ANNUAL REPORT

ANAR TELEPHONE/CHAT 2022

ANAR Foundation

53 years working for a happy childhood and adolescence with full rights

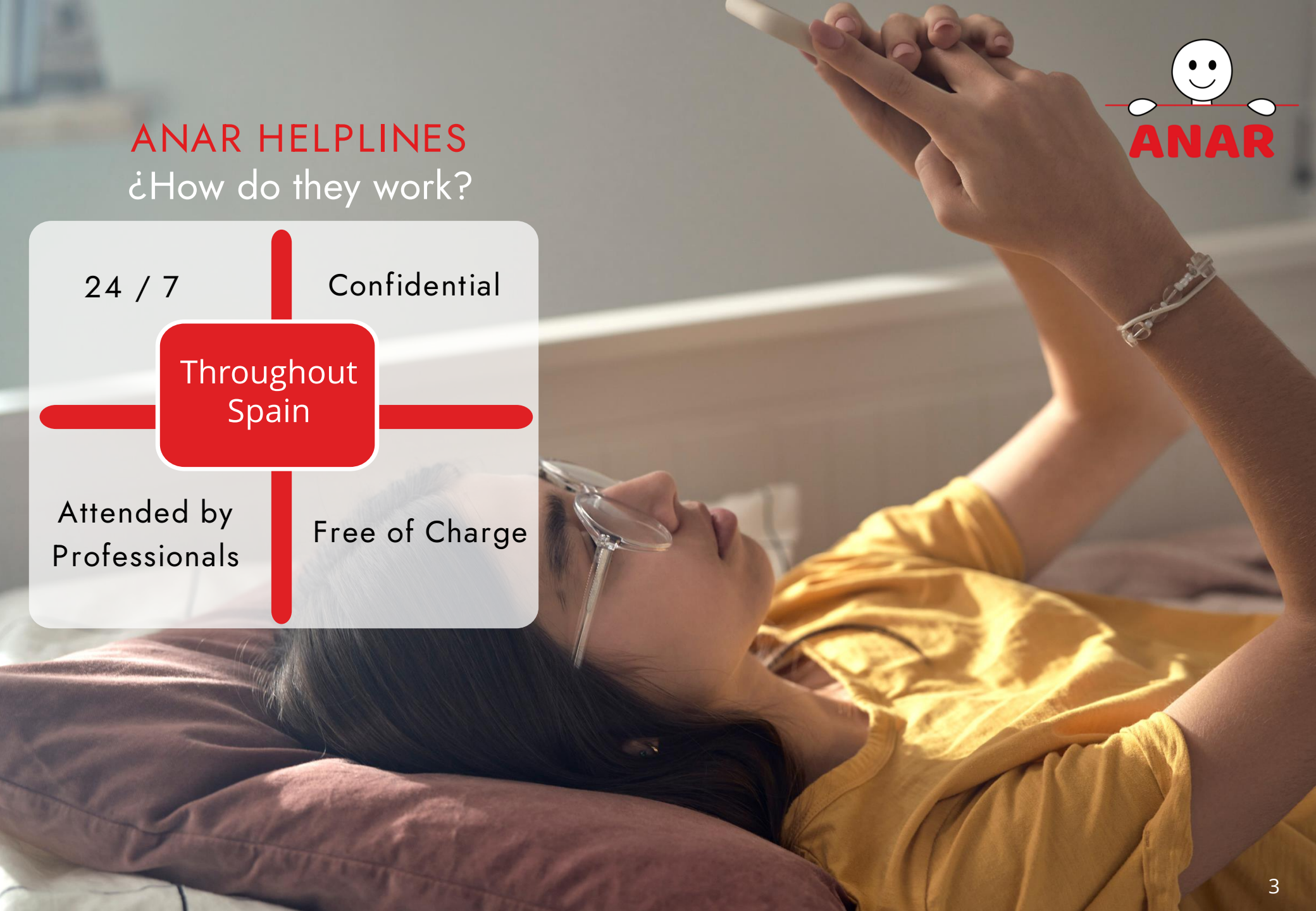
ANAR Foundation is a non-profit organization founded in 1970, in order to guarantee the promotion and defense of the rights of children and adolescents within the framework of The United Nations Convention on the Rights of the Child (UNCRC).

ANAR
Helping at Risk Children and Adolescents

This report is based on the help requests from children and adolescents that we have assisted in 2022, including their families, teachers and other adults from their immediate environment who have contacted asking for help regarding a child or adolescent.

The ANAR Studies and Research Center has a unique data base in our country, including 6,267,999 help requests from children and adolescents that ANAR has helped since 1994.

For that reason, we are the voice of children and adolescents, and through this report, we want to return their voices to society, about what they have told us.



ANAR HELPLINES

¿How do they work?

24 / 7

Confidential

Throughout Spain

Attended by Professionals

Free of Charge

ANAR FOUNDATION

Process

When we receive a call or help request:

Levels of Counseling

1 Psychological counseling

We offer psychological counseling and, together with the child or adolescent, we seek a solution to their problem, taking support from those in their immediate environment (parents, grandparents, other family members, teachers, etc.).

2 Referral

If it is not possible to solve the problem through the child or adolescent and their family, we refer to the appropriate social, educational, health, police and/or legal resources, depending on each case.

3 Intervention

When no one in their immediate environment can help, and there is a high risk or helplessness situation due to abandonment, abuse, sexual aggression or any other emergency situation, we transfer the case to the appropriate institutions or authorities, with the subsequent follow-up.

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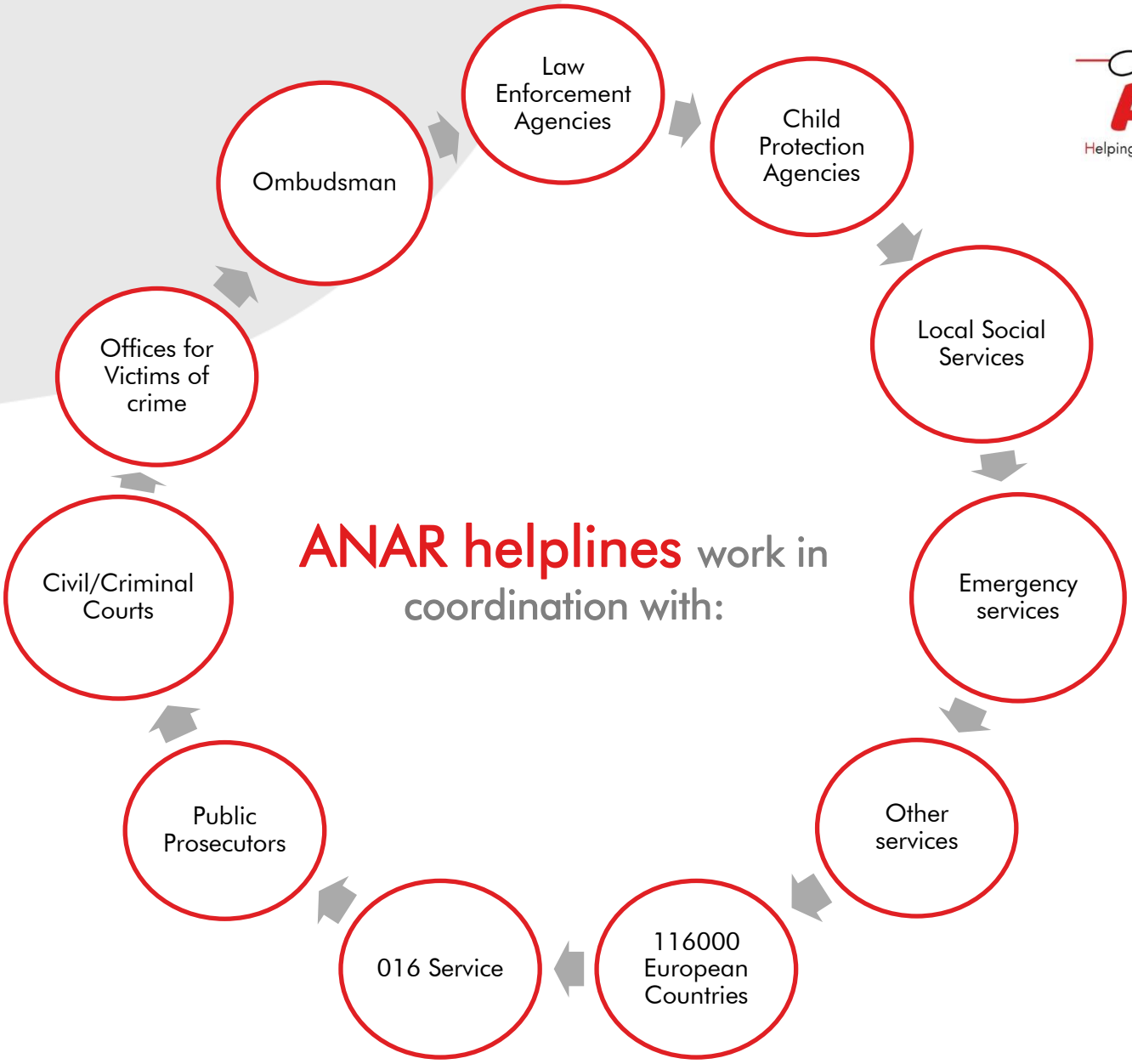

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In 2022, we helped 17,896 children and adolescents from all over Spain, which was necessary to answer

217,693

help requests

HELP REQUESTS THROUGH TELEPHONE / CHAT BY AUTONOMOUS COMMUNITY

Help requests answered **217,693** from Spain

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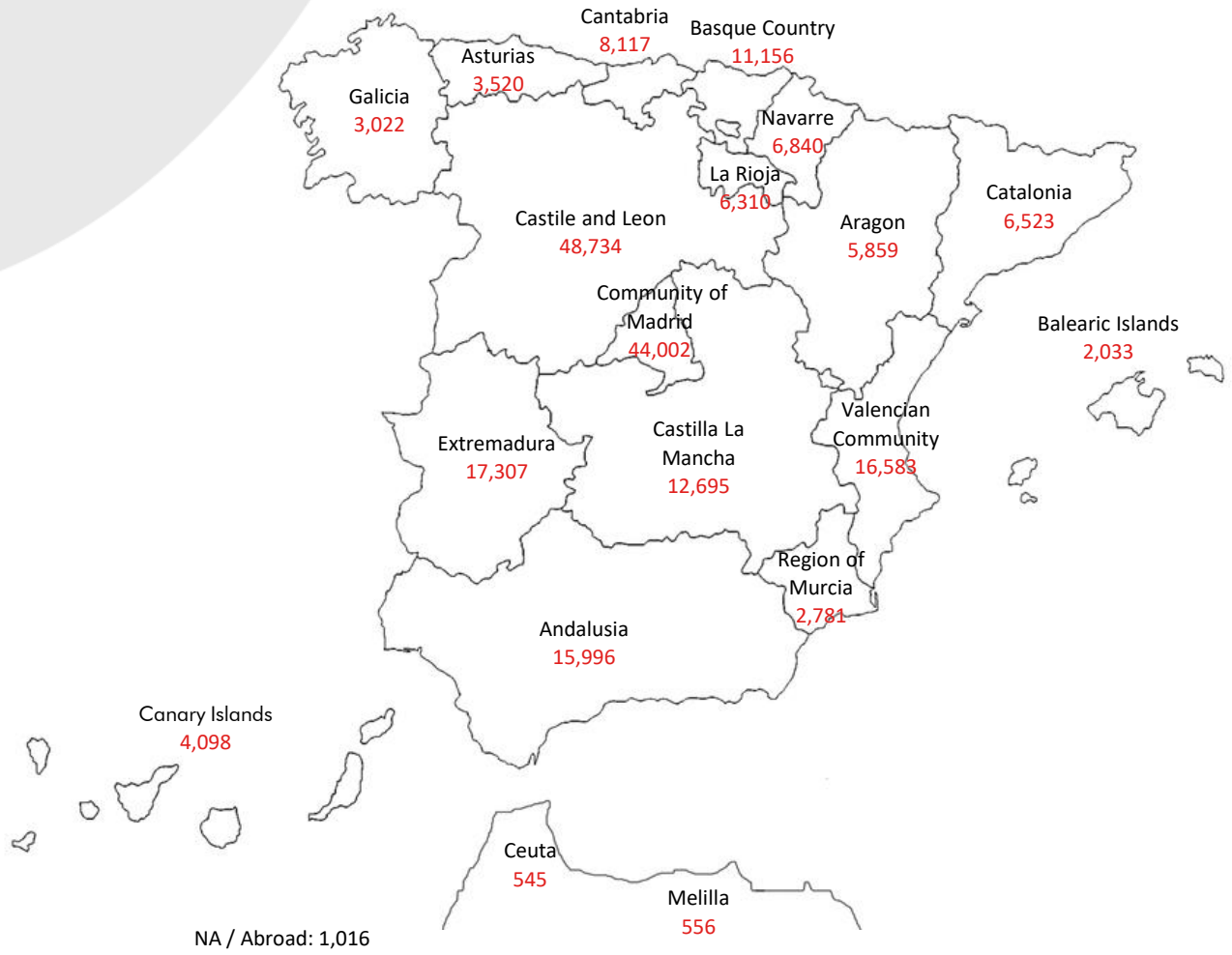


NA / Abroad: 1,016

Child population in Spain from 2022, National Institute of Statistics (INE) data	
Andalusia	1,545,851
Aragon	218,055
Asturias	128,667
Balearic Islands	205,345
Canary Islands	332,630
Cantabria	89,763
Castile and Leon	332,487
Castilla - La Mancha	361,233
Catalonia	1,374,251
Valencian Community	872,942
Extremadura	168,038
Galicia	373,989
Community of Madrid	1,183,040
Region of Murcia	305,445
Navarre	120,078
Basque Country	353,022
Rioja, La	54,473
Ceuta	19,300
Melilla	21,794
Total	8,060,403

Across all ANAR Helplines we answered to 217,693* help requests

900 20 20 10 / 116111
ANAR Telephone for Children and Adolescents
181,543

91 726 01 01 / 600 50 51 52
ANAR Telephone for Families and School Centers
10,492

116000
ANAR Telephone for Missing Children Cases**
2,832

ANAR Chat
www.anar.org
7,878

ANAR Email
www.anar.org/email-anar
862

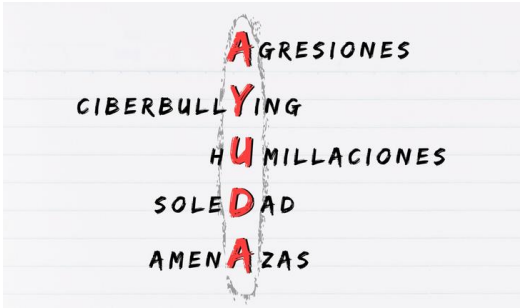
*This figure includes all the help requests from the ANAR Helplines, including the 15,716 from the 900018018 Telephone Against School Bullying and Abuse from the Spanish Educational System that belongs to the Ministry of Education and Professional Training.
**This figure includes all the help requests from missing children through the 116000 Telephone (1,202) and the other ANAR Helplines (1,630).

ANAR against Gender Violence and School Bullying

ANAR

900 20 20 10
ANAR Telephone against Gender Violence for Children and Adolescents
9,579 help requests
900 20 20 10

ANAR



ANAR Help requests against School Bullying
30,737 help requests***

***This figure combines the 15,716 help requests from the 9000018018 Telephone and the 15,021 from the other ANAR Helplines.

TOTAL HELP REQUESTS: 217,693

General Counseling: 192,025

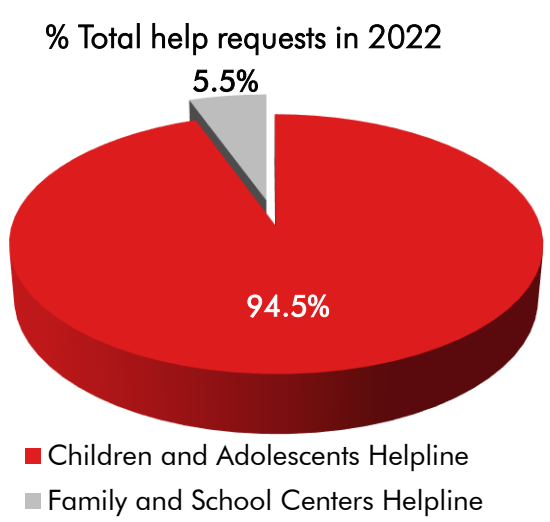
These require a less complex or more generic counseling, but very necessary to get them trust our Helplines so they tell us what really worries them. Whenever possible, we do a prevention work. They often ask us some doubt or information about the service, first approaches, silences, they hang up, ask small information about an external resource and other situations that, being not necessarily real, are usually things that worry them and they don't know other way to talk about it (e.g., "My friend has a problem"). These are a necessary step to get to the real cases.

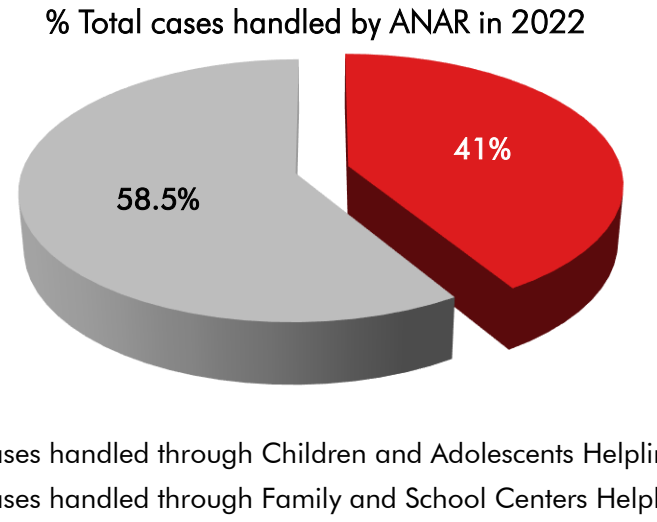
Special Counseling
25,668

These require a psychological and/or legal and social evaluation and counseling. In most cases, these orientations require the referral to an external resource (the one appropriate for each case), For example, law enforcement, Child Protection System, Social Services, Emergency Services, Health Centers, Public Prosecutor, lawyers, psychologists, non-profit organizations, etc.

Cases
17,896

Each time a child, adolescent or adult contacts for the first time, we open a file for the case in our database. The following special counseling contacts made by the same child, adolescent or adult are incorporated to the same file. This is why a case can have several contacts.

