advancements to women's access and equality in the public sphere, it has also amplified the problematic gender dynamics at all levels of society, and enabled more and complex forms of abuse and violence against women and girls. ICT has facilitated violence that occurs in the offline sphere, such as intimate partner violence or sexual harassment. For instance, harassers are able to reach the victims easier through mobile phones or social media platforms, also, ICTs has provided tools for surveillance and stalking that offenders use. Blackmailing and non-consensual nudity have also been common problems faced by women and girls globally. In addition, women have been pushed out of the digital public sphere through forms of violence that include trolling and bullying. Unfortunately, there is a lack of research in the MENA region on the psychosocial impact of cyberviolence on women and girls. Yet, experience and research from other parts of the world has shown that cyberviolence victims exhibit specific symptoms due to the nature of this violence. For example, women survivors of cyberviolence are more likely to internalize blame and believe that they caused the violent incident. In addition, a pattern of extreme fear and isolation is observed among victims who lose control of their information, communications, and photos on the internet. Moreover, cyberviolence victimization impacts women and girls' (especially adolescent girls) sense of self and may be related to engaging in high risk and self-destructive behavior.

This manual is a resource guide for service providers, project managers and frontline workers addressing cyberviolence, specifically online gender-based violence and specifically in the MENA region. It is tailored to provide a deeper understanding to service providers on the experiences and needs of women survivors of cyberviolence within this context. It aims to address one of the main challenges in dealing with survivors of cyberviolence, which is a lack of qualified, trained and experienced psychosocial service providers who can support the rehabilitation and ensure the wellbeing of survivors of cyberviolence, which the next chapter will address in depth.

Chapter 3

This chapter will provide a brief overview of the current issues and gaps in the services provided to women survivors of cyberviolence, as well as present the model of psychosocial support services that Salam@ program offers among its community.

In addition to the challenges referenced in Chapter 2, several issues hinder women's access to the much-needed psychosocial support when they are subjected to TFV. Some of these issues are lack of quality mental health support services, inadequate training and supervision among service providers, and a lack of awareness and resources to address online GBV. When a community worker is providing support to a victim of any violence or abuse, it is critical that they practice within their training and scope; providing mental health support or counselling without appropriate training and supervision can cause more harm than good. Additionally, service providers supporting victims and survivors of TFV must have adequate knowledge of the nature and parameters of TFV in order to guide and support women appropriately. If not appropriately trained, service providers may not know when to refer to a specialist or a medical professional. This leaves women who need the referral stranded, and women who do not need the referral may also be subjected to unneeded medication because psychiatrists tend to focus on medication instead of psychotherapy. This may result in women being on antidepressants or antianxiety medication, while what they really need is counseling and psychological support to be able to make informed decisions and break free of the violence.

Second, it is important to note that psychotherapy and mental health support in general is lacking in availability and accessibility to different extents across the MENA region. It is more common to seek medical doctors and psychiatrists and trust them more than psychotherapists and psychologists. This is part of a social perception that psychologists are less qualified than psychiatrists since they are not medical doctors. This also leads to poor educational systems, less investment in training for psychologists and scarcity of resources for them and their clients, impacting the availability and accessibility of this service.

Another major gap that impacts the provision of services for survivors and contributes to the inadequacy of providers is the lack of supervision. Supervision is an integral part of the training and practice process of counseling and psychosocial service provision. It has been defined by the British Association for Counselling and Psychotherapy (BACP, 2008) provides the following explanation:

> *"Supervision is a formal arrangement for therapists to discuss their work regularly with someone who is experienced in both therapy and supervision. The task is to work together to ensure and develop the efficacy of the therapist/client relationship. The*

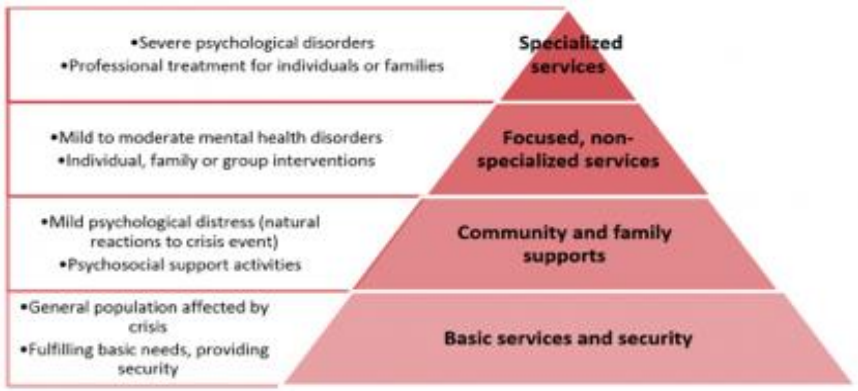
agenda will be the therapy and feeling about that work, together with the supervisor's reactions, comments and challenges. Thus, supervision is a process to maintain adequate standards of therapy and a method of consultancy to widen the horizons of an experienced practitioner."

It allows practitioners to reflect on their own personal struggles, biases, and stereotypes that could interfere with the service provided. In addition, supervision ensures personal and professional growth and accountability. The lack of the provision of supervision results in professional burn out and under trained professionals and clinicians. This has been a common challenge among service providers in areas of conflict, for example during uprisings and natural disasters when resources and capacities are depleted. Psychologists and social workers operate under stressful conditions, overwork themselves, and lack the resources and time for supervision, hence, they start to show signs of secondary trauma and emotional fatigue, in many cases, causing them to leave their jobs. Practitioners working with victims of TFV are also exposed constantly to these kinds of violations, especially if they receive reports online and through their personal devices. This has been apparent in countries like Egypt, Syria, Yemen and Palestine who have all been experiencing different levels of stressful events, conflict and trauma.

LEVELS OF PSYCHOSOCIAL SUPPORT

Different levels of service provision

The Inter-Agency Standing Committee (IASC) reference group on Mental Health and Psychosocial Support developed a multilayered response framework to support and meet the different needs of vulnerable groups. The framework helps to identify the different levels of service provision, draw clear guidelines for the roles and responsibilities of each service provider, and avoid the above-mentioned challenges.



