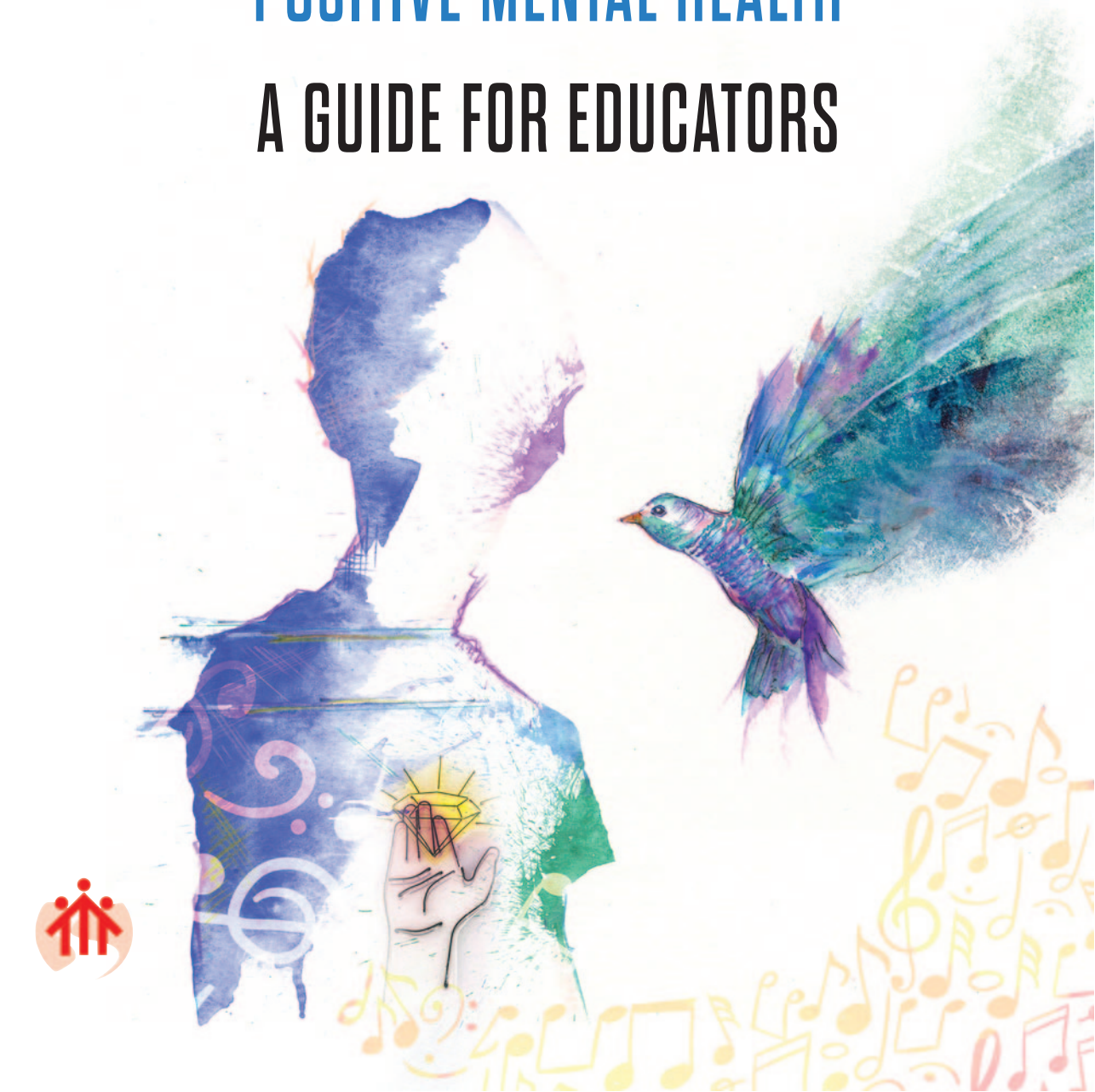
SALESIAN YOUTH MINISTRY SECTOR

ACCOMPANYING THE YOUNG TOWARDS POSITIVE MENTAL HEALTH

A GUIDE FOR EDUCATORS



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Cover Illustration

A teenager or young adult, somewhat undefined in terms of age and gender so as to encompass every stage of life and every person.

On one side, the stains, scratches, candles, faded colors, reflecting the various and varied ailments and illnesses one can experience in life.

On the other side, a fantastic bird representing the companion, a figure well known in many cultures, which can also be seen as the Holy Spirit, or rather the Father, who brings us through the Spirit to those who need us.

Hence the musical notes, like a song, like "Don Bosco's little words" whispered in the ear, trying to help and penetrate the shell of difficulties until they reach the most precious part in every young person.

The wings of the bird open and reach out to the blood to connect with God (the infinity of the Creator).

The diamond in every young person's heart speaks of the fact that despite all the destruction, turmoil, depression, etc., there is a heart that shines, the gem that we all carry within us, our inner diamond.

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Via Marsala, 42 00185 Rome

Graphic design, photocomposition, printing: Graphic Art 6 srl - Rome
Cover illustration: Javier Carabaño

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Introduction

[1] The transition from adolescence to adulthood is a crucial period of biopsychosocial change. It is a time when environmental factors, including family dynamics, friendships and social interactions, neglect or abuse, education and employment, can have powerful and lasting effects on a young person's well-being and development. While the physical health of young people in the world has improved significantly in recent decades, largely due to improvements in the control of infectious diseases, the opposite is true for mental health.

We know that an estimated 10-20% of adolescents in the world suffer from mental disorders, but these **are underdiagnosed and undertreated**. Signs of mental disorders can be overlooked for a variety of reasons, including a lack of knowledge or general awareness about mental health, also on the part of educators, or social workers or the stigma that prevents people from seeking help.

Some statistics:

- An estimated 62,000 adolescents died from self-injury in 2016.
- Suicide is the third leading cause of death among older adolescents (15-19 years old).
- Nearly 90 per cent of all adolescents in the world live in low- and middle-income countries; more than 90 per cent of suicides occur among adolescents in these countries.
- Approximately 800,000 people die each year from suicide, the second leading cause of death among people aged 15-29. (OPAS/WHO[1], 2024).

> But do young people have enough safe spaces and tools to be able to talk about these issues in schools, youth centers, associations, social work and universities, where most of their experiences take place?

[2] Children and adolescents with mental disorders are **particularly vulnerable to social exclusion**, which means discrimination, learning disabilities, risky behaviour, physical health problems, and human rights violations.

[1] What is the WHO and what does it do? The World Health Organization (WHO) is the governing and coordinating authority for health within the United Nations system. Its goal is to achieve the highest possible level of health for all people.

Even today, the stigma surrounding this issue is strong. Mental health stigma remains an outstanding issue in society and in educational settings, where it is necessary to promote a stigma-free view and integrate emotional well-being in a transversal way. Adolescents and young people need to have a safe space where they can talk about mental health and seek help when they need it. In fact, with this guide we want to **break the silence surrounding mental health by challenging prejudices and promoting awareness and educational support.**

Therefore, **early identification and early accompaniment/treatment** will be extremely urgent. We could literally change the course of a person's entire life. Healthy early childhood development strongly influences an individual's mental and physical well-being and enables the development and implementation of both cognitive and social skills throughout life[2].

[3] Schools, associations and groups are much more than just places of learning. They are environments of growth, of relationships and, often, the first place where signs of psychological distress manifest themselves in young people. For Salesian pedagogy, the integral growth of young people, including their mental health, is as essential to their well-being as their physical health. **A good education also provides a solid foundation for the most important protective factors for their well-being**: healthy habits, supportive social relationships, the ability to cope with the challenges of life, etc.

This book is intended as a GUIDE FOR EDUCATORS on the importance of promoting **well-being in educational settings**. The focus is on the context, understood as the environment inhabited not only by children, adolescents and young people, but also by consecrated persons, educators, workers, parents, grandparents and significant figures, who bring with them teachings, knowledge, values and above all, emotions. The promotion of a global perspective through the promotion of an alliance among the various significant figures who accompany children in their development allows for the co-construction not only of new knowledge, but also of new educational contexts.

Health promotion should be considered a priority and an essential aspect in all realities and contexts. But what is meant by health? The concept of health encompasses

[2] "Adolescence (ages 10 to 19) is a unique period that shapes people for adulthood. Although most adolescents enjoy good mental health, many physical, emotional, and social changes, including exposure to poverty, abuse or violence, can make adolescents vulnerable to mental health conditions. Promoting psychological well-being and protecting them from adverse experiences and risk factors that can impair their growth potential is not only critical for their well-being, but also for their physical and mental health in adulthood." (World Health Organization, 2024)

not only the mere absence of disease, but also "a state of complete physical, mental and social well-being" (World Health Organization, 1948)[3].

The promotion of health – in its **personal, physical, spiritual and mental dimensions**- concerns not only the health sector, but all interventions, structures, actions and services designed to help young people become aware of their own health status. This exercise is extremely important in order to successfully cultivate one's own life plan and joy of living.

Designing educational interventions, carrying them out by implementing strategies, reviewing the work done and redesigning, setting new goals and adapting the goal: these are the actions of the educator, which are made complex (but why not, also interesting) by the fact that the working material is not inert but has its own life, thinking and decision-making capacity. In short, **educating the world of youth for health consciousness**. That is why the first part of each disorder or phenomenon will focus on RECOGNITION and the second part on HOW to ACCOMPANY in the field of education.

Therefore, we provide this material which can help to interpret situations, identify warning signs, and then design actions and interventions.

Don Miguel Ángel GARCÍA MORCUENDE
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[3] Although this definition has played a significant role in formulating a vision of health and, in some cases, even health policies that took into account social, relational and psychological factors, it is now coming under increasing scrutiny. In 2011, for example, Huber and colleagues proposed a new definition: "Health is the ability to adapt and self-manage in the face of social, physical and emotional challenges." There are several authors who find it useful to move beyond the idea of an "ideal state" of health (unattainable for many) by emphasizing the process of positive adaptation to context and self-regulation. The innovative idea is to define health in dynamic terms, as «the ability to adapt and self-manage one's health». This definition is based on the ability to cope with adversity and to maintain and restore one's balance and sense of well-being. When a person is able to develop effective coping strategies, the perceived quality of life is not diminished even by impairments in physical and mental functioning.

CHAPTER

1

Stigma in mental health

1.1 HOW TO RECOGNIZE MENTAL HEALTH STIGMA

Social stigma still permeates many cultures

From an educational point of view, we must emphasize the educational process as the best strategy to prevent mental illness. Unfortunately, when a person has difficulties in this personal area, stigma is created, which goes hand in hand with discrimination.

> The term "stigma" comes from the Greek and means a mark or stain. If we transfer this definition to the sociological level, the process of stigma is the **set of false attitudes and beliefs** (stereotypes and prejudices) that **discredit or reject** (discrimination) a person or social group because they are seen as different, devaluing them and having major consequences on the way they perceive themselves (self-stigma).

In the health and social sectors, the process of stigmatization has been used to negatively indicate a socio-cultural, functional, physical or mental condition, trait or behaviour, as well as race, ethnicity, age, gender, sexual identity, nationality, creed or religion.

When we talk about stigma in mental health, we are referring to the **attribution of negative and offensive qualities to a group of people** who have a problem. With this negative identification, these people are socially perceived with a set of beliefs, myths and prejudices based on a lack of information and ignorance[4]. These beliefs have been built up over the years and are often not challenged because they are part of the collective imagination.

However, it is important to understand that at some point in our lives we will all experience emotional distress that can lead to mental disorders. According to the World Health Organization, **one in four people in the world** will experience a mental health problem in their lifetime, and half of them will not seek professional help precisely because of stigma.

Discrimination, the result of stigma

[1] The attribution of negative characteristics and traits to people with mental health problems determines the attitudes we have towards them, and the way we behave and relate to them. In fact, the relationship between ideas about people with mental health problems (stereotypes), the attitudes we have towards them (prejudice), and the translation of these ideas into negative actions and behaviors (discrimination) follows a circular feedback pattern. Thus, discriminatory behaviors towards people with mental health problems promote and reinforce the stereotypes we hold about them.

> This systematic discrimination is one of the major barriers to recovery, well-being and ultimately to achieving a full and normalized life for people with mental disorders.

Mental health stigma creates a variety of discriminatory situations that hinder the family, social, work or educational development of millions of people with mental disorders. We believe we can affirm that the two responses we adopt towards people with mental disorders are:

[4] Stigma is a social phenomenon that has three dimensions: stereotypes (beliefs shared by society, collective assumptions about a group that are used to categorize it, among the most prevalent, those associated with people with mental disorders are characteristics such as incompetence, guilt, dangerousness and unpredictability); prejudice (when a person agrees with learned stereotypes, so they are cognitive and affective responses to stereotypes and lead to discrimination and hostile behavior); discrimination (negative behavior directed against the stigmatized social group, i.e., when there is a social distance between a "them" and an "us," the same evaluation criteria are not used among people, thus creating unfair and discriminatory situations).

- **Fear:** This is probably the most immediate consequence of the stereotypes attributed to people with mental disorders. This attitude of fear determines the way we relate to them. A fear motivated by ignorance, but also by people's fear of having a mental disorder, of seeing the other person as the other side of the mirror, their own potential self.
- **Abuse:** One of the most common forms of discrimination is the abuse or negative treatment of people with mental disorders. This abuse can be physical, but it can also occur through the use of discriminatory language and attitudes of avoidance, rejection, contempt, overprotection, and control (control and especially overprotection may need to be further distinguished, because they have a different meaning, which is also positive in itself, but inadequate, while the others are presented as negative behaviors).

[2] Mental health stigma is therefore a **global problem** that causes a variety of discriminatory situations that hinder the family, social, work or educational development of millions of people with mental disorders.

> The fear of being labelled as having a mental health problem also reduces the likelihood that people will seek treatment. The stigma associated with mental health socially devalues the person and their contribution as a member of the society of which they are a part. In fact, almost all people with a mental health problem say that stigma and discrimination have a negative impact on them.

Strictly speaking, people who experience stigma and discrimination are more likely to experience:

- Reluctance to seek treatment.
- Delay in treatment.
- Rejection, alienation and social isolation.
- Decreased psychological well-being.
- Lack of understanding from friends, family and educators.
- Harassment, violence or bullying.
- Poor quality of life and increased socio-economic strain.
- Increased feelings of shame and self-doubt.

In addition, mental health stigma is often combined with **other social stereotypes** related to aspects such as age, gender, ethnicity or other unfavourable economic and social situations, resulting in a double stigma for these people, thus making their social and personal development even more difficult.

1.2 MAIN MYTHS AND MISCONCEPTIONS ABOUT MENTAL HEALTH

Over the decades, popular culture, the audiovisual industry and the media have promoted the stigmatization and perpetuation of negative stereotypes associated with people with mental disorders. In other words, **there are several myths about mental health that are perpetrated in different educational, social and cultural contexts.**

Most of these myths are far from reality and have no scientific basis, but stereotypes -inherited from generation to generation – persist in our society. Some of these misconceptions that contribute to stigma and discrimination are:

People with mental illness are violent and aggressive. FALSE

People with a mental health problem are just as likely to be violent as people without a mental health problem. On the contrary, they are often victims of violence and other crimes because of their vulnerability.

People with mental disorders are social outcasts. FALSE

People with mental disorders are not loners, locked up in their own world, showing no interest in the social environment and maintaining an attitude of social withdrawal and isolation. On the contrary, having a good social network (professional, family, friends, partners, etc.) anticipates better development and is a protective factor against relapse. People with mental disorders can live perfectly well in society if they have the support and resources they need to live independently and autonomously.

Mental health disorders are irreversible. FALSE

Studies show that people with mental disorders do get better and many recover completely. Recovery is the process by which people are able to live, work, learn and participate fully in their communities.

People with a mental health problem cannot work. FALSE

People with mental disorders can work, just like anyone else, if they are given the conditions and support they need. The barrier to employment is not so much due to the disorder itself, but the failure of organizations, society and governments to adapt workplaces and provide the necessary resources.

Mental disorders affect certain people; it won't happen to me. FALSE

Mental health disorders can affect anyone, regardless of age, gender, culture or economic status. One in four people will experience a mental disorder in their lifetime.

People with mental disorders are better off in psychiatric hospitals. FALSE

More than 80 per cent of people with mental disorders live in their own homes. Mental disorders should not interfere with normal living and should be treated in the person's usual environment. Community-based treatment has been shown to be effective. At present, with some exceptions, mental health hospitals are designed as temporary containment spaces for acute episodes (the most or least known being compulsory health treatment). People treated in the community have a better and more sustainable development over time.

Children and adolescents do not have mental disorders. FALSE

Young children can show early signs of mental disorders. These problems can be identified clinically and can be the result of the interaction of biological, psychological and social (sometimes even family) factors.

Mental disorders cause intellectual disability. FALSE

A mental disorder does not cause an intellectual disability and is not an intellectual disability. They are two different things. A person with a mental disorder does not always have impaired cognitive abilities or skills.

People with mental disorders are lazy. FALSE

The development of a mental health problem has nothing to do with laziness or a lack of energy. The onset of a mental disorder is *multifactorial*: biological factors, traumatic life experiences, adverse socio-economic environment, etc.

We cannot help people with mental disorders. FALSE

Society as a whole has a responsibility to prevent mental disorders, promote health and provide the support and resources necessary for people with mental disorders to live their lives to the full. In addition, when a person has a mental health problem, the environment is critical in recognizing warning signs and guiding the person through the various stages of the disorder.

The disorder defines every behaviour the person has. FALSE

Not all of a person's attitudes and behaviors are symptoms of their disorder, and the disorder is not the absolute explanation for everything. In other words, *the person with mental disorders exists independently of their disorder.* When we analyse their behavior as a symptom of the disorder, the person tends to lose legitimacy when it comes to expressing their feelings or opinions, which are pathologized and despised.

Another common belief is that we must behave in a specific and particular way with people who have a mental disorder and, therefore, usually not knowing how to do so, people tend to avoid interaction.

1.3 HOW TO DEAL WITH STIGMATIZATION IN EDUCATIONAL SETTINGS

[1] Education is one of the most important spheres in building any society, but mental health continues to be an outstanding issue in educational centers, groups or associations, where **it is necessary to promote a stigma-free view of mental health**, encouraging children, adolescents and young people to speak up and ask for help when they need it.

> Seventy-five per cent of mental disorders begin in adolescence, before the age of 18, yet some people with mental disorders continue to **be discriminated against by educators and peers in educational settings:** avoidance or rejection, overprotection or control, teasing, belittling or ridicule are some common expressions.

[2] Programs to combat stigma in schools, educational centers, associations and groups should follow a strategy that focuses on:

- Preventing, identifying and addressing mental health stigma and discrimination from the earliest possible age.
- Encouraging young people to seek help to prevent mental disorders from developing or becoming chronic and intervening early in order to prevent the onset of more serious difficulties.
- Improving the attitudes and behaviors of young people and educators toward mental disorders.
- Attracting the attention and interest of the educational community (youth, educators, parents) in combating stigma and the discrimination against people with mental disorders.
- Improving the resilience of young people.

[3] To break down the taboos and stigma surrounding mental health, **the first step is to talk about mental health in a normal, everyday way.** How?

- By reminding people that mental disorders are not strange and isolated things but are more common than they seem.