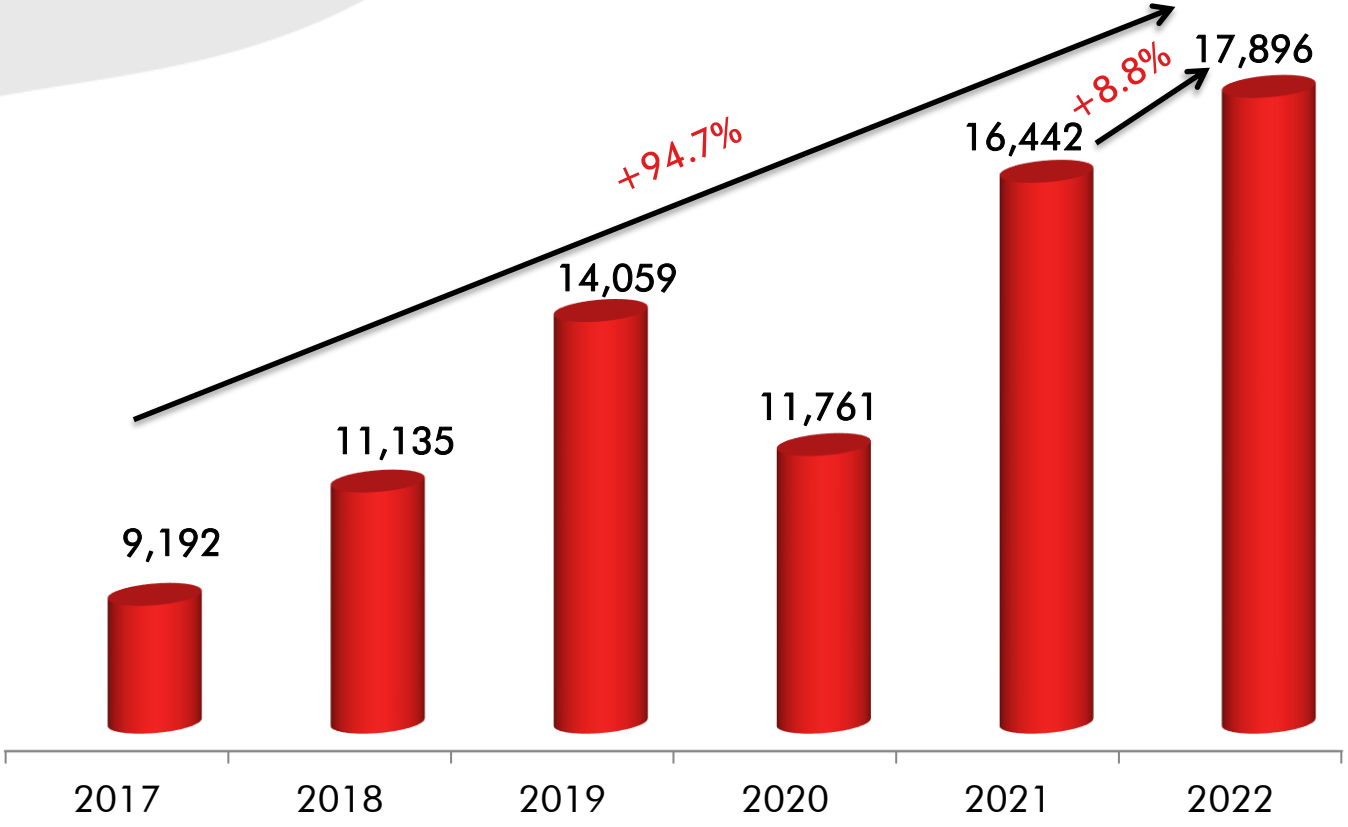




CASES EVOLUTION

In 2022 we handled **17,896 cases.**

We were able to help **1,454 more cases** than in 2021. Furthermore, for the last six years we have duplicated the number of handled cases, with a **94.7% increase**.



REASONS FOR CONTACT AND EXPERTS' ASSESSMENT

Reason for contact
Children, adolescents and the adults who contact us, expose their reasons for contact

The psychologist's team from ANAR Telephone analyzes and explores all the different related areas combined and…

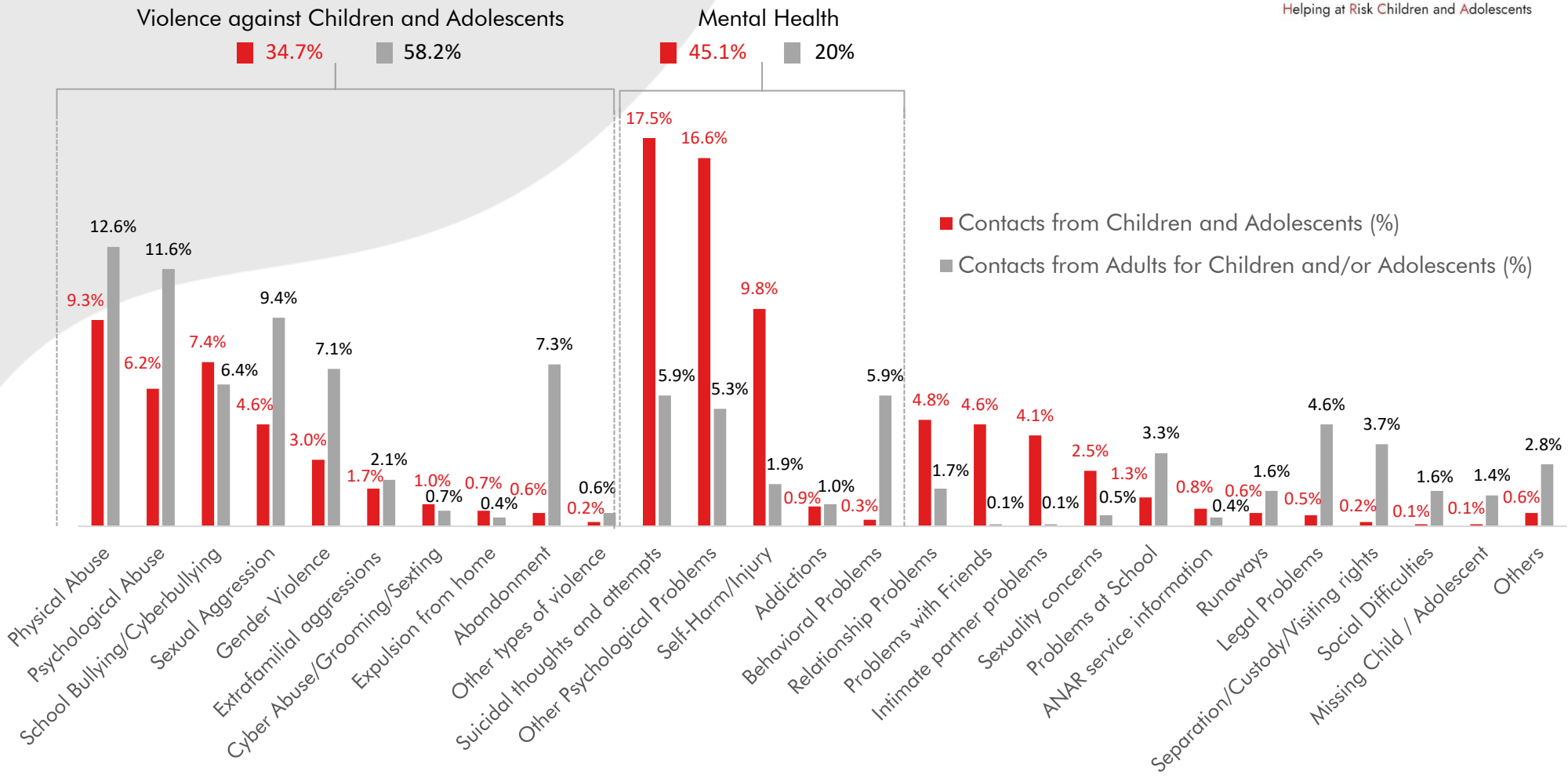
Problems associated with Childhood and Adolescence

Problems from the environment, in the child and adolescent's family

…once all the problems are analyzed, we get to the…

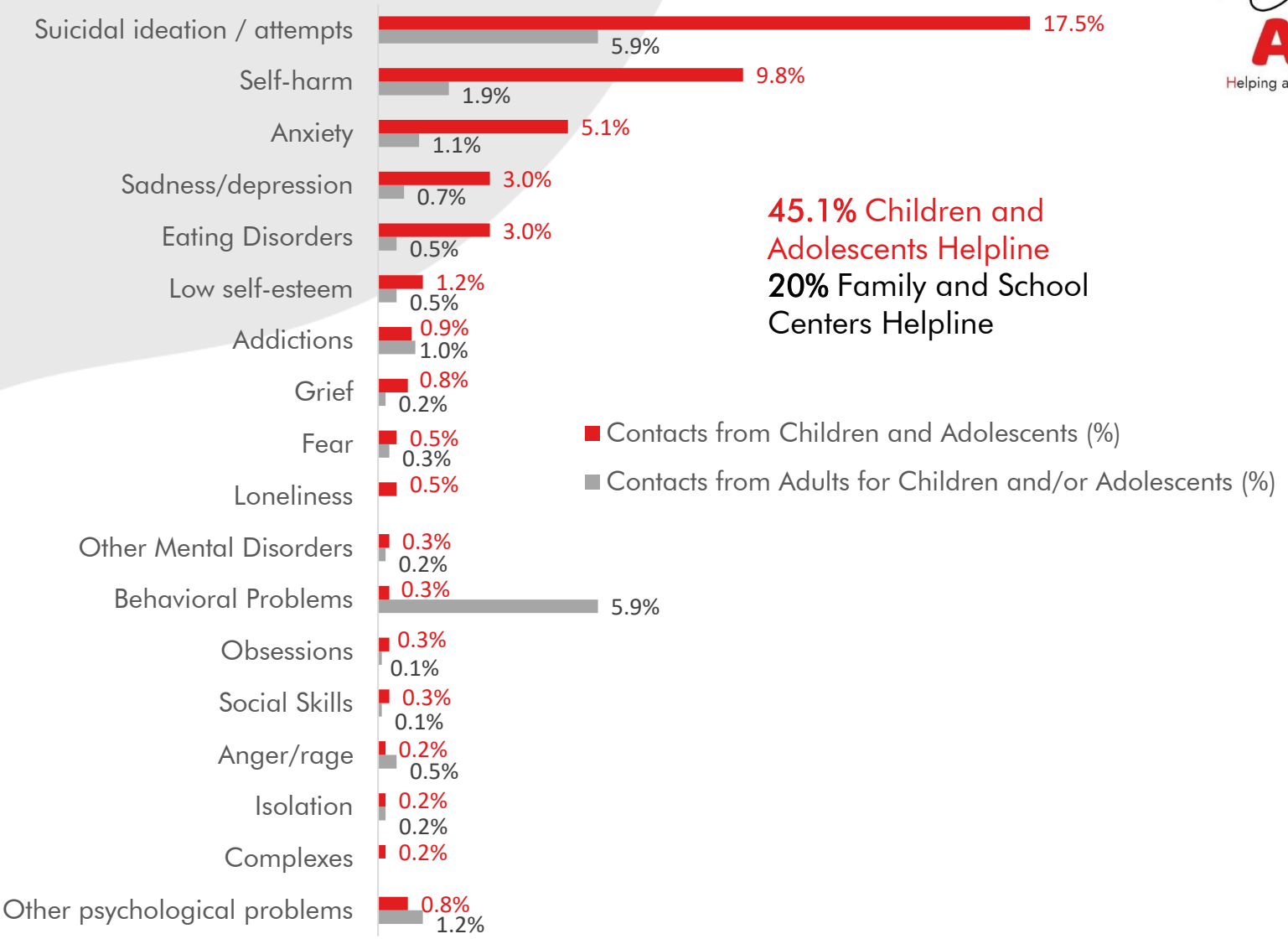
Technical Assessment
Made by the ANAR team of expert psychologists

REASONS FOR CONTACT IN 2022 (%)



Base: the attended cases in 2022 through Children and Adolescents Helpline, Family and School Centers Helpline, ANAR Chat, ANAR Email, and the Missing Children Cases Telephone.

MENTAL HEALTH IN CHILDREN AND ADOLESCENTS (%)



45.1% Children and Adolescents Helpline

20% Family and School Centers Helpline

Base: the cases attended in 2022 through Children and Adolescents Helpline, Family and School Centers Helpline, ANAR Chat, ANAR Email, and the Missing Children Cases Telephone.

PROBLEMS ASSOCIATED TO THE MAIN REASON FOR CONTACT (%)

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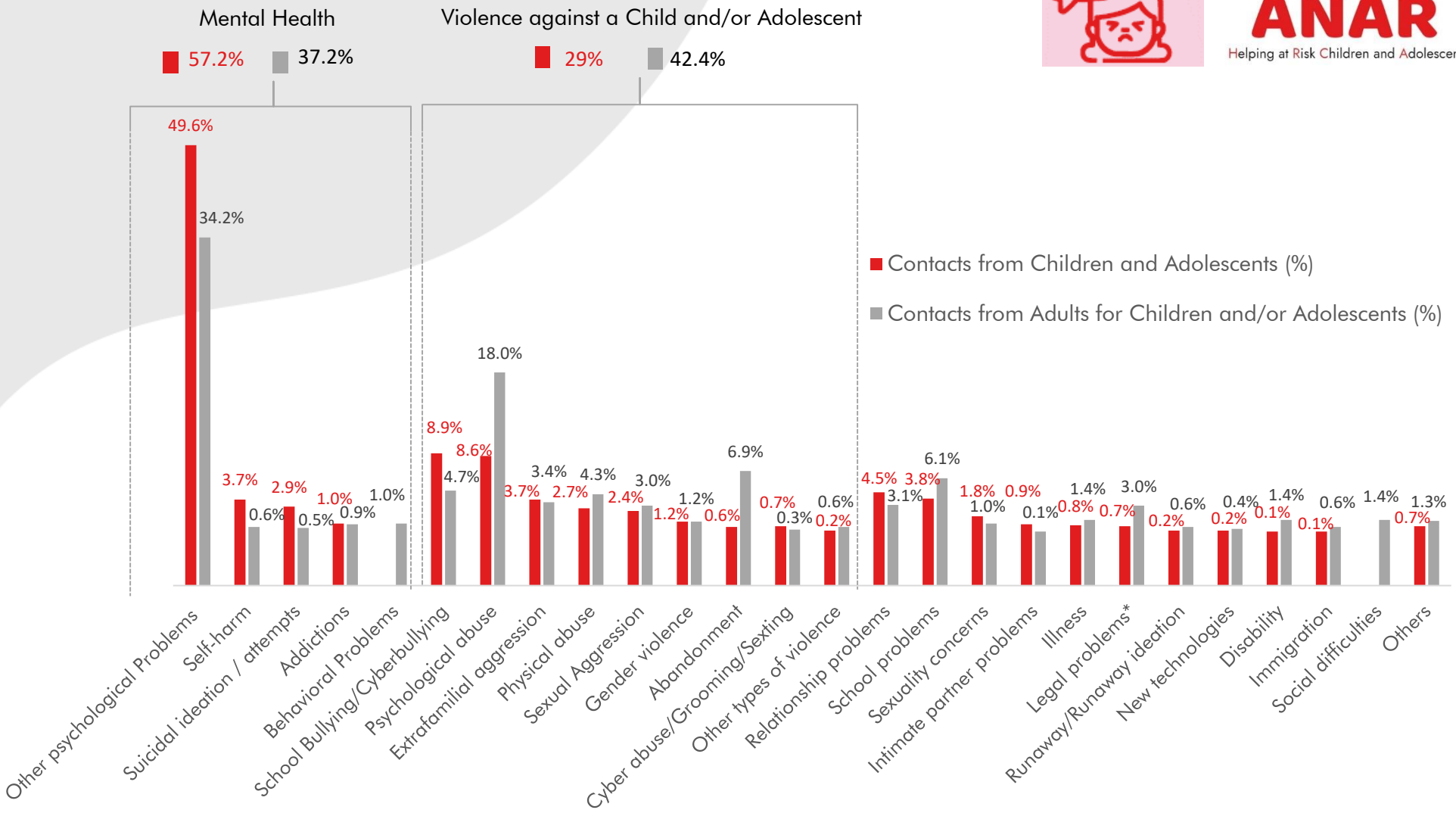
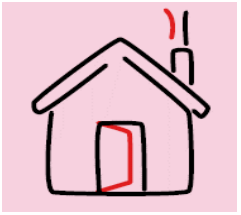
OTHER PROBLEMS FOUND IN ATTENDED CASES



*Legal problems include separation, custody, guardianship, visiting rights, etc.

PROBLEMS IN THE FAMILY ENVIRONMENT (%)

OTHER PROBLEMS FOUND IN THE ATTENDED CASES



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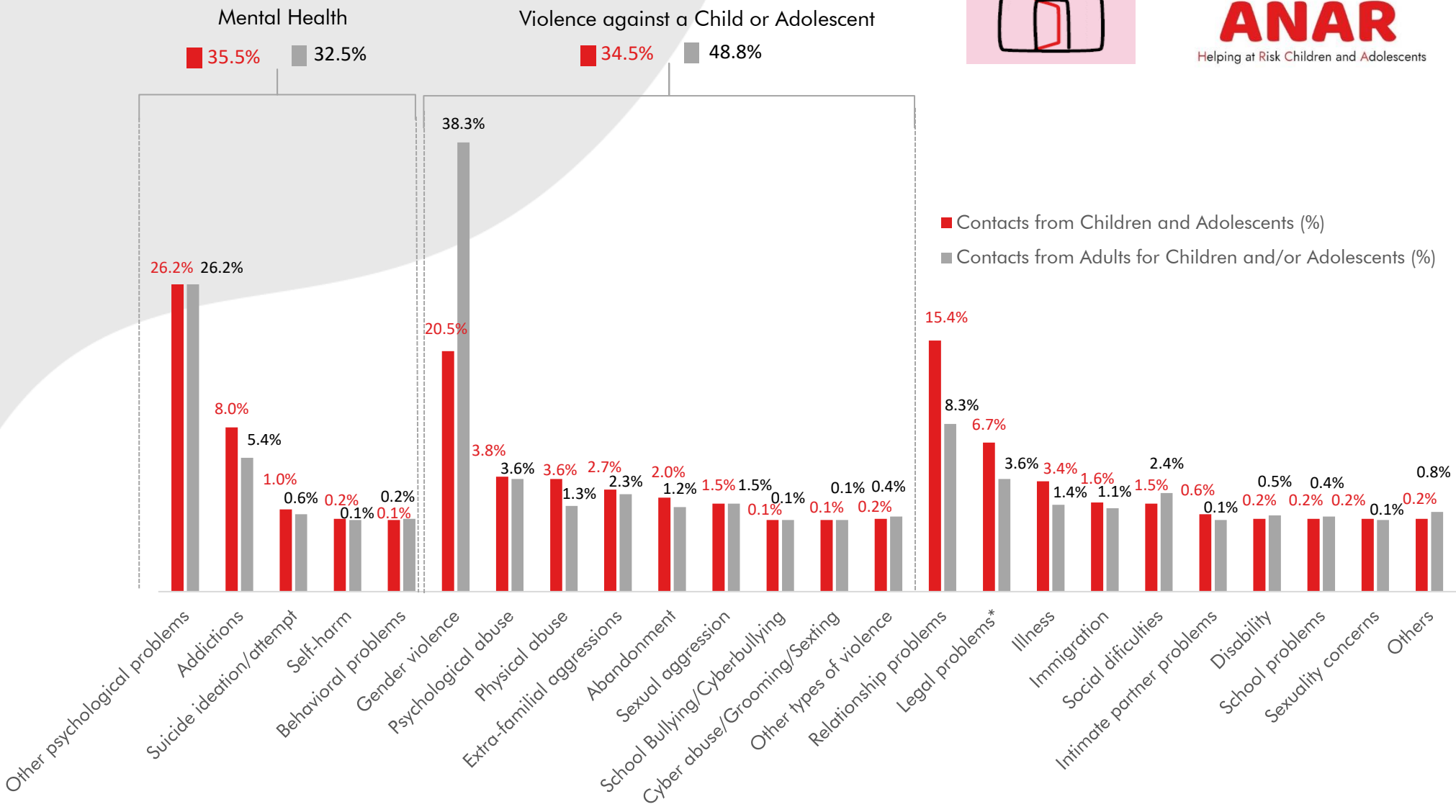

*Legal problems include separation, custody, guardianship, visiting rights, etc.