This illustration is based on the intervention pyramid for mental health and psychosocial support in the IASC Guidelines (2007).

The *first layer*; from the bottom up, represents the basic needs of vulnerable communities and includes establishing or re-establishing safety and security. In this regard, service providers and governmental entities need to ensure that the affected groups are accommodated in a safe space, with their basic needs met. Access to safe spaces is often a challenge in the MENA region, with the lack of emergency housing and shelters for survivors of gender-based or intimate partner violence. It is usually a greater challenge for survivors of TFV as they may not be deemed as urgent cases as others, if the violence is happening online.

The second layer represents the interventions required for survivors who show mild trauma response to violence or crisis, for example, mild distress that does not disrupt their daily activities and functioning. This level of care can be provided by a case manager, whose job description is to receive cases, follow guidelines and provide basic psychological support, including assess the needs of the survivor and direct them to appropriate services. At this level, with adequate community and family support, survivors working with a case manager are not likely to exhibit a chronic mental health problem and are able to maintain their overall well-being.

The third layer is focused, but non-specialized, support that can be provided by psychosocial trained workers who receive supervision from licensed and trained psychotherapists. It represents the support necessary for the people who require additional, more focused individual, family, or group interventions by trained and supervised workers. The trained psychosocial worker does not have to be a clinical psychologist or therapist; they can be a service provider who is able to implement a level of focused care with appropriate training. These service providers must also understand the nature, complexity and parameters of TFV. For example, survivors may need a combination of emotional and social support and psychoeducation. This layer also includes psychological first aid (PFA) and basic mental health care by primary health care workers. In the MENA region, the difference between the second and third layer is not always clear for service providers. It is common to find case workers providing counseling and specialized services to survivors. It is not uncommon to even see personnel who assume admin or managerial roles, or lawyers, to provide a combination of these services. Similarly, it is common to see service providers advising victims of TFV without adequately understanding the environment around digital tools and technologies, and gender power dynamics within them. At the organizational level, it would be beneficial for entities to identify a clear scope of work for each of their care providers, taking into consideration training and experience.

The top layer of the pyramid represents the focused and specialized support and interventions needed for the group of survivors who demonstrate serious signs of trauma which disrupt activities of daily living. Assistance at this level should include specialized, clinical psychological (therapeutic) or psychiatric (medical) support. For any organization/service provider creating a

response pathway for victims of cyberviolence, it will be vital to appreciate the local context and the availability and limitations of specialized mental health supports. There are two main challenges when it comes to specialized mental health services in the MENA region. First, mental health care can be inaccessible, either due to high cost or lack of services. Second, the background and training of the mental health professionals with regard to GBV and online GBV. Best practice for victims of online GBV may include a broad scope of treatments and services, as well as an ethical care team that has a deep understanding of trauma-informed care and patient confidentiality. Unfortunately, the availability of both quality diagnostic/medical approaches as well as counselling and different forms of therapy to address cognitive and behavioral issues are not readily available to all communities in the MENA region.

As mentioned above, case management is considered the first step to providing any form of psychosocial support. A case manager would assess, plan, facilitate and follow up with survivors to ensure that they are receiving the services they need. Their job would also entail advocating for clients and communicating with other service providers as part of a circle of client-centered care. Psychosocial support refers to the resources, services, and referrals provided with the purpose of supporting survivors of violence in coping with and overcoming the consequences of violence. The term “psychosocial” refers to the impact of the environment on the psychological state of the survivor, including cognitive, emotional, and behavioral functions, in addition to the social aspect of the survivor’s life and their social integration. This service is provided through several stages: assessment and evaluation, planning, implementation, and follow up.

PROVIDING VIRTUAL SUPPORT

One of the advantages of the online sphere is improved access for women to reach out to both technical and psychosocial support when they face TFV. One challenge with remote/virtual support services is establishing trust with the client, without having face-to-face interaction. This next section outlines guiding practices to the frontline workers or intake staff who receive reports of online GBV and requests for support, with a focus on virtual/remote services.

Outreach

Individuals seeking support services after experiencing online GBV may connect with an organization through referral from a friend, web search, or through referral from another community organization. Organizations/groups offering support services should identify ways to reach their target community, for example through online awareness campaigns, partnerships with other community groups, professional services, and community leaders, or collaborations with schools or training centers. Information and services offered should be clear and easy to find on the organization's website. If referrals are available to legal or psychosocial support, this

also must be clearly mentioned. To promote trust in the organization, it is good practice to have the confidentiality policy clearly stated on the website/social media pages as well. Intake staff who respond to inquiries or requests for services should be well-versed on:

- Gender issues, gender roles and expectations, and gender-based violence
- Social norms and their impact on survivors seeking services or making decisions
- An understanding of a survivor's centered approach
- Active listening and counseling skills and principles, including consent and confidentiality
- Basic knowledge of psychological and mental health responses to trauma and violence to the ability to assess the psychological state of the survivor in order to make appropriate referrals
- Basic knowledge on the legal frameworks related to issues of VAW
- Knowledge of local support services and resources for victims of online GBV

Intake

A major step in setting up virtual support services is creating a process for intake. Organization websites/social media pages should make the contact information clear to individuals seeking support services; users can be directed to contact the support team through email, direct message, and/or phone call or text, etc. An automatic reply message can be set up on any page that offers help to victims/survivors of violence and can explain the confidentiality policy and provide information about data sharing and security. Any confidentiality policy should indicate who has access to the messages sent by the individual and how communications are documented and stored. Furthermore, the user should be assured that their information will not be shared with anyone outside the page except with informed consent.

It is recommended that survivors are all also informed about what this page can, and cannot do, to support the survivor. This would allow the survivor or sender to provide an informed consent for support services.

Guiding Principles for Virtual Support

Confidentiality: Confidentiality means that the survivor's data and information are kept private and there are rules and systems in place to ensure that. It also entails that no data about a survivor is shared with anyone; whether another service provider or a supervisor or others, unless the survivor gives their consent for sharing.