- By teaching empathy for people with mental health problems.
- By helping young people learn firsthand about the experiences of people who have been diagnosed and by working with mental health organizations in their community.
- By respecting and encouraging young people who want to speak publicly about their mental health and recognizing their courage in front of the group.
- By giving space to the emotions that may arise from the young people in the classroom or in the various groups and associations.

CHAPTER

2

Social Anxiety Disorder

2.1 HOW TO RECOGNIZE SOCIAL ANXIETY DISORDER

"I feel like everyone is watching me; I feel like a fish out of water."

What is an anxiety disorder, and which types are most common among young people? What are the warning signs, risk factors and protective factors? How can anxiety be managed and what kind of support is needed?

> Anxiety disorder is a disabling condition characterized by **a response of fear and disproportionate or chronic worry** about everyday events that interferes with a person's normal functioning. Anxiety is a natural response, and it is useful in certain situations of danger or stress, but in an anxiety disorder it becomes **persistent, excessive and unwarranted in relation to the actual situation.**

There are several types of anxiety disorders, including **generalized anxiety disorder (GAD), panic disorder, specific phobias,** and especially **social anxiety disorder** (or social phobia). The latter is a specific type of disorder characterized by an intense and persistent fear of social or performance situations in which the person fears being observed, judged or criticized by others. This reaction is not simply a matter of being

shy or introverted; it is a disorder that can significantly interfere with daily life, causing the person to avoid even common social situations.

The symptoms of social anxiety

[1] The symptoms of social anxiety, or social anxiety disorder, are specifically outlined in the *Diagnostic and Statistical Manual of Mental Disorders*[5], namely, it is a "marked, or intense fear or anxiety about social situations in which the individual may be scrutinized by others." Key diagnostic criteria include:

- Marked, persistent fear of one or more social or performance situations in which the person is exposed to possible judgment by others.
- The person fears that they will act in a way or show symptoms of anxiety that will be judged negatively.
- The feared social situations almost always cause fear or anxiety.
- The feared social situations are avoided or endured with intense fear or anxiety.
- The fear or anxiety is disproportionate to the actual threat posed by the social situation or sociocultural context.
- The fear, anxiety and avoidance are persistent, typically lasting 6 months or more.
- They cause clinically significant distress and impaired functioning in multiple domains.

[2] The symptoms of social anxiety can be divided into several categories that include cognitive, behavioral and physical symptoms.

People with social anxiety disorder often experience **cognitive symptoms**, which are negative thoughts and cognitive distortions about themselves and social situations. These thoughts may include:

- ***Fear of judgment.*** A constant fear of being judged negatively by others, leading to the belief that any interaction will result in embarrassment or rejection.
- ***Catastrophizing.*** The idea that a small criticism can turn into a catastrophic event, leading to devastating consequences in their social or professional life.
- ***Distorted perception of social situations.*** Excessive attention to details, such as the behaviour or facial expression of others, which fuels anxiety.

[5] American Psychiatric Association (2023). *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, Text Revision (DSM-5-TR). American Psychiatric Publishing. This fifth edition manual provides clear diagnostic criteria for identifying the disorder and helps mental health professionals accurately assess and diagnose individuals with these symptoms.

In terms of **behavioral symptoms**, the behaviour of people with social anxiety may be influenced by their fear. Some common behaviors include:

- ***Avoidance.*** The individual may avoid social events, group situations or any context in which they may be subject to the judgment of others. They may appear as absent at parties, social withdrawals or even work environments.
- ***Safety behaviors.*** Even when social situations cannot be avoided, the individual may adopt safety behaviors, such as speaking in monosyllables, avoiding eye contact or remaining silent to reduce the risk of embarrassment.

Finally, the **physical symptoms** of social anxiety are often very intense and can manifest in various ways. These symptoms may include:

- ***Autonomic symptoms.*** Tachycardia, excessive sweating, trembling, nausea, dry mouth, difficulty breathing and feeling faint or dizzy. These physical symptoms can increase fear and anxiety, creating a vicious cycle.
- ***Physiological reactions.*** The individual may notice an intense physical response whenever they are in a social situation, contributing to the belief that anxiety is unbearable.

Prevalence

[1] Over the past decade, social anxiety disorder has received increasing attention in research, especially with regard to its **prevalence among young people**. Particularly in the adolescent and young adult age groups, it has been documented in numerous studies. Estimates vary, but it is generally accepted that the disorder affects approximately 7-13% of young people, with an increasing trend in recent years. This increase could be attributed to an increased awareness and reduced stigma associated with mental disorders, which has led more people to seek help and receive a diagnosis.

One of the most interesting aspects of social anxiety disorder is its **distribution between males and females**. Research shows that women tend to report higher rates of social anxiety than men.

> In many studies, the prevalence ratio ranges from 2:1 to 3:1, in favor of women. This may be due to several factors, including biological, psychological and sociocultural factors. Women may be more likely to express and acknowledge their feelings of anxiety, while men may manifest their anxiety in different ways, such as aggression or avoidance.

2.2 TYPES OF SOCIAL ANXIETY DISORDER

The different faces of social anxiety

[1] Social anxiety disorder can manifest itself in several forms of social anxiety, and the most common include these four:

- ***Social Anxiety Disorder (Social Phobia)*** is characterized by a significant fear of being judged or humiliated in social situations. People may avoid events such as parties, business meetings or even simple everyday interactions. It may also occur in performance situations, such as public speaking, or in more informal settings, such as eating with friends.
- ***Generalized Social Anxiety*** is a more widespread form of social anxiety in which the person experiences anxiety in almost any social situation, not limited to specific events.
- **With *Panic Disorder in Social Situations*** some people may experience panic attacks in social situations, making the fear of judgment even more intense. The fear of having a panic attack itself can lead to avoidance of social situations.
- Although not directly considered a social anxiety disorder, ***Specific Phobias***, such as the fear of speaking in public (glossophobia), can overlap with social anxiety disorder.

[2] Finally, let us say one last word about **social withdrawal, the Hikikomori phenomenon**.

> The word "Hikikomori" refers to a social phenomenon originating in Japan in which individuals, often teenagers and young adults, **completely isolate themselves from society for extended periods of time**, sometimes months or years.

This social withdrawal behaviour is often associated with:

- ***Social Anxiety.*** Many hikikomori show signs of social anxiety and find it extremely difficult to cope with social situations or the outside world.
- ***Pressure from School and Work.*** In high-pressure cultures such as Japan, individuals may withdraw due to fear of failure or failure to meet expectations.

- ***Family Factors.*** Family dynamics, such as an overly protective or critical environment, may contribute to isolation. Some hikikomori may also experience family conflict.
- ***Hikikomori.*** *The illusion of Heaven in a room.*

Extreme isolation leads to several negative consequences, including:

- ***Mental disorders.*** Isolation can increase anxiety and depression, creating a vicious cycle that is difficult to break.
- ***Impaired Social and Occupational Functioning.*** Hikikomori youth may miss out on educational and employment opportunities, making it more difficult to reintegrate into society.
- ***Relational Difficulties.*** Withdrawal can lead to an impoverishment of social skills, making future socialization more difficult.

Causes that Contribute to Social Anxiety

> The causes of social anxiety are complex and multifactorial, influenced by a combination of genetic, psychological, environmental and social factors. Understanding these causes is critical to developing effective intervention and support strategies.

[1] First, **genetic factors** play a significant role in predisposing an individual to develop social anxiety. Twin and family studies have shown that there is a hereditary component associated with anxiety disorders. If a close family member, such as a parent or sibling, suffers from social anxiety, an individual is more likely to develop similar problems. However, genetics alone does not determine the disorder; it interacts with other factors.

[2] From a **psychological** perspective, personal experiences and how an individual interprets and reacts to social situations are crucial. People with social anxiety tend to develop automatic negative thoughts about how they are perceived by others. These thoughts may include beliefs that they are being judged negatively, ridiculed, or not living up to social expectations. Such distorted beliefs may be rooted in past life experiences, such as episodes of humiliation or rejection, which lead to increased vulnerability to social anxiety. Experiencing social events that are perceived as threatening or dangerous fuels the cycle of anxiety, making social interactions increasingly difficult to manage.

[3] Another key factor is **family dynamics** and the environment in which children grow up. Families in which there is a high degree of control, criticism or unrealistic expectations may contribute to the development of social anxiety. A family environment that rewards perfectionism or minimizes emotions may lead a young person to internalize fear of judgment and failure. In addition, experiences of bullying or social exclusion during childhood and adolescence can have a lasting impact and lay the groundwork for social anxiety. Individuals who have experienced bullying may develop an acute sensitivity to rejection and a tendency to avoid social situations to protect themselves from further possible painful experiences.

[4] Another important element is **peer influence**. During adolescence, the peer group becomes crucial for identity formation and self-esteem. Social pressures can increase social anxiety, especially in contexts that compare social skills, academic performance or perceived popularity. Social expectations and norms that emerge in these contexts may contribute to an increased fear of being judged or excluded, thus exacerbating the symptoms of anxiety.

[5] **Cultural and social variables** also play an important role. In some cultures, where the importance of social approval is emphasized and failure is stigmatized, individuals may develop a greater vulnerability to social anxiety. Globalization and the use of social media have further complicated this phenomenon, as the constant exposure to idealized role models tends to increase the pressure on young people, leading to a fear of failing to meet these standards.

[6] Finally, **biological factors** may influence predisposition to social anxiety. Neurotransmitters, such as serotonin and dopamine, have been linked to the regulation of mood and anxiety. An imbalance in these chemical systems may contribute to the development of anxiety symptoms. In addition, the autonomic nervous system plays a crucial role in the stress response and the fight-or-flight response, which can lead to an overreaction in social situations.

2.3 WARNING SIGNS OF SOCIAL ANXIETY

The warning signs associated with social anxiety can manifest themselves in a variety of ways and at different stages of an individual's life. Recognizing these signs is critical to early identification and effective intervention.

[1] One of the most important warning signs is the **intensification of fear in social situations**. Individuals may begin to feel excessively anxious or nervous when they are in social situations, even in those that did not previously cause them distress. This intensification can lead to constant worry about the judgment of others, leading to catastrophic thoughts about what might happen during social interactions.

[2] Another important sign is **avoidance behaviour**. People who begin to avoid social events, such as parties, meetings, or simple gatherings with friends and family, may be at risk for developing social anxiety. This avoidance behaviour can manifest itself in very obvious ways, such as refusing invitations or making excuses not to participate in situations that were once enjoyable. Over time, this social isolation can increase, thus creating a vicious cycle in which the fear of facing social situations increases precisely because of the avoidance.

[3] In addition, it is important to consider changes in daily social interactions. Warning signs may include **increased shyness or insecurity** in situations that require interaction, such as talking to coworkers or participating in group discussions. Individuals may begin to feel overwhelmed by situations they previously handled with ease. This feeling of vulnerability may be accompanied by physical symptoms, such as heart palpitations, sweating or nausea that occur in response to anticipatory anxiety.

[4] One aspect that should not be underestimated is personal history. Past experiences of **humiliation or social rejection** can be significant risk signals. If an individual has been bullied or has experienced situations in which they have been harshly criticized, they may develop a greater sensitivity to other people's judgment and opinion. This history of negative experiences may profoundly influence their self-perception and how they cope with future social situations.

[5] Finally, the presence of **environmental stressors** can increase the risk of developing social anxiety. School pressures, complex family dynamics or stressful life situations may act as triggers. Individuals facing high levels of stress may be more prone to developing anxiety, especially in contexts where they feel exposed to the judgment of others.

2.4 MAIN MYTHS AND MISCONCEPTIONS ABOUT SOCIAL ANXIETY

Social anxiety is just shyness. **FALSE**

Social anxiety is a recognized mental disorder that goes beyond shyness. While a shy person may feel uncomfortable in certain situations, people with social anxiety experience intense fear, avoidance and significant discomfort that interferes with their daily lives.

People with social anxiety do not want to interact with others. **FALSE**

People with social anxiety often want relationships and connections, but fear of judgment and fear of making mistakes or appearing inadequate can hold them back.

Simply stepping out of your comfort zone can overcome social anxiety. **FALSE**

Although gradual exposure to one's fears can help (exposure therapy), social anxiety cannot be overcome by simply "forcing oneself". A structured approach, often with the help of a professional, is needed to manage the symptoms and work on the underlying causes.

People who suffer from social anxiety are simply too sensitive. **FALSE**

Social anxiety is not a sign of weakness or oversensitivity, but a complex condition involving genetic, biological and environmental factors.

If a person doesn't look nervous, they don't have social anxiety. **FALSE**

Not all people with social anxiety show obvious signs of distress. Many are able to hide their symptoms, but that doesn't mean they aren't struggling on the inside.

It's just a phase that will pass with time. **FALSE**

Social anxiety tends to persist if not treated. Early intervention with appropriate therapies increases the chances of overcoming it.

2.5 HOW TO DEAL WITH SOCIAL ANXIETY IN EDUCATIONAL SETTINGS

A systematic, empathetic and personalized approach

To support young people living with social anxiety disorder, educators must develop a systematic, empathetic and personalized approach based on interventions designed to reduce anxiety, promote social self-efficacy and improve interpersonal skills.

Any educational intervention must consider both the individual and group levels to create a supportive environment that facilitates emotional expression and social interaction.

Techniques for working in depth on various aspects of social anxiety

Here are some practical examples of specific educational interventions to help young people with social anxiety disorder. These include practical exercises, focus group questions and group activities designed to develop social skills and improve anxiety management.

[1] Self-awareness and Reflection exercises

Journal of emotions. Ask young people to keep a daily journal of their emotions, noting down moments during the day when they felt socially uncomfortable. They should identify the situation, the level of anxiety felt, and the thoughts associated with it. This will help them become aware of situations that trigger anxiety and the thoughts that accompany it.

Social skills self-assessment. Use a list of self-assessment questions to help them reflect on how they view their social skills. Some examples of questions include:

- «In what situations do I feel most uncomfortable?»,
- «What thoughts come to mind before a social interaction?»,
- «What social skills would I like to improve?».

This exercise helps to identify specific areas of work

Alternative Thoughts Exercise. After identifying a negative thought ("Everyone thinks I'm going to say something wrong"), ask the young people to write down more positive or neutral alternative thoughts ("I can't know what others are thinking," "I may be wrong, but it happens to everyone"). This exercise promotes a more realistic and flexible view of social interactions.

[2] Questions for a Focus Group

Explore social difficulties. "What social situations make you feel most anxious? How do you feel when you are in these situations?" and" What strategies have you used to deal with these situations? Were they effective?"

Thoughts and emotions in interactions. "When you are in a group of people, what do you think of yourself? And what do you think the others think?" This question en-

courages the sharing of common negative thoughts or fears, making it easier for young people to understand that they are not alone in their fears.

Share successes. "Were there times when you were able to manage your social anxiety well? How did you do that? What helped you?" Sharing personal successes can be very motivating and provide insight into useful strategies.

Goals for improvement. "What skills would you like to improve in your social interactions? What do you think would help you feel more confident?" This question helps young people identify their goals and see the path to improvement as achievable.

[3] Role-Playing and Simulation activities

Role plays in everyday situations. Suggest specific situations to young people (asking a teacher for information, talking to a new classmate, presenting a project) and have them role-play in pairs or small groups. After the activity, discuss how they felt and what was most difficult, giving positive feedback on each interaction.

Improvisation games. Activities such as improvising a conversation on a random topic can reduce social anxiety by helping young people experience unexpected situations in a controlled environment. After each round, discuss the experience and strengthen their ability to adapt.

Simulation of anxiety-provoking situations. Prepare an anxiety-provoking situation, such as public speaking, in a progressive manner. For example, the young people could start by speaking in front of one person and gradually move on to speaking in front of the whole group. Each time they successfully complete a stage; they receive positive feedback and discuss their progress.

[4] Mindfulness and Relaxation Exercises

Diaphragmatic breathing. Before each group meeting, spend five minutes on diaphragmatic breathing. Teach the kids to inhale slowly while counting to four, hold their breath for two seconds and then exhale slowly while counting to four. This exercise helps to relax and reduce anxiety levels.

"Body scan" technique. Lead the young people in a body scan exercise, asking them to focus on each part of their body and gradually relax. This exercise can be used before an anxiety-provoking situation or during tense moments.

Positive visualization. Suggest visualizing an ideal and peaceful social situation, guiding the young people to imagine a scene where they feel safe and welcome. Encourage them to recall this mental image during moments of anxiety.

[5] Group Activities to Strengthen Social Skills

Work on a creative project together. Divide the group into small teams and come up with a collaborative project, such as creating a mural or collage on a theme you choose together. Working together on a project helps develop trust and communication and allows youth to work on social skills in an informal setting.

Trust games. Activities such as "the circle of trust" or the "scavenger hunt" game in which they must work together to achieve a goal help youth overcome their fear of judgment and develop a sense of belonging to the group.

Structured discussions on topics of interest. Organize group discussions on relevant topics (music, social media, sports). Give everyone a set amount of time to speak without interruption to encourage participation without feeling pressured. After each person speaks, the others can ask questions or express opinions, making the discussion an opportunity for constructive debate.

[6] In order to maintain the effectiveness of the interventions and personalize educational efforts, it is important to refer to **specific tools and educational materials**, such as:

Self-help books and resources. Texts such as *Mind Over Mood* by Greenberger and Padesky or *How to Overcome Social Anxiety* by Dayhoff Signe can be used as references by both educators and youth, providing anxiety management techniques that can be practiced independently.

Meditation and mindfulness apps. Apps such as *Headspace* or *Insight Timer* include meditation programs specifically for youth with social anxiety and can be easily integrated into daily routines.

Visuals and posters. Create or download posters and infographics that illustrate breathing techniques or tips for reducing anxiety. These can be placed in the classroom or in common areas as visual reminders for the young people. Suggested films include:

- ***«Inside Out 2»*** (2024), an animated film that explores managing emotions and social difficulties in an accessible way, which is useful for sparking conversations among young people about anxiety and emotionality.
- ***«Wonder»*** (2017), the story about a young man with a rare medical condition trying to fit into a traditional school environment delicately addresses issues of anxiety, acceptance and bullying.
- ***«Someday this pain will be useful for you»*** (2011), a film that portrays a teenager with relationship difficulties and shows the way to overcoming anxiety and social alienation.

Educational and testimonial videos. Videos that illustrate the experiences of young people who have successfully coped with their social anxiety can be used to create discussions and moments of reflection.

Group witnesses. Encourage meetings with expert psychologists or therapists, or people who have overcome social anxiety, to give young people positive, concrete examples.

[5] Drama therapy

Drama therapy is a form of art therapy that uses drama as a tool for personal, relational and emotional exploration. In the case of social anxiety, it can be particularly useful because it provides a safe and structured environment in which to experiment with ways of relating, managing emotions and overcoming fears of being judged by others. Here are some specific benefits:

- *Creative expression:* Acting helps explore aspects of the self that may be suppressed, thereby improving self-image and fostering a sense of self-efficacy.
- *Overcoming fear of judgment:* Working in a group and receiving positive and constructive feedback helps reduce the fear of being judged negatively.
- *Improve verbal and nonverbal language:* Drama exercises focus on the use of voice, body and facial expressions that are critical to communicating effectively with others.
- *Group collaboration:* Theatre activities are often performed in groups, encouraging teamwork and building positive relationships.
- *Experimenting with different roles:* Playing characters with different characteristics allows one to break out of one's own patterns and explore new ways of relating to others.
- *Emotional regulation:* The act of playing a role allows one to distance oneself from one's emotions, thus facilitating greater awareness and control.
- *Coping with exposure:* Gradually, participants can gain the strength they need to expose themselves outside of the theatrical setting.