MENTAL HEALTH IN THE CHILD AND/OR ADOLESCENT'S ENVIRONMENT (%)

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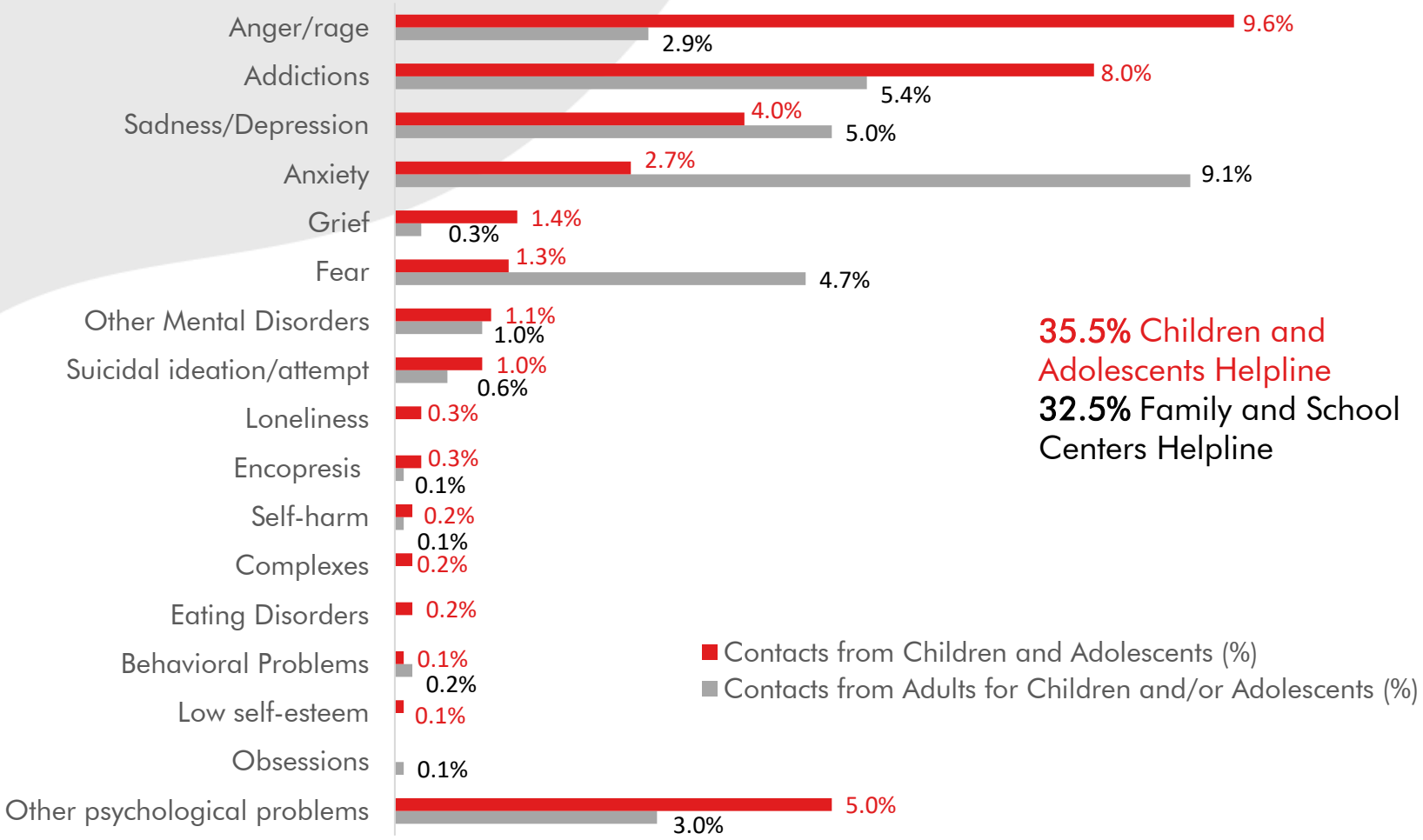


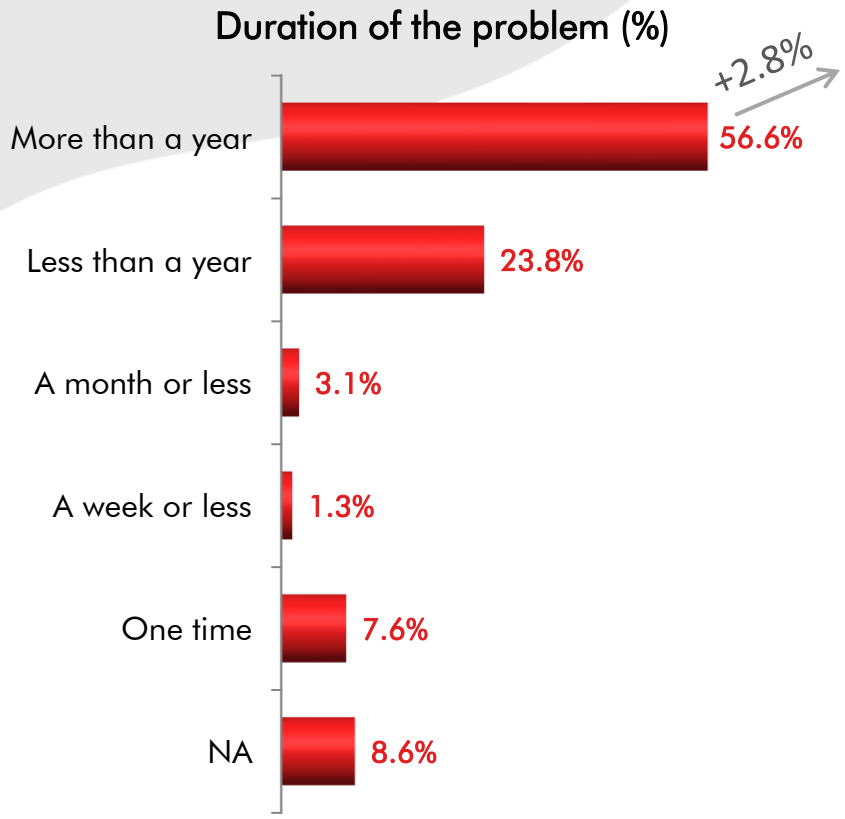
35.5% Children and Adolescents Helpline
32.5% Family and School Centers Helpline

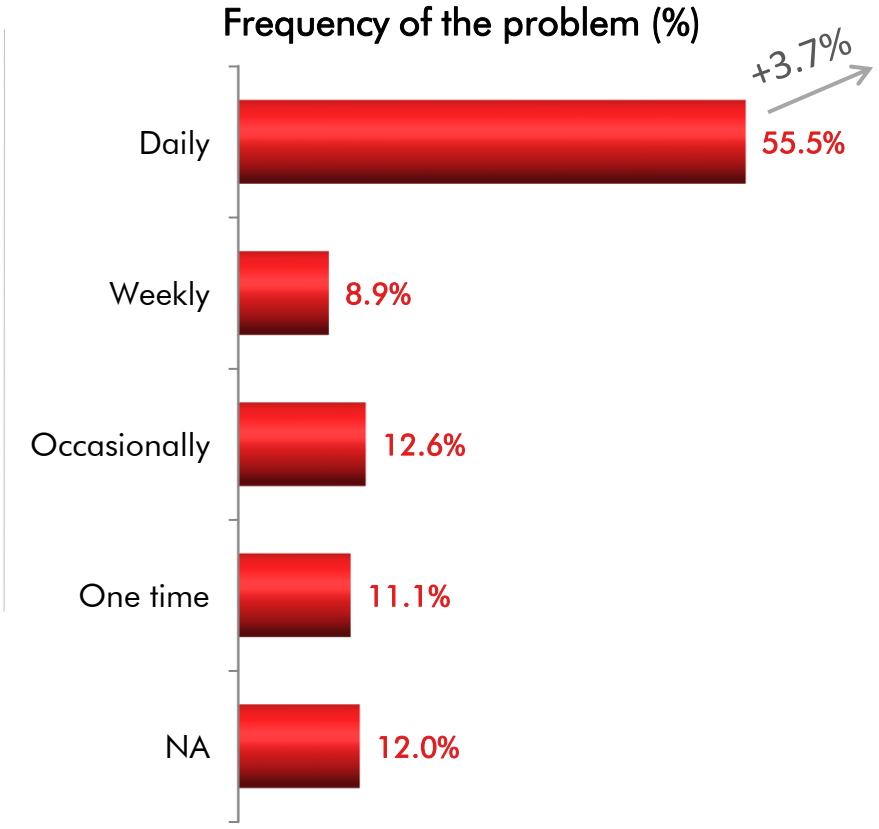
Base: the attended cases in 2022 through Children and Adolescents Helpline, Family and School Centers Helpline, ANAR Chat, ANAR Email, and the Missing Children Cases Telephone.

DURATION AND FREQUENCY OF PROBLEMS ADDRESSED IN 2022

We detect that the problems children and adolescents suffer have been happening **for more than a year, in more than half of the situations (56.6%)**. Compared to 2021, it has been increased by 2.8% percentage points.

The situation for children and adolescents is even worse considering revictimization, since the **frequency is daily in 55.5%** (an increase of 3.7% percentage points compared to 2021).





Base: Special Orientation contacts through all Helplines (telephone, chat, email) Total = 25,668.

LEVEL OF URGENCY AND GRAVITY OF THE PROBLEMS HANDLED IN 2022

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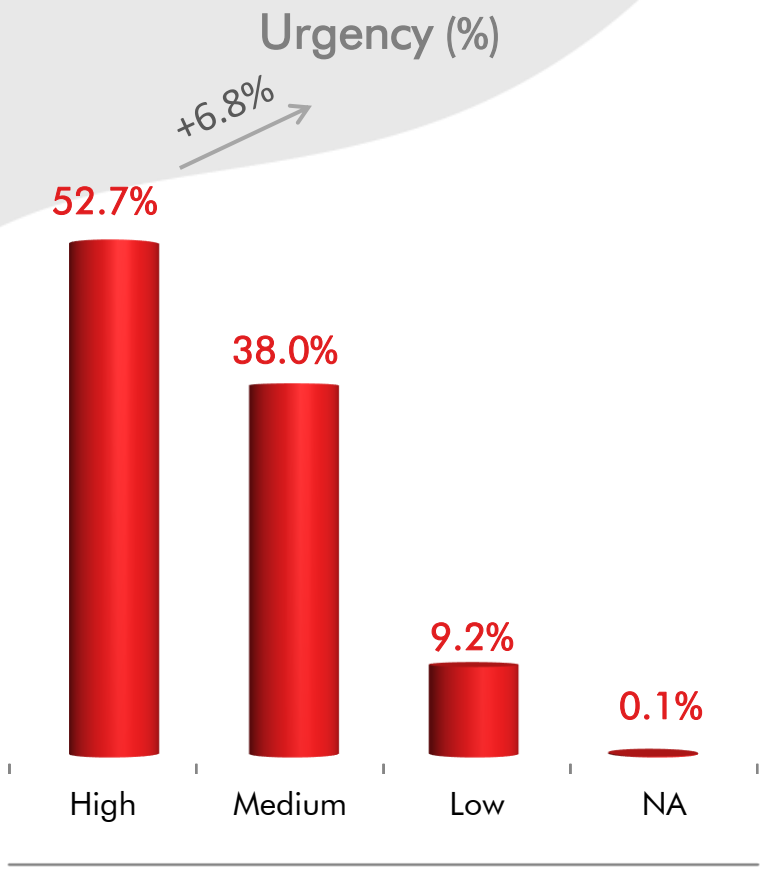
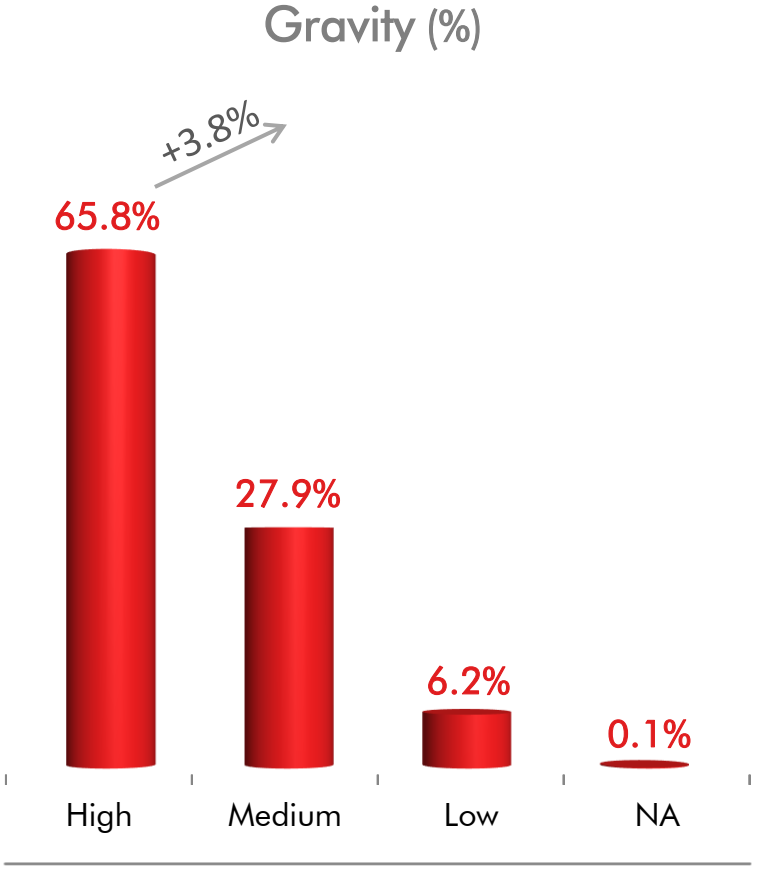
The urgency of the problems addressed is increasingly greater, representing already **52.7% of high urgency cases.** Also, **the gravity of the cases has increased to seven out of ten (65.8%)** of the cases serviced.

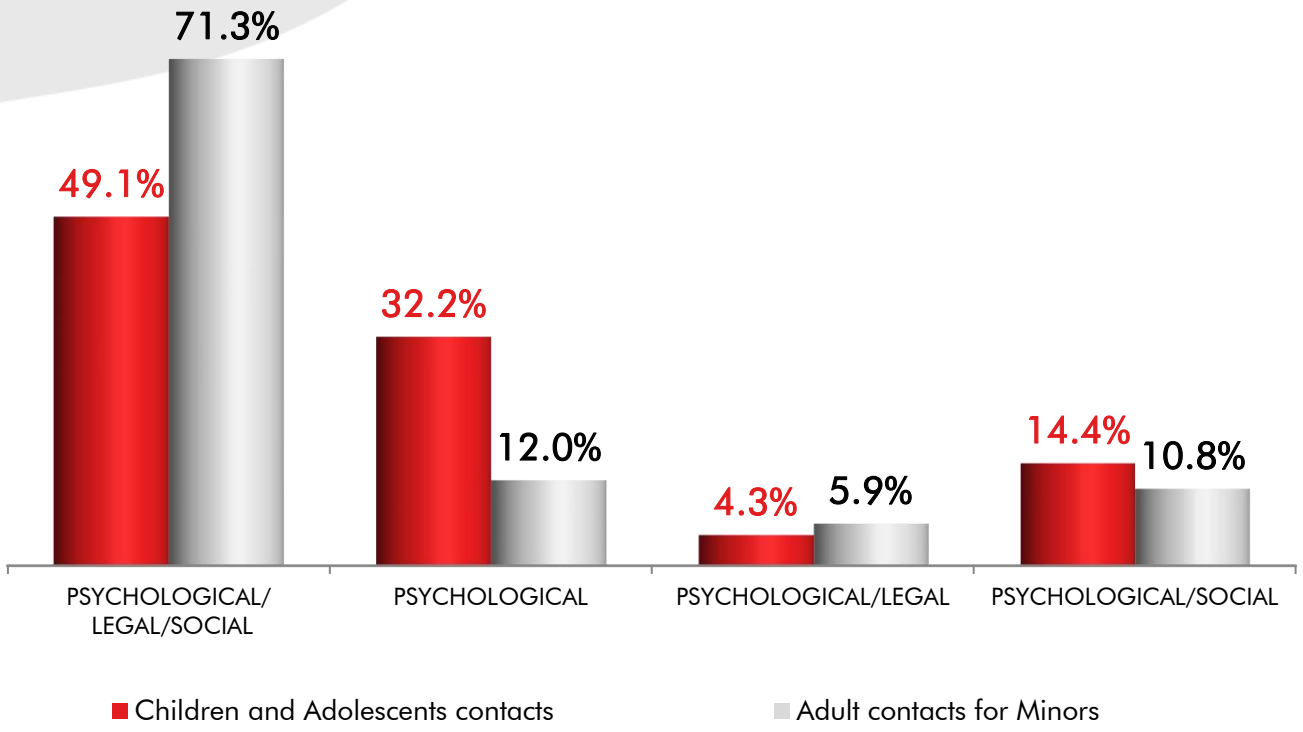




Base: Special Orientation contacts through all Helplines (telephone, chat, email), Total = 25,668.

COUNSELING PROVIDED (%)

The type of counseling that was required **in six out of ten help requests from both helplines was psychological, legal and social**, the most complex that we can facilitate, given that it includes orientations of psychological nature in addition to our evaluations by social workers and lawyers teams, with referrals to specialized resources.