Data Sharing: In the process of providing case management or psychosocial support, any data or information provided by the survivor should be kept confidential and not shared to a third party. The exception is for instances that require mandatory reporting:

- If there are concerns about the safety of the survivor (eg: self-harm or suicide)

- If there is are concerns for the safety of others

In that case, the frontliner should contact the psychologist or psychiatrists that the project is working with to provide emergency intervention. The frontline worker can also contact the emergency contact, if the victim/survivor has provided one. It is important that an organization's leadership reviews any local, legal parameters for mandatory reporting and outlines a clear protocol for staff on when and where to report threats to the safety of the client or others. These conditions should also be included in the organization's confidentiality policy that is provided to each client.

Informed Consent: Informed consent is the voluntary agreement given by the client for services and actions taken on their behalf. Consent must be given based on information of the benefits, limitations or risks of an offered service. The intake staff can explain to the client that there will be no action taken without their informed consent. The service provider can also note to the client that by engaging with the page or sending their questions, they are giving their consent to start the discussion online. For a person to give consent, they should:

- Have all the available information presented to them
- Be over 18 years old
- Be conscious and a right state of mind
- Not be diagnosed with any mental disabilities

In case the survivor is under 18 or has a mental disability, the guardian of the survivor should give consent.

The concept of consent is not uniformly interpreted or applied in service provision in the MENA region. Civil society organizations and advocates struggle with translating the term and applying it to their context; many avoid using it. In some cases, women's consent can be given by a male guardian or an elder. In addition, silence may be understood as consent, based on a famous regional concept that 'silence is a sign of agreement/ satisfaction'. It is important to set these cultural considerations aside, and utilize an evidence-based approach to informed consent. Providing consent is essential to the process of service provision, it ensures that the client fully understands the process they are about to start and are making an informed decision. It also allows the individual to exercise autonomy and control over how their situation is handled, which is considered a first step to regaining control and empowerment after an act of violence

Below is a sample script for an individual conducting a virtual for a client seeking support services:

"*This page provides technical support, and could refer you to the available services. For example: legal consultations, psychological support and other services based on your needs.*

Everything you say in this conversation is confidential, and cannot be shared without your consent.

This conversation will be deleted from this platform. Information that is essential to providing you with future support and referrals will be stored in a secure space without your name and the information will not be identifiable.

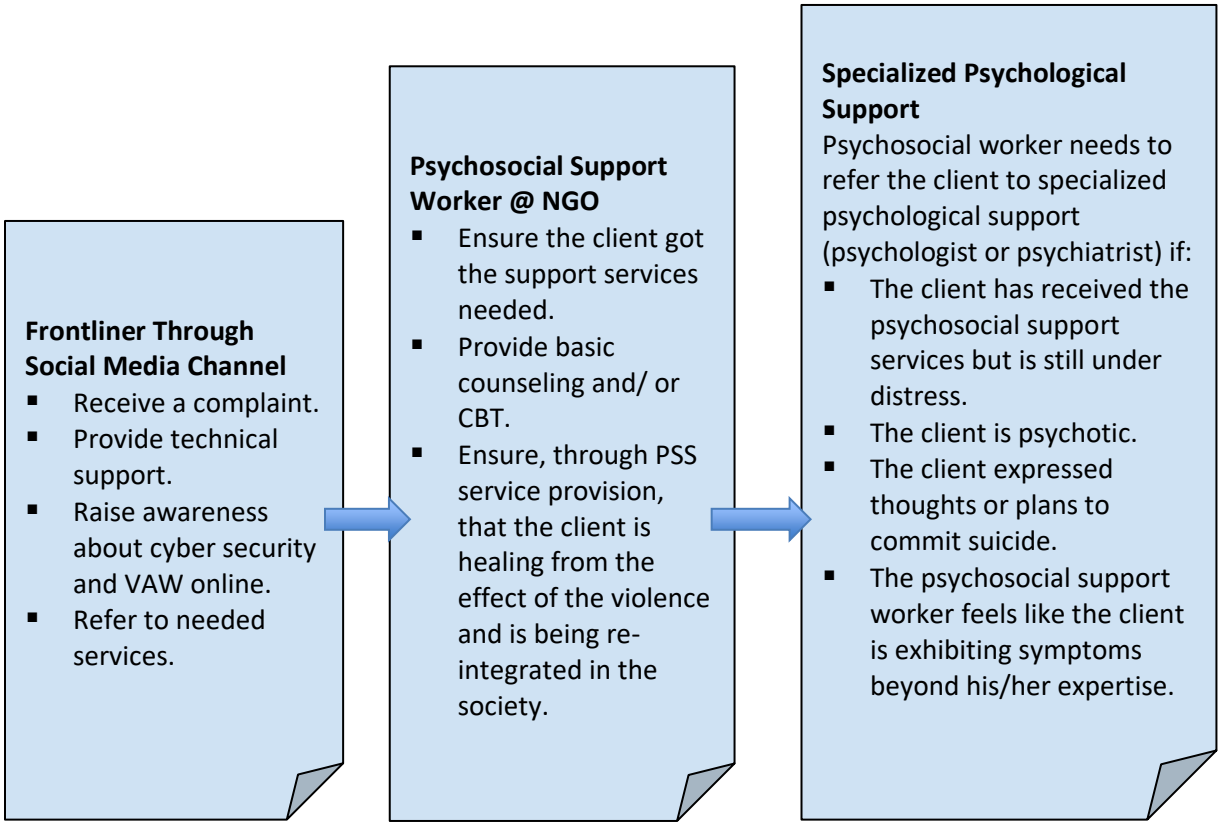
You have the right to decline to answer any questions.

If you would like to provide an emergency contact in case of an emergency, please do.

If you are comfortable, you can provide information about your issue and ask your questions."