CHAPTER

3

Youth Depression

3.1 HOW TO RECOGNIZE DEPRESSION

Crushed by a deep feeling of emptiness

What does it mean to be depressed; what are the warning signs of depression; how can it be treated; what are the risk and protective factors; what educational measures can be taken?

[1] Depression is a very common mental disorder, affecting more than 300 million people worldwide. It can occur at any age, including children and the elderly, it is more common in women than in men, it manifests differently in different individuals, and it can vary in severity.

> The main symptoms are **persistent low mood and loss of pleasure in most activities.**

Biological factors that may contribute to its onset include hormonal changes, changes in brain neurotransmitters and even genetic components. Physical health problems can worsen depression, or depression can lead to physical health problems.

[2] **Depression should not be confused** with common mood swings and short-term emotional reactions to everyday problems. Sadness or worry about unpleasant or difficult situations are part of normal life and their presence alone does not constitute a depressive disorder. On the other hand, it is important to note that depression is an illness and *should not be interpreted as a sign of weakness.*

In fact, depression **can become a major health problem** when it is of long duration and intensity and prevents the person from performing their usual activities in all areas. It can become chronic, when it does not improve over time, or recurrent, when episodes recur, and it can make it difficult to function at home, at work or school and in daily life. In its most severe form, it can lead to suicide.

The symptoms of depression

[1] Not all people with depression experience the same symptoms. **The severity, frequency and duration of symptoms may vary from person to person** and from disorder to disorder and the symptoms may manifest differently depending on cultural background.

There are several **signs that can indicate the presence of depression** and help distinguish it from other common moods, so that you can decide to seek help from the appropriate health care center. In addition to the symptoms listed below, the feeling of sadness is often different from that experienced at other times and is not a temporary situation because it does not improve over time.

Typically, the first symptom of depression is of a depressive episode, which is a temporary manifestation of the symptoms of depression. Depending on the intensity and recurrence of these episodes, we speak of **mild, moderate, or severe depressive disorders.**

[2] Although there are different types of depression, varying in duration and presumed origin, the common feature is the presence of certain symptoms that significantly affect the person's personal, relational and social life:

- Unusual and persistent sadness and tendency to cry in situations that would not normally trigger this response.
- Loss of interest or pleasure in activities that are normally enjoyed.
- Feelings of worthlessness, contempt and guilt.
- Difficulty thinking and concentrating, remembering and paying attention.
- Irritability, anxiety.
- General malaise, fatigue and lack of energy.

- Pains, headaches or digestive problems.
- Difficulty falling asleep or oversleeping.
- Changes in appetite (eating more or less than usual).

> Some symptoms may be warning signs of more serious depression. If they occur, **a healthcare professional should be consulted** as soon as possible to evaluate treatment alternatives.

Prevalence

Depression is one of the most important health problems in the world today because of its incidence and consequences. Its prevalence is very high, with an estimated **8-16% of people suffering from depression during their lifetime**. It is currently the second leading cause of disability worldwide (accounting for 4.3% of the global burden of disease), but the World Health Organization (WHO) estimates that it will become the leading cause by 2030.

According to recent WHO data, more than **322 million people worldwide suffer from depression**, and fewer than 25 per cent of them have access to effective treatment. It also warns that one in five people will develop depression in their lifetime and that this number increases with other factors, such as comorbidity or stressful situations.

The estimated total number of people with depression has increased in recent years due to several factors: *an aging population, the level of stress we experience on a daily basis, social and economic problems and an increased use of toxic substances and drugs.*

3.2 TYPES OF DEPRESSIVE DISORDERS

The different faces of depression

[1] Depression can be **mild, moderate or severe** depending on its severity and is considered chronic when the person lives with it for more than 2 years (it usually disappears after 5 months)[6]. In the different classifications we find different types of depressive disorders, the most common being:

[6] There are several types of classifications for depressive disorders that are used both clinically and in research, such as the *International Statistical Classification of Diseases and Related Health Problems* (ICD) and the American Psychiatric Association's classification in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

- ***Major depression.*** depressive symptoms last at least two weeks and are severe enough to interfere with daily life. In some cases, this type of depression may be recurrent, with episodes occurring several times in a lifetime. It can be mild, moderate or severe.
- ***Chronic depression or dysthymia.*** Symptoms may be less severe but persist for at least two years.
- ***Postpartum depression.*** When the episode occurs in a woman who has just had a baby; it can be a severe episode influenced by hormonal factors.
- ***Adjustment disorder with depressive symptoms.*** Appears as a result of a difficult problem in the person's life, such as a job problem, separation from a partner, family problem, etc.
- ***Bipolar depression.*** Occurs in the context of bipolar disorder. In this case, episodes of depression alternate with episodes of euphoria, which is an elevated, excessively happy, cheerful or altered state of mind that does not correspond to what is happening in the person's life. These episodes last for several days and are separated by periods when the person is in a normal mood.

[2] **Depression and sadness can be confused, but they are not the same thing.** It is not always easy to recognize how we are feeling. Sometimes we happen to use the expression "I'm depressed" but we probably do it wrong. Experiencing a moment of sadness is normal, but we need to distinguish it from depression, which is a real disabling disorder that needs to be treated with the help of a professional.

It often happens that we go through particularly difficult periods of life and as a result we *feel sad, resigned, discouraged and without energy*. Sometimes it is a consequence of bereavement, understood not only as the disappearance of a loved one, but as an experience of loss: we feel that we have lost something permanently. A loss can be both material and symbolic: the loss of a job, the end of a love affair the breakup of a friendship, moving away from home, etc.

It is natural to experience these feelings in these situations; however, if the symptoms are particularly intense and interfere with daily life, it could be major depression. Although the state of sadness, lack of enthusiasm and energy may be a temporary consequence of a bereavement and thus an expression of the loss, this does not mean that one cannot turn to a professional for help in accepting, experiencing and processing the grief.

> In short, **sadness** is an emotion and as such it is more transient and limited in time, more closely related to grief, the elaboration of the loss of something dear. **Depression** is an emotionally prolonged condition that affects various aspects of the personality; it is certainly not a transient problem that goes to affect only one day of the week.

Causes that contribute to depression

Depression is the result of complex interactions between **factors** that can be **biological** (biochemical, genetic, hormonal, health), **psychological** (traumatic events in childhood or adulthood, adverse and stressful situations) and **social** (such as social isolation or lack of resources).

[1] First, **biological** factors play a critical role. Genetics is one of the key elements: the presence of family members with a history of depression increases the likelihood of developing the disorder. Studies have shown that neurotransmitters, such as serotonin, dopamine and norepinephrine, are involved in mood regulation and that an imbalance of these neurotransmitters may contribute to the onset of depression. Structural and functional changes in the brain, such as a reduction in certain brain areas associated with mood and emotion regulation, have been observed in depressed individuals.

In addition to genetic and neurochemical factors, **hormonal aspects** may also influence the risk of depression. Hormonal changes, such as those that occur during pregnancy, the menstrual cycle, or menopause can trigger depressive episodes in some women. However, biological predisposition alone is not enough to explain the disorder; it often interacts with environmental and psychological factors.

[2] On a **psychological** level, depression is often associated with negative thinking patterns and a pessimistic view of oneself and the world. People who tend to interpret events negatively, or who dwell on painful past experiences, may find themselves trapped in a vicious cycle of negative thoughts and emotions. Low self-esteem is another psychological element which is common among people suffering from depression. Feeling inadequate or unable to cope with daily challenges can fuel feelings of helplessness and despair.

Childhood trauma or negative experiences of childhood, such as physical, emotional or sexual abuse, can also have a lasting impact on mental health. These events can affect the development of self-efficacy and coping skills, which are the ways in which an individual manages and copes with severe distress. This makes the individual more vulnerable to depression in adulthood. In addition, chronic stress, resulting from situations such as work, difficult relationships or financial pressures can contribute to the development of the disorder.

[3] On a **social** level, isolation and lack of social support are significant risk factors. People who lack a support network or feel lonely may be more susceptible to depression. Relationship difficulties, such as family conflict or compromised friendships, can increase feelings of loneliness and sadness. In a cultural context that stigmatizes

mental illness, people who suffer from depression may feel even more isolated and reluctant to seek help, making their situation worse.

Finally, **significant life events**, such as the loss of a loved one, a separation, or a drastic change in life circumstances, can act as triggers. These events can provoke a deep emotional response that, combined with pre-existing vulnerabilities, can lead to the onset of depression.

3.3 WARNING SIGNS OF DEPRESSION

[1] It is important for those suffering from depression to be able to recognize the early warning signs of the disorder so that they can implement appropriate strategies and seek help to prevent a possible depressive episode. In general, **the first warning signs** to pay special attention to are:

- Not wanting to leave the house or even getting out of bed
- Inability to perform daily activities (hygiene, eating, family responsibilities, etc.).
- Feeling hopeless, believing that there is no solution to the situation, that nothing can be done to improve it.
- Psychomotor inhibition: difficulty moving and speaking, feeling that thinking slows down and that the voice sounds monotonous, slow and muffled.
- Thoughts of death or suicide attempts.

[2] There are several signs and symptoms of depression, and they can vary according to age.

> In fact, **depression in children (preschool age, up to 6/7 years)** exists and is often overlooked or underestimated, but it is important to treat it with sensitivity.

It can manifest itself the following ways:

- Physical symptoms: pain (headache and abdominal pain), fatigue, dizziness.
- Anxiety (especially separation anxiety).
- Phobias.
- Psychomotor agitation or hyperactivity.

- Irritability.
- Loss of appetite (weight loss).
- Changes in sleep.
- Decreased enjoyment of school or play.
- Impairment of social skills.

And also…

- Defecation disorders.
- A sad face (constant sadness).
- Poor communication.
- Frequent crying.
- Repetitive movements.
- Self-aggression and hetero aggression.

We also recognize some signs in **children of school-age (6/7 – 12 years):**

Verbalized depressed mood: sadness, irritability, boredom.

- Sad appearance, crying easily, apathy, fatigue, isolation.
- Poor academic performance.
- Poor concentration.
- Somatic disorders.
- Weight loss.
- Insomnia.
- Psychotic symptoms congruent with mood.
- Poor peer relationships.
- Desire to die.
- Exclusive and excessive attachment to animals.
- Difficulty having fun (anhedonia).
- Low self-esteem.

Depression in **adolescents (>12)** consists not only of a depressed mood and occasional melancholy but is a disorder that can manifest itself with different symptoms than those observed in adults. The following is a list of the most common symptoms; it should be noted that not all of them are always present:

- Irritability and instability.
- Depressed and irritable mood.
- Loss of energy.
- Demotivation and lack of interest.
- Psychomotor slowing down.
- Feelings of despair and guilt.
- Sleep disturbances (hypersomnia).
- Changes in appetite and weight.
- Isolation.
- Difficulty concentrating.
- Decreased academic performance.
- Low self-esteem.
- Suicidal thoughts and attempts.
- Severe behavioral problems (alcohol and drug use).

More specifically, the most common subjective symptoms in **girls** are sadness, emptiness, boredom, anger, anxiety, greater concern for popularity, less satisfaction with appearance, lower self-esteem.

In contrast, **boys'** express feelings of contempt and defiance, as well as behavioral problems (truancy, running away from home, physical violence, theft, substance abuse).

Although **the symptoms of depression in adolescents and adults may seem similar, there are some differences:**

- Adolescents never wear a "depression mask": their appearance and facial expressions are not depressed.
- Adolescents do not verbally say they are sad, let alone depressed; they may say they are bored, tired or fed up.
- They do not seek empathetic understanding and comfort from adults – they tend to reject help and be hostile or indifferent.

Being depressed is like looking at life through a pair of sunglasses that do no not allow you to see reality as it is, but rather filter it through these lenses, where everything seems so difficult or impossible to achieve.

3.4 MAIN MYTHS AND MISCONCEPTIONS ABOUT DEPRESSION

Many people with depression are **victims of the misunderstanding of the general population**, which fails to grasp the extent of this illness or the real impact it has on the daily lives of those who suffer from it. Understanding the reality of depression is a great help in normalizing this mental health problem. In this sense, it is very interesting to hear and debunk false myths.

Depression and sadness are the same thing. FALSE

Sadness is a temporary, transient emotion that occurs at certain times in life. Depression, on the other hand, is a mental disorder that significantly affects the daily life of those who experience it. It is important to be able to distinguish the symptoms that indicate the presence of depression.

Depression is lifelong. FALSE

With a good diagnosis and proper treatment, a person can lead a normal life. Professionals tell each person what kind of treatment they need, based on the best available scientific evidence. The active involvement of the person with depression and their family is crucial during the treatment process.

Depression can be simulated. FALSE

Depression is very difficult to simulate. It is important to remember that depression causes great pain to the person.

Depression in the elderly is different and more difficult to treat than depression in adolescents. FALSE

The picture of depression in the elderly is identical to that in young people. The response to depression is just as good in the elderly as in the young.

Depression does not affect children. FALSE

Depression does affect children, but the symptoms are different from those of adults and, most importantly, it goes unnoticed because it is not thought of or is confused with other health problems. In other children, depression can be very disabling and progress to a higher level of illness.

Depression can be treated on its own. FALSE

The symptoms of depression, such as physical fatigue, insomnia, muscle pains, stomach problems, or changes in mood, prevent the person with depression from re-

covering. It is important to recognize that you have depression and to seek professional help to get the help you need.

People with depression are always sad. **FALSE**

It is possible for some people with depression to feel sad all the time. Each person may experience different symptoms. It is very common to experience anhedonia, the inability to experience pleasure, which can lead to a state of deep sadness.

Depression is a result of trauma. **FALSE**

It is true that depression can result from a negative situation, such as the loss of a loved one, a failure, the loss of a job, or the loss of a sentimental relationship. Therefore, depressed people are unable to identify an external factor that has caused the manifestation of this distress.

Medication is sufficient to treat depression. **FALSE**

Medication intervenes by regulating the biochemical basis of depression. In most cases, however, medication is not enough, and other psychotherapeutic, educational and life-environment interventions are needed to complete treatment and maximize recovery.

3.5 HOW TO DEAL WITH DEPRESSION IN EDUCATIONAL SETTINGS

Particular attention to primary prevention

[1] As we know, *primary prevention* aims to reduce the incidence of a disorder by targeting the risk factors that precede the disease. *Secondary prevention* aims to reduce the prevalence and focuses on the treatment of the disorder. *Tertiary prevention* focuses on rehabilitation and relapse prevention.

> At this point we would like to highlight aspects of the **primary prevention of depression** by focusing on intervention before the onset of symptoms, looking at the environment in which a person lives to promote greater resilience and emotional well-being.

In this regard, some *personal protective factors* that can reduce the risk of developing depression should be emphasized and promoted in educational settings:

- Express feelings with people close to you, a stable social support network to share your mood with people you trust.
- Rely on family and friends, i.e., maintaining close and cohesive relationships.
- Cultivate spiritual or religious beliefs.
- Regular physical exercise.
- Establish a daily routine and set realistic goals.
- Reflect daily on the positive things that have happened to you and be grateful and appreciative of the positive aspects of life.
- Make plans.
- Maintain a healthy diet.
- Maintain a good sleep and rest routine.
- Avoid alcohol and drugs.
- Engage in activities that make you feel better, such as volunteering or community service.
- Keep your thoughts positive and develop self-esteem.
- Learn to tolerate uncertainty and ambiguity. These are uncertain times.
- Learn to relax.
- Maintain a sense of perspective. Some situations will not last forever, and you need to set new realistic goals that are in line with current circumstances.
- If you have suicidal thoughts, seek help immediately.
- Seek help from health professionals if necessary.

[2] On the other hand, to effectively and thoroughly address adolescent depression, educators create a welcoming and non-judgmental environment in which young people can feel safe to open a dialogue about feelings and difficulties. An essential educational criterion is the **promotion of empathy and active listening** so that educators can establish a trusting relationship with young people. To this end, it is helpful to organize individual and group meetings where young people can talk freely about their experiences.

In a community setting, protected spaces such as sharing circles can be created where each participant has the opportunity to speak without being interrupted. An educator can lead these sessions by introducing a theme for reflection such as, "What are the things that worry you most right now?"; "In what situations do you feel happiest?"

The use of open-ended questions is crucial in order to encourage honest sharing.

[3] There are **educational interventions that promote and prevent mental health** in adolescents, namely family-centered interventions – such as skills training – and in schools and educational settings, such as:

- Organizational changes for a safe and positive mental health environment.
- Teaching the value of mental health and life skills.
- Staff training in basic suicide risk identification and management.
- Interventions based on peer leadership or mentoring programs.
- Prevention programs targeting youth in vulnerable situations, such as those affected by fragile humanitarian environments and minority or discriminated groups.
- Multilevel interventions to prevent alcohol and drug abuse.
- Programs to help prevent risky sexual behaviour.

Techniques for working in depth on various aspects of depression

Here are some hands-on activities with specific techniques that educators can use to help young people cope with depression and develop emotional skills. These techniques promote self-awareness, improve interpersonal skills and provide concrete tools for coping with emotional difficulties.

[1] **Gratitude and Well-Being Journal.** A writing exercise that helps young people focus on the positive aspects of their lives and reduce the impact of negative thoughts.

Activity. Ask young people to write down three things for which they feel grateful or happy each night, even something as small as a pleasant conversation or a beautiful landscape seen during the day. The educator can then lead a weekly discussion about their favorite "moment of gratitude."

Materials. Notebook for each participant and pens.

Duration. 10-15 minutes each day.

[2] **Focus Group on Emotions.** Moments of sharing where young people can discuss specific issues and develop a common understanding.

Activity. The educator introduces a specific topic, such as "How do you deal with moments of sadness?" or "What worries you most?" Participants respond and discuss in a circle, listening to and respecting each other's experiences. Each focus group can end with a short, guided reflection in which each person expresses what they have learned from the meeting.

Materials. Quiet space for the circle, slips of paper for taking personal notes.

Duration. 45-60 minutes

[3] Collage of the Future. Helps young people visualize and organize their dreams and goals, providing a tool for insight that strengthens hope for the future.

Activity. The educator provides magazines, paper, scissors and glue and invites the youth to cut out pictures or words that represent how they see their future or what they want. At the end of the activity, each person presents their collage and explains what it represents to them. Finally, you can ask them to choose a key word to represent their future project.

Materials. Magazines, paper, scissors, glue.

Duration. 60-90 minutes.

[4] Expressive Writing Activity: "A Letter to Yourself". Expressive writing helps young people express their feelings and thoughts and encourages deep personal reflection.

Activity. The educator asks the young people to write a letter addressed to themselves at a difficult time or to themselves in the future, offering advice and encouragement.

A theme can be suggested, such as "What would you like to say to yourself when you feel sad?" or "What advice would you give yourself to overcome difficulties?" At the end, those who wish can read their letter to the group. This exercise can help create a sense of self-awareness and mutual understanding

Materials. Paper, pens.

Duration. 30 minutes for writing, 30 minutes for sharing.

[5] Art Therapy Workshop. Through art therapy, young people can visually express emotions that are difficult to verbalize.

Activity. The educator asks the youth to draw or paint something that represents their current emotional state or a challenge they are facing. Enough room is given for creative freedom, without judging artistic ability. When the drawings are completed, each person can share the meaning of their work with the group, if desired.

Materials. Drawing paper, markers, paint, crayons.

Duration. 45-60 minutes.