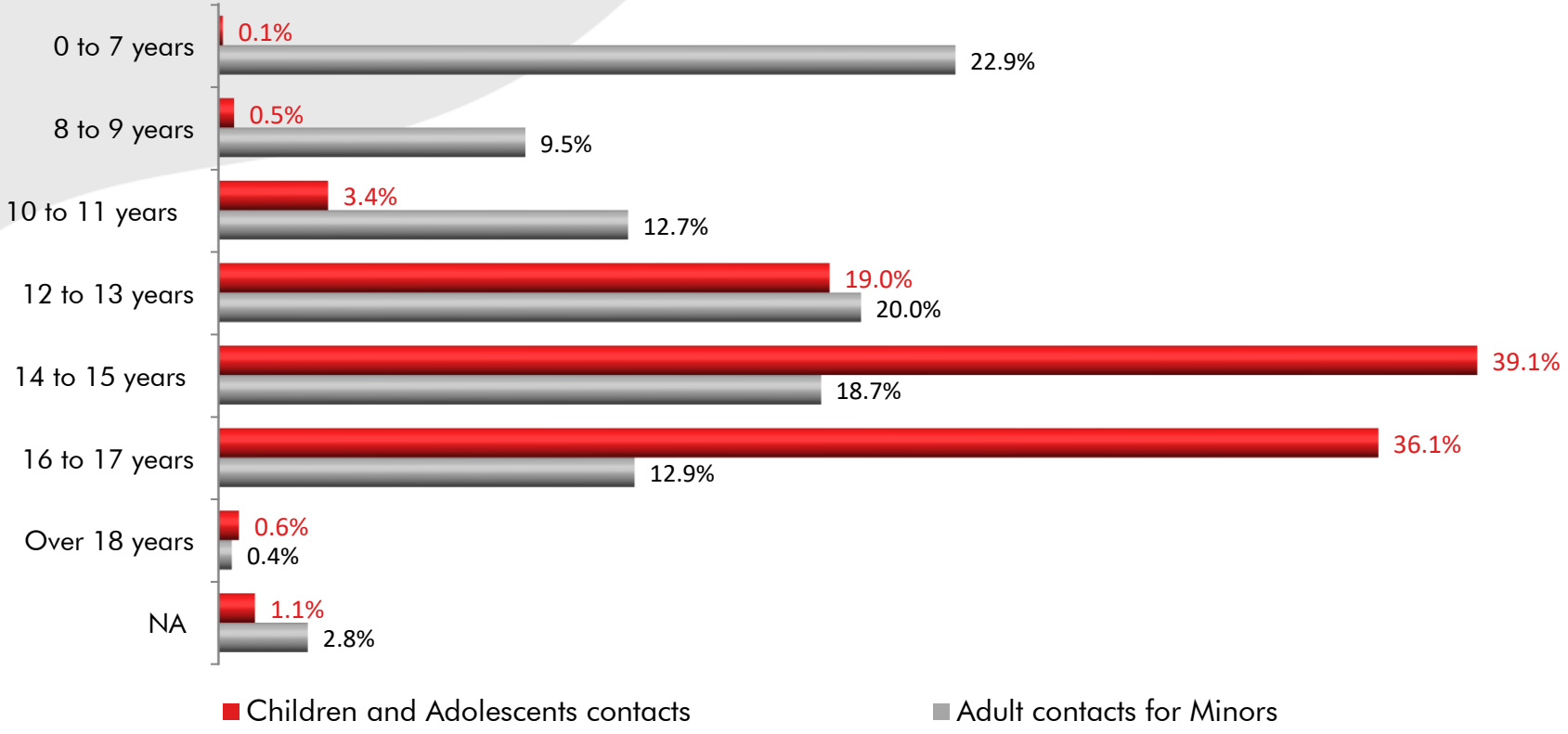


Base: Special Orientation contacts by Helpline (telephone, chat, email) 25,668.

AGE OF CHILDREN AND ADOLESCENTS (%)

As we can see in the graphic below, the ANAR Helplines reach all ages through the different Helplines.

The youngest are served primarily thanks to the contacts made by adults from their environment.

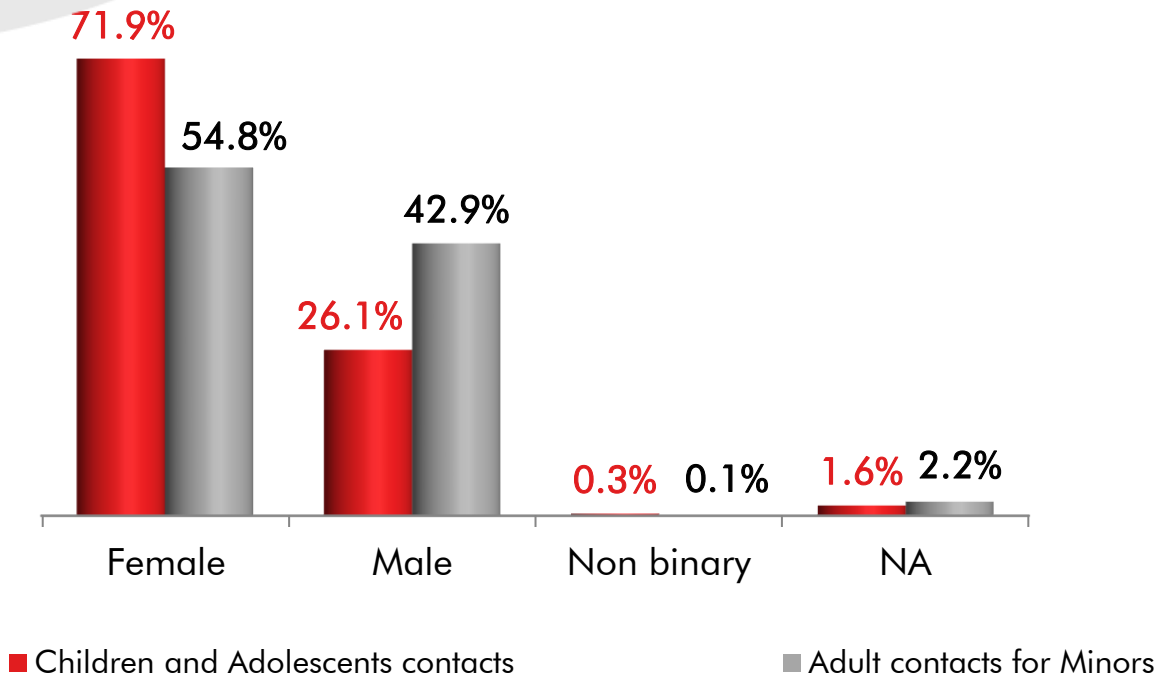


Base: Total casos atendidos según Línea de Ayuda (teléfono, chat, email): 17,896 casos.

GENDER OF CHILDREN AND ADOLESCENTS (%)

Across the children and adolescents contacts, 7 out of 10 cases received are from female, while those received by male are much less (26.1%).

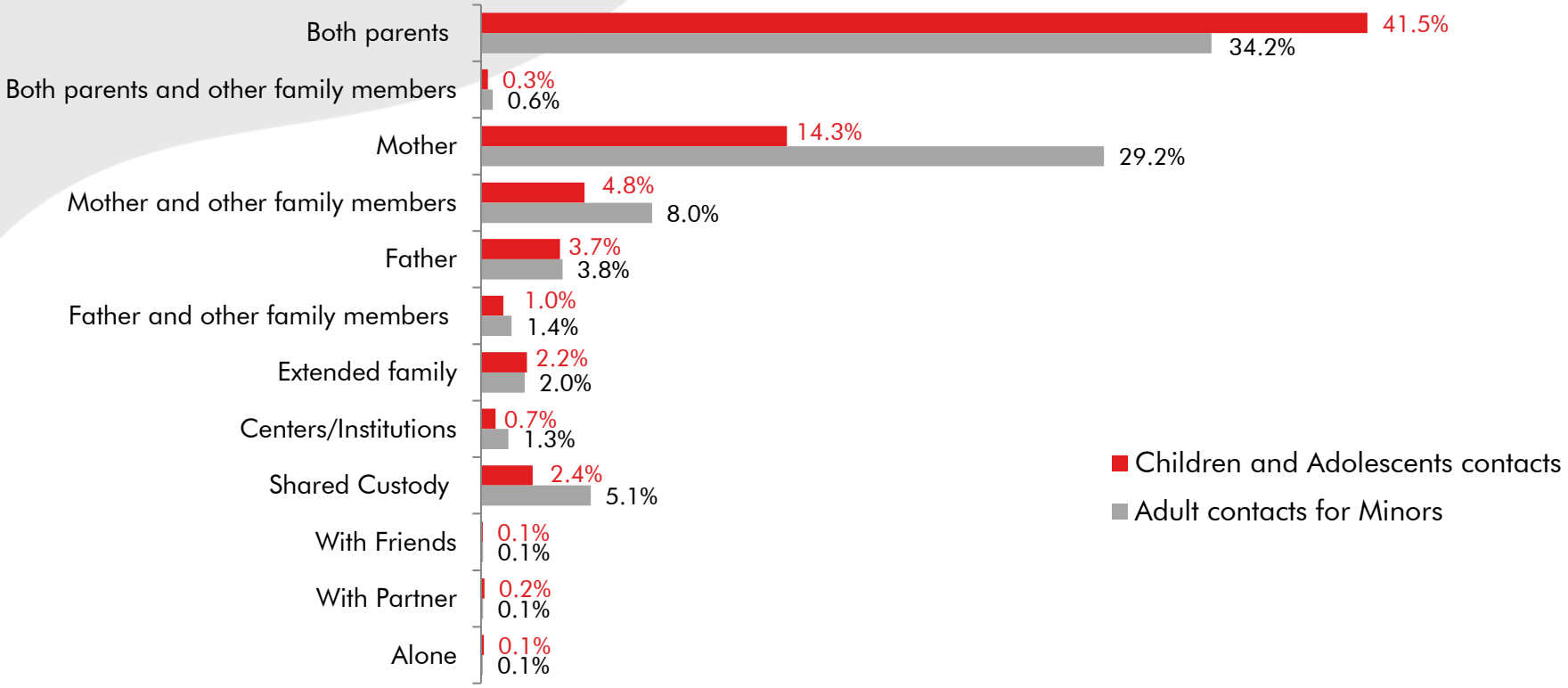
In regards to adult contacts, more than half (54.8%) referred to female, and four out of ten (42.9%) to male, although there is a lower percentage difference.



Base: All attended cases through Helplines (telephone, chat, Email): 17,896 cases.

WITH WHOM ARE THE CHILDREN AND ADOLESCENTS LIVING? (%)

In the cases handled through children and adolescents contacts, 67.8% live with a family member, highlighting those that live with both parents (41.5%), This percentage increases to 79.2% in the adult contacts about minors.

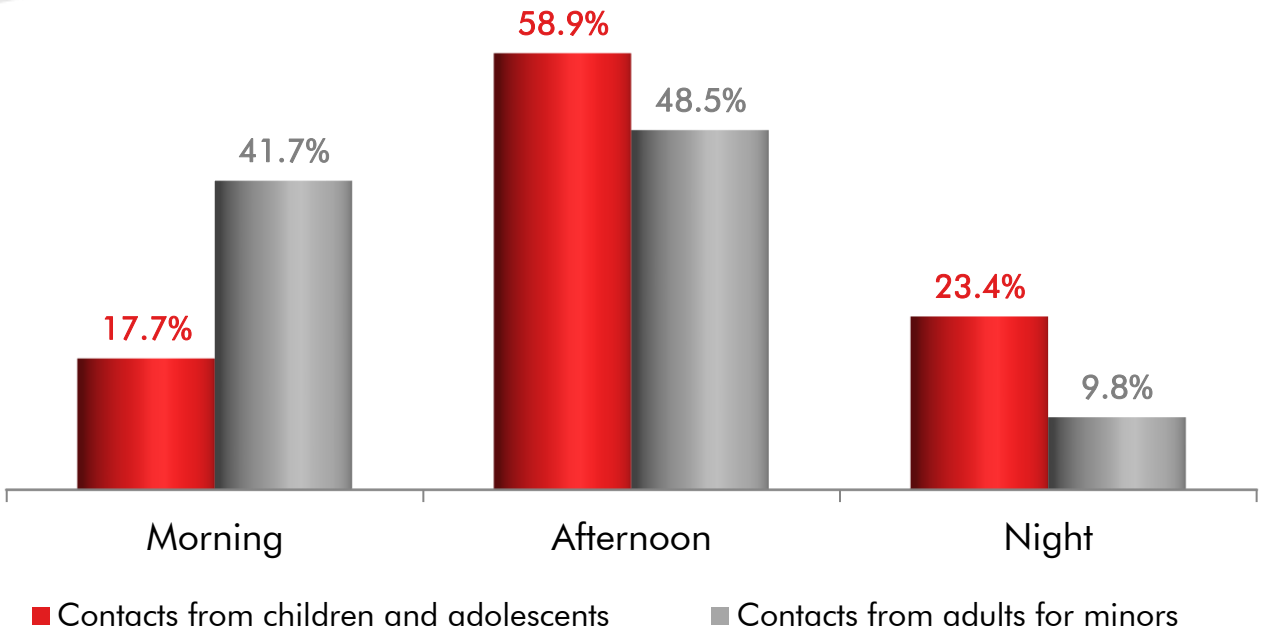


Base: All cases attended through Helplines (telephone, chat, Email): 17,896 cases.
In 28,7% of children and adolescents cases and 15% of adult cases there is no knowledge about who the child lives with.

TIMES SLOTS WHEN THE CONTACTS ARE MADE (%)

The distribution of calls and chats requiring special counseling at different times during the day explains the need of providing a **24/7 service.** All of the time slots are indispensable in order to handle the severe cases that ANAR services.

Compared to 2021, 2022 brought a **significant increase in calls from children and adolescents during the night, an increase of 9.7 percentage points.**

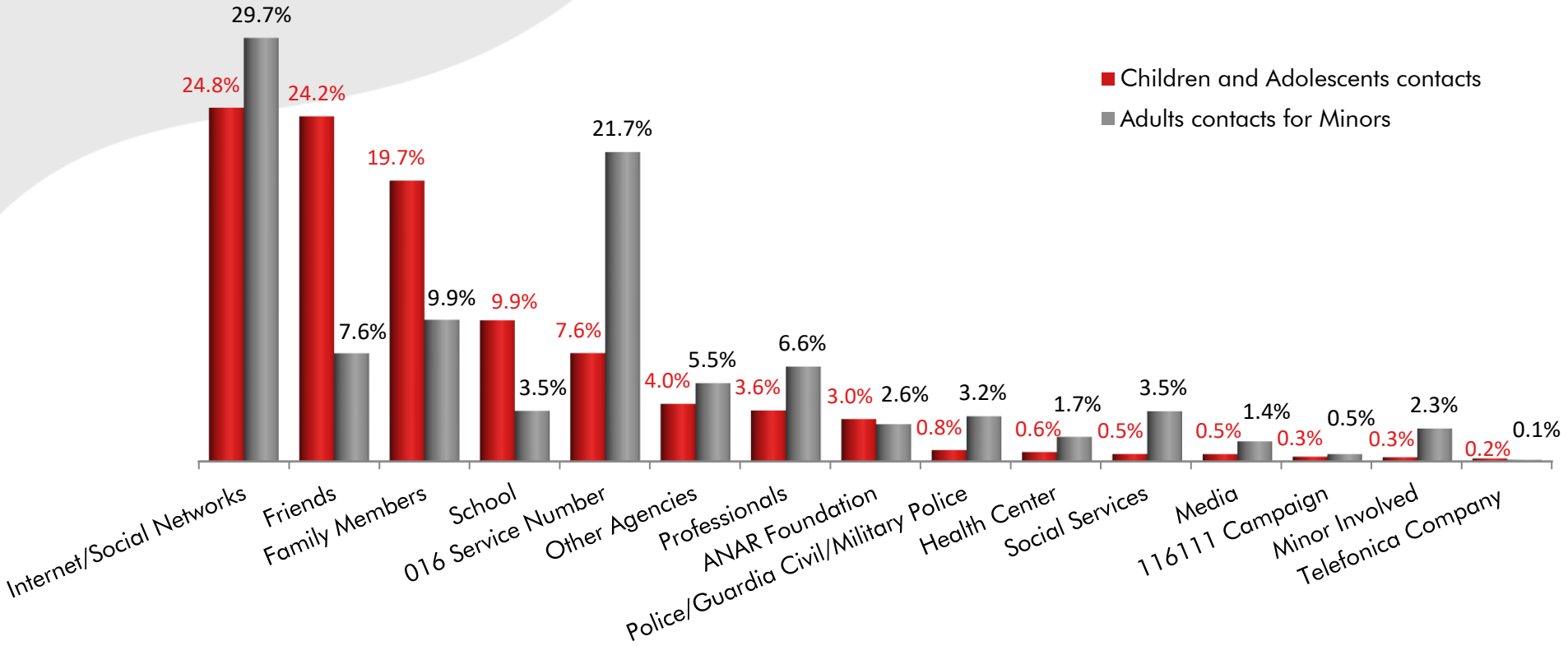


Base: Special Orientation contacts from Helplines (telephone, chat, email): 25,668.

KNOWLEDGE OF ANAR HELPLINES IN 2022

Main channels of dissemination (%)

During 2022, children and adolescents found out about us mainly through **Internet/Social Networks (24.8%),** from **friends (24.2%)** and from their own **family members (19.7%)**. Adults learned about us through **Internet/Social Networks (29.7%)** and through coordination with the **016 Service Number (21.7%).**



Base: All cases attended through the Helplines (telephone, chat, email): 17,896 cases.
No data about the source of knowledge of our helpline in 71% of children and adolescent cases, and 62.2% of adult cases.

LEGAL AND SOCIAL REFERRALS AND INTERVENTIONS

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Total Referrals
74,428

- 47,858 Social Dept.
- 26,570 Legal Dept.

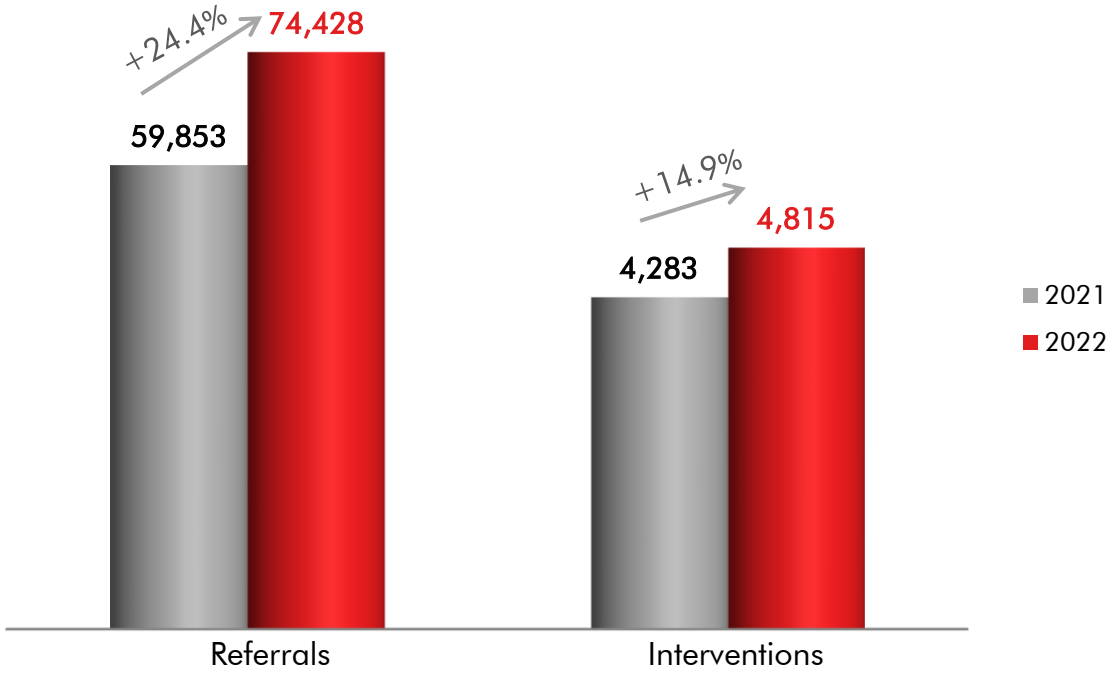
Severe cases
4,923
Interventions

- 2,414 Social Dept.
- 2,509 Legal Dept.