REFERRAL PATHWAY

The service provision pathway starts from the initial online outreach (via a platform) to raise awareness and receives requests related to cyberviolence. The intake person receives a request for support services and conducts an initial needs assessment in order to refer the client to needed services, whether legal, psychosocial or others.



ROLES AND RESPONSIBILITIES

The roles and responsibilities of the organization staff at each level of support should be clearly outlined.

The intake worker's responsibilities entail:

- Receiving requests for support from clients
- Providing technical support to address any urgent issues and vulnerabilities in the client's digital safety status; raising awareness about cybersecurity and online GBV
- Assess the needs of the client
- Referring clients to appropriate services (legal, psychosocial, medical, etc.)
- Educating clients about available services
- Creating partnerships with other service providers who would provide needed services
- Following up with clients, if needed, to ensure that they received the needed service and evaluate the service.

The intake worker would suggest psychosocial support services if the survivor expressed:

- Feelings of distress
- Loss of hope
- Feeling helpless
- Extreme fear and anxiety
- Changes in appetite or sleep patterns
- Changes in daily routine (going to school or work)
- Unable to perform their daily activities of living

If a client is in acute distress, the intake worker would make a referral within or outside of the organization for appropriate urgent care and case management support.

The psychosocial worker's responsibilities are to:

- Ensure the client has access to appropriate support services
- Provide basic counseling and/ or CBT
- Support the client to heal from the effect of the violence and reintegrate in society, including the ability to start using technological tools and social media platforms again confidently and safely.
- Use strengths-based approach with client to build skills and identify resources to overcome the impacts and trauma of violence
- Provide education to help the client process and understand their experiences, with a focus on understanding digital threats, and the importance of digital safety best practices.
- Connect clients with appropriate peer and support networks, including organizations specialized in digital safety and technical support.

A psychosocial worker would ideally be a trained psychologist or social worker. The service can also include a number of activities that are provided by an outsourced specialist, e.g.,: drama therapists, art therapists, mindfulness specialists.

A psychosocial worker who receives and treats cases of TFV ideally should have basic training in:

- Gendered analysis in violence against women/ gender-based violence, specifically TFV
- Adequate understanding of TFV and its different parameters, risks and prevention mechanisms.
- Trauma and coping mechanisms
- Psychological reactions and defense mechanisms
- Wellbeing and social inclusion
- Basic counseling skills
- Basics of Cognitive Behavioral Therapy (CBT)[12]

Psychosocial support is a form of non-specialized support provided by trained service providers, but not clinical specialists to promote wellbeing for individuals and communities that have experienced trauma and/or crisis. Psychosocial support alone may not be sufficient to address the needs of an individual who has been the victim of violence. In this case, the psychosocial worker would refer to a specialized psychologist or psychiatrist, for example when:

- The client has received the psychosocial support services and expresses still being unable to cope
- The client is experiencing acute psychiatric distress
- The client expressed thoughts or plans to for self-harm or suicidal ideation
- The psychosocial support worker feels like the client is exhibiting symptoms beyond their expertise

Adapting and implementing a service and referral pathway like the one outlined above will help organizations to establish clear boundaries based on their team's skills, training, certifications, and capacity, which is essential to providing safe and competent care to victims of cyberviolence. It is the responsibility of the service provider to recognize their abilities and practice within their appropriate scope when providing care to victims of violence/abuse, in order to prevent further harm or trauma. Organizations and service providers are encouraged to work collaboratively with community and professional partners to complete their referral pathway and ensure clients can access necessary support and services. It is highly recommended that service providers partner

[12] UN Women. (2011). Emotional care and support. Endvawnow. Retrieved from https://www.endvawnow.org/en/articles/670-emotional-care-and-support.html

or connect with stakeholders who work in the digital safety and TFV domains to offer timely and trustworthy referral services for technical support when needed.

MAPPING OF AVAILABLE SERVICES

Before initiating the service provision system, service providers can conduct a mapping exercise to identify other organizations providing services relevant to the needs of survivors of TFV. These services include:

- Legal aid and legal services
- Psychosocial supports
- Specialized psychological or psychiatric services (including outpatient and inpatient clinics)
- Medical and health services
- Digital safety and mitigation services
- Shelters
- Educational organizations
- Livelihoods and charitable organizations, especially for victims/survivors of VAW
- Relevant national councils and ministries

Some important information to consider while looking for those partners are:

- Available services
- Target audience and eligibility criteria
- Geographical scope the service covers
- Strengths and capacities
- Weaknesses
- Whether they understand experiences of women survivors of cyberviolence
- Website and contact information

Memorandums of Understanding (MOU) can be formed with the partner organizations to ensure the quality of service provided and agree on referral mechanisms. It is important to ensure that not all the information of the survivor is communicated with the organization she is being referred to, only the information she agrees or gives consent to share and that the organization initially agreed on with the project.

A formal referral process and pathway is valuable to both the client accessing support as well as the service provider and their partners, to ensure effective and time service.

HIGHER LEVEL OF REFERRALS

When a client requires more specialized or clinical support, the team can ensure that the immediate basic needs are met and the individual is safe, then initiate referral to appropriate higher level supports, according to the following steps:

Assessment

The psychosocial worker needs to have a holistic understanding of the situation of the client and should assess the 1) level of functioning of the client (their ability to independently fulfill their basic need, and undertake some social interactions such as going to work) 2) client's primary concerns and stressors 3) personal strengths of the client and 4) sources of support and resources.

The provider can start by asking the client to share why they are seeking help. The provider should employ active listening skills to understand the client's request; various methods of communication, including speaking (in person or over the phone/voice message), writing and drawing can be offered. Focus on the main psychological and social consequences of the incident they have been subjected to and document what they say.