[6] "Problem Solving" activities to deal with everyday challenges. They help young people develop a practical and positive approach to difficulties.

Activity. The educator introduces a problem situation, such as "You have a difficult test, and you feel overwhelmed" or "You had a fight with a friend, and you don't know how to deal with it." Each participant has to come up with strategy to deal with the problem and try to solve it with the resources available to them. At the end, they share and discuss which solution was most effective and why.

Materials. Cards with problem situations.

Duration. 30 minutes.

[7] Empathetic Communication Exercises. They help develop empathy and mutual understanding, skills that are fundamental to relationship well-being.

Activity. In pairs, participants share stories about a difficult situation. Each member must then summarize what they have heard, trying to understand the other person's point of view. The group then reflects on the importance of "feeling listened to" and how to improve communication.

Materials. No specific materials.

Duration. 15-20 minutes for pairs, 20 minutes for group reflection.

CHAPTER

4

Somatic Symptom Disorder

4.1 HOW TO RECOGNIZE SOMATIC SYMPTOMS

When the body speaks

Indeed, the body has always been given greater importance. It can also be a valid means of communicating a state of distress or psychological suffering. Therefore, there are sufferings that find a space of expression and try to give a signal to the person by appearing through physical pain. They affect the person on all levels, mind and body. There is undoubtedly a close connection between physical and mental illness/well-being.

> Somatoform disorders, now classified in the DSM-5 as "**Somatic symptom and related disorders**," are a group of conditions characterized by physical symptoms that cannot be explained by a general medical condition or other mental disorder.

However, these physical symptoms cause significant distress or interfere with a person's social, occupational, or other important areas of life.

The symptoms of psychosomatic disorders

In the DSM-5, somatic and related disorders are divided into two main categories: somatic symptom disorders and related disorders, each with distinct characteristics.

[1] Somatic symptom disorders are characterized by the presence of one or more somatic symptoms that cause significant distress and are associated with excessive concern about the severity of the symptoms themselves. These symptoms can vary widely and include pain, gastrointestinal disorders, fatigue and other physical manifestations. What distinguishes these disorders is that the person's focus is not so much on the illness itself, but rather on its interpretation and the anxiety they feel about it. Often, the person repeatedly seeks medical attention even though medical examinations reveal no obvious physical cause for the symptoms.

[2] Another group consists of **related disorders**, including *conversion disorder*, illness anxiety disorder and somatization disorder. *Conversion disorder* presents with neurological symptoms (such as paralysis or incoordination) that cannot be explained by a medical condition, often in response to emotional stress or trauma. *Health anxiety disorder* involves a persistent worry about having a serious illness based on a misinterpretation of normal physical symptoms.

Finally, *somatization disorder* refers to a history of recurrent and variable somatic symptoms that cannot be explained by a medical condition or other mental disorder. The DSM-5 emphasizes that although somatic symptoms are real and can cause significant distress, the underlying mechanism is not necessarily related to a physical illness.

[3] Body dysmorphic disorder is a somatic symptom disorder. This disorder is characterized by an excessive preoccupation with a perceived defect in physical appearance, which may be slight or even non-existent in the eyes of others.

> It can be said to be a psychological condition characterized by an obsession with perceived defects in physical appearance, which may be minor or non-existent.
>
> Although these defects may seem unimportant or invisible to others, **they are a source of great anxiety and distress to the sufferer, to the point of interfering with daily life.**

Main features of body dysmorphic disorder:

- **Obsessive preoccupation with physical appearance**: Individuals spends a great deal of time focusing on specific parts of the body, such as skin, hair, nose,

eyes, face shape, teeth or other features. Even if the imperfections are minor or imaginary, the person sees them as serious aesthetic flaws.

- **Repetitive behaviors related to appearance**: These include repeatedly checking oneself in the mirror, comparing oneself to others, camouflaging the perceived defect (e.g., with makeup or clothing), and resorting to plastic surgery to correct it. The person may constantly seek reassurance from others or, on the contrary, avoid the mirror and social contact completely out of shame.
- **Impact on daily life:** The disorder can cause severe emotional distress and interfere with daily activities. People with Body Dysmorphic Disorder often avoid social situations for fear of being judged for their appearance and may isolate themselves. The distress can also lead to depression, social anxiety and suicidal thoughts.
- **Compulsive search for cosmetic surgery**: Despite the surgeries or plastic surgery that people often seek to correct their perceived flaws, the relief is only temporary. In many cases, the dissatisfaction persists or moves to other areas of the body, rendering the surgery useless.
- **Psychological and psychiatric aspects:** The disorder is associated with low levels of self-esteem, perfectionism and anxiety disorders. In many cases, individuals also develop depressive disorders, generalized anxiety or eating disorders. Body dysmorphic disorder can coexist with social anxiety, as people fear the judgment of others.

Prevalence

[1] Data on somatic disorders are difficult to determine precisely because of the variability in the definition and diagnosis of these conditions. However, it is estimated that between 5% and 7% of the general population may be affected by somatic disorders. These disorders are **more common in women than in men**, although the ratio varies, but it is generally accepted that women are about twice as likely to develop somatic disorders.

[2] The age group most affected by these disorders tends to be young and middle-aged adults, with **a peak incidence between the ages of 20 and 40**. However, it is important to note that symptoms can also occur in adolescence and, in some cases, in old age, where they may be complicated by other factors such as the presence of chronic physical illnesses or declining cognitive abilities.

[3] Relevant features include a significant comorbidity with other mental disorders, such as anxiety and depression, which can further complicate diagnosis and treat-

ment. In addition, people with somatic disorders **often have a history of traumatic or stressful experiences** that can affect their mental and physical health.

[4] Geographically, the prevalence of somatic disorders can vary. In the United States and Europe, diagnosis rates may be higher, in part due to greater awareness and access to mental health services. However, in many regions of Asia and Africa, somatic disorders may be underdiagnosed due to stigma, lack of professional training and cultural differences in perceptions of mental health.

4.2 CAUSES THAT CONTRIBUTE TO SOMATIC DISORDERS

The causes of somatic symptom disorders are complex and multifactorial, resulting from a combination of biological, psychological and social factors. **Although there is no single cause that can explain their origin**, it is widely accepted that a dynamic interaction between the mind and the body plays a key role.

[1] One important factor is **genetic predisposition**. Studies have shown that there is a hereditary component that makes some people more susceptible to developing anxiety-related psychiatric disorders, such as somatic disorders. People with a family history of anxiety disorders, depressive disorders, or other mental disorders are more likely to develop somatic symptoms. This genetic predisposition affects the sensitivity of the central nervous system, which may respond more strongly to physical and emotional stimuli, increasing the perception of pain or physical symptoms.

From a neurobiological perspective, it has been found that people with somatic symptom disorders may have alterations in the brain circuits involved in pain perception and processing of bodily stimuli. The central nervous system may be more activated or hypersensitive to normal body signals, leading to an increased perception and amplification of physical symptoms. The involvement of neurotransmitters such as serotonin and dopamine, which regulate both mood and pain sensitivity, has also been suggested.

[2] **Psychological factors** play a critical role in the development and maintenance of somatic symptom disorders. People who tend to interpret physical signs in a catastrophic way or who pay too much attention to their bodies are more likely to develop

this type of disorder. The belief that a physical symptom is a sign of a serious illness, even in the absence of medical evidence, is common among these individuals. Traumatic or emotional experiences, especially during childhood, such as physical or sexual abuse, neglect or psychological trauma, can increase the likelihood of developing somatic disorders.

Such experiences can lead to difficulties in managing emotions, causing the person to express psychological distress through physical symptoms. In other words, the body becomes the medium through which emotional conflict or unresolved stress is manifested. Some people also develop a form of "hypervigilance" to their bodily signals, constantly monitoring the slightest change or sensation, which can lead to an overestimation of the importance of physical symptoms.

[3] The **family context** also plays an important role. Patterns of illness observed in childhood can influence how an individual perceives and responds to their physical symptoms. If there is a tendency in the family to be overly attentive to bodily signals or to treat any physical discomfort as something serious, a child is more likely to grow up with similar beliefs. In some cases, physical symptoms may become a means of gaining attention, comfort, or avoiding responsibility and pressure. This mechanism may be unconsciously reinforced by the surrounding environment, leading the person to maintain or increase somatic symptoms.

[4] Finally, **cultural and social factors** contribute significantly to the manifestation and interpretation of somatic disorders. In some cultures, expressing emotional distress through somatic symptoms may be more acceptable or understandable than verbalizing emotions. Social and cultural norms can influence how an individual interprets and copes with physical symptoms. For example, in some societies, mental illness is still stigmatized and less accepted than physical illness. Beauty ideals promoted by the media, social pressures and expectations regarding physical appearance may exacerbate the condition. As a result, people may be more likely to express psychological distress through their bodies rather than recognizing it as an emotional or mental problem.

4.3 WARNING SIGNS OF SOMATIC DISORDERS

The warning signs of somatic symptom disorders can vary from person to person, but there are some common symptoms that can indicate the presence of a disorder. It is important to recognize them in order to intervene early and seek appropriate treatment.

[1] One of the main signs is an **excessive and persistent preoccupation with physical symptoms**, even when there is no clear medical explanation. People with somatic symptom disorders tend to obsess over their symptoms and interpret them as signs of serious illness. This preoccupation may not abate even after several negative medical examinations or reassurances from health professionals.

[2] Another important warning sign is **persistent pain or discomfort that has no clear medical cause**. People may experience chronic pain or other physical symptoms such as fatigue, dizziness, or difficulty breathing, even though tests show no obvious physical problem. Although the symptoms may be real and debilitating, the level of anxiety experienced by the person is out of proportion to the actual severity of the symptom.

[3] Another warning sign is **frequent visits to the doctor** or different specialists. Individuals tend to consult several doctors or undergo frequent tests in the hope of finding an answer or diagnosis that can explain their symptoms. They are often not satisfied with negative results and continue to believe they have a serious physical condition.

[4] A common behaviour is **constant symptom checking**. People with somatic symptom disorders may repeatedly check their bodies for signs of illness, such as constantly taking their temperature, measuring their blood pressure, or inspecting a particular part of their body. This can lead to a compulsive cycle of monitoring symptoms, which worsens the worry.

[5] **Excessive reassurance** from family, friends, or doctors is another sign. These people often seek reassurance from others, asking if their symptoms seem worrisome or if they should be worried about an illness. Despite the reassurance they receive, their anxiety does not diminish, and they continue to seek reassurance.

[6] **Impairment of daily activities** is an important sign. Somatic symptom disorders can significantly interfere with daily life, affecting work, social relationships and personal activities. People may avoid certain activities for fear of worsening their symptoms or because they do not feel physically able to participate. This can lead to social isolation, reduced productivity and a decline in quality of life.

[7] Finally, the **onset of accompanying psychological symptoms** such as anxiety and depression is another warning sign. The anxiety and frustration caused by the persistence of physical symptoms, combined with the lack of a medical explanation, can worsen their emotional state. People may develop anxiety disorders, panic attacks or depression, further exacerbating their overall condition.

4.4 MAIN MYTHS AND MISCONCEPTIONS ABOUT SOMATIC DISORDERS

Somatic symptom disorders are imaginary: people make up their symptoms. **FALSE**

People with somatic symptom disorders are not faking. They experience real pain or distress, although there is not always an obvious medical cause. The suffering is real, and it is often exacerbated by anxiety and unconscious mental processes.

People with body dysmorphic disorder are simply vain. **FALSE**

Body dysmorphic disorder is not about vanity, but about a pathological obsession with perceived (often non-existent or minimal) physical defects. These preoccupations cause intense distress and interfere with one's social and work life.

Somatic symptom disorders can be resolved through willpower. **FALSE**

It is not a matter of "choosing to feel good." These disorders require a multidisciplinary approach that includes psychological support and, in some cases, medical treatment for both physical and mental symptoms.

If doctors find nothing, it means there really is nothing. **FALSE**

The lack of a medical explanation does not make the symptoms any less real. Somatic symptom disorders have psychological and neurobiological bases, although they are not always detected by medical tests.

Somatic symptom disorders affect only women. **FALSE**

Although they are more common in women, they can also affect men. They may be less commonly diagnosed because of gender stereotypes or a different presentation of the symptoms.

4.5 HOW TO DEAL WITH SOMATIC SYMPTOMS IN EDUCATIONAL SETTINGS

A very careful, sensitive and multidisciplinary approach

[1] The first factor to consider is the importance of **social support**. Having a strong social network of friends, family or other trusted people, can be an impor-

tant protective mechanism. Positive interpersonal relationships help to cope with stress, normalize health concerns and reduce anxiety associated with physical symptoms.

> People who feel supported are **more likely to interpret their body's signals correctly and seek professional help when needed**, without falling into hyper-catastrophic attitudes.

[2] **Good emotional regulation** and **the ability to cope with stress** are another important protective factor. People who develop effective coping skills, such as relaxation techniques, mindfulness, or cognitive strategies for managing negative emotions, are less likely to somatise psychological distress. Good **emotional regulation** makes it possible to cope with everyday stress without transferring it to the body, thus avoiding the onset of physical symptoms related to emotional tension or anxiety.

[3] In the field of education it is also important to insist on **health education and knowledge**. People who have an adequate understanding of how the body works and normal physiological responses to stress are less likely to misinterpret physical symptoms as signs of serious illness. Health education can help reduce health-related anxiety by promoting a more realistic attitude toward physical symptoms.

[4] In general, the primary goal is to provide support and **create a safe and inclusive environment** where young people can explore and address their concerns about physical appearance and general well-being, without feeling judged or stigmatized. An educational intervention should therefore be based on a set of basic criteria, including both preventive measures and structured activities, in order to provide comprehensive and effective awareness and support.

[5] First and foremost, the educational approach should include accurate information about somatic disorders, such as body dysmorphia, and more generally about the impact of body image on mental and physical health. The educator should provide clear and scientifically accurate content on what such disorders are, while also highlighting the **impact that media and social networks** can have on body image.

Techniques for working in depth on various aspects of somatic disorders and body dysmorphism

Body Image and Emotional Well-Being Questionnaire

Anonymous questionnaires are essential tools for a preliminary identification of the level of distress or insecurity related to body image. Before starting an educational program, it is helpful to give the participants a questionnaire with structured questions for assessment:

- Self-perception
- The influence of social media
- Emotional state related to body image
- Psychophysical well-being

Self-perception and Body Image

- How satisfied are you with your overall physical appearance?
- Very satisfied – Somewhat satisfied – Not very satisfied – Not at all satisfied.
- Which parts of your body are you most satisfied with? (Open answer)
- With which parts of your body are you least satisfied? (Open answer)
- To what extent do you think your physical appearance affects your mood?
- Very much – Somewhat – Not much – Not at all
- How many times a day do you think about the way you look?
- Never – Once or twice – 3 to 5 times – More than 5 times
- Do you often feel worried or self-conscious about your body?
- Always – Often – Sometimes – Rarely – Never

Influence of Social Media

- How much time do you spend on social media each day?
- Less than 1 hour – 1-3 hours – 3-5 hours – More than 5 hours
- Do you ever compare your appearance to people you see on social media?
- Always – Often – Sometimes – Rarely – Never
- Do you think social media influences the way you perceive your body?
- A lot – Somewhat – Not much – Not at all
- When you look at the photos of "perfect" people on social media, how do you feel?

- Motivated to improve myself – Dissatisfied with my appearance – Indifferent – Other (specify):
- Have you ever edited or touched up a photo before posting it on social media?
- Always – Often – Sometimes – Never

Self-Esteem and Self-Acceptance

- How would you describe your overall self-esteem?
- Very high – Somewhat high – Moderate – Low – Very low
- To what extent do you feel accepted by your friends?
- Totally – Somewhat – Not much – Not at all
- Have you ever been the victim of negative comments or teasing about your appearance?
- Never – Rarely – Often – Very often
- How confident do you feel in showing up as you are, without any changes or make-up?
- Very confident – Somewhat confident – Not very confident – Not at all confident

Psychophysical Well-being

- How often do you feel anxious or stressed about your body or image?
- Always – Often – Sometimes – Never
- When you are with friends or in public, do you ever think about how you look?
- Always – Often – Sometimes – Never
- How much do you think your self-esteem is affected by your physical appearance?
- Very much – Somewhat – Not much – Not at all
- What strategies or habits do you use to take care of your mental and physical well-being? (e.g., sport, meditation, other self-care activities ((Open answer)

Reflections and Suggestions

- What are the main difficulties you have in accepting your body? (Open answer)
- What activities or strategies do you think can help you improve your self-image? (Open answer)

- If you could receive support on this topic, what kind of support would you find helpful? (e.g., counselling, discussion groups, educational materials) (Open answer)
- Is there anything else you would like to add or share about your body image? (Open answer)

Focus Group on Body Image and Beauty Stereotypes

Organizing group sessions in which young people can express their opinions about beauty models and societal aesthetic pressures allows them to develop critical thinking skills. During these sessions, the educator can use stimulating questions such as:

- "What standards of beauty do you think social media promote?"
- "To what extent do you feel conditioned by the aesthetic standards promoted in the media?"
- "Do you think body image has changed over time?"

These discussions not only help young people to reflect, but they also create an environment where they feel listened to and where they can find mutual support. To encourage open participation, use a sharing circle where everyone has the right to speak without being interrupted.

Body Awareness Workshops

Mindfulness is a powerful technique to help young people develop a more balanced relationship with their bodies, based on awareness and acceptance. During these sessions, participants can be guided through:

[1] **Breathing and awareness exercises.** The educator invites the young people to close their eyes, focus on their breathing and notice physical sensations without judgment. This helps them develop a non-judgmental awareness of themselves.

[2] **Guided imagery.** The educator guides the young people to imagine a time when they felt peaceful and in tune with their bodies and then asks them to think about how to maintain that feeling.

[3] **Body gratitude journal**. Invite participants to keep a journal in which, at the end of the day, they write down at least one quality of their body for which they are grateful. This exercise builds acceptance and reduces self-criticism.

Creative Projects to Explore Body Identity

Creating collective art projects allows youth to explore body authenticity in a safe and non-judgmental context. Some practical ideas include:

[1] **Personal photo exhibit.** Each participant takes a photo that represents an aspect of themselves that they find authentic or meaningful. The photo is then displayed in a school gallery with a brief description of what it represents.

[2] **Body identity collage.** Each person can create a collage of images and words that represent their physical and emotional identity. This project encourages self-reflection and promotes diversity.

[3] **Self-image mural:** Young people can work together to paint a mural that represents the idea of beauty and acceptance. This type of activity not only strengthens the group but also allows participants to explore body image in a constructive way.

Discussions with a Panel of Experts

Inviting psychologists, nutritionists and personal trainers who specialize in promoting health and physical well-being can be to provide young people with professional information about taking care of their bodies. During these meetings, experts can discuss topics such as:

- The difference between healthy eating and restrictive diets.
- How to set realistic physical goals based on wellness rather than appearance.
- Techniques to improve self-perception without becoming obsessed with physical appearance

This type of meeting can also be accompanied by a question-and-answer session, where teens can express their doubts and receive practical advice.

Education Paths for a Conscious Use of Social Media

Media literacy education helps young people understand the impact of social media on body image. For example, the following activities can be organized:

[1] **Critical analysis of social profiles.** The educator shows profiles of influencers and advertisers in order to discuss in groups how perfect images are constructed and what tools are used (filters, photo editing). The goal is to expose the artificial nature of many images.