Referrals to legal and social entities

Cases that required Immediate Intervention:

- Law enforcement agencies
- Social Services and Child Protection System



LEGAL NATURE REFERRALS

In 2022, a total of **26,570 referrals** were made to legal nature resources.

Compared to 2021, the high increase in Law enforcement agencies referrals stands out: 3,683 more, to Courts 994 more, to the Assistance Office to Victims, 967 more and to the Bar Association, 248 more.

JUDICIAL RESOURCES	TOTAL
Law enforcement agencies	6,488
Courts	1,538
Lawyer	1,206
Assistance Office to Victims	1,094
Bar Association /Legal Counselling Service	817
Prosecutors	18
Spanish Agency for Data Protection	16
Legal Information	15,393
TOTAL	26,570

ANAR TELEPHONE/CHAT LEGAL NATURE INTERVENTIONS

In 2022, the ANAR Foundation contacted external resources in **2,509 cases.**

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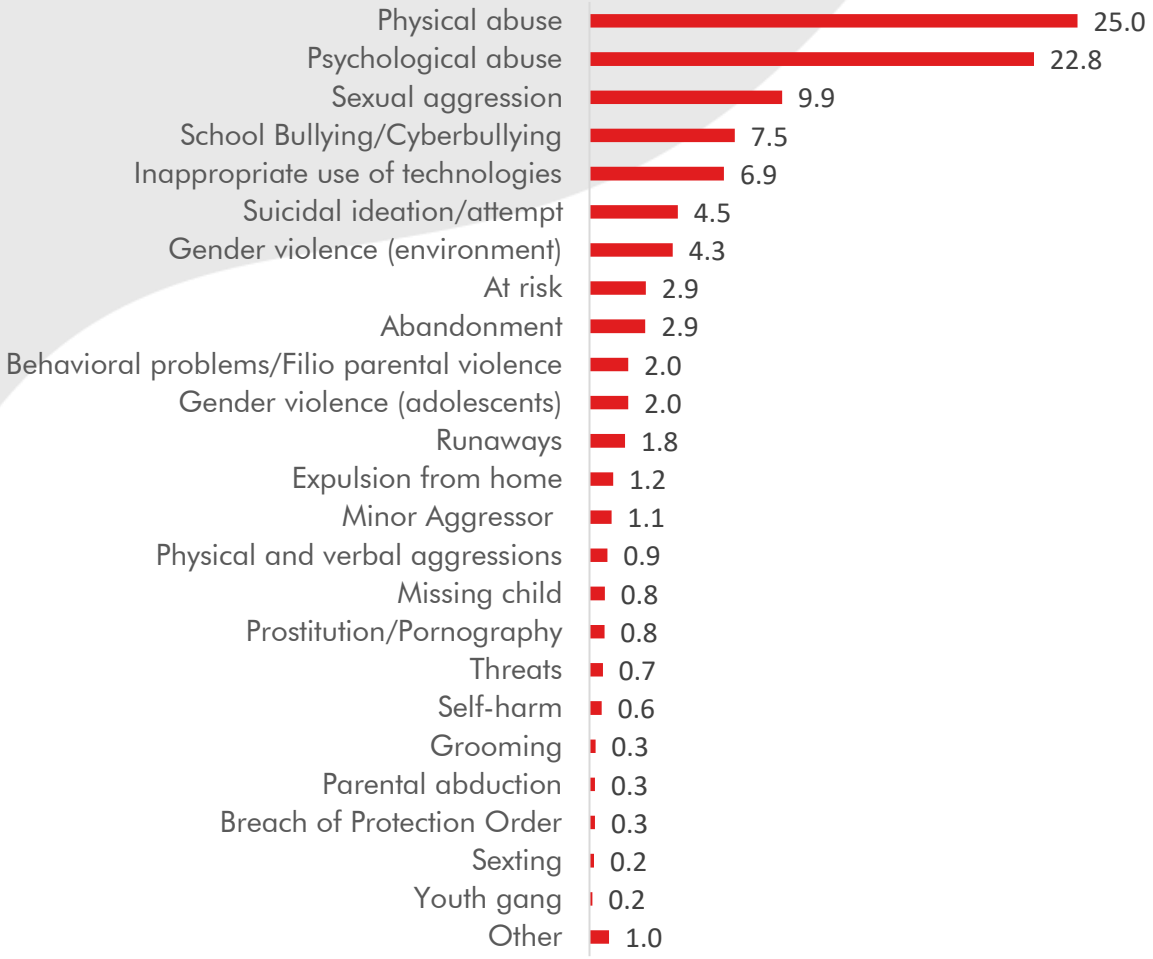
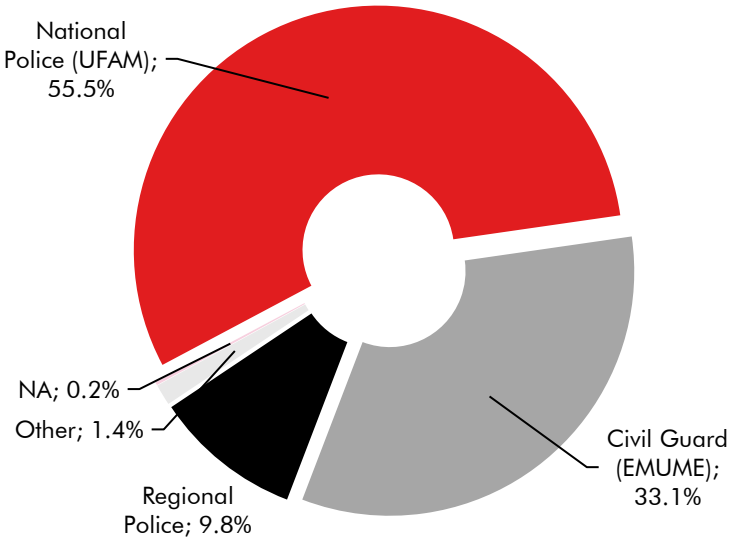
Reason for intervention (%)



Agencies (%)



*Several agencies and/or authorities may intervene in the same case

*The 'Other" category includes: Abuse of authority, Drug trafficking, Identity theft, Violence in living environment, Exhibitionism, Young offenders, Gender violence witness, Crime against sexual choice, Pregnancy termination, Institutional abuse, Unaccompanied migrant minor, Child Begging.

REFERRALS TO SOCIAL NATURE RESOURCES

In 2022, we made **47,858 referrals** to social nature resources.

SOCIAL RESOURCES	TOTAL
Emergency Services 112	6,795
School Centers	6,732
Local Social Services	6,538
Health Centers and Specialties	4,947
Mental Health Centers	3,008
Psychological therapy	3,005
Educational Inspection Services	1,422
School Bullying Resources	986
Resources for Women	950
Hospitals	660
Professional association (Psychologists, Social Workers)	449
NGO's	398
Sexual Abuse Resources	281
Child Protection Agencies	260
Intervention for child Abuse in Madrid (CIASI)	172
Filio parental Violence Resources	148
#You Matter# Resource (#TU CUENTAS#)	122
AMPA	82
Planned Parenthood and Youth Sexuality Centers	59
Family Counseling Centers	53
Centers of Hope Telephone	53
Youth Information Centers	43
International Child Helplines	41
Center for Adolescents victims of Gender Violence	33
CAI (Childhood Protection Center)	32
Informational Telephone Contacts (Drugs, Sexuality, Eating Disorders, etc.)	31
Other Public Agencies	29
Foster Homes and Protection Centers	28
Others	84
Social Information	10,417
TOTAL	47,858

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ANAR TELEPHONE/CHAT INTERVENTIONS OF SOCIAL NATURE

In 2022, the ANAR Foundation contacted external resources in **2,414 cases.**

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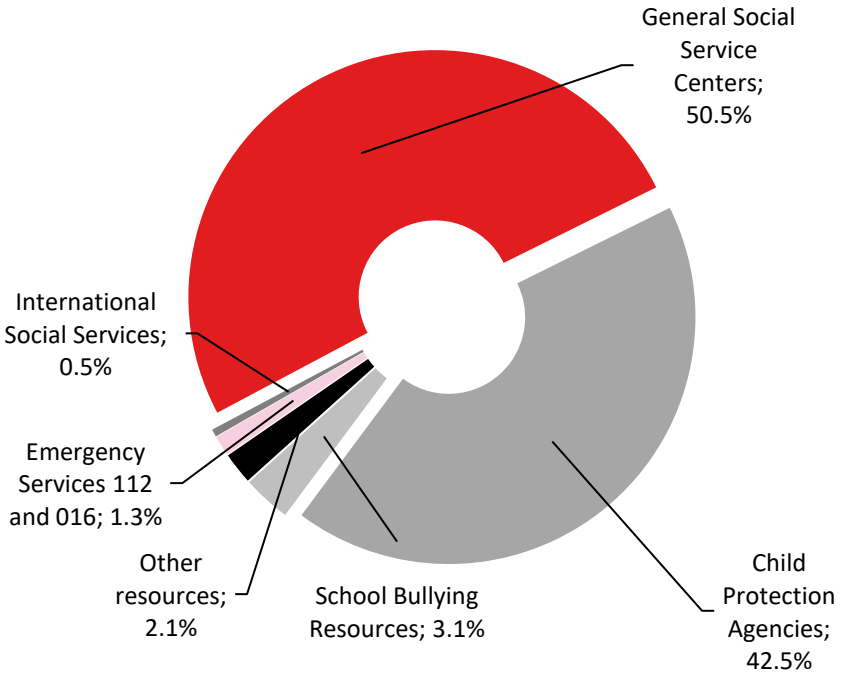
Reason for the intervention (%)

Agencies (%)



The 'Other' category includes the following: Abortion, Family placement, Physical assault, Sexual assault, Verbal abuse, Threats, Anxiety in the environment, Anxiety/Sadness, Youth gangs, Eviction, Missing child, Functional diversity, Pregnancy, Mental illness, Physical illness, Ideation/Suicide Attempt, Institutional abuse, Forced marriage, Unaccompanied migrant child, Pre-school age children, Genital mutilation, Other mental problems, Loss or Accident and Other, Prostitution, Prostitution (environment), Pornography, Economic problems, Housing problems, Institutional complaints, Sextortion, Homelessness, Parental abduction, Eating disorder, Custody.

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ADDITIONAL INFORMATION

SUICIDAL IDEATION/ATTEMPTS AND SELF-HARM

Evolution of Suicidal Ideation, Suicide Attempt and Self-harm Cases

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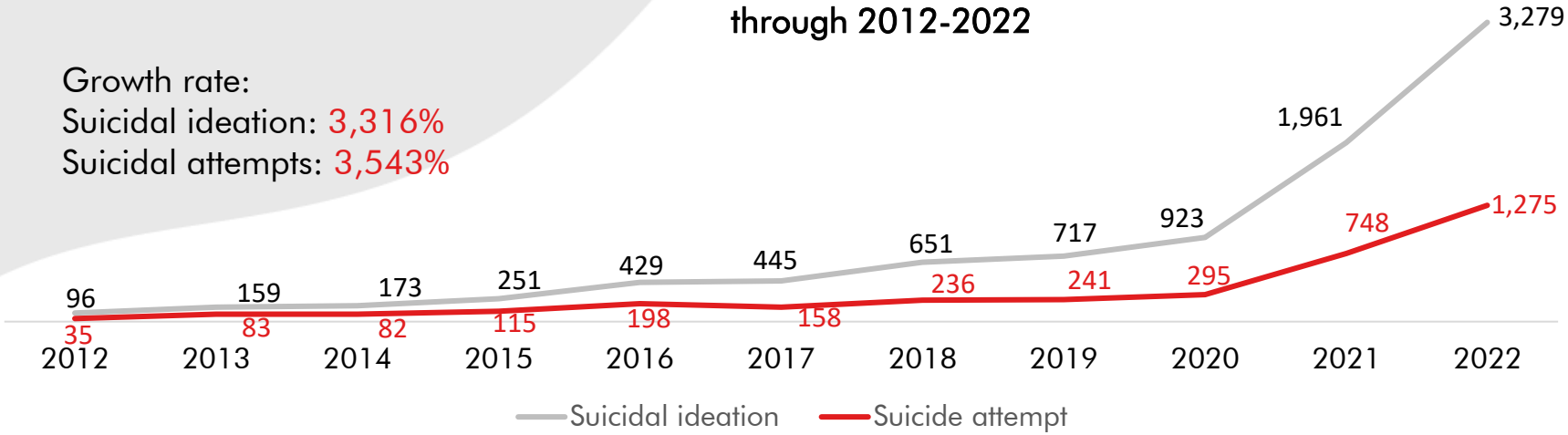
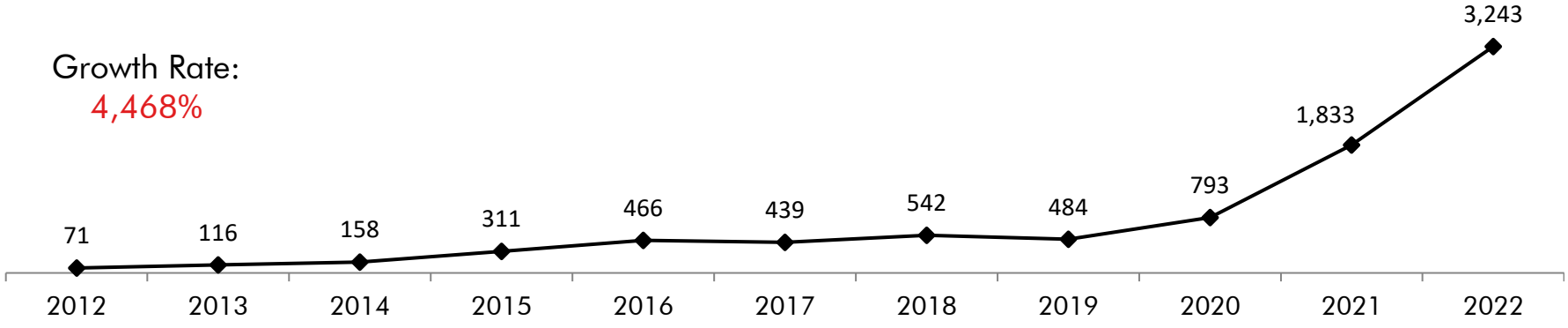
Number of cases evolution for suicidal ideation and suicidal attempts through 2012-2022

Growth rate:
Suicidal ideation: 3,316%
Suicidal attempts: 3,543%



Number of cases evolution for self-harm through 2012-2022

Growth Rate:
4,468%



* Data corresponding to suicide behavior (ideation and attempts) was extracted erasing duplicities, as many cases include both categories.

ANAR CHAT/EMAIL

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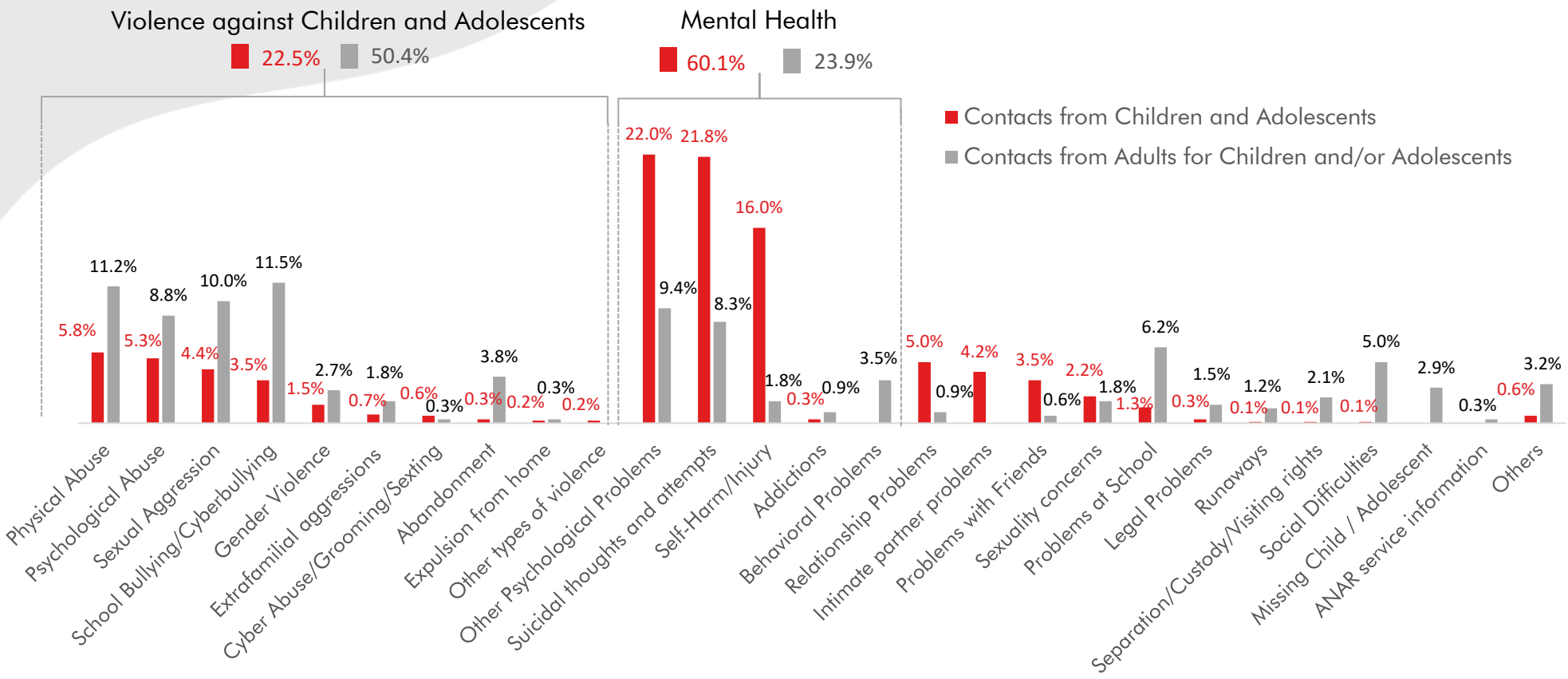
Helping at Risk Children and Adolescents