1) Psychological State & Level of Functioning

Each person has an individual response and reaction to traumatic experiences. Service providers can recognize that trauma responses are presented differently, depending on the individual. When providing support to someone who has experienced TFV, look for the following signs that they are in distress or having difficulty coping:

- Extreme and prolonged emotional withdrawal (i.e., expressing numbness, no emotional response, expression seems flat with no negative or positive expressions)
- Signs of dissociation (i.e., not aware of time or place)
- Experiencing anxiety and/ or panic attacks
- Withdrawn and avoiding social interactions, work, school, daily activities
- Complaints of physical pain (stomach aches, body aches, headaches) that have no biological source
- Crying intensely
- Changes in appetite and sleep patterns
- Unable to leave the house

If the survivor is experiencing hallucinations [i.e., is hearing voices that are not real (auditory hallucinations) or seeing things/people that are not real (visual hallucinations)], or paranoia or dissociation, they should be referred to a more specialized mental health service right away.

However, survivors don't need to exhibit extreme emotional reactions to prove that they have been subjected to TFV. Some people will experience numbness; a person's account of their trauma should be believed and acknowledged even when they appear calm and unaffected. Physiological symptoms of stress and trauma may be presented as unexplained headaches, stomach ache, cardiac issues, sudden weight loss or gain, loss of vision or speech, among others. These symptoms are called psychosomatic symptoms and can be resolved through therapy and treatment for trauma. If clients experiencing psychosomatic symptoms should be referred to appropriate health care professionals.

Some questions to consider when assessing the client's level of functioning:

- Is the client able to carry out daily activities?
- Have they stopped leaving the house?
- Have they withdrawn from their social activities (virtual and in-person)?
- Are they experiencing physical pain (stomach aches, body aches, headaches)?
- Have they had changes in sleep patterns (too much or too little sleep)?
- Have they had a change in appetite or sudden weight loss or gain?

2) Main Problems, Symptoms and Worries

Working with the client to identify their priority concerns is important to deciding the best referral and support pathway. The service provider can ask the survivor to list the main problems they need support with, and/or their greatest stressors. As a result of the cultural focus on social acceptance and cohesion, it is common for women and girls in the MENA region to prioritize social concerns over psychological ones. Even if there is no immediate danger from the perpetrator (e.g., blackmailing online), the survivors tend to worry that they are not meeting their obligations as mothers, daughters, wives, sisters or any other roles that are given to them by the society. The practitioner should be able to explore these concerns with the survivor, ask questions and use triangulation methods to ensure that the survivor is aware of the impact of the violence incident on their wellbeing.

It is also important to note that, especially with adolescent victims of cyberviolence, they may be driven to engage in high-risk behaviors. It is not unusual for youth to engage in destructive behaviors towards themselves or others in order to regain a sense of power and control. Although there is not enough research in MENA on cyberviolence against women, research around the world has shown that psychological factors, such as self-esteem and social anxiety, have been related to the probability of suffering cybervictimization. Victims of cyberviolence

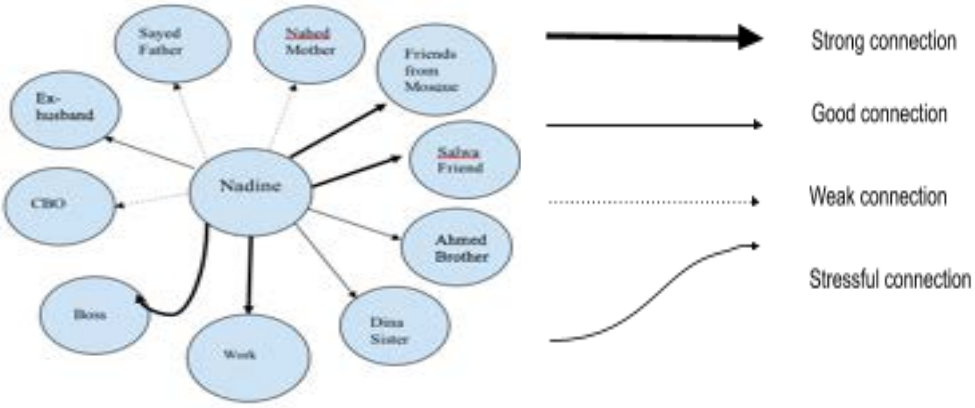
usually have lower levels of self-esteem and higher social anxiety. These issues remain and need to be addressed through service provision and the action plan.

3) Personal Strengths of the Survivor

When applying a strengths-based approach to psychosocial support service, the provider would work with the client to identify positive coping mechanisms and sources of strengths to build an action plan. Spirituality could also present a source of strength to many survivors. It is important, while taking a survivor's centered approach, to draw on the survivor's perception of the world. Spirituality is highly valued in the MENA region and research has found that it helps survivors make sense of the injustice, generate internal peace, forgiveness and seek healing. In one of the discussions with a Jordanian partner running a shelter for women refugees, she shared an experience in which refugees from African countries showed significant change in behavior when they began accessing support through their local spiritual communities. This was suggested by an external psychologist after working with one of the clients and has accelerated the rehabilitation process for several women. Yet, sensitivity and experience are required to ensure that when addressing issues of spirituality and religiosity; the client should identify the areas and space from which they draw strength, and the service provider can facilitate access and engagement. A psychosocial service provider should respect the beliefs and values of the survivor and build on their already existing practices to find meaning and support the process of rehabilitation.

4) Sources of Support

Identifying sources of family and social support is important in the provision of psychosocial support services. The provider can work with the client to identify positive and safe personal relationships and networks where the individual can turn to for support. One of the simple assessment tools used to show the nature of the relationship between the survivors and the people around them is the "Eco-Map" tool. The map is a diagram that highlights the relationship between a survivor and individuals, resources, and institutions around them. Links on the map may include friends, family members, school, church, mosque, community-based organizations, social media contacts and acquaintances, virtual support circles or organizations, or others. It allows the service provider and client to identify safe and reliable sources of support, which can help to aid in the client's safety and recovery.



INTERVENTION PLANNING

Providing Psychoeducation

The first step after the assessment is helping the survivor to process how they are feeling, to provide information about cyberviolence, and to outline common symptoms and emotions associated with this type of abuse. At this time, the service provider would also provide information about support resources available. Psychoeducation is a form of evidence-based psychological intervention that involves educating survivors and their families about the trauma and mental health conditions, to support healing and coping. Being educated and informed about the process of trauma and healing provides the survivors with predictability and a sense of control; it has proved to be highly effective. From the training provided to Salam@'s partners and other service providers, it was apparent that psychoeducation is not commonly used, but there is opportunity and capacity for uptake.