[2] **Create realistic content.** Young people can be encouraged to create realistic content that promotes authenticity by documenting moments of their lives without editing or filtering. This promotes authenticity and helps counteract the pressure to create the perfect image.

Educational Materials and Informational Brochures

The educator can use support materials, such as brochures and informational posters that can be placed in common areas and cover topics such as:

- The risks of paying excessive attention to the body.
- The importance of self-esteem and self-acceptance.
- Strategies for improving body image.

Distributing informational materials in places frequented by young people (classrooms, libraries, gyms) helps normalize these issues and creates an environment where young people feel less alone in their journey toward body acceptance.

CHAPTER

5 Eating Disorders

5.1 HOW TO RECOGNIZE EATING DISORDERS

"I am sick, but it is difficult to admit it."

What are the different types of eating disorders, what are the causes, what are the warning signs that can make us suspicious, where can we go and what treatment should we follow, what are the protective factors against this disease? These are some of the questions that this section will briefly answer in order to provide the most relevant information about these disorders.

Eating disorders (EDs) are psychiatric disorders characterized by abnormal eating behaviors that negatively affect a person's physical and psychological health.

These disorders **involve an excessive preoccupation with body weight, body shape and food**, and can lead to serious health consequences. Eating disorders manifest in a variety of ways, each with specific characteristics and diagnostic criteria, but they are all linked by a dysfunctional relationship with food and a distorted perception of the body.

A common feature of these disorders is a lack of awareness of the disorder and, consequently, a lack of motivation to recover. For this reason, treatment is long and complex, and the role of the family is essential to recovery.

Symptoms of eating disorders

Certain behaviors or signs may indicate an eating disorder. These are things to look for, because if it is diagnosed as soon as possible, recovery will be easier and faster. The warning signs related to the onset of an eating disorder are as follows:

First, **physical signs and symptoms:**

- Weight loss in a short period of time without knowing the cause.
- Delay in normal growth for age and weight.
- Sudden changes in weight.
- Menstrual disorders, lack of menstruation without medical cause.
- Bone decalcification (osteoporosis).
- Puffy cheeks due to self-induced vomiting (parotid gland hypertrophy).
- Dental abnormalities (loss of enamel, tooth decay).
- Calluses on the knuckles of some fingers.

Second, **psychological signs and symptoms:**

- Extreme concern about one's figure, diet and weight.
- Mocking comments about one's body.
- Severe distortion of body image.
- Perfectionism and dissatisfaction.
- Emotional instability.
- Isolation and excessive preoccupation with studies.
- Irritability.
- Low self-esteem.
- Impulsiveness.
- Increased rigidity and obsession.

Finally, **behavioral signs and symptoms:**

- Constant dieting, even if the person is very thin.
- Change in eating habits (becoming vegetarian or vegan).
- Increased interest in cooking, clothing and fashion.
- Disappearing after meals and locking oneself in the bathroom.

- Tendency to hide certain parts of the body with clothing.
- Purchasing and using weight loss products.
- Strange rituals with food, such as cutting it up into small pieces.
- Excessive exercise.
- Obsession with constantly weighing oneself.
- Social isolation.

Prevalence

[1] Epidemiologic studies in the most at risk population show a prevalence of about 5% in women aged 12-21 years. By diagnosis, the prevalence is 0.31% for anorexia nervosa, 0.77% for bulimia nervosa, and 3.07% for eating disorders not otherwise specified (Pérez-Gaspar et al., 2000). Among adolescents, risk behaviors for these disorders range from 11% to 18%.

It is estimated that in Italy alone more than **three million people** suffer from Feeding and Eating Disorders (FEDs) and tens of millions of adolescents and adults around the world fall ill every year. The pandemic has aggravated the situation, with an estimated increase in cases of at least 30-35% and a **decrease in the age of onset**.

[2] Typically, these disorders begin in childhood and primarily affect the female population, although the number of males is increasing, especially in adolescence and preadolescence. **Feeding and Eating Disorders are also beginning to spread consistently in the child population,** with children as young as 8-9 years old experiencing FED symptoms typical of adolescence and adulthood, especially the anorexic type, and no longer eating disorders specific to childhood as was the case a few years ago.

5.2 TYPES OF EATING DISORDERS

The different faces of eating disorders

> "Feeding and eating disorders are characterized by a persistent disordered eating or eating-related behavior that results in changes in food consumption or intake and that significantly impairs physical health or psychosocial functioning"[7].

[7] Definition of feeding and eating disorders from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR) (American Psychiatric Association, 2023).

The following is a brief overview of primary eating disorders, whose reading may help to better understand this reality:

- ***Anorexia nervosa.*** Manifested as an uncontrollable desire to be thin, which may be accompanied by compensatory measures and procedures: a strict and restrictive diet (or even fasting), excessive exercise and/or purging behaviors (self-induced vomiting, abuse of laxatives and/or diuretics).

  Individuals express an intense fear of weight gain and the possibility of becoming obese, or persistent behaviors that interfere with weight gain. They have a distorted body image with extreme concerns about diet, shape and weight.

  As their attention is focused on weight loss, nutritional deficiencies may result leading to life-threatening conditions. On a psychological level, there are personality traits characterized by extreme perfectionism, self-demanding and low self-esteem.

- ***Bulimia nervosa.*** Is characterized by episodes of binge eating, in which the person consumes large amounts of food in a short period of time, usually in secret and with a feeling of loss of control. Individuals may attempt to compensate for the effects of overeating by self-induced vomiting, the abuse of laxatives and/or diuretics, fasting, or excessive exercise.

  Like anorexia nervosa, people with bulimia nervosa have excessive concerns about weight, body image and body shape. What distinguishes it from anorexia is the lack of control overeating. It is often a more difficult disorder to recognize because it can go unnoticed (the person may be normal weight, underweight, or overweight) and is associated with feelings of shame and guilt.

- ***Binge eating.*** Is characterized by recurrent episode of overeating, similar to those of people with bulimia nervosa. The difference is that the person does not engage in compensatory mechanisms for overeating, so over time the person moves inexorably towards becoming overweight or obese.

Many people with binge-eating disorder use food as a way to cope with negative emotions and feelings. They have difficulty coping with anxiety and find eating to be comforting and soothing. However, they end up feeling sad and guilty about not being able to control their eating, which increases stress, and the cycle continues.

- ***Pica.*** A disorder involving the ingestion of non-nutritive substances, such as sand or chalk. The ingestion of such substances is considered inappropriate for the

developmental level of the individual. The typical substance ingested tends to vary with age; young children often ingest paint, chalk, string, hair or clothing. The disorder is most common in childhood and in some cases occurs in children with autism or mental retardation.

- ***Rumination disorder.*** Involves the regular regurgitation of food (without nausea or associated gastrointestinal disease, such as oesophageal reflux) from the stomach to the mouth to be chewed, swallowed or spit out. The disorder is most common in childhood (between 3 and 12 months of age), but it can also be found in older people, especially those with mental retardation. It is not diagnosed when it occurs in the context of anorexia nervosa or bulimia nervosa.

- ***Avoidant/Restrictive Food Intake Disorder.*** Is characterized by the presence of restrictive eating behaviors, significant weight loss or stagnation after weight loss, dependence on tube feeding or oral nutritional supplements and psychosocial problems. Unlike anorexia nervosa and bulimia nervosa, these individuals do not manifest symptoms such as body image distortion or fear of gaining weight.

  It generally affects prepubertal boys and girls (with males being more affected) who have a history of eating problems (often associated with gastrointestinal problems), with a very restricted eating repertoire. This disorder is associated with anxiety, attention deficit hyperactivity disorder, obsessive-compulsive disorder and autism spectrum disorder.

- ***Other specified feeding and eating disorder.*** This category applies to manifestations in which symptoms characteristic of a feeding and eating disorder that cause significant distress or impairment in social, occupational, or other important areas of functioning predominate, but they do not meet the full criteria for any of the disorders in the Feeding and Eating Disorders Diagnostic Category.

Nevertheless, this category of eating disorders brings to light important features and characteristic symptoms of a problem with food and one's own body. These symptoms, even if they do not fall under the diagnostic criteria of the most common types of eating disorders, deserve to be recognized and given all the attention necessary for recovery.

- ***Night eating syndrome (NES).*** This is an eating disorder characterized by nocturnal binge eating and insomnia. It is a condition that causes the person suffering from it to eat compulsively in the evening and at night, in larger quantities than during the rest of the day. This triggers a vicious circle that

has a negative impact on the biological clock, both in terms of sleep and eating. Sometimes the pathology occurs in conjunction with depression and anxiety, and often, but not exclusively, affects obese people.

- Another emerging category of eating disorders is *orthorexia nervosa*, which manifests as an unhealthy obsession with "healthy" or "pure" food. Although not yet officially recognized as a separate disorder in diagnostic manuals, orthorexia involves excessive concern about the quality and purity of food, resulting in dietary restrictions that can lead to nutritional deficiencies and social isolation.

Causes that Contribute to Eating Disorders

Many factors contribute to the development of eating disorders. Various biological and genetic factors, psychological characteristics, sociocultural aspects and environmental stressors are involved in their development. The specific weight of each is not yet well defined.

> The onset of these disorders usually occurs in adolescence, although an increasing incidence is observed in preadolescence and adulthood.
>
> They mainly affect the female population: about 9 out of 10 cases are female and 1 is male.

Factors that cause eating disorders include the following:

[1] Biological factors (family susceptibility): Studies of families show a higher incidence of eating disorders among family members of people with eating disorders than among those without the disorder. In the case of anorexia nervosa, genetics appears to explain 60-70% of the risk for the disorder.

[2] Sociocultural factors: Several studies have found a relationship between eating disorders and overprotective, strict and demanding, conflicted and not very close family models. On the other hand, there are cultural factors related to the cult of the body, an excessively thin ideal of beauty, the influence of fashion and the media, and the influence of social networks on young people.

The importance of socio-cultural aspects should be noted in developed countries, where thinness and stereotypical beauty are understood and sold as synonymous with social and personal success. There is a massive bombardment of this message through social media, mass media, and the environment. Significant and disturbing data:

- In the last 5 years, social media content promoting pathological eating behaviors has increased by 47%.
- The use of constant "thinness-inspiring" images and viral challenges (*iPhone Knees* – a smartphone is placed at knee height and if they both remain covered by the phone it means they are thin to the point; participate in challenges – count the number of coins that fit in the hollow of the collarbone; or *Headphones around Waist* – post photos of headphones tied around your waist to prove you are thin).

[3] Psychological factors: Personality traits such as excessive rigidity, perfectionism, self-demanding, social withdrawal and a personal history of eating problems have been associated with eating disorders. In particular, bulimia and binge eating have a more impulsive personality profile, with difficulty persevering in the face of frustration, leading to anxious overeating. Low self-esteem is a common factor in most eating disorders.

[4] Potentially stressful life events: Childhood sexual and/or physical abuse, body criticism and a history of life crises have been linked.

5.3 WARNING SIGNS OF EATING DISORDERS

[1] Eating disorders are complex and potentially life-threatening conditions and recognizing **the warning signs** is critical for early intervention. A significant change in eating habits is often the first sign. This may be manifested by following **extreme dieting, rejection of foods considered "unhealthy," or severe portion control**. People with eating disorders may also begin to skip meals or eat in secret, exhibiting avoidance behaviors and hiding their relationship with food.

[2] In addition, the body may begin to show obvious physical signs. **Drastic weight loss** is one of the most common symptoms, especially in cases of anorexia, where the person may appear visibly underweight. In contrast, bulimia may be characterized by **weight fluctuations**, with episodes of binge eating followed by compensatory behaviors such as vomiting or the excessive use of laxatives. Other physical signs, such as **weakness**, **fatigue, dry skin, hair loss and menstrual irregularities** may also be signs of an ongoing eating disorder.

[3] On an emotional and behavioral level, warning signs may include an obsession with weight and body shape, with a constant concern about body image. The person may express **dissatisfaction with their body**, even though they are normal weight or underweight condition. Changes in mood, such as irritability, anxiety or depression, may also be observed and often accompany the decline in mental and physical health. Finally, **social isolation** is another important sign, as the person may begin to avoid social situations involving food, such as dinners with friends or family events.

[4] Warning signs **in school, recreational and associational contexts** are:

- Recreation or social situations (throwing away food, not eating).
- Avoiding places where meals are shared with others.
- Perfectionist students.
- Intense physical exercise.
- Lack of concentration.
- Burnout.
- Spring and summer changes.
- Mood swings.

5.4 MAIN MYTHS AND MISCONCEPTIONS ABOUT EATING DISORDERS

The following is a list of some of the misconceptions about eating disorders in today's society. Although we know more about these disorders today than we did a few years ago, there are still some misconceptions that need to be eliminated in order to gain a good understanding of these complex illnesses:

Eating disorders are not a disease. FALSE

Eating disorders are not simply bad eating habits; they are diseases that have a multifactorial origin and development and require specific treatment.

Eating disorders are a choice. FALSE

No one consciously chooses to have an eating disorder; on the contrary, it is the onset of the disorder that leads the person to engage in behaviors such as restricting food intake, inducing vomiting, or binge eating. The person does not control these phenomena voluntarily, and their presence requires specialized intervention.

Eating disorders affect only women. FALSE

In recent years there has been a significant increase in eating disorders in the male population. Although they are more common in the female population, eating disorders also occur among boys and men.

Dieting is a normal behavior for adolescents. FALSE

Many adolescents do not diet; others choose to diet, perhaps following in the footsteps of one or more friends. An excessive focus on weight and going on diets without a doctor's prescription may be a red flag to watch for.

Anorexia and bulimia are the only eating disorders. FALSE

In addition to anorexia and bulimia, other eating disorders include other specified feeding and eating disorders and unspecified feeding and eating disorders (see DSM 5-TR).

Anorexia is the most common eating disorder. FALSE

More cases of bulimia and unspecified eating disorders are diagnosed than anorexia.

When a person has an eating disorder, they are always very thin. FALSE

In many cases, the physical appearance of a person with an eating disorder is normal. That is, they are not necessarily thin or excessively thin. The misconception that all people are thin can make it difficult to identify eating disorders.

Eating disorders are never completely cured. FALSE

About 50-60% of cases recover completely, 20-30% recover partially, and only 10-20% of people become chronic. Specialized medical and psychological treatment is essential for recovery from an eating disorder.

People who have an eating disorder have it because they "brought it on themselves". FALSE

These are mental illnesses that no one chooses to have. They are disorders that cause great suffering to both the person and their family. They are always multi-causal, involving multiple individual, family and social factors.

Anorexia is a diet that "went wrong". FALSE

Sometimes anorexia can occur in a person who was previously overweight, decided to go on a diet, and developed an excessive focus on thinness, further restricting the diet. At the same time, there are anorexic people who begin to engage in behaviors such as food restriction, self-induced vomiting, or excessive exercise without having been on a diet prior to the onset of the disorder.

Eating disorders affect only young girls. FALSE

Although it is more common in women (9 out of 10 cases are female), it affects both sexes. They are also diagnosed in people of all ages. What is common is that the age of onset of the disease is adolescence, and once diagnosed, the disorder follows the person until treatment.

Overeating in bulimia and binge eating is a matter of willpower. FALSE

When we talk about bulimia and binge eating, we are talking about mental disorders characterized by a lack of ability to control eating. There is absolutely no lack of willpower.

5.5 HOW TO DEAL WITH EATING DISORDERS IN EDUCATIONAL SETTINGS

The main areas and factors to work on

[1] In education, it is especially important to understand the importance of self-esteem. Building strong **self-esteem** is an important protective factor. People who feel good about themselves and are able to cope with life's challenges resiliently are less likely to develop eating disorders. Social support, such as having positive and stimulating friendships, also helps to create to an environment where a person feels accepted and valued beyond their physical appearance.

Finally, **education about body image** is crucial. Programs that promote acceptance of body diversity and encourage nutrition education can help prevent the development of dysfunctional behaviors. In this way, people can be better equipped to cope with social pressures and maintain a healthy relationship with food and their bodies.

[2] In this regard, there are **several factors that need to be addressed**. They can be grouped as follows:

- **Individual factors:**
  - Good self-esteem.
  - Positive body image.
  - Providing tools to develop a critical sense of beauty stereotypes propagated by the media and information on miracle diets.
  - Emotional well-being.
  - Good school adjustment (performance and peer relationships).
  - Assertiveness.
  - Good social skills.
  - Problem-solving and coping skills.

- **Family factors:**
  - Belonging to a family that does not place too much emphasis on weight and physical attractiveness, but rather promotes a positive body image, acceptance of differences among people and respect for everyone, regardless of their physical appearance.
  - Eating at least one of the main meals as a family: making eating a social and family act.
  - Strengthening self-esteem at home, that is, praising children for who they are and positively reinforcing their personality and skills, rather than what is related to physical appearance.
  - Encouraging healthy eating habits and a healthy lifestyle. The family should be a model of health for children.
  - Encouraging communication within the family, listening to opinions, creating spaces for communication with adolescents.
  - Sharing leisure activities: doing sports together, cultural outings, reading, watching television, surfing the Internet, etc.

- **Sociocultural factors:**
  - Belonging to a less Westernized culture that accepts a variety of body shapes and sizes.
  - Participation in sports or industries that do not emphasize physical attractiveness or thinness.
  - Supportive social relationships where weight and appearance are not a major concern.
  - Rejecting unrealistic aesthetic ideals that may jeopardize our children's health.
  - Warning about harmful content on the Internet and social networks: websites and social networks that promote anorexia and bulimia as a lifestyle.

[3] Working with families

- Assess the structure and functioning of the family.
- It is important to identify any variations in its proper functioning (disorganized families, strict rules, mothers who are very critical of physical appearance, family conflicts, etc.).
- It is necessary to establish a good communication channel with the family from the beginning.
- Promote the ability and willingness to cooperate in the treatment.
- Families can promote the factors that maintain the illness.

How to talk to the family

It is advisable to have an *initial contact* between the educators and the parents only, during which the following topics are discussed: meeting with the child and the suspected eating disorder. At a *later stage*, the child can be included in the meeting.

Discussion about:

- Current problems.
- The importance of early diagnosis and treatment.
- Existing health care and social resources.

In the case of minors, the possibility of informing social services should be considered if the parents refuse to talk, or if there is other evidence of neglect.

Aspects likely to complicate the family situation

- Denial of the illness.
- Biopsychosocial changes that perpetuate the problem.
- Social isolation.
- Overprotection.
- Lack of agreement between parents.
- Minimization of the problem.

[4] The importance of the educational environment

The role of educators is crucial as they have direct and continuous contact with the at-risk/affected population. There are three educational tasks to be considered:

- Identifying warning signs and possible cases.
- Providing support and guidance throughout the process.
- Collaboration with the boy/girl.

In addition, there are some details to consider:

- Obvious changes.
- Physical and emotional consequences.
- Relationship with family.
- Need to inform relatives.
- If the young person refuses to talk to the parents, encourage mediation.

Recommendations for accompaniment and support

- The main obstacle is the person's difficulty in disclosing symptoms. Therefore, empathy and support will be crucial in convincing the person to explain their fears, concerns and behaviors.
- Create an atmosphere of trust and support.
- Avoid blaming or pointing fingers. Avoid an accusatory tone.
- Although the educators are in contact with the family, they will try not to be identified as the family's ally, but as someone who is concerned about the family's health and emotional situation.
- Take into account the lack of awareness of the illness, the tendency to deny the disorder and the lack of motivation to change, which is more pronounced the shorter the evolution.