In 2022 we have handled **3,524 cases** (19.7% of the total cases) through ANAR Chat. We have answered a total of **7,878 help requests ANAR Chat.**

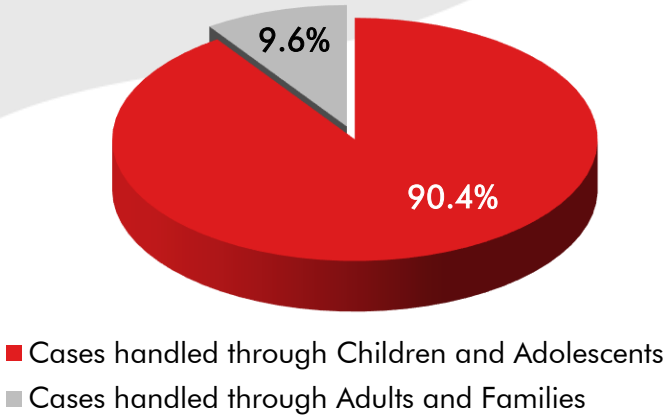
REASONS FOR CONTACT THROUGH ANAR CHAT IN 2022 (%)



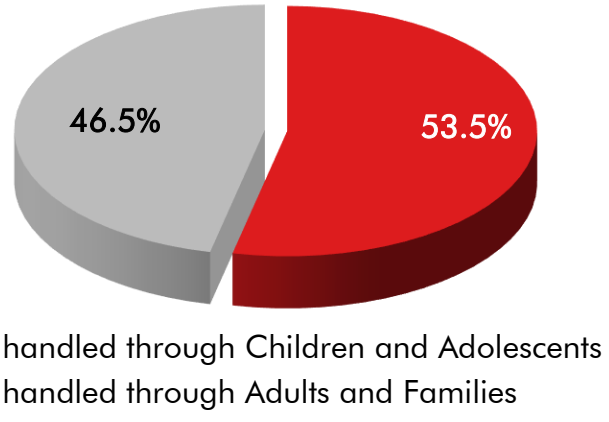
ANAR CHAT/EMAIL

In 2022 we have handled **391 cases** (2.2% of the total cases) through ANAR Email. We have answered a total of **862 help requests through ANAR Email.**

% Total cases handled through ANAR CHAT 2022



% Total cases handled through ANAR EMAIL 2022



Referrals		
	CHAT	EMAIL
Social Dept.	8,426	920
Legal Dept.	4,075	582

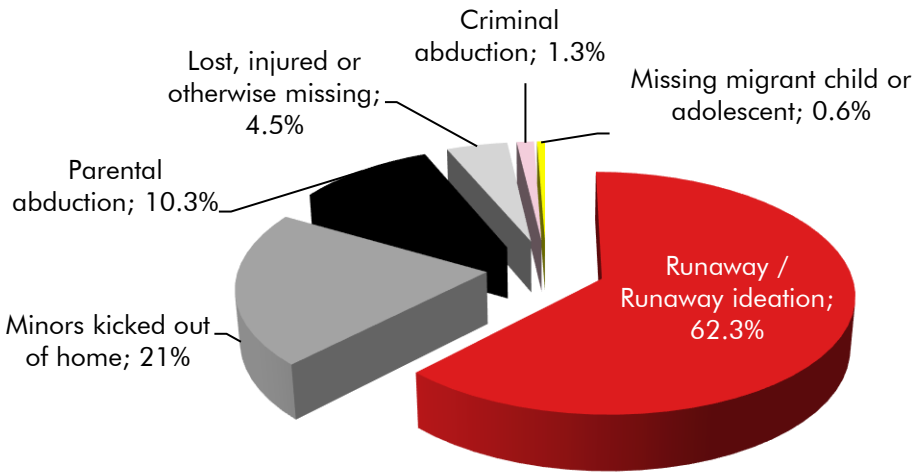
Interventions		
	CHAT	EMAIL
Social Dept.	243	13
Legal Dept.	295	27

ANAR CHAT/TELEPHONE 116 000 FOR MISSING CHILDREN CASES

Total calls and emails answered at ANAR Telephone regarding to missing children cases in 2022, amounts to **2,832 calls/chats.** The missing children **cases** or at risk of disappearance amounts to **1,015**. Of the total calls and emails:

- Through the **ANAR Telephone 116000** for missing children cases, we have answered 1,202 calls.
- Through the **ANAR Telephone for Children and Adolescents**, we have answered 410 calls.
- Through the **ANAR Telephone for Families and School Centers** we have answered 969 calls.
- Through our **ANAR Email** service we have answered 31 emails (26 from adults and 5 from children and/or adolescents)
- Through our **ANAR Chat** service we have answered 197 contacts (50 from adults and 147 from children and/or adolescents).
- Through the **Telephone against School Bullying and Abuse** we have answered 23 calls (21 adults y 2 from children and/or adolescents).

Reasons for contact (%)



CASES BY REASON FOR CONTACT (ABSOLUTE NUMBERS)		2022	2021
Runaway / Runaway ideation	↓	632	779
Minors kicked out of home	↑	213	212
Parental abduction	↑	105	101
Lost, injured or otherwise missing	↓	46	58
Criminal abduction	↓	13	18
Missing migrant child or adolescent	↑	6	4

* Data extracted from the ANAR Telephone for Missing Children cases Report (2022).

ANAR TELEPHONE/CHAT 116 000 FOR MISSING CHILDREN CASES

REFERRALS AND INTERVENTIONS IN 2022

In 2022, ANAR Foundation made 1,723 legal and social nature referrals from the special counseling contacts about missing children.

67 interventions were made by the Legal and Social Departments. In addition, we have intervened in 9 cases of international coordination given the cross-border component of the disappearance.

760 Legal nature Referrals

Law enforcement agencies (National Police, Autonomic, Local, Civil Guard)	204
Lawyer	52
Courts	24
Foreing Affairs Ministry	1
Bar Associations / Legal Counseling Service	19
Office for Victims of crime	14
Legal counseling	515

963 Social nature referrals

Local Social Services	214
Emergency Services 112	124
School Centers	72
Health Centers and Specialties	60
Psychological therapy	49
Mental Health Centers	37
Resources for Women	19
Filio parental Violence Resources	18
Child Protection Agencies	16
NGO's: Addictions, Immigration, Therapy, Family Mediation, etc.	13
CAI (Childhood Protection Center) CAF (Family Counseling Centers)	7
Foster Homes and Protection Centers	5
International Social Services	5
Hospitals	4
Mediation and Therapy Services from Public Entities	3
Hope Telephone	3
International Child Helplines	3
Others	7
Social Counseling	304

Severe cases
67
Interventions

ANAR TELEPHONE/CHAT FOR GENDER VIOLENCE IN CHILDREN AND ADOLESCENTS

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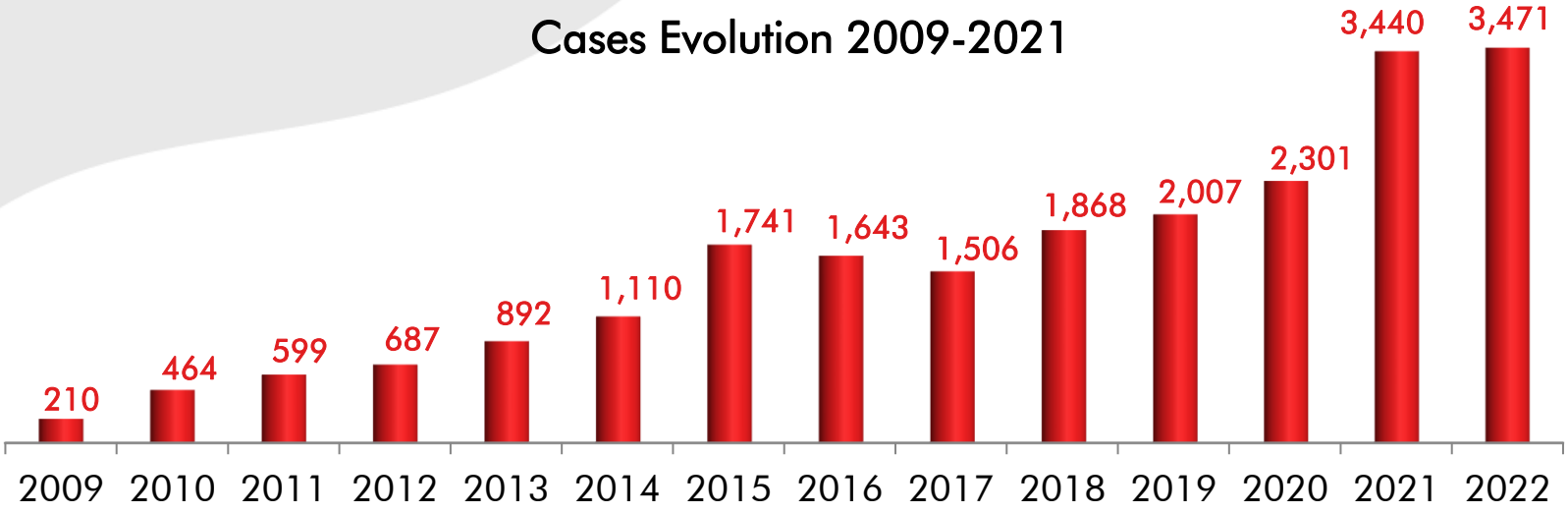
To detect these situations was necessary to answer **9,579 help requests of gender violence for children and adolescents**, of which **5,403 required special counseling**.

In 2022 we have handled **3,471 cases** for gender violence in childhood and adolescence.

Cases Evolution 2009-2021



Referrals			
Social Dept.	GV in adolescents	1,459	10.575
	GV in the environment	9,116	
Legal Dept.	GV in adolescents	954	8.181
	GV in the environment	7,227	

Interventions			
Social Dept.	GV in adolescents	65	168
	GV in the environment	103	
Legal Dept.	GV in adolescents	80	453
	GV in the environment	373	

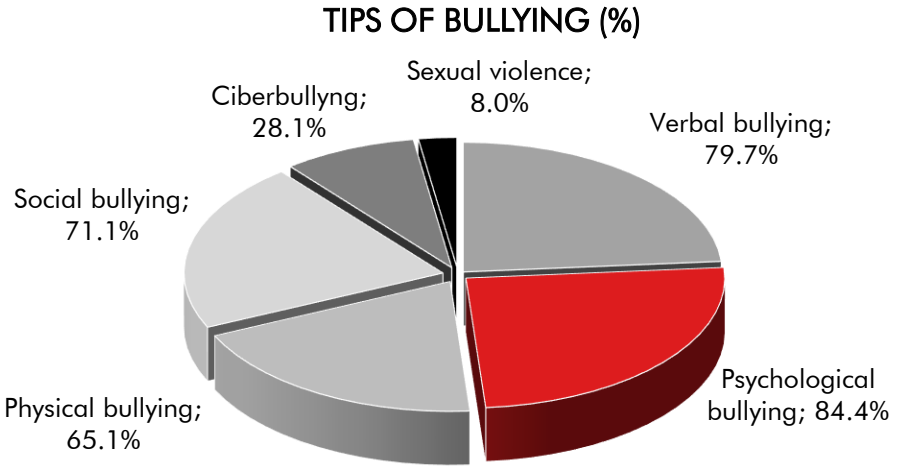
ANAR TELEPHONE/CHAT AGAINST SCHOOL BULLYING AND CIBERBULLYING

During 2022 we have received **18,485** help requests for school bullying situations.

- Through the **Telephone Against School Bullying and Abuse of the Ministry of Education (900 018 018)** we have answered 15,716 calls.
- Through the **ANAR Telephone for Children and Adolescents**, we have answered 917 calls.
- Through the **ANAR Telephone for Families and School Centers** we have answered 1,096 calls.
- Through our **ANAR Chat** service we have answered 646 contacts.
- Through our **ANAR Email** service we have answered 110 emails.

During 2022 we have handled **3,841** cases for school bullying situations.

- Through the **Telephone Against School Bullying and Abuse of the Ministry of Education (900 018 018)** we have handled 1,943 cases.
- Through the **ANAR Telephone for Children and Adolescents**, we have handled 730 cases.
- Through the **ANAR Telephone for Families and School Centers** we have handled 761 cases.
- Through our **ANAR Chat** service we have answered 376 contacts.
- Through our **ANAR Email** service we have answered 31 emails.



* The same case can reference different types of bullying, which is why the sum of all percentages can be higher or lower than 100%.

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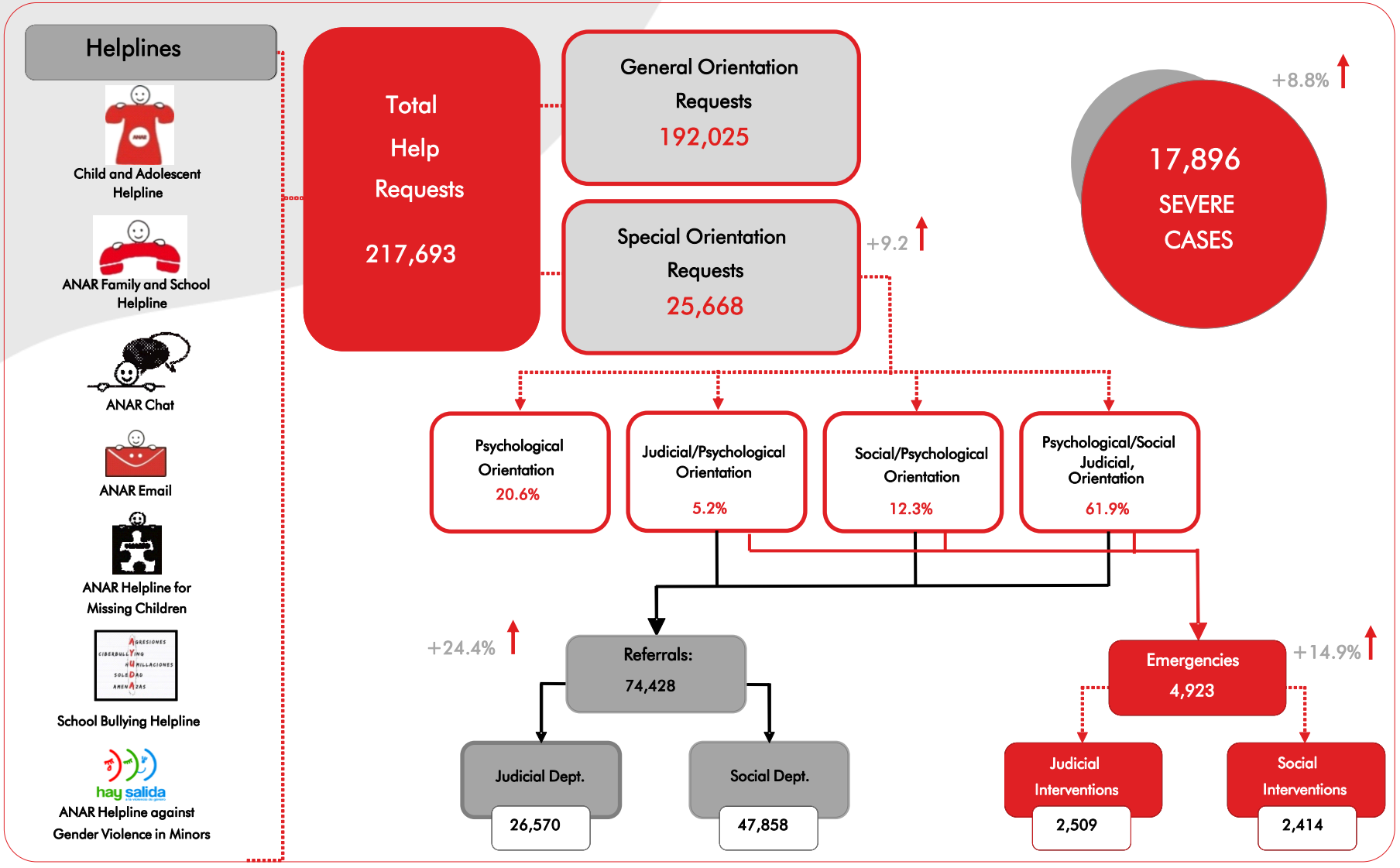
CONCLUSIONS

CONCLUSIONS

SUMMARY OF ANAR HELPLINES IN 2022

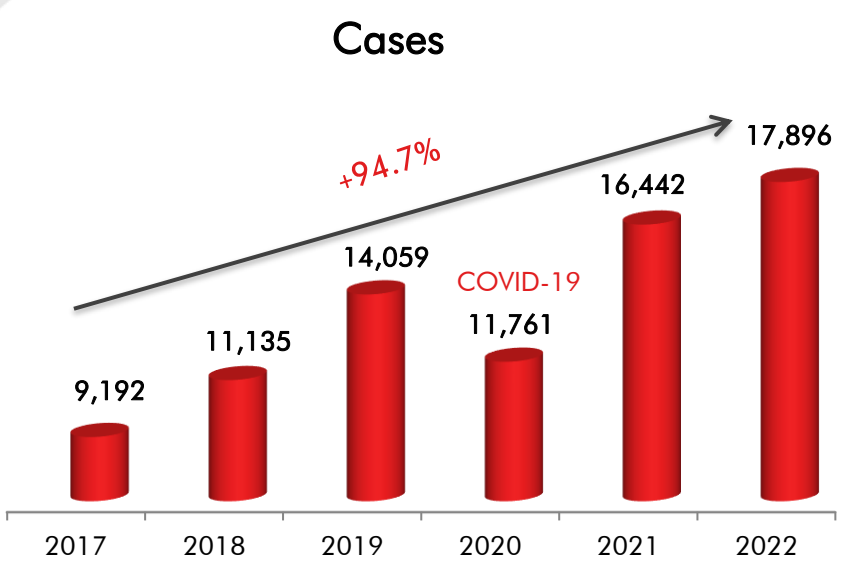


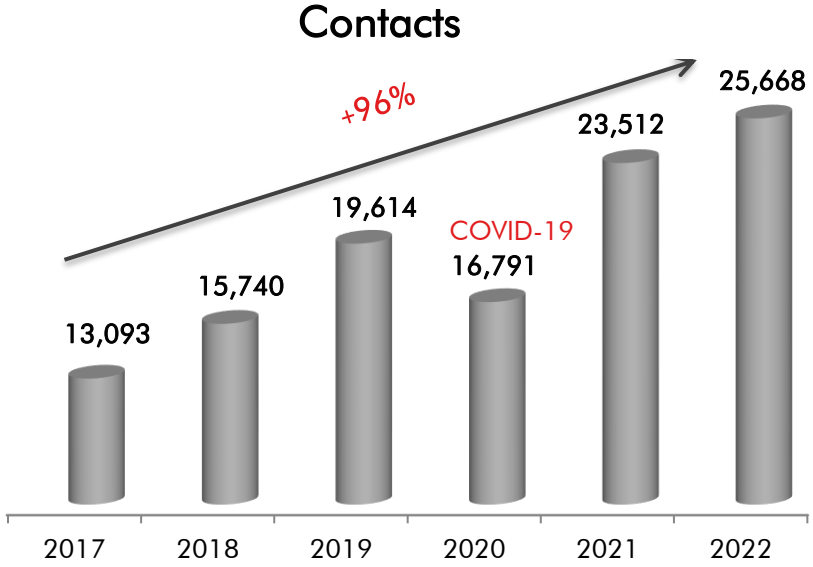
CONCLUSIONS

1. HELP REQUESTS

• In 2022 we have answered **217,693 help requests** at the ANAR Telephone/Chat throughout Spain, necessary to cover a total of **17,896 severe cases** where ANAR has helped, representing the biggest figure of answered cases to date, which means an increase of **94.7%** in the last 6 years. Only in the last year, it has increased by **8.8%.**

• In regards to the **special counseling contacts** (those that require the assistance of a professional child expert: psychologist, lawyer, social worker) a total of **25,668** have been attended, which implies an increase of **96%** over the last 6 years. Also, it had a significant increase **compared to 2021 (+9.2%).**





CONCLUSIONS

• **REFERRALS AND INTERVENTIONS:** Both the increase in the number of contacts and the severity and urgency of the cases have led our Legal and Social Departments to increase their activity significantly.