This is an example of a script of part of a psychoeducation intervention:

Sample Script:

> "*Unfortunately, we do not have a lot of statistics on cyberviolence against women. Not everyone is aware that online harassment and abuse **IS** a form of violence; not everyone chooses to report it. Cyberviolence, like any other form of violence, is a crime and is punished by the law. It also impacts women's psychological state, wellbeing and their social interactions. Thank you for reporting your experience. Please know there are others who have experienced similar abuse, and there is support available to you.*
>
> *Not all women necessarily react the same to cyberviolence. In fact, it is common to go through several phases of emotions. It is normal to feel extremely angry or extremely*

numb. Some people express that they feel guilt, shame and the desire to isolate themselves. It is a normal response to trauma to experience change in sleep and appetite patterns. The severity of these symptoms differ and would go away with time and through the recovery and healing process. It is clear you have many strengths.

[For women survivors of sexual violence]

It is possible to experience flashbacks from the incident or re-experiencing what happened during the incident; these flashbacks can occur after a trigger. A trigger is a psychological stimulus, which brings back memories and emotions of a traumatic incident. The trigger could be passing by the place of the incident, seeing someone who has characteristics similar to or looks or dresses like the perpetrator, a smell or sound from the incident or others. They are symptoms of what we call Post Traumatic Stresses to protect us; mainly the Fight, Flight or Freeze response. The brain turns to survival mode and the primitive part overrides the conscious. The brain stops thinking rationally or filling memories and is focused on either sending signals for your muscles to run away, fight back or freeze. This also means that you will not be able to recall details of the incident for some time after. Gaps in memory of the event are typical and do not suggest that your account of events should be questioned by others.
These symptoms might persist for a few days to a few months. Through the available services and interventions, symptoms should decrease and we will be able to monitor them together."

Creating an Action Plan

Based on the information provided by the assessment, the care provider would work with the survivor to 1) identify the problems that concern her the most, 2) prioritize problems, 3) design a plan to address each problem. This plan should be divided based on the client's immediate, short term or long-term needs.

Below is one example for case planning:

Issue	Goal	Strategy/ Action	Timeline	Responsible Person	Priority High Low	Achieved

Referrals

After planning the actions with the client, the service provider should inform and refer them to available, appropriate psychosocial activities, whether through their NGO or partner organizations. Organizations providing basic psychosocial support services may offer one-on-one and group counseling by trained in-house or outsourced psychologists. Other forms of psychosocial support are also usually outsourced, for example art or drama therapy, couples counseling, or family mediation. These activities can be implemented in parallel with advocacy for laws and policies on a safer internet for women, awareness raising on digital safety, and community dialogue activities on TFV, which are vital to long-term wellbeing of communities.

It is again useful to emphasize that all partner services/professionals should be screened by the organization prior to referring clients, to ensure services are being offered by trained professionals with all required certifications. In assessing whether a partner or professional is a good fit for program referrals, the service provider can consider the organization/individual qualifications, training, regulating bodies, principles of practice, policies, and ethics. It is also important to assess the entities' experience and expertise in working with victims of TFV, as well as knowledge of cyberviolence, in particular. When there is a lack of resources and capacity in a community, it is not unusual for individuals to offer professional services, such as counselling or mediation and therapies, without proper training or qualifications. In these cases, it is best to avoid referring to any individual or group that lacks official training; victims of online GBV are a vulnerable population, and treatment from an individual who lacks appropriate training in psychosocial support can ultimately result in greater harm than good.

Follow up, Evaluation and Case Closure

Throughout the provision of support services, regular follow-ups should be conducted. Preferably, the service provider should review and monitor high risk cases twice a week, medium-risk cases once a week, and low-risk cases once every other week. High-risk cases include individuals who are presently experiencing violence and lack access to physical and emotional safety. Medium-risk cases are women who experienced TFV but are not currently at-risk; these individuals are likely to have ongoing mental health and physical health risks. Low-risk cases would include clients who were subjected to violence, but are not suffering from serious or long-term symptoms that require immediate intervention.

Follow-up can be done through home visits, phone calls, or in-person/virtual one-on-one sessions. The follow-up sessions aim to re-assess the psychosocial state of the survivor, functionality, and wellbeing. The service provider should 1) evaluate the accessibility, efficiency and satisfaction of the services the survivor has accessed 2) identify whether any new needs have emerged, 3) revisit the action plan. If the client does not feel an improvement or progress

towards their healing, the problems they identified earlier are not being solved, or they are further isolating themselves, then they should be referred to more specialized psychological or psychiatric services. If the survivor's psychosocial needs were met and no new needs emerged then with her agreement, the case file could be closed.

Case Closure

Case closure is an important step in the service provision pathway; a formal end to the case management support helps the survivor to assess their needs and encourage structure and independence. The case is closed after discussion and agreement with the client and following an evaluation and discussion with the supervisor of the psychosocial support services or case manager, as well in close coordination with other service providers involved in the client care.

SPECIAL CONSIDERATIONS

Death By Suicide

Some survivors may express that they wish they were not alive, that they want to disappear, or wish they were dead. Cases of suicidal ideation or self-harm require careful attention and an in-depth urgent assessment and response. This assessment should only be done by a trained psychosocial worker who is also receiving supervision. If the service provider is not trained on handling cases of suicidal ideation, they should invite in the supervisor to assess the case and intervene. While supporting an individual who expresses feelings of self-harm or suicidal ideation, it is important to address immediate threats to the individual safety, which include ensuring the individual is not alone or without support for any amount of time. The provider should also remove any objects that could be used for self-harm from the client's environment including, scissors, scarfs, glass bottles, aluminum cans, etc.