[5] How to work in a group

- Work with all the young people in the following skills:
- Participating in homework.
- Dividing the day into parts (study, hobbies, friends, etc.).
- Activities that promote social skills and interpersonal relationships.
- Seeking new interests.
- Encouraging personal autonomy and decision making.
- Learning to verbalize and identify problems, thoughts and feelings.
- Encouraging reflection on behaviors and attitudes and their impact on others.
- Encouraging spontaneity and talking about feelings.
- Encouraging more flexible rules and self-esteem.
- Avoiding manipulation and lying as a way of relating.
- Encouraging a positive evaluation of their achievements.

[6] Prevention program for schools[8]

Eating disorders are conditions with complex etiologist and variable clinical manifestations. In settings where at-risk populations are present, it is essential to have adequate training in order to take prompt action, acting as prevention and identification agents.

Although the psychotherapeutic approach is a central axis of treatment, **interventions in the child's school and social environment are crucial** for the prognosis of the illness. All therapeutic models agree on the importance of the role of the family in the recovery process, so it is essential to involve them in the recovery process.

It is recommended that **the various professionals involved** (paediatricians, educators, counsellors, psychologists, psychiatrists, social workers, nutritionists, etc.) work in a coordinated manner, with agreed actions integrated into a common treatment plan.

One of the most important educational criteria is to provide a **safe, non-judgmental and trusting environment** in which young people can feel free to talk about their problems without fear of being stigmatized. Educators need to be trained to recognize the early signs of a possible eating disorder, such as obsession with weight, avoidance of certain foods, or abnormal behaviors such as skipping meals or compulsive eating.

To meet educational needs, prevention efforts can be divided into **awareness and emotional education activities**. Educators can organize seminars and information sessions that discuss healthy eating, but more importantly, address issues of body acceptance, stress and emotion management and social pressures related to body image are addressed. These sessions should be structured with age-appropriate language and encourage interaction and active participation by the young people. **Programs** could include the following content and objectives:

- Healthy habits – Critical thinking in relation to aesthetic values.
- Initiative, coping – acceptance, diversity.
- Content:
  - Healthy eating habits: pyramid, variety, 5 a day, daily exercise, false myths, Harvard plate, etc.
  - Impulsivity: rational problem solving, self-control.

[8] National programs (Spain): ZARIMA, DITCA, AMEMC, others. International programs: The Body Project, The Bodies of Youth, Healthy weight.

- Media: critical thinking, influence on one's tastes and ideals, differentiation.
- Assertiveness: expressing and respecting one's opinions.
- Perfectionism: risks, negative consequences.
- Beauty and body image: puberty-related changes, the influence of our image on self-esteem, changes in the ideal of beauty throughout history, diversity, etc.
- Self-esteem: the consequences of self-esteem in our actions, how to take care of it.

Another essential educational criterion is the **personalization of the interventions**. Each young person experiences the relationship with food and their body in a different way, so it is essential to adapt the interventions according to their individual needs. This may require the use of tools such as questionnaires and individual interviews in order to better understand each young person's experiences and needs. For example, a body image questionnaire may include questions that explore how much the young person feels influenced by the media or social expectations and how comfortable they feel with their own body.

Techniques for working in depth on various aspects of eating disorders

Useful Educational Tools and Materials

[1] Among the tools that can be used are **questionnaires** to assess body image, self-esteem and eating habits in adolescents. There are standardized questionnaires (*Body Image Questionnaire; Eating Attitudes Test*) that assess symptoms related to eating disorders. Self-assessment scales, such as the *Body Appreciation Scale*, which measures how much one appreciates one's body, can also be used. These tools can be administered periodically by professionals to monitor the development of adolescents' perceptions and to identify early signs of risk.

[2] Another useful tool is **self-reflection cards** that encourage adolescents to think about their feelings and relationship with food. These cards can include questions such as "How do you feel after eating your favorite food?" or "What kind of thoughts are you having about your body today?" These exercises are essential for developing awareness and understanding of the relationship between emotions and food.

[3] Audiovisual resources can be a valuable support for educational activities. Informative videos on eating disorders, self-esteem and body image can stimulate discussion and bring these issues to life. Educators can use short documentaries, testimonial videos or animations that explain in a simple and direct way what eating disorders are and how to deal with them.

[4] Finally, it is advisable to create an **awareness-raising project** that actively involves young people in the creation of prevention campaigns. This can include creating posters, flyers, or digital content (such as social media posts) that promoted messages of body positivity and acceptance. Young people involved in these activities will not only learn how to communicate positive messages but will also build their self-esteem and communication skills.

Educational Materials and Tests

To supplement the activities, educators can find and download a variety of educational materials and tests online. Examples include *The Body Image Workbook*, which provides self-reflection exercises and activities to improve body image, and the *Nutrition Education Handbook*, which can provide practical information on proper nutrition. In addition, several validated psychometric tests, such as the *Eating Disorder Inventory (EDI)* or the *Rosenberg Self-Esteem Questionnaire*, are available online for education and prevention purposes. These tools help monitor self-esteem and eating behaviors.

It is important to emphasize that these tools must be interpreted by qualified professionals and that their proper administration requires specific training to ensure accurate and meaningful results.

Body Image and Self-Esteem Workshops

The workshops address the concept of self-esteem and body image through reflection and discussion activities. The main goals are to improve self-perception and to encourage open dialogue about social pressures related to physical appearance.

[1] Mirror exercise. Participants are asked to look in the mirror and describe three aspects of their appearance that they like. The group then discusses how they chose these aspects and what emotions they felt. This exercise allows young people to focus on the positive aspects of their bodies and to develop a language of self-appreciation.

[2] Collage activity. Young people are asked to make a collage of magazine clippings and pictures that they feel represent a healthy and realistic body image. The collages are then analysed together, highlighting the differences between the ideal body imposed by the media and a real, healthy body image. This exercise promotes critical awareness of media messages.

Discussion and Sharing Focus Groups

Focus groups are useful for encouraging young people to talk openly about their experiences and feelings about food and their bodies. Educators can facilitate conversations by asking questions that encourage reflection and discussion.

[1] Leader questions for the focus group. Some sample questions include, "What are the main factors that influence how you view your body?", "What pressure do you feel about your appearance or the way you eat?", "How do other people's comments about your body make you feel?" This type of discussion helps to normalize certain concerns and to help understand that many of the participants share the same struggles.

[2] Active listening activity. Each participant is invited to share an experience or thought while others listen silently and without judgment. After each intervention, participants can ask questions or share reflections in a respectful manner. This technique fosters an environment of listening and mutual support.

Role-playing to Manage Emotions

Role-playing is an excellent technique for helping young people explore their feelings and develop strategies for coping with stressful situations or social pressures.

[1] Simulate a difficult conversation. Educators can create scenarios in which young people face stressful situations, such as responding to a negative comment about their bodies or saying "no" to external pressure to lose weight. Youth are asked to play the roles, alternating between those who comment and those who respond. After each simulation, they reflect together on how they felt and possible alternative responses. This type of activity helps develop social skills and builds emotional resilience.

[2] Cognitive restructuring. The concept of "negative automatic thoughts" (such as "I am not thin enough" or "I am worthless") is introduced and then transformed. For example, participants are asked to write down a negative thought and then replace it with a more positive and realistic alternative thought ("My body is fine the way it is"

or "My worth does not depend on how I look"). This helps to reduce self-criticism and promote a more positive mindset.

Nutrition Education and Awareness Workshops

An important goal is to develop a healthy relationship with food, away from restrictive rules or constraints. Educators can introduce the topic of mindful eating through hands-on activities.

[1] **Mindful shopping simulation.** An activity is created in which young people simulate a shopping trip to the supermarket, where they must select a variety of balanced foods. They then discuss their choices, talking about nutritional value and the importance of food variety. This helps young people make informed choices and understand the importance of a balanced diet.

[2] **Cooking workshop**: During the workshop, participants prepare simple, nutritious meals together. During preparation, the educator talks about different food groups, the importance of portion control and the pleasure of eating together in a relaxed setting. This activity makes the idea of a healthy and balanced diet more tangible and promotes the enjoyment of food without fear or restriction.

Art Therapy and Writing Activities

Art techniques such as drawing, painting or writing can help young people explore their feelings in a creative and less direct way.

[1] **Drawing the "Ideal Self and the Real Self".** Young people are asked to draw on two separate sheets of paper the self-image they actually see and the self-image they would like to have. Then then analyse the differences between the two images and discuss why these differences exist. This helps participants explore the discrepancy between their actual body and their ideal body and highlights the influence of social expectations.

[2] **Emotional writing.** Educators can suggest that participants write a letter to themselves or their body, expressing feelings of gratitude or exploring painful feelings related to physical appearance. For example, the letter might begin with "Dear body, I want to thank you for…" or "Dear body, I want you to know that…." This activity helps to develop a more compassionate dialogue with one's body.

Awareness Projects

Involving young people in awareness-raising projects allows them to reflect on what they have learned and to spread positive messages to the outside world.

[1] Body positivity campaign. Young people can design posters, videos or social content to promote body acceptance and body diversity. As they plan, they work on messages of inclusion and explore ways to counteract the toxic messages in the media.

[2] Information days. Educators can organize awareness days on eating disorders and body positivity, a social movement focused on combating body shaming, promoting acceptance of all aspects of the body regardless of size, shape, skin colour, gender and physical ability, and challenging beauty standards as a social construct that should be abandoned. The young people actively participate in meetings, debates and presentations. Experts, such as nutritionists or psychologists, may be invited to elaborate on the topic and answer questions.

CHAPTER

6

Behavioral Addictions

6.1 HOW TO RECOGNIZE BEHAVIORAL ADDICTIONS

Behind every addiction lies a great dissatisfaction

[1] Until a few decades ago, **the concept of addiction was related only to the use of drugs**, but in recent years addictions that do not involve the use of psychoactive substances, such as the excessive use of video games, have become the subject of study and demand in clinical consultation:

- Excessive use of video games.
- Compulsive shopping.
- Gambling.
- Sex addiction.
- etc.

Behavioral addictions are defined as the **loss of control** over a behavior that creates the appearance of negative consequences and the inability to resist the impulse to perform a harmful act.

In addition, the performance of these behaviors creates a decrease in anxiety or a feeling of euphoria, instilling **a high level of interference** in all spheres of the person's daily life.

All of these addictions are known as **Behavioral Addictions** (BA). In general, they are pleasant and harmless human activities, but depending on their use and under certain circumstances, they can lead to:

- **Loss of self-control.** One loses control over the problematic behavior or activity, knowing that it can have negative consequences for the person (family, social, economic, academic, work, legal problems…).
- **Addiction.** To the action or behavior. The person needs to perform the action more and more in order to obtain the effect originally obtained.
- **Dangerous interference in daily life.** Causing one to stop doing activities that were previously enjoyable (e.g., a child who is 'hooked' on a video game may stop hanging out with friends, playing soccer, etc.).
- **Abstinence.** The person is unable to control their discomfort (nervousness, irritability, etc.) when trying to stop the habit of engaging in the problem behavior.

Although the request for treatment is increasingly common in clinical consultations, the main diagnostic manual for mental disorders (DSM-5) only recognizes gambling disorder (with gambling) and online video game addiction as such.

It should be noted that although the scientific community supports the existence of behavioral addictions, there is currently an open debate on certain aspects, such as whether the generalization of the use of this concept may lead to an **excessive pathologization of everyday activities performed in excess**. Therefore, there are two key elements for considering a behavior as pathological and therefore as a disorder:

- When this behavior is accompanied by a change in the person's daily functioning.
- When this behavior persists over time.

Prevalence

[1] Several reports have shown **an increase in behavioral addictions during and after the pandemic**. More than 1.1 million people under the age of 35 are at high risk of social media addiction, and young people are among the most exposed to the behavioral traps of the Web, accounting for nearly 40 per cent of the total. This is the result of a study by Demoskopika, which, using the *Bergen Social Media Addiction Scale*, found some alarming behaviors: from the need to use social media more and more frequently to the inability to stop using them. In addition, from anxious or restless behavior for not using social media to the reduction of hours devoted to study and work due to their excessive use

According to the analysis of Demoskopika researchers, there is an inverse relationship between the age of young people and the incidence of a high-risk level of social media addiction. In other words, as age decreases, possible alarming behavioral factors increase. In particular, they found that there were 430 thousand young people in the 18-23 age group falling into the "High Addiction" category, indicating a high risk of pathological levels of addiction, that is, 38% of the total, followed by the 390 thousand individuals aged 24-29 (34.5%) and, finally, the "more adult" under-35s (30-35 years old), who slightly exceed the 308 thousand who are most exposed.

[2] Some characteristics:

- Social media beats friends: 85.7% vs. 36.6%.
- Record: Instagram beats all.
- Social consumption. One in 10 young people in the tunnel of highest likelihood of submission.
- Online hate: condemnation prevails (81.6%), but justification can be heard (40.6%).

6.2 TYPES OF BEHAVIORAL ADDICTIONS

The different faces of behavioral addiction

[1] A first reflection focuses on behavioral addictions **in digital environments**. What is the relationship of children and adolescents to new technologies? What is the difference between excessive use, problematic use and addiction? What can we do to

prevent them in educational, family and social contexts? What is the most appropriate treatment in these cases? We want to answer these and other questions that we may ask ourselves when we talk about behavioral addictions that, in the case of children and adolescents, mostly occur in digital environments.

> The use of mobile devices and the Internet has many positive aspects, but an improper use can lead to health problems, poorer sleep quality, difficulties in face-to-face interaction, and even poorer academic performance.

In recent decades, the proliferation of digital technologies has brought about major changes in society, and their rapid integration into everyday life has revolutionized the way we behave. This connectivity has affected the way we present ourselves socially and relate to others, as well as information processing, memorization, learning processes, and even the classical mechanisms of participation in our environment. A major concern is the impact of this reality on children and adolescents.

[2] While in the past years the use of these technologies was associated with devices and the possession of profiles on digital social networks as a rite of passage into adolescence -which coincided with the transition to secondary school – **they are now used at an increasingly early age** and are part of the daily lives of boys and girls.

This generation lives with devices as integrated objects from the first moments of their lives. In this way, a smartphone or an Internet connection itself becomes an everyday device, providing them with a complementary logic to the face-to-face physical world. There are also gender differences: in the case of boys, the use of screens is associated with leisure activities, while in the case of girls it is associated with their relational and conversational function.

[3] Children and adolescents use very powerful technological devices, preferably portable, always connected and multifunctional: communication, image storage, calendar and organization, games, messaging, homework, etc. And, although the market is very dynamic and constantly imposes new formulas, there are 'star' applications: Instagram, Tik-Tok and YouTube have established themselves as regular channels. Moreover, they **are constantly connected** (24 hours a day, seven days a week). Therefore, in an era of essential hyper-connectivity, one of the challenges must be to define disconnection and availability.

The smartphone, or the Internet connection itself, is becoming an everyday device, providing a complementary logic to the physical face-to-face.

[4] As a result, **new dimensions** (new forms of knowledge) **are formed**, trends and new (market, professional, referential, etc.) **influences** are being constructed, which become **new 'receptacles'** (of discomfort, time management, etc.), and **new sources of relationships**, entertainment and management of daily life (with all its derivatives) are being created.

As they grow older, in their construction as individuals, digitality 'performs' several functions: to exist (I exist); to participate (in groups and socially); to be informed (learning and discovering); to relate to each other (they interact); to identify themselves (*being liked*, among other possibilities) and to be recognized (*being liked*, validating ourselves). In this story, they talk (narrate) about themselves and become the authors and protagonists of their lives.

At the same time, the possibility of multitasking is experienced as normal. For example, studying while checking one's cell phone. Despite this alleged ability to multitask, the agility to switch from one task to another should not be confused with a deep attention span.

[5] In conclusion, an increase in negative consequences and problems associated with an **excessive use of certain applications** has been observed: emotional distress, isolation at home, or the presence of other risky behaviors. In clinical practice, in child and adolescent mental health services, there has been a progressive increase in requests for treatment due to the misuse of these environments (without it being clear whether the problem lies with the devices, social networks, video games, etc.). The most common concerns of professionals and educators are:

- **The consequences of an excessive use** and possible addiction.
- **The imbalance of time** devoted to other activities, including personal interactions. On the one hand, *excessive use corresponds to use that exceeds in frequency and intensity* what is reasonable to expect according to age and time. It is framed in a much more behavioral and episodic logic, where aspects such as schedules, limits and rules are the main regulators. They are generally related to the person's sense of boredom or the online relationship with known friends. Problematic use, on the other hand, is related to problems associated with more specific behaviors, not necessarily the number of hours, but the impact on the quality of relationships and one's identity: cyberbullying, relationship problems, etc.
- **Impact on key aspects such as exercise and sleep**. Although the evidence for causality is still developing, studies suggest correlations with weight, mood and body image.
- **Control over access** to and viewing of certain content, with particular relevance to 'new' pornography.

- New representations of **bullying**.
- New media for certain **behavioral problems**: gambling, sex addiction, etc.
- The impact on **psychiatric and psychological comorbidities** and the risks of overexposure.
- **Privacy** and **security** aspects.

[6] Finally, we will discuss **gambling disorder**. Despite the wide acceptance of behavioral addictions by the scientific community, only gambling disorder (with gambling) has been included in the latest version of the *Diagnostic and Statistical Manual of Mental Disorders DSM-5* under the same heading as substance addictions.

Among the so-called "technology addictions," only Internet gaming disorder has so far merited inclusion in this manual, specifically in the appendix dedicated to "Disorders Requiring Further Research." On the other hand, the World Health Organization (WHO), in its *International Classification of Diseases* (ICD-11) (2019), for the first time includes gaming disorder in the "Mental, Behavioral or Neurodevelopmental Disorders" section, right after *gambling disorder*. In fact, in this conceptualization, the WHO officially included the video game addiction disorder in the introduction of this manual on January 1, 2022.

Causes that contribute to addiction

[1] An increase in negative consequences and problems associated with excessive use of certain applications has been observed: emotional distress, isolation at home, or the presence of other risky behaviors. Evidence explains the presence of two main perspectives: on the one hand, externalized (behavioral) or internalized (affective and anxious) disorders. Experience has shown that for the latter disorders, the digital environment serves as a "refuge" or "relief valve": social anxiety, depression and emotional loneliness emerge as the main explanatory factors. The boy or girl uses the Internet as a **self-efficacy mechanism to compensate for the deficiencies or negatively experienced situations**.

[2] Therefore, if we assume that addiction – to video games, social networks, etc. – fulfils several criteria that would classify it as a disorder in its own right, the digital environment and the specific use associated with it would become a **causal factor** in the emergence of certain problems. At the same time, while there is an underlying disorder that leads to problematic use of the Internet, it becomes a symptom of another psychopathology or mental health problem that precedes it (isolation, lack of social relationships, communication difficulties). It cannot be ruled out that, over time, the **"dual pathology" model** (well known in the field of substance addiction)

will be applied: mental health disorders and Internet addiction disorders will influence each other as they develop. This will be particularly important, because it is very likely that the symptom will eventually collapse and become relevant enough to be treated on its own.

[3] Internet-use disorder is a complex issue. While there are many examples of problematic use (especially in terms of addiction), there are still **different perspectives on what is or is not addictive behavior associated with its use**. There is some consensus on concepts such as overuse, addiction, or habituation, but more work needs to be done to understand whether these problems are a cause or symptom of an underlying disorder.