• To be able to help in these cases we had to do **74,428 referrals** to health resources, educational, police, etc., which means an **increase of 24.4%** compared to last year.

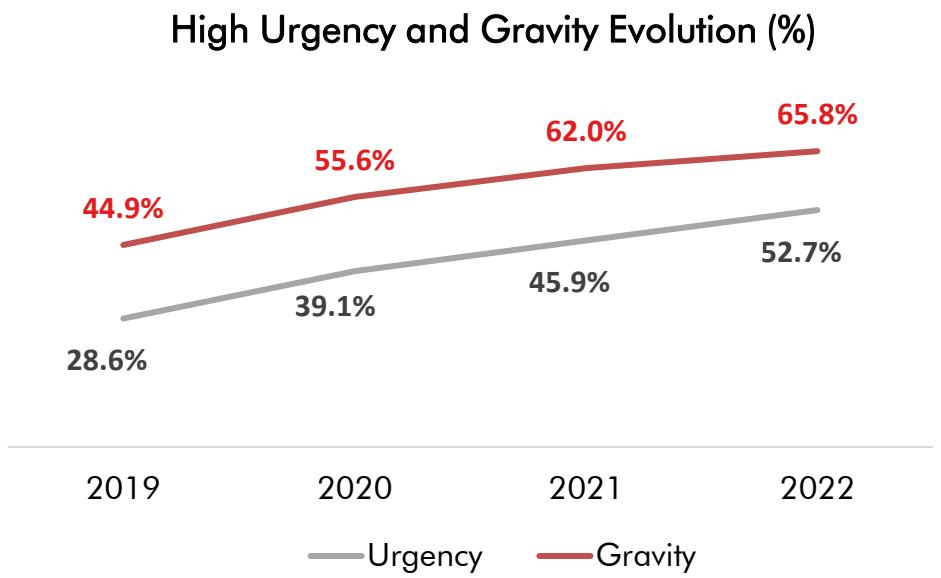
• We have carried out **4,923 interventions in extreme situations** where the child and/or adolescent was at risk, helplessness or emergency, so ANAR intervened through the law enforcement agencies (police and civil guard), emergency services, etc., with an **increase of 12.4%** compared to last year.

• **DURATION AND FREQUENCY OF THE ATTENDED CASES**: In 2022, in more than half of the contacts **(56.6%), the problem lasts more than one year,** and, in addition, it happens **daily (55.5%).** Comparing the last three years, we can conclude that the rate of problems attended with a duration longer than one year, shows an increasing tendency, and a daily frequency.

CONCLUSIONS

• **URGENCY OF THE ATTENDED PROBLEMS**: In 2022, more than the half of the problems (52.7%) have had a high urgency and only 9.2% has had a low urgency. If we take into account what happened for the last three years, a rising pattern of problems requiring urgent attention can be observed. Actually, from 2019 to 2022, high urgency problems have been increased 24.1 percentage points. On the other hand, those matters of low urgency have been decreasing during this period of time.

• **GRAVITY OF THE ATTENDED PROBLEMS**: In 2022, a 65.8% are high gravity (includes very high and extreme gravity), and only the 6.2% has a low gravity. Same way it happens with the gravity, also the problems attended with high frequency have been increased, 20.9 percentage points from 2019 to 2022.



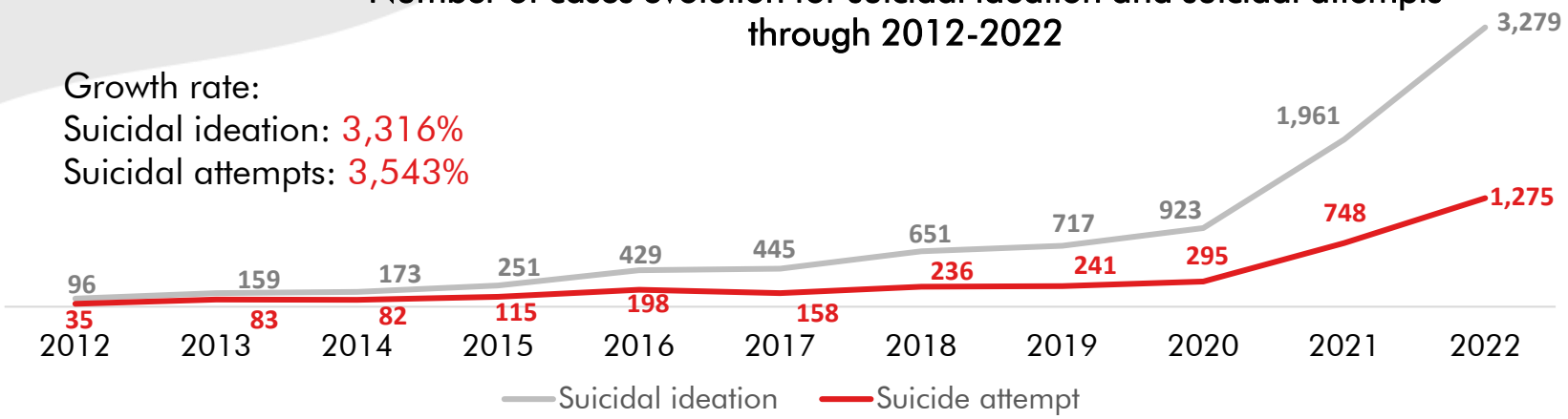
CONCLUSIONS

2. MENTAL HEALTH

- Mental Health problems grow very significantly. In 2022, 45.1% of Children and Adolescents contacts are for this reason, with an increase of 12.6 percentage points compared to last year (32.5%).
- The most worrying increase in Mental Health is the one in cases of suicidal ideation, suicide attempts already initiated, and self-harm which meant in 2022 a total of 7,797 cases, a 71.7% increase compared to last year.

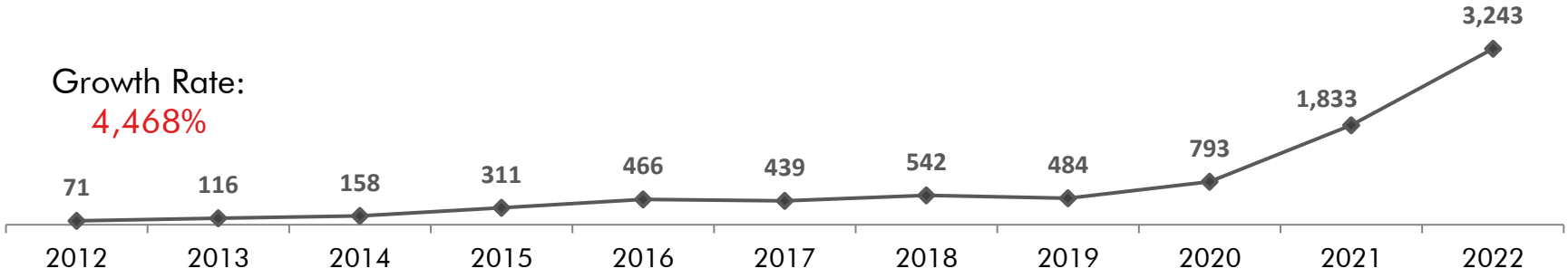
Number of cases evolution for suicidal ideation and suicidal attempts through 2012-2022

Growth rate:
Suicidal ideation: 3,316%
Suicidal attempts: 3,543%



Number of cases evolution for self-harm through 2012-2022

Growth Rate:
4,468%

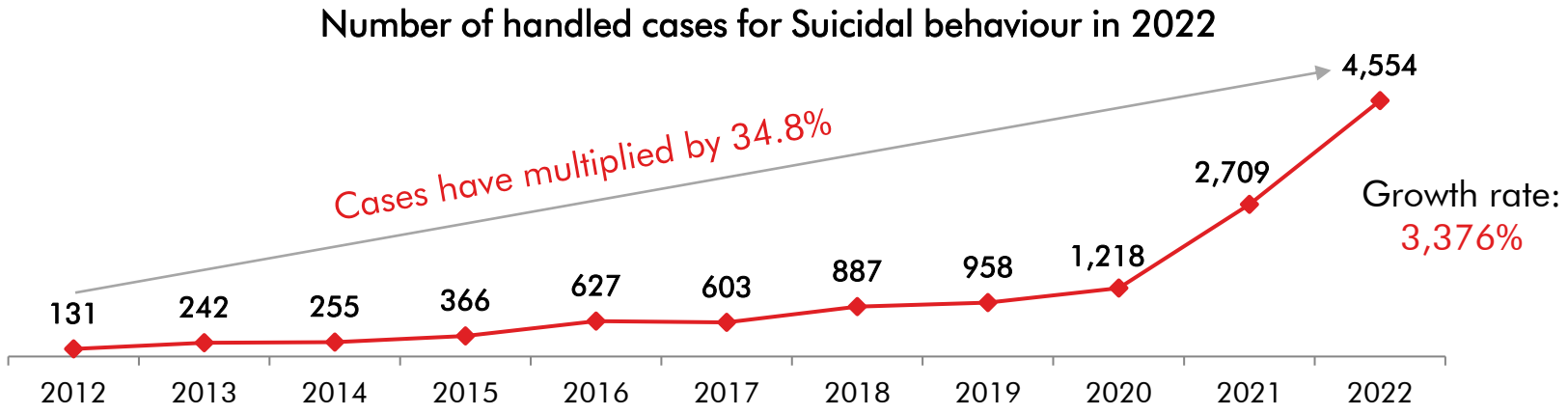


CONCLUSIONS

2.1. SUICIDAL BEHAVIOUR: The first conclusion we want to highlight is that, in 2022, **suicidal behaviour** (suicidal ideation and attempt) **has turned into the first reason for contact for children and adolescents.** In the 29 years that ANAR Foundation has been providing telephone assistance to children, adolescents and adults in their environment, this is the first time that suicidal behavior has been the first reason for consultation among minors.

Among the different Mental Health problems, suicidal behaviour is the one that has experienced the most worrying growth, as well as being the most serious and with the worst consequences for our young people. In recent years, ANAR has been warning society about this alarming growth and the COVID phenomenon has only aggravated it. In the past year alone, we have attended **7,928 contacts** for suicidal ideation and suicide attempts, which represent **4,554 cases** where ANAR saved children and adolescents lives.

In recent years, the number of cases of this phenomenon **has multiplied by 34.8%** (meaning the growth rate over the last eleven years has been of **3,376%**). In the past year alone, it has grown by **68.1%.**



CONCLUSIONS

• SUICIDAL ATTEMPT: BEHAVIOUR: RISK AND PROTECTIVE FACTORS

RISK FACTORS

GROWS

INDIVIDUAL

- Female
- 13 years or older
- Secondary education or higher
- Low school performance
- Low school satisfaction
- LGTBI
- Associated problems:
  - Selfharm
  - Sadness/depression
  - Eating disorders
  - School bullying

INTERPERSONAL/FAMILY

- Poor intrafamily relationship:
  - Poor communication
  - Physical abuse
  - Psychological abuse
  - Lack of trust/cohesion
  - Conflicts/arguments
  - GV exposure
- Underestimate/minimize the emotional discomfort of children and adolescents
- Immigrant family
- Family uprooting
- Family rigidity
- Poor social support (colleagues, Friends)

COMMUNITY/CONTEXT

- Accessibility difficulties to psychological/psychiatric assistance resources (waiting lists for public health services, economic cost of private health services).
- Inaction from school professionals in bullying
- Online accessibility to selfharming/cybersuicide procedures (Internet, social networks, theme web, etc.)
- Socially prescribed perfectionism (imposed beauty canons, …)
- Social exclusion

SUICIDAL ATTEMPT

DECREASES

INDIVIDUAL

- Coping strategies at continuous and frequent discomfort/stressful situations
- Positive self-concept
- Emotional self-control
- Feeling protected and supported
- Sense of belonging
- Hobbies and interests

INTERPERSONAL/FAMILY

- Trusted family relationships with strong bonds of affection
- Lack of conflict in family relationships
- Feeling loved, accepted
- Better communication, connection or bonding with other people
- Social and cultural in reference groups

COMMUNITY/CONTEXT

- Accessibility to psychological/psychiatric assistance resources
- Quality and consistent social support
- Early detection and action at risk situations
- Access limitations to physical or digital tools to commit suicide
- Absence of crisis (health, economic, social, …)

PROTECTIVE FACTORS

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CONCLUSIONS

- **DANGER SIGNS. HOW TO DETECT SUICIDAL IDEATION IN ADOLESCENTS?**

We want to emphasize the importance of identifying signs of risk, knowing that not only by having one of these behaviors should we think that the child or adolescent is having suicidal ideation, there must be a set of unusual behaviors, such as:

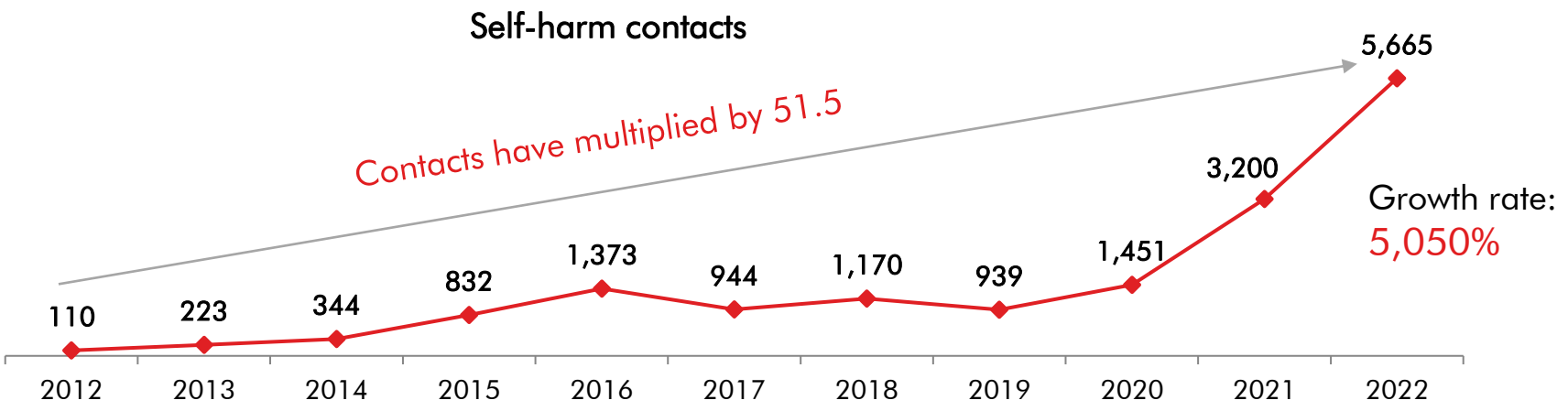
- Mood and behavioral changes
- Prolonged social isolation
- Sadness/hopelessness, psychopathological symptomatology or emotional disturbance
- Feeling immersed in a problem with no way out
- Restless sleep, lack of rest and eating problems
- Performance problems and school absenteeism
- Previous self-harm or suicide attempts
- If he/she has a PLAN, means and attitude to carry it out.
- If your child behaves impulsively and/or aggressively in the way s/he acts or is a compulsive substance user
- Having verbalized ideas of death, for example, "I want to disappear", "I don't want to continue", etc. .... Giving away personal belongings, getting rid of belongings
- If protective factors (having a good social and family network, restrictions in acquiring harmful objects or drugs, having the possibility of receiving treatment, social and emotional management skills, ability to resolve conflicts, cognitive flexibility, among others) are not seen to counteract the risk.

CONCLUSIONS

2.2. SELF-HARM: This differentiated phenomenon is closely related to suicide attempts, due to the high probability of a fatal outcome when children and adolescents change procedures. This reason **has multiplied by 51.5 during the last years** (with a growth rate in the last eleven years of **5,050%**), going from **110 contacts in 2012 to 5,665 in 2022.** Compared to 2021, contacts for this reason has increased by **77%**.

• The increase in cases and consultations, both for suicidal behaviour (suicidal ideation and attempts) and self-injury compared to 2021, has been mainly due to consultations made by children and adolescents themselves.

• It is also worth noting that, in the consultations made by children and adolescents through the ANAR Chat, the number of cases referring to both problems (suicide and self-injury) has also increased significantly.



CONCLUSIONS

OTHER MENTAL HEALTH PROBLEMS THAT HAVE INCREASED

2.3. LOW SELF-ESTEEM (+494% compared to 2021): Self-esteem is a fundamental dimension of personality that plays an important role in adolescence in psychological and social development. It is essential for health and well-being. Many of the risk behaviors at this stage are related to negative self-esteem, or a weak self-image.

2.4. OBSESSIONS (+440%): Recurrent thoughts, sometimes associated with unwanted images, which generate anxiety and anguish in the adolescent, as they have no emotional regulation mechanisms to cope with it and may interfere in their daily life. The most frequent obsessions are those related to the physical appearance of the child or adolescent.

2.5. COMPLEXES (+350%): Closely related to the concept of self-esteem and the construction of it, as well as the judgment that we finally form of ourselves and of the world constructed through family, school, media and social environment. A devalued self-image of oneself is related to complexes in the way of being and being in the world.

2.6. EATING DISORDERS (+291%): The adolescent comments on his/her difficulties in fitting into the demanding "ideal social image", resulting in an inadequate emotional management that leads to harmful compensatory mechanisms typical of eating disorders. The adolescent sometimes feels the need for control, which s/he sometimes externalizes through control of his/her body and image.