Assess Current/past Suicidal Thoughts

If a provider is concerned that a client is having thoughts of self-harm or suicide, they can ask the client to elaborate on statements or comments suggesting self-harm. Providers can also ask clients directly "*Are you or have you ever thought about hurting yourself? Did you act on these thoughts? Are you planning to act on them?"*

Intervention

If a client expresses feelings of self-harm or suicidal ideation and has a plan to act on them, the service provider would take steps to intervene, following their organizations policies and according to available resources. At minimum, the provider notifies their case manager or

supervisor and arranges for immediate medical care. If the client has an emergency contact on file and consents/has already consented, the provider would speak with the emergency contact to engage them in the response plan. A plan should be arranged to ensure the client has constant accompaniment from a trusted contact or care provider, until they are under the care of trained medical professionals. Any case of potential death by suicide should be treated in a hospital/health care setting in order to ensure safety, responsiveness, and proper care.

Develop a Safety Agreement

If the survivor said they had these thoughts but they do not wish to act on it, some organizations develop a "Safety Agreement" to mitigate the risk of suicide. The plan would help the client to identify triggers or warning signs such as thoughts, situations, or behaviors and determine how they will reach out for support. The service provider will need to identify additional safety contacts for the client to reach out to in case they are unavailable. In addition, the plan will identify strategies that the survivor could resort to in case they feel triggered. This agreement can be documented, signed and a copy can be given to the client for reference. An example of this agreement is included in Annex I.

SAFETY PLANS

Another important point to consider when working with women survivors of violence in the MENA region and especially in the context of domestic violence, is that many women may choose to remain with their abuser (whether it is a husband, partner, father or brother), or simply may not have the option to leave the place. This abuse can be of a digital nature, such as when husbands blackmail their wives, and it can be a form of secondary victimization. This is especially the case when a girl has fallen prey to a digital violence case, and as a consequence, she is beaten and locked up by her male guardians. It is often difficult for women to leave these situations. In some cases, women are either financially dependent on the perpetrator, and fear not being able to care for themselves or their children financially after leaving the place of abuse. In many MENA countries, male guardians still have the legal authority to finalize paperwork and issue legal documents for other family members, and therefore, women may not be able to navigate important legal or official processes on their own. It is also discouraged by society and families for women to live alone; they may face pressure from their families to not leave the family home or alienation if they choose to live on their own. The provider should acknowledge the complexity of the decision to leave an abusive home and escape violence that may be digital violence, or physical and emotional violence exercised on the woman/girl as secondary victimization and avoid pressuring women into leaving; alternatively, the provider can focus their attention on formulating a safety plan with the client and to build-up a network of safety supports that will the client the best chance at having options for a safe, secure life.

In cases where the survivor decides not to leave a violent or abusive partner, the assessment and safety planning should identify relatives or friends that the client can reach out to in case of violence or threatening situations; the client can also be advised on how to access their documents and essential items they and their children would need in case of fleeing the situation, as well as supported with developing a plan how to leave and where to find safety.

An example of the safety plan could be found in Annex II.

COUNTRY SPECIFIC REGULATIONS

To be able to support the survivor in making an informed decision and ensure their well-being, the service provider should be familiar with regulations and procedures related to issues of gender-based violence in their country, in addition to weaknesses and general attitudes of relevant stakeholders and institutions.

For example, in the case of sexual assault or rape in the last 72-120 hours, the victim may expect a medical examination, medication to avoid pregnancy, and STI and STDs testing as part of the clinical response. If the victim decides to file a police report, it is important to be aware of what this process may entail, so that the individual can be informed and guided through the process. The service provider also needs to be fully aware of the laws and regulations criminalizing cyberviolence, state agencies responsible for such crimes, in addition to the procedures taken to ensure that the evidence is legitimate and could be used to support their case formally. These decisions are usually made with the support of the case manager (a step prior to psychosocial support service provision), however, the legal process could greatly impact the psychological state of the survivor, leaving them in a constant state of distress. The legal process may not be confidential and the identity of the reporter may not be protected, despite the existence of laws to ensure that. The survivor could be blackmailed or further subjected to violence for reporting. It would be important for a victim to know this may be the case, and that they may have to tell their story several times and/ or identify suspects, and some of the questions might be triggering or re-traumatizing. Providing clients with accurate expectations around the reporting process will enable proper support to be in place.

Chapter 4: Best Practice for Service Provides

SUPERVISION

As mentioned previously, supervision is an essential component of providing effective psychosocial services. It means that a mental health professional or psychosocial practitioner in this case seeks the services of another trained psychotherapist for professional and personal development and revision and reflection of progress with survivors/ clients. Supervision acts as a quality assurance mechanism, preventing unnecessary interventions and providing efficient and impactful services to women survivors of violence. In addition, supervision helps prevent burnout and secondary or vicarious trauma, through the process of reflecting on how working with survivors of violence affects the practitioner.

Supervisors are ideally trained and have years of experience working, in this case, with survivors of violence, preferably those in cases of TFV. However, it was clear through the work of Salam@ with its partners, other organizations in the MENA region and our research for this manual that supervision is almost nonexistent. In 2021, Salam@ Program organized a training session on the provision of psychosocial support to survivors of cyberviolence that involved practitioners from Yemen, Jordan, Kurdistan, Tunisia and Bahrain. During the training, the practitioners expressed that none of them received or even knew about supervision. This is the case because of the lack of knowledge, lack of capacity, and constant state of urgency for some organizations' operations. Unfortunately, supervision integration results in an organization that is burnt out with staff members who need support and psychological intervention and affects the sustainability of the available services. Supervision is provided in many forms:

***Shadowing*:** During the training period of any psychosocial support provider, they should shadow a senior staff member, who does not necessarily have to be the supervisor, but allows them to observe and experience the support provided to survivors. After the practitioner starts taking clients and providing sessions, the supervisor starts shadowing the practitioner undertraining to ensure that they have the capacities and are ready to work with survivors.