Although we live with societal discussions that oscillate between absolute normalization and the pathological relationship, not all excesses end up in addiction, nor do all addictions exclusively involve excessive use.

6.3 WARNING SIGNS OF BEHAVIORAL ADDICTION

[1] In general, the onset of addiction is a more or less gradual process ranging from the first sporadic exposures, in which the person experiences pleasurable aspects that encourage repetition (positive reinforcement), to the need to perform the behavior again and again to relieve discomfort (negative reinforcement).

It is also important to consider the developmental stage of the assessment. Indeed, at certain points in time, there are natural changes in relationships with peers and family and even in daily routines such as sleeping habits. In this regard, in the early stages of any process, it may be **difficult to distinguish between normal adolescent behavior and behavior caused by the early stages of an addiction**.

[2] Therefore, in this case, the warning signs are **small changes that the adolescent incorporates** in a subtle but continuous way and that at some point go from being unusual and justifiable, both to them and their environment, to not being so. Some of these indicators, which must be repeated and maintained over time, are:

- **Changes in sleep patterns**, secondary to a change in sleep habits and a reduction in hours of sleep to continue the addictive behavior. For example, staying connected all night, going to bed late, difficulty getting up in the morning.

- **Changes in appetite patterns**. Eating fast and poorly to save time, may even skip meals.
- **Less attention to hygiene**. They need to remember basic hygiene habits they used to have (brushing teeth, showering, changing clothes).
- **Neglect of important aspects of their lives** due to the increased time spent on addictive behavior or its preparation. Loss of sense of time.
- **Changes in leisure activities**, interests and environment.
- **Loss of friendships** or loss of interest in seeing them in person. They only have friends online.
- **Irritability** when they do not engage in the addictive behavior. Or they may be idle, lying in bed for hours.
- **Mood changes** and a tendency to be sad. They are not very communicative, withdrawing into their own world and getting annoyed when you ask them questions about their daily life.
- **Changes in academic performance**, truancy, increased reports of uncooperative or reproachful attitudes, increased failures and expulsions.
- **Requests for products or applications that cost money**. They may steal, usually small amounts of money, especially from immediate family members.
- **High concentration or excitement about the addictive activity**, not responding to external stimuli. For example, not responding when called, raising their voice or using foul language when interacting with the screen.
- **They start stealing,** usually small amounts of money, especially from close family members.

In this context, in order to identify these signs, we can ask the following questions:

- What do we see that worries us?
- What do we see when they interact that we do not see at home?
- What changes are not logical?
- Which attitudes are part of adolescence, and which are not?
- Is it a negative experience, a temporary discomfort or an established way of functioning?

6.4 MAIN MYTHS AND MISCONCEPTIONS ABOUT BEHAVIORAL ADDICTION

Behavioral addictions are not real addictions because they do not involve chemical substances. FALSE

Behavioral addictions (such as pathological gambling, compulsive shopping or social media addiction) activate the same reward circuits in the brain as substance addictions. Dopamine and other neurotransmitters also play a critical role in these forms of addiction.

People with behavioral addictions can quit whenever they want, with just a little willpower. FALSE

Like substance addictions, behavioral addictions involve a loss of control and neurological changes that make it difficult to quit without help. Willpower alone is often not enough.

Only people with economic or social problems develop behavioral addictions. FALSE

Behavioral addictions can affect anyone, regardless of social class, age or education. They are influenced by a combination of genetic, environmental and psychological factors.

Behavioral addictions do not have the serious consequences of substance addictions. FALSE

Behavioral addictions can have a serious impact on people's lives, including financial problems, relationship problems, job loss and poor mental health.

Behavioral addictions are just passing fads of our time. FALSE

Although some addictions (e.g. technology addiction) are more apparent today, the mechanisms underlying behavioral addictions are rooted in neurobiology and human behavior and have always existed.

6.5 HOW TO DEAL WITH BEHAVIORAL ADDICTIONS IN EDUCATIONAL SETTINGS

Educational and supportive interventions to develop social and behavioral skills

Childhood and adolescence are important periods in an individual's maturation and development. These life cycles are particularly vulnerable to the development of addiction problems, both substance and behavioral.

Behavioral addictions involve an addiction that affects the person's daily life and over which the person loses control. Addiction occurs when playing or using the Internet or video games takes precedence over situations that are considered more important to the young person. Their use becomes a priority and is associated with serious consequences for the individual and their environment.

> The debate about the use of digital technologies, the **problems they pose and how to deal with them** is ongoing and a cause for concern in society. Are we using these devices appropriately? Are any changes in behavior within the normal range? What do we mean by normal use, misuse or excessive or problematic use?

[1] In general, some of the factors that need to be addressed to **prevent substance or behavioral addiction among young people are as follows:**

- Maintaining a healthy lifestyle (diet, sleep, exercise) and recreational habits.
- Healthy relationships with significant others.
- Facilitating community networks, so that young people have adequate support for their needs.
- Appropriate use and management of technology and promotion of responsible recreation.
- Social skills training and awareness of the consequences of drug use.
- Establishing clear boundaries and consciously applying discipline.
- Providing motivating and healthy recreational opportunities.
- Promoting positive values in society.
- Equal access to resources and services.
- Belonging to a community and strong social ties.

[2] Emotions are subjective responses to the environment. It is important to teach children how to properly express, process, regulate and channel their emotions, an ongoing process throughout their evolutionary development. **Good emotional education must be encouraged**. The whole family and educators must learn to express their feelings and be consistent with the way they feel and act:

- **Empathize.** Put yourself in the child's or adolescent's place, try to understand their point of view, even if you do not share it.
- **Build their self-esteem.** Build confidence and positive expectations and encourage them to achieve their goals, by valuing their efforts and perseverance.
- **Teach them positive ways to express themselves.** Through assertive communication, respecting their rights without violating the rights of others.
- **Spend time building emotional bonds.** Expressing our feelings and affection. No one is ever too old to say we love them.

[3] **Addiction to video games or the Internet** is a complex issue that requires a variety of approaches to overcome. Prevention is fundamental and involves promoting healthy attitudes and habits in the various areas of our children's lives, starting with examining our role as role models. Here are some basic suggestions:

- **We are role models.** Children learn primarily by imitation. Use information technology responsibly, communicate, be seen while enjoying other activities.
- **Establish clear rules to regulate screen use according to age.** Set a schedule, choose appropriate content, use parental control filters. Involving the whole family in setting rules will help improve self-control and shared responsibility.
- **Family time.** Encourage scree-free time. It improves family cohesion and is a protective factor for overall health (physical, cultural or social activity).
- **Urgent digital literacy.** Keeping up to date with information technologies allows you to be closer to your children, to know more about their risks and potential and to accompany them in their use (privacy, responsibility and respect in social networks).
- **Encourage dialogue and critical thinking**, this helps to make better decisions and to share any doubts or problems that may arise.
- **Quickly recognizing that "something is wrong"** helps stop the downward spiral and redirect the situation. If warning signs are detected, seek advice from the school, a primary care center or a specialized center.

Prevention strategies for various aspects of addiction

[1] Tips for preventing addiction in the family

Prevention is understood as an organized set of strategies to anticipate the emergence of addictive behaviors. These interventions aim to reduce risk factors and increase protective factors against these behaviors. This is achieved through the application of different strategies, implemented in different fields and at three levels, depending on the target population:

- **Universal prevention**. Aimed at the entire population, this is the most general prevention.
- **Selective prevention**. Aimed at the population at risk.
- **Indicated prevention.** Aimed at the population in which the problem already exists.

The family (or adults, mentors or the environment in which they live) is a key element in the digital education of children and adolescents. To educate means to accompany, guide, direct, protect, etc. Their role in this new context is crucial to accompany them on their digital journey. However, this is a challenge that requires time and commitment.

Let us start with the values of **positive digital parenting**. According to the United Nations Convention on the Rights of the Child, it is "a parenting behavior based on the best interests of the child, which is caring, nurturing, non-violent, and which provides recognition and guidance, including setting limits, that enable the child to develop to their full potential." Parents have a fundamental responsibility to educate, nurture and care for their children; therefore, the welfare and development of the child must be a priority.

Based on these premises, it is advisable to:

- **Lead by example.** Children learn by imitation, so it is important to be **consistent** between what we do and what we say. Albert Einstein said that *"Leading by example is not the main way to influence others; it's the only way".* The family should be an example of responsible use of ICT (Information and Communication Technology).
- **Establish rules and limits** that are consistent and age appropriate. Limit the time, the use of screens and the location of the activity. How?
  - By encouraging moments of disconnection: do not use electronic devices during meals (use this time to chat with them), or before bedtime, as they stimulate mental activity and make it difficult to sleep.

  - Prioritize common areas in the home for device use and try to share them.
  - Rationalize usage time by prioritizing daily responsibilities and obligations: academic, household, etc.

- **Encourage positive communication between parents and children**. It is essential to establish good communication with children, so that they can tell us about their "things," but this must be a mutual, two-way communication:
  - Listen to children with interest, "through their eyes," with active listening, taking into account and respecting their opinions.
  - Look for spaces and opportunities for conversation.

- **Encourage critical thinking.** Teach them to contrast information and identify its sources. Not everything published on the Internet is true and accurate.

- **Practice netiquette**. Promote issues such as empathy and respect. The use of social networks should be governed by the same rules of conduct and respect as face-to-face communication.

- **Share leisure and family time activities:** sports, culture, etc. Make a list of common activities and interests and create meeting places to share them as a family.

- **Teach them to protect personal information** and privacy and to understand the importance of digital reputation. They should also limit the posting of pictures of their children on social networking sites. Many parents often practice *sharenting* (overexposure of children on social networks, i.e., excessive use of social networks to constantly document and report on their children's progress).

Interventions

- Workshops for families to promote the healthy use of technology by their children. Focus on families with children aged 0-3.

- Workshops for parents and children to reflect together on the use of technology.

- Creation of spaces on accredited websites with specific information and advice services.

- Development and dissemination of information and prevention materials.

[2] Prevention tips for schools

Although the family is the primary agent involved in the education of its sons and daughters, the school and the institution play a key role as places of learning

and socialization. Therefore, they are very appropriate places to work on prevention. We can assume that the older children are, the more screens they have, the more social networking accounts they have, the more devices they own, and the greater their access to the Internet. In addition, the school environment allows us to work on both universal and selective prevention, adding a deeper level to the task of prevention.

One of the challenges that may arise is the coexistence of screens that exist in many centers (computers, projectors, tablets, televisions, school social networks, etc.), while at the same time the use of others (cell phones or handheld consoles) is prohibited.

Another challenge is the mixed messages that may exist with the family, so school-based prevention should also include working with the adults who are the reference points for these boys and girls in order to implement a comprehensive intervention scheme.

Interventions:

- Workshops for young people to promote critical thinking about screens.
- Workshops for young people to work on the emotional aspects screen use.
- Workshops for adults to promote critical thinking about screen use.

[3] Tips for addiction prevention as a community

The experience of prevention shows us the need to act from the different sectors that make up the community. And not to implement isolated initiatives, but to integrate them into a unified and broader proposal, through the active participation, involvement and shared responsibility of various social actors, by joining forces, establishing horizontal communication and sharing common goals and defining prevention strategies:

- **Sports and leisure educators.** These professionals are a point of reference for young people, they play a key role as trainers and can identify situations of risk and problematic use.
- **The media**. The information and news they disseminate and the way they deal with it have an impact on citizens, which should be used to disseminate good practices, advice, resources, etc.
- **Primary care and health professionals**. As health promoters, they can play a role in promoting healthy habits and early diagnosis.

We need to standardize and integrate prevention in the different sectors of the community, with a global and transversal perspective.

Interventions:

- Prevention activities among peers, youth trained to deliver health messages.
- Organize information and awareness campaigns and use the media to address health issues and ICT.
- Promote technical training for social actors in the prevention and identification of problematic screen use among young people.
- Establish action and referral protocols for problematic screen use among adolescents and young people.
- Develop technical documents and methodological guides for prevention and intervention in ICT use and abuse.

[4] Tips for addiction prevention at the environmental or structural level

This type of prevention that has proven to be very effective, but at the same time its strategies have often proven to be unpopular and have met with considerable resistance among young people and various groups. It involves changing the cultural, social and physical environment. These strategies include:

- Regulating the number of gambling and betting establishments.
- Regulating access to gambling.
- Changing the form of gambling and prizes.
- Raising the age of access to gambling establishments.
- Increased penalties for non-compliance with current regulations.
- Warnings about problem gambling in gambling and betting establishments.

CHAPTER

7

Psychosis

7.1 HOW TO RECOGNIZE PSYCHOSIS

A strange feeling, like something from within

The following is the most important information about psychosis: what it is; what causes it; what are the symptoms and warning signs; how it is treated and what is the recovery process; how can we prevent relapses?

> Psychosis is a mental health disorder characterized by a **distorted perception of reality** and **significant impairment of mental functioning** (thoughts, emotions and behavior). An example: "I started hearing voices on TV, in commercials, on the Internet.... Internet surveillance, spies – everything was connected to me."

The symptoms of psychosis vary from person to person, but some of the most common are delusional thoughts or misconceptions, hallucinations, changes in mood and state of mind, confused thoughts and changes in behavior. The presence of these symptoms can lead to a change in the person's daily functioning in all areas of their life (studies, work, social relationships...) and have a very signifi-

cant impact on the family. The onset of symptoms is known as a psychotic episode or a psychotic break.

The symptoms of psychosis

[1] Psychosis is a mental state characterized by a disconnection or loss of contact with reality (World Health Organization, 1992). In addition, there are a number of other more specific symptoms that interfere with the person's daily functioning, alter behavior, and require medical attention (Volkmar, 1996).

[2] The major clinical symptoms of psychotic disorders, as described in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013), are:

- ***Hallucinations.*** Are imagined perceptions that occur in the absence of external stimuli. They are involuntary, intensely experienced and cause the individual a great deal of anxiety. People may hear, feel, smell or see things that are not there. The most common type of hallucination is auditory.
- ***Delusions.*** Are false and fixed beliefs that are experienced with conviction and cannot be changed by logical argument. Their content can vary greatly. The most common are persecutory delusions and referential delusions.
- ***Disorganized thinking.*** Is the loss of logical associations in thinking, the relationship between ideas. The person may jump from one topic to another or even lose the thread of speech, making it incomprehensible.
- ***Grossly disorganized or abnormal motor behavior or movements (including catatonia).*** Various motor behaviors or senseless movements that interfere with the person's daily activities. The person may become extremely active or, on the contrary, remain inactive throughout the day.
- ***Negative symptoms.*** These symptoms indicate an impoverishment of the person's personality, affecting mood and social relationships. Predominant negative symptoms include diminished emotional expression, social withdrawal, lack of energy to do things (abulia), decreased ability to experience pleasure in doing pleasant things (anhedonia) and emotional indifference.

In addition to the symptoms listed above, psychosis may also present with other symptoms, such as **cognitive** symptoms (difficulty concentrating, slow processing, memory lapses…) and affective symptoms, such as depression and anxiety.

All of these symptoms are not always stable; they can vary within and between individuals, both, in the onset and course of the disorder and in its duration, with great inter- and intra-individual variability (Heckers et al., 2013).

Prevalence

Psychotic disorders usually present in late adolescence or early adulthood. The most common age of onset is between the ages of 18 and 24, but most cases occur between the ages of 13 and 30. Approximately 3 in 100 young adults will experience a psychotic episode in their lifetime. Identification and treatment in the early stages of the disorder are crucial to recovery.

7.2 TYPES OF PSYCHOSIS

The different faces of psychosis

[1] The presence of defining symptoms and their duration determine the different faces. The main reference studies[9] describe the following diagnoses:

- **Short-term psychotic disorder.** The person has one or more of the following symptoms: delusions, hallucinations, disorganized speech and grossly disorganized or catatonic behavior. And at least one of the following three symptoms: delusions, hallucinations or disorganized speech. The duration of the disorder is at least one day but less than one month, with an eventual complete return to pre-disorder functioning.
- **Substance- or drug-induced psychotic disorder.** The person has delusions and/or hallucinations. The medical history, physical examination, or laboratory tests must show that the symptoms developed during and shortly after the intoxication or withdrawal from substances, or after intoxication from a drug, and that the substance or drug involved can produce the current symptoms. The disorder causes clinically significant distress or impairment in social, occupational, or other important functioning.

[9] As it is well known, the two most widely used manuals for diagnosing mental disorders are the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)* and the World Health Organization's International Classification of Mental and Behavioral Disorders (ICD-10).

- **Schizophrenia.** The person has two or more of the following symptoms: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior and/or negative symptoms. They must have at least one of the following three symptoms: delusions, hallucinations or disorganized speech. The person's level of functioning is impaired or compromised in one or more major areas, such as work, interpersonal relationships, or personal care. Symptoms of the disorder last for at least 6 months.
- **Schizophreniform disorder**. The person has two or more of the following symptoms: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior and/or negative symptoms. At least one of the following three symptoms must be present: delusions, hallucinations or disorganized speech. The episode of the disorder lasts at least one month, but less than six months.
- **Delusional disorder.** The person has one or more delusions that last at least one month. Hallucinations are absent and, if present, are not significant and are related to the delusional theme. The person's functioning is not severely impaired, and behavior is not bizarre or odd.
- **Schizoaffective disorder.** The person has two or more of the following symptoms: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior and/or negative symptoms. In addition, diagnostic criteria for a mood episode (manic episode or major depressive episode) must be met.
- **Shared psychotic disorder**. Two or more people share the same delusional theme or system of ideas and support each other in their beliefs. The two people have an extraordinarily close relationship. There is temporal and circumstantial evidence that delusions are induced in the passive (dominated) person by contact with the active (dominant) person.
- **Psychotic disorder caused by another medical condition.** The person has prominent hallucinations or delusions. There must be evidence from the medical history, physical examination, or laboratory testing that the symptoms of the disorder are the direct pathophysiologic result of another medical condition. The disorder is not better explained by another mental disorder and causes clearly significant distress or impairment in social, occupational, or other important areas of functioning.
- **Psychotic disorder not otherwise specified.** This category applies when characteristic symptoms of a schizophrenia spectrum disorder and another psychotic disorder predominate and cause clinically significant distress or impairment in social, occupational, or other functioning, but do not meet the full criteria for any of the disorders in the diagnostic category. It is used in situations where the clinician chooses not to specify the reason for not meeting the diagnostic category criteria. It also includes situations where there is insufficient information to make a more specific diagnosis.

It is important to keep in mind that it may be difficult to make a specific diagnosis at the onset of the disorder and that the diagnosis may change over time as the disorder progresses. In addition, such diagnoses cannot be made when the disorder or symptoms can be attributed to the physiological effects of a substance (drug or medication) or other medical condition.

Causes that contribute to psychosis

> Psychoses are mental illnesses characterized by an **altered perception of reality** and understanding the causes that can lead to these experiences is essential for diagnosis and treatment.
>
> The causes of psychosis can be divided into several areas: biological, psychological and environmental, all of which are interrelated and often overlap.

[1] First, **biological factors** play a critical role in the development of psychosis. Genetics is one of the most studied aspects, as research indicates that people with a family history of psychiatric disorders, particularly schizophrenia or related disorders, have a significantly higher risk of developing psychosis. Neurochemical abnormalities, particularly those related to neurotransmitters such as dopamine and serotonin, have also been linked to psychotic experiences. For example, dopamine hyperactivity in certain areas of the brain has been linked to psychotic symptoms such as delusions and hallucinations.