2.7. SOCIAL SKILLS (+243%): Difficulties demonstrated by the minor in those skills necessary to relate to other people and the world around them.

CONCLUSIONS

2.8. ISOLATION (+100%): We are not referring to the adolescent's own isolation in search of his/her own private space, but rather to something more striking, where the adolescent does not want to interact with his/her peers either and takes refuge in his/her habituation and sometimes in the technological world with the dangers it entails.

2.9. ANXIETY (+96%): When the adolescent verbalizes that s/he finds it difficult to deal with unpleasant emotions, generating an emotional overload and a feeling of constant threat and danger in the face of external stimuli. Situations that may be more or less chronic at the time of the help request.

2.10. LONELINESS (+82%): The adolescent tells us that s/he feels lonely even though s/he is in company. It is typical of adolescents to go through this subjective experience of loneliness, but sometimes it becomes a difficulty in their daily life, which may be related to the lack of available emotional references.

2.11. SADNESS/DEPRESSION (+55%): Consultations related to a low mood that sometimes is under medical and psychological treatment and supervision but in many cases has not yet obtained previous assistance.

2.13. FEAR (+32%): Sometimes as a consequence of very serious situations that occur in their family, school or social environment (violence, addictions, psychological problems, etc.). They tell us about the uncertainty that arises as a result of these experiences.

CONCLUSIONS

2.14. OTHER MENTAL HEALTH PROLBEMS: we have also had a large number of consultations on: Educational/evolutionary guidelines, Anger and rage, Sleeping disorders, Phobias, etc.

• **MENTAL HEALTH PROBLEMS IN THE ENVIRONMENT**: children and adolescents are living in families with serious mental health problems (33.6%): Anxiety (6.8%), Addictions (6.3%), Anger and Rage (5.3%), Sadness/depression (4.6%), Fear (3.5%), Educational/evolutionary guidelines (2.9%), are the main mental health problems suffered by the families of the children and adolescents we helped throughout 2022.

CONCLUSIONS

3. VIOLENCE AGAINST CHILDREN AND ADOLESCENTS

- Violence against a child or adolescent continues to be the main reason for adults to call for a minor (58.2%), and the second reason for minors to contact (34.7%). This year, the severity, urgency, duration and frequency of violence are also of concern in these cases. All these parameters have worsened significantly.

3.1. PHYSICAL AND PSYCHOLOGICAL ABUSE: In 2022 physical and psychological abuse continues to be the most prevalent form of violence among all forms of violence (3,045). Domestic violence against children and adolescents continues to be tolerated and admitted as an educational pattern in our society by many people.

3.2 SEXUAL AGGRESSION: The visibility of this social problem, to which the study published by ANAR Foundation about sexual abuse, has been useful for us to help many children and adolescents who are victims of this type of aggression this year as well. In 2022, 1,088 cases contacted us for this reason.

3.3. GENDER VIOLENCE: From 2009 to 2022, the cases of gender violence where ANAR has helped have multiplied by 16.5. This year there has been a slight increase in the number of cases helped for this reason, going from 3,440 in 2021 to 3,471 in 2022. An increase in the number of consultations for gender violence in adolescents has been observed, going from 10.1% in 2021 to 13.2% in 2022. In 47.5% of cases (+3.9 percentage points compared to 2021) the adolescent victim does not seem to be aware of the problem, which means she does not admit to being a victim of this type of violence, according to the judgment of the counseling psychologist from ANAR Telephone/Chat.

CONCLUSIONS

3.4. SCHOOL BULLYING AND CYBERBULLYING: The number of cases involving bullying and cyberbullying continues to increase, going from 3,225 in 2021 to 3,841 in 2022 (+19.1%) in just one year. Among the types of school bullying, psychological (84.9%), verbal (79.9%), social (71.5%) and physical (61.5%) are the most frequent. Within psychological bullying, humiliation, intimidation and isolation stand out; in verbal bullying, direct insults, vexation, mockery and offenses; in social bullying, ridiculing and social exclusion (isolation, not allowing participation, removal from the group, etc.) and in physical bullying, hitting, pushing, beating, punching, kicking and throwing objects. It is also worth noting the significant percentage of cyberbullying (28.1%).

3. PROBLEMS IN THE CHILD'S AND ADOLESCENT'S ENVIRONMENT

• **VIOLENCE PROBLEMS IN THE ENVIRONMENT** have increase in 2022 compared to 2021, going from 6,774 to 7,821 cases in 2022 (+15.5%). Within violence, there were significant increases in: Sexual aggression (+36%), Physical abuse (+34.3%), Abandonment (+25.2%) and Gender violence (+18.1%), compared to 2021.

ANAR
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SUICIDE

MYTHS AND BIASES
Misconceptions that incite stigma or taboo

1. Bias by definition :

Suicide is the active search for death.

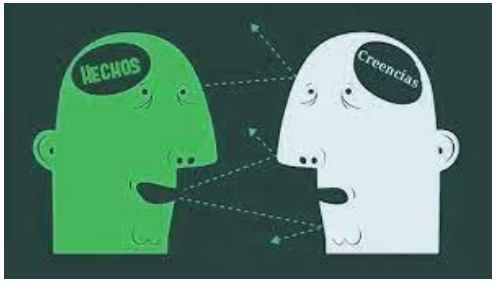
In most cases, the behaviour is caused by severe personal suffering that the person perceives as incapable of bearing and that keeps them with the ambivalence between dying and continuing to live... If the person finds an alternative to face the suffering, they will not end their life.

López-Vega, D.J, de Quesada, M., Morell, M. F., Martínez-Vallier, C., Córdoba-Santos, G., Tornero, D., Sánchez-Alegre, Serra-Olives, N. (2022). *En mis zapatos. Guía de recomendaciones para comunicar sobre el suicidio*. Sevilla: Papageno, La Niña Amarilla & AFASIB

2. Bias by taboo:

Talking about suicide might be a precipitant to do it.

Talking directly about suicide is one of the key tools for prevention. Silence and isolation can make the situation worse.



3. Health bias:

Suicide is just a mental health problem.

Suicide is a public health problem. Suicide transcends merely health issues. It is a major social problem and, therefore, its solution requires a forceful response from society as a whole.

López-Vega, D.J, de Quesada, M., Morell, M. F., Martínez-Vallier, C., Córdoba-Santos, G., Tornero, D., Sánchez-Alegre, Serra-Olives, N. (2022). *En mis zapatos. Guía de recomendaciones para comunicar sobre el suicidio*. Sevilla: Papageno, La Niña Amarilla & AFASIB

4. Biological bias:

Suicide is hereditary.

Although some risk factors may have a biological origin, suicide is a complex phenomenon that is also determined by psychological and social factors and is the result of the interaction between all these components.

5. Exclusiveness bias:

Only people with mental health disorder, depressed or of certain groups, ages or gender have suicidal behaviour.

Although suicide is affected by social inequalities in health, it is a universal phenomenon that can affect people of all socio-cultural and economic levels. People who end their lives often have in common suffering, a sense of inability to cope by other means, and hopelessness, without belonging exclusively to a particular group.

López-Vega, D.J, de Quesada, M., Morell, M. F., Martínez-Vallier, C., Córdoba-Santos, G., Tornero, D., Sánchez-Alegre, Serra-Olives, N. (2022). *En mis zapatos. Guía de recomendaciones para comunicar sobre el suicidio*. Sevilla: Papageno, La Niña Amarilla & AFASIB

6. Moral bias:

Suicide is unnatural and the people who commit suicide are coward, selfish,
childish, dangerous, incapable and manipulative.

The suicidal act is a wake-up call, whoever achieves it, gets it by, for example, choosing more lethal methods.

There is no scientific evidence to differentiate between causes of death. This is a natural phenomenon in all its aspects and consubstantial to life. Assimilating suicide to sin, crime or the unnatural is part of the stigma. On the other hand, those who threaten to commit suicide are asking for help and support. Even if it is done inappropriately, it is important not to minimize the risk or act in fear.

López-Vega, D.J, de Quesada, M., Morell, M. F., Martínez-Vallier, C., Córdoba-Santos, G., Tornero, D., Sánchez-Alegre, Serra-Olives, N. (2022). *En mis zapatos. Guía de recomendaciones para comunicar sobre el suicidio*. Sevilla: Papageno, La Niña Amarilla & AFASIB

7. Guilt bias:

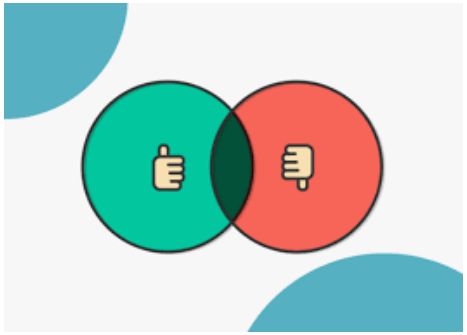
If someone close to me commits suicide it is my fault for not having noticed or acted appropriately.

Each person is only responsible for their own behaviour. We can act as well as possible in each situation, but taking into account our limitations as to what we can do and achieve or not.

8. Bias of Identifying with the Label:

Suicidal people will always be.

In many cases, suicidal behaviour is temporary, and although a suicide attempt is a key risk indicator, it is not always decisive. After an attempt, extreme care should be taken, and it is not useful to confuse by imposing labels.



López-Vega, D.J, de Quesada, M., Morell, M. F., Martínez-Vallier, C., Córdoba-Santos, G., Tornero, D., Sánchez-Alegre, Serra-Olives, N. (2022). *En mis zapatos. Guía de recomendaciones para comunicar sobre el suicidio*. Sevilla: Papageno, La Niña Amarilla & AFASIB

9. Romantic bias:

People with suicidal behaviour are courageous, heroic, altruistic, or romantic.

Suicide is a source of suffering and is not related to moral values, nor to model behaviour that make the person with suicidal behaviour someone special or to be imitated.

10. Unpredictability bias:

Suicide is an impulsive, sudden, unpredictable act that happens unannounced and in the absence of warning signs and is therefore not preventable.

Suicide is a preventable phenomenon. Knowing the signs can help in the detection and early assistance of the problem. Sometimes the person who ends their life even verbalizes it directly.

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Myths about suicide WHO (2006)

1. Belief

"The person who says it does not do it"

"Those who talk about suicide have no intention to commit it"

This is a mistaken approach because it leads to minimizing suicidal threats, which can be mistakenly considered as blackmail, manipulation, boast, etc. A significant number of people contemplating suicide may think that they have no other option.

Scientific criterion: Everyone who commits suicide expressed with words, threats, gestures and behavioural changes what would happen.

Myths about suicide WHO (2006)

2. Belief

"Talking about suicide is a bad idea. We are going to prompt the person and can be interpreted as encouragement".

Given the general stigma around suicide, most people who consider suicide do not know who to talk to rather than encouraging suicidal behaviour, talking openly may lead to find options or time to reflect on their decision. Preventing suicide.

3. Belief

"Those who attempt suicide do not wish to die, just make the boast".

Wrong approach because it conditions an attitude of rejection to those who attempt against their live, which hinders the help they need.

Scientific criterion : Although not all those who attempt suicide wish to die, it is a mistake to label them as boastful, since they are people whose useful coping mechanisms have failed and who cannot find alternatives.

Myths about suicide WHO (2006)

4. Belief

"Suicidal people really want to die"

Scientific criterion: most suicidal people communicate their thoughts to at least one person, or call to a crisis helpline, or the doctor, which is evidence of ambivalence, not an irrevocable intention to kill themselves. They tend to be ambivalent about life and death. There may be impulsive acts involved, even if the person would have preferred to live. The access to emotional support at the right time can prevent suicide.

5. Belief

"When someone shows signs of improvement, or survives a suicide attempt, they are no longer in danger"

Scientific criterion: In fact, one of the most dangerous times is immediately after the crisis or when the person is at the hospital after a suicide attempt. The week after discharge is when the person is particularly fragile and in danger of harming themselves. Since past behaviour is prognosis of future behaviour, the suicidal person remains at risk.

Myths about suicide WHO (2006)

6. Belief

"Suicide is always hereditary"

Scientific criterion: Not all suicide can be related to heredity, and conclusive studies are limited. However, family history of suicide is an important risk factor for suicidal behaviour, particularly in families where depression is common.

7. Belief

"People who commit suicide or attempt always have a mental disorder."

Scientific criterion: Suicidal behaviours have been associated with depression, substance abuse, schizophrenia and other mental disorders, as well as destructive and aggressive behaviours. However, this association should not be overestimated. The relative proportion of these disorders varies at different places, and there are cases in which no mental disorder was evident.

Myths about suicide WHO (2006)

8. Belief

"If you challenge a suicidal person, they do not do it."

Scientific criterion: Challenging a suicidal person is an irresponsible act, since we are dealing with a vulnerable person in a crisis situation whose coping mechanisms have failed, and whose desires for self-destruction predominate.

9. Belief

"Talking about suicide with someone at this risk, may encourage them to commit suicide."

Scientific criterion: It has been shown that talking about suicide with a person at such risk, instead of inciting, provoking or introducing the idea in their head, reduces the danger of committing suicide and may be the only possibility offered by the subject for the analysis of their self-destructive intentions.

Myths about suicide WHO (2006)

10. Belief

"When a severe depression gets better there is no longer a risk of suicide."

Scientific criterion: Almost half of those who went through a suicidal crisis and committed suicide, did so during the first three months after the emotional crisis, when everyone believed that the danger had passed. It happens that when the person improves, their movements become more agile, they are in a position to actually carry out the suicidal thoughts that still persist, and before, due to inactivity and inability of agile movements, they could not do it.

ANAR
Helping at Risk Children and Adolescents

THE ROLE OF THE MEDIA IN THE FACE OF SUICIDE

RECOMMENDATIONS

The Role of the Media in the face of Suicide

The media have a growing role in the socialization of people and can therefore play an active role in suicide prevention. As the document "Suicide prevention: A tool for media professionals", published by WHO in 2000, reminds us, the way suicide is communicated can help to prevent it or, on the contrary, it can lead to an increased risk of causing the contagion effect.

In this sense, ANAR wants to add to the following recommendations:

- Avoid using descriptive terms that make it look desirable and appealing, like "quick", "simple" or "painless"
- Do not associate it with heroic acts, glorification, romanticism or bravery which might justify or normalize suicide.
- Do not use excessively alarmist descriptors.
- Do not explicitly describe the place, the method used and how the victim attained it, or any other details of the death that might be offensive for them, their families and those around them. Much less if it might encourage imitation.

The Role of the Media in the face of Suicide

- Avoid giving a simplistic vision or based on speculation, for example "s/he commits suicide because of bullying". Suicide is a multifaceted action that never has only one cause.

- Instead of focusing on isolated cases, present statistics and objective facts, from reliable sources, contextualizing the social problem and using expert opinions on suicidal behavior that bring context with a vison more focused on the problem and not the concrete case.

- Do not use photographs of the scene where the suicide occurred or share the suicide note.

- Exercise caution when a famous person commits suicide or provokes heightened social alarm due to the age, method used or the situation in which it occurred.

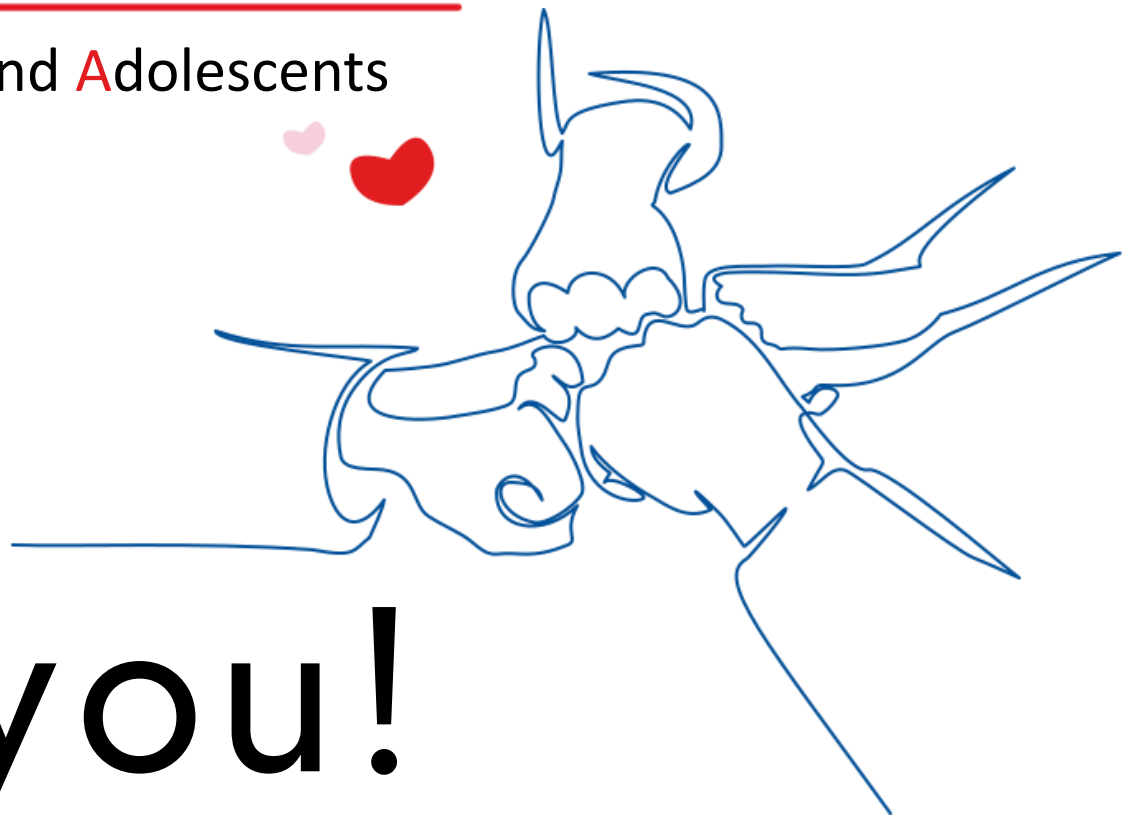
- Refer to death by suicide as a fact, not as an accomplishment or as a coping strategy, nor refer to the people affected as persons with suicidal behavior or label them as "suicidal".

The Role of the Media in the face of Suicide

- Avoid gender, ethnic, sexual orientation, cultural or socio-economic stereotypes of the persons.
- Present the information in a positive way, focusing on healing and as something that can be overcome. It might be useful to include personal testimonies of those who have overcome it.
- Report about risk or protection factors and signs of alarm.
- Always consider the impact for the family and other survivors in terms of stigma and psychological suffering
- As the WHO points out, describing the physical consequences of a suicide attempt (brain damage, paralysis, etc.), can help to dissuade.
- Provide helpful resources, such as ANAR Helplines, and about the need to ask for help.

FUNDACIÓN ANAR

Helping at Risk Children and Adolescents



Thank you!