One on One Supervision: One-on-one supervision that happens weekly or bi-monthly, and is similar to regular sessions in which the practitioner and supervisor meet to discuss cases, challenges that they are facing with them, whether they are on the right track, or any other issues related to work and their own development.

Group & Peer Supervision: Peer supervision is a process of monthly or bi-monthly meetings in which supervisors and psychosocial practitioners in the organization come together, present a challenging case they are working on and share strategies, techniques and recommendations, while ensuring anonymity. They should also discuss and identify areas where they need support, training or capacity building. These sessions are facilitated by one of the supervisors. Supervision can include presentations via case discussion, video review or live presentation/demonstrations. Several organizations also allocate a budget to outsource a trained supervisor who comes in bi-monthly and implements group and peer supervision sessions and follows up individually with the service providers providing technical support.

STAFF CARE

Service providers working with survivors of TFV or any vulnerable group are more likely to experience burnout, secondary trauma and vicarious fatigue. This is because of their emotional engagement and empathetic listening to stories of violence and their desire to help others which could often mask their own needs. The ICD-11 defined burnout as "a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions:

- Feelings of energy depletion or exhaustion;
- Increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and
- Reduced professional efficacy."

Secondary trauma is defined as indirect exposure to trauma through a firsthand account or narrative of a traumatic event. The service providers suffering from secondary trauma would exhibit symptoms similar to those of PTSD. They could be re-experiencing traumas of stories they heard from survivors, avoiding going to work, avoiding ICTs, change in appetite and sleep patterns and/ or behavior. They could experience nightmares, and are usually triggered by the same triggers other survivors of gender based violence.

Vicarious trauma also results from emotional engagement with vulnerable groups for an extended period of time. Service providers who experience either exhaustion, feeling overwhelmed, isolated, and disconnected. Vicarious trauma has a significant impact on those who experience it, it affects and changes the body, mind, character and their belief systems.

Throughout Salam@ Program experience with service providers in the MENA region and from our research, it was apparent that they were not aware of these issues, although the vast majority of them did admit that they are experiencing at least one of those issues and that the work they

do affects their lives to the core. The lack of available resources and knowledge, and working under constant sense of urgency does not allow them or their organizations to take serious steps to prevent them from experiencing any of these symptoms and ensuring their wellbeing.

It is important to note that the responsibility of preventing secondary trauma or burnout and ensuring the wellbeing of staff members is not the individual's responsibility but the organization's responsibility. Organizations need to put policies in place to educate staff about the impact of their work on them, encourage self-care, and foster a healthy, inclusive and supportive work environment. The organization should:

- Ensure there is an effective and quality supervision system in the organization
- Make psychological support and independent therapy services available for all staff
- Build a sense of community between staff members and ensure creating a supportive environment
- Provide training (and psychoeducation) on wellbeing, burnout, self-care and different topics related to the impact of working on such issues on their lives and personalities
- Provide different wellbeing services in house or outsourced
- Provide medical insurance
- Have emergency meetings after a crisis or intense cases to reflect and discuss lessons learnt and best practices.
- Ensure that staff are taking their paid leaves, sick leaves and not working overtime
- Have flexible working conditions and work from home policies, when possible.
- Ensure that they are not taking on more than the assigned workload
- Ideally, identify a line item from the organization's budget for wellbeing activities and services (therapy, gyms, physiotherapy, and others)
- If they are handling hotline cases (24/7), have a rotation system in which each staff member would only answer the phone for a number of days/ hours

For frontline workers and coordinators working remotely or receiving cases from Salam@'s Pages:

- Ensure that they are working within working hours, unless there is an emergency (a case in danger in terms of security or a case of suicide)
- They should not have Salam@'s pages on their personal phones (e.g., Instagram, Facebook)
- They should not manage these pages from their own personal accounts
- All digital security measures should be taken

ANNEXES

Annex I: Safety Agreement

This is an agreement between my counselor _____and _____ (client's name), to keep me safe from hurting myself.

1) I agree that if I have thoughts about physically hurting myself or anyone else while I am at _ (school or work), I will call _____ (service provider, teacher, counselor, emergency contact from friends or family, depending on the agreement).
2) I agree that if I have thoughts about physically hurting myself or anyone else while I am at home, I will call _____ (service provider, emergency contact from friends or family, depending on the agreement or suicide hotline in the country).

Signing my name on this paper means that I agree not to hurt myself or anyone else. This means that my counselor may need to talk to my chosen emergency contact in case of an emergency.

Client
Date

Counselor
Date

Annex II: Safety Planning

Client: _____
Case Manager: _____
Date: _____

1. If my own or my children's safety is in danger at home, I can go to _____ or _____.
2. In a violent or threatening situation a safe way out is _____ (e.g., which doors, windows, elevator, stairs or emergency exit I could use).
3. If an argument seems unavoidable, I will try to have it in a room or an area that I can leave easily. I will try to avoid any room where weapons may be available (identify the rooms).
4. I will remove any weapons or objects that can be used violently against me or my children (identify them).
5. I can talk about violence with the following persons and ask them to call the police, my emergency contact (family or friends) or my case worker if they hear suspicious noises in my house: _____.
6. I can use (e.g., a sign, word, noise) _____ as a code with my children or friends so that they can call for help.
7. If my partner does not live with me anymore, I can ensure my safety at home (locks, keys, alarm system etc.) _____.
8. I can keep my handbag/safety bag with my documents and official papers (marriage certificate, children's birth certificates, passports, IDs) at (a place at home/at a friend's home): _____.
9. I need the following in case of a quick departure from home (content of the safety bag)[13]:
   - extra pair of home keys
   - money/cash
   - extra clothes
   - personal hygiene items
   - mobile phone/phone card
   - important phone numbers
   - medical prescriptions
   - important documents/cards (passport/identity card, health insurance card, marriage certificate, passports, IDs etc.)
   - children's favourite toys
   - other, _____
10. I can keep this safety plan without endangering my own or my children's safety at: ----------

[13] http://femroadmap.eu/SOPs_psycho-social_services_eng.pdf