[2] In addition to genetic and neurochemical influences, there are also **structural** factors that may contribute to the onset of psychosis. Studies have shown that people with schizophrenia may have structural differences in the brain, such as an enlargement of the brain's ventricles and a reduction in grey matter volume. These abnormalities may affect the way the brain processes information and responds to external stimuli, contributing to a distorted perception of reality.

[3] **Psychological factors** are also important. Traumatic experiences, particularly during childhood, have been linked to the development of psychosis in adulthood. Trauma such as physical, emotional or sexual abuse can impair mental health and lead to personality disorders that increase the risk of psychotic experiences. In addition, conditions such as anxiety and depression can predispose a person to developing psychosis, especially if these disorders are not treated.

[4] Another psychological aspect to consider is the presence of **dysfunctional cognitive patterns**. People who tend to misinterpret information or develop paranoid thoughts may be more susceptible to psychotic experiences. These patterns may be influenced by environmental or relational stressors that increase vulnerability.

[5] At the **environmental** level, several elements can act as triggers for psychosis. Intense stressful situations, such as the loss of a loved one, significant life changes (such as separation or redundancy) or economic difficulties can trigger psychotic episodes, especially in people who are already vulnerable. The use of psychoactive substances, such as alcohol, recreational drugs or medications, is another environmental factor that can trigger psychotic episodes. In particular, the use of cannabinoid-related substances – such as THC found in marijuana – has been associated with an increased risk of psychosis, especially in individuals with a predisposition.

A social context of isolation or stigma can exacerbate the condition of a person predisposed to psychosis. Lack of social support and meaningful relationships can contribute to feelings of loneliness and despair, increasing the likelihood of psychotic episodes. In this regard, the support of family, friends and the community play a key role in protecting mental health.

[6] Finally, it is important to remember that psychosis can also be the result of **general medical conditions**, such as infections, or neurological or metabolic disorders. Conditions such as delusions or encephalitis can lead to psychotic symptoms, so a full medical evaluation is important to rule out other causes.

7.3 WARNING SIGNS OF PSYCHOSIS

Psychosis is not always easy to recognize. The onset of psychotic symptoms may be preceded by other, more non-specific symptoms or warning signs, some days or even weeks earlier. Warning signs include indicators of an absence of normality and can be highlighted in some of the following points. They must recur and persist over time:

- Feeling more nervous, more fearful or more anxious.
- Racing thoughts: having many thoughts at the same time, not being able to focus on one thing.
- Becoming quieter and more isolated.
- Being in a bad mood, less willing to do things or more irritable.
- Feeling more tired.
- Having strange feelings that make you feel confused.
- Not being very hungry, losing weight.
- Frequent forgetfulness.
- Suddenly not being sleepy.
- Neglecting one's physical appearance.

Detecting and treating the disorder in its early stages is essential for recovery. Therefore, **it is very important to consult a professional** as soon as these symptoms change daily activities or cause discomfort.

7.4 MAIN MYTHS AND MISCONCEPTIONS ABOUT PSYCHOSIS

Some of the myths about psychosis include:

Psychosis has no effective treatment. **FALSE**

There are different treatments for psychosis: psychological, social and supportive. And medication is useful to treat symptoms, achieve stability and help the person live a "normal" life.

People with psychosis are dangerous. **FALSE**

People with a mental disorder are much more likely to be assaulted or abused by other people than those who do not have a mental disorder. Only in some cases, when the person has not received treatment or is not following treatment properly, can they have severe hallucinations or delusional thoughts that make them believe things that are not true and end up hurting themselves or someone else.

People with psychosis have done something wrong. **FALSE**

Anyone can develop a mental disorder, regardless of gender, age, or social status. Although the onset of psychosis may sometimes be related to a very intense stressor or the ingestion of a toxin, psychosis is not caused by a single cause, but by the occurrence and interaction of several factors. Some of these factors are biological, i.e. there is a genetic predisposition, while others are environmental and related to lifestyle.

All medications have many negative side effects and override the person's will. **FALSE**

Not all treatments have the same effect, nor do they try to override the person's will, nor do they produce the same indescribable effects. In fact, there are more and more drug treatments that are well tolerated and have fewer negative side effects. With proper control and monitoring by professionals, the possible effects should be minimal.

People who have had a psychological explosion cannot recover and must be confined to a center. FALSE

Knowledge about psychosis is increasing, and this has led to improved pharmacological and psychological treatments to help the person recover. People with psychosis can recover fully, they can study or work, start a family, maintain their social activities, etc. In some cases, when recovery is not complete, the goal is to achieve a quality of life similar to the one they had before the psychotic episode. In these processes, community integration plays a very important role.

People with psychosis are extravagant and behave strangely. FALSE

The media and Hollywood movies often misuse the words "psychotic" and "schizophrenic" to refer to someone who commits depraved or bizarre acts or who behaves strangely and differently from others. Most people with psychosis are no different from us and other people, and they go unnoticed on the streets of our cities.

Psychosis is hereditary. FALSE

Having parents or siblings with psychosis does not mean that you will develop the disorder. In fact, most people with psychosis do not have relatives with the same disorder. While it is true that there is a genetic component to the development of psychosis, there is no single gene that explains its onset, as several biological and environmental factors are involved.

Use of cannabis does not cause psychosis to develop. FALSE

Although not all people who use cannabis develop psychosis, the active ingredient in this substance is strongly associated with the development of psychotic symptoms. There is growing evidence of an association between cannabis use, especially in younger age groups, and an increased risk of developing a mental disorder.

Psychosis is related to the way one was raised by one's parents. FALSE

Contrary to one of the most widespread myths of the last century, psychosis has nothing to do with the upbringing, education or behavior of parents. This belief has caused a great deal of guilt among parents and even more distress in the families of people with psychosis. The causes of psychosis are multifactorial, genetic and environmental.

7.5 HOW TO DEAL WITH PSYCHOSIS IN EDUCATIONAL SETTINGS

An effective educational intervention: empathy, active listening and emotional support

In order to address in great detail, the criteria and educational interventions related to psychotic disorders in adolescents, it is essential to consider the strategies and practical activities that educators can put into practice.

> Effective educational intervention for youth psychosis must be based on a combination of empathy, active listening and emotional support in a safe and welcoming environment, but it must also be based **on professional tools and methods** that enable young people to understand and cope with their psychotic experiences.

The following is a comprehensive guide to working in educational and community settings, based on specific activities, support tools and practical resources.

[1] Create an environment of support and understanding. First and foremost, the educator must establish a trusting relationship in which young people feel welcomed and not judged. This includes an approach that normalizes the conversation about psychotic disorders and creates an environment where young people can talk freely about their experiences without fear of being stigmatized. A concrete example is organizing weekly "open space" moments where young people can freely express their feelings and thoughts. This can also be done through an "emotion corner" with boards where they can write down their feelings or key words that describe their experiences. The aim is to facilitate communication and sharing of experiences, leading young people to recognize and cope with their own psychological difficulties.

[2] Group activities based on dialogue and discussion. The focus group is a powerful tool for encouraging peer sharing and discussion. The educator can organize themed sessions that explore specific aspects of the psychotic experience, such as "understanding inner voices" or "coping with feelings of isolation." These sessions should be handled with great sensitivity, allowing participants to talk spontaneously and genuinely about their experiences without the pressure of getting "right" answers. To stimulate discussion, a series of guiding questions can be suggested, such as, "What does it mean to you to feel understood?", "How would it help you to talk about how you feel?" In addition, using creative techniques such as drawing or writing to express feelings can be very helpful for those who find it difficult to express themselves verbally.

[3] Empowerment and resilience projects. The goal of an empowerment project is to give young people with psychotic disorders the skills and confidence they need to cope with everyday challenges. Educators can create individualized self-help pathways in which each young person sets practical and realistic goals to help them improve their mental well-being. For example, a pathway might include setting short-term goals such as "establish a sleep routine" or "practice breathing techniques to manage anxiety."

[4] Create educational and self-help materials. Educational products such as brochures, guides and informational videos are valuable resources that young people can refer to on their own. Materials should explain in a simple and straightforward way what psychotic disorders are, what the common symptoms are, and how to manage them. For example, a guide might include sections such as "What are delusions?", "How can hallucinations be managed" and "Strategies to reduce social isolation." Materials should be interactive and engaging, perhaps including self-reflection exercises such as "Write a letter to your anxiety," or open-ended questions for reflection, such as "What times of day do you feel calmest?" It is also helpful to create a digital version of these materials that can be easily accessed on mobile devices.

[5] Hands-on activities to improve social skills and stress management. In community settings, it is important to provide hands-on activities that build social skills and reduce stress levels. The educator can organize role-plays or simulations of social situations in which young people can learn how to handle everyday conversations and interactions. For example, a simulation might involve a telephone conversation, a moment of conflict with a peer, or an uncomfortable situation in a public setting. In these simulations, young people learn to identify and regulate their emotional reactions, by receiving constructive feedback from the educator and peers. Other exercises may include guided relaxation activities, such as the "progressive muscle relaxation" technique, or meditation sessions to help them reduce anxiety and improve their overall well-being.

Techniques for working in depth on various aspects of psychosis

These activities focus on techniques for managing emotions, improving social skills and increasing a sense of awareness and control over one's psychotic experience. Each activity includes clear objectives, a description of the activity and practical ways to implement it.

[1] Art projects to express emotions and thoughts. Provide a channel for nonverbal expression to help youth externalize complex emotions and psychotic experiences in

a safe environment. Specifically, the educator provides drawing, painting, creative writing or collage activities to explore emotions, thoughts and mental images. These activities allow for the processing and reworking of inner experiences that may be difficult to verbalize. There are two practical ways to do this:

- ***Drawing emotions.*** Ask young people to visually represent the primary emotions they are feeling. They can use colours and shapes that they feel represent moods such as anxiety, fear or hope. At the end, they can choose to share or reflect on their work.
- ***Writing a letter to yourself.*** In this exercise, participants are asked to write a letter to their "future self" or "past self." This allows them to put their desires, concerns or recurring thoughts into words, which encourages self-reflection and greater self-understanding.

[2] Focus Groups for peer discussion. Facilitate mutual support, sharing of experiences and reduction of internal and external stigma related to one's mental condition. In particular, the focus group creates a space where young people can discuss their psychotic experiences in a safe context. The sessions are structured around themes such as "understanding one's inner voice" or "overcoming a sense of isolation." There are two practical methods:

- ***Guided sharing on a specific topic.*** Each meeting begins with a topic to discuss. For example, "What strategies help you calm down when you feel anxious?" or "What does it mean to you to have 'voices?" The educator facilitates the conversation, encouraging active listening and mutual respect.
- ***Group activities to explore stigma.*** The educator can suggest activities such as writing negative phrases on a poster and then symbolically destroying it or replacing it with phrases of self-acceptance, thus encouraging the creation of a positive narrative of belonging.

[3] Autonomy projects and personal goals. Strengthen self-efficacy by increasing confidence in one's abilities and motivation through the achievement of small goals. That is, educators help youth identify simple, concrete goals, such as establishing a daily routine or improving self-care skills. Each young person can choose a personal goal, plan the necessary steps and monitor their progress. There are two practical methods:

- ***Create a journal of goals.*** Each person keeps a journal in which they write down goals, difficulties encountered, and progress made. For example, if the goal is to wake up at a certain time each day, jotting down successes and difficulties allows them to have tangible feedback and to reflect on small improvements. The educator can set aside time each week to review the journal together and provide constructive feedback and positive reinforcement.

- ***Plan and review goals.*** At the beginning of each month, the educator guides the youth in planning specific and realistic goals. For example, a goal might be to "participate in a group activity" or "reduce the time spent in isolation." A periodic review is conducted to monitor progress and adjust the action plan as needed. Educators should encourage young people to celebrate any progress, no matter how small, in order to build their confidence in their own abilities.

[4] Reflective writing activities. Develop the capacity for personal analysis and awareness by exploring one's thoughts and feelings related to the psychotic experience. Basically, reflective writing is a powerful technique that allows young people to put their experiences into words, thus fostering a process of emotional self-analysis and re-elaboration. Personal journals can be used, with no obligation to share, or group activities in which there is free discussion. There are two practical methods:

- ***Daily or weekly journals.*** Ask the young people to keep a journal in which they write about their feelings, difficult moments and positive moments. Reflection questions such as "What did I learn about myself today?", "What was the most significant moment of my day?" or "What made me feel better?" can guide the writing.
- ***Letter to one's fears or intrusive thoughts.*** This activity involves writing a letter addressed to an emotion, such as fear, or an experience such as voices. The goal is to face one's fears or thoughts without feeling judged, and to explore emotions in a detached and rational way.

[5] Psychoeducation program in collaboration with families. Educate both youth and families to better understand psychosis, reduce stigma and improve family support. From a practical point of view, the educator organizes regular educational meetings with families to explain the mechanisms of psychosis, communication methods and family stress management techniques. It is essential to involve families in order to create a comprehensive supportive environment. There are two practical methods:

- ***Information sessions on the characteristics of psychotic disorders.*** In these sessions, symptoms, causes and treatment techniques are explained using specific cases or practical examples, while always respecting privacy.
- ***Discussion of empathetic communication and positive support.*** Ways to handle difficult conversations are suggested, explaining the importance of active listening and words of encouragement. Practical examples such as "I'm here to listen to you without judging" can be helpful in providing models of positive communication.

[6] Establish routine and time management activities. Provide structures and models to help young people establish a stable routine, which is essential for managing anxiety and psychotic symptoms. As a result, creating a routine helps to improve stability and reduce stress by improving time management skills. Daily or weekly activities can be planned that take into account the youth's interests and needs. There are two practical methods:

- ***Create a personalized weekly calendar.*** Young people create their own calendar, divided into routine activities (e.g., waking up, meals, school) and personal or leisure activities. This calendar can be updated weekly and adjusted as needed, promoting a sense of control and predictability.
- ***Routine review sessions.*** At the end of the week, the educator can offer a reflection on the weekly routine, highlighting which activities worked best and identifying areas for improvement.

[7] Support self-acceptance and stigma reduction activities. Foster positive attitudes about oneself and one's experience by reducing self-stigma and encouraging a more compassionate view of oneself. This means that the educator guides youth through reflection, awareness and self-acceptance activities to help them reduce self-judgment and promote a positive and authentic self-image. There are two practical methods:

- ***Create a "success notebook".*** Ask youth to keep a notebook in which they record small daily successes, skills they are improving, or positive moments. This notebook becomes a visible reminder of their progress and importance.
- ***Positive affirmations and self-reflection.*** During each meeting, youth can choose or create a positive affirmation about themselves (e.g., "I am able to cope with difficulties" or "I am improving every day"). Educators guide reflection on these affirmations, helping to internalize a more positive narrative.

CHAPTER

8

Self-Injury

8.1 HOW TO RECOGNIZE SELF-INJURY

Cuts as a cry for help to communicate the pain of the soul

[1] What is self-injurious behavior? How many types of self-injury do we know about and what are the warning signs? In addition to answering these questions we will also analyse the trigger and protective factors below. What are the strategies to follow when self-injury occurs: when and who to ask for help.

> **Self-injury**, specifically **non-suicidal** self-injury is defined as **the direct and deliberate destruction of one's own body tissue without the intent to commit suicide**. After decades of increasing incidence of non-suicidal self-injury among adolescents and young adults and growing scientific interest in the topic, the disorder has been included in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* as a problem that requires clinical attention when it meets established severity criteria.

However, these behaviors do not always occur in the context of a mental disorder and **do not always require clinical attention**, as they are increasingly observed in the general population and, in many cases, action can be addressed in a non-health

care setting. In fact, in recent decades, there has been an increase in self-injury among boys and girls without a mental health diagnosis as a **way of expressing distress**.

[2] Two types of self-injury can be distinguished: **direct harm** (cuts, burns, scratches, bites, punches, etc.) and **indirect harm** (overmedication, binge eating, heavy alcohol consumption or exposure to risky situations such as extreme sports, reckless driving, etc.). Forms of protest against established social or religious norms are excluded. However, the current concept of **non-suicidal self-injury**, both clinically and in research studies, refers to direct self-injury, not indirect self-injury. Therefore, when we talk about self-injury, we are most often referring to the first type[10].

[3] According to the DSM-5, the **criteria for diagnosing** the non-suicidal self-injurious behavior disorder include:

- Five or more days of repetitive self-injurious behavior in the past year (under review, as some authors propose raising the threshold to ten days).
- Self-injury must serve a specific function:
  - To eliminate negative thoughts or feelings.
  - To resolve an interpersonal conflict.
  - To create a positive state of mind.
- Self-injury must be caused by:
  - Negative thoughts or feelings.
  - Recurring thoughts about self-injury.
  - The urge to self-injury.
- Behaviors that are not socially sanctioned, such as acts of protest or identity marking, are excluded.

The symptoms of self-injury behavior

Self-injurious behavior is **a complex manifestation of emotional and psychological distress** and can take many forms and methods.
It is important to understand the symptoms associated with this type of behavior in order to recognize its presence and take appropriate action.

[10] As of 2013, the DSM-5, the International Classification System of Mental Disorders, includes direct and repetitive (five or more times) self-injurious behaviors as a new category under investigation: non-suicidal self-injurious behavior disorder (often referred to by the acronym non-suicidal self-injury, NSAB).

[1] First, one of the most obvious symptoms is **physical self-injury**, which can manifest itself in various ways, including cuts, burns, bruises, or punches to body parts. These acts may be performed in easily covered areas, such as the arms and thighs, in order to hide the scars or signs of injury. The person may perform these acts in a ritualized manner, using specific objects or following a particular procedure, which may provide a sense of control or temporary relief from overwhelming emotions.

[2] Self-injurious behavior is often associated with **intense emotions that are difficult to manage**, such as sadness, anxiety, anger, or feelings of emptiness. Those who engage in such acts may describe a kind of immediate emotional release after self-injury, as if the physical injury were a way to express or relieve an internal emotional pain. This behavior may provide a temporary sense of relief or control, creating a cycle in which the person feels compelled to repeat the act to cope with the emotional distress.

[3] In addition, it is common for self-injurious behavior to be accompanied by **low self-esteem** and feelings of self-hatred. Those who self-injury may have a negative view of themselves and feel unworthy of love or attention, and self-injury becomes a way of punishing themselves for perceived shortcomings or failures. This self-punishment can also be seen as a way of expressing pain in situations where the person feels helpless to communicate their own suffering to others.

[4] In addition to physical signs, emotional and behavioral symptoms play a crucial role in the manifestation of self-injury. A **change in social relationships** can be observed, with the individuals tending to isolate themselves from friends and family, creating a barrier that prevents others from understanding their state of mind. This reluctance may be due to fear of being judged or misunderstood. The person may also show signs of **anxiety or depression**, with mood swings, difficulty concentrating and feelings of hopelessness.

[5] In some cases, people who engage in self-injurious behaviors may also use physical pain as a form of **coping**, in which external pain becomes a way of dealing with internal pain. This strategy may seem like an attempt to transform emotional distress into tangible pain that is easier to deal with. However, this solution is temporary and often leads to further emotional and physical complications.

[6] It is important to note that while self-injurious behavior may seem like a way to cope with pain, it does not address the underlying causes and can lead to complications, such as infection, permanent scarring and an increased risk of suicidal behavior. People who engage in these acts often do not intend to cause their own death but rather are seeking an escape from pain. However, lack of adequate support and continued distress may lead to suicidal thoughts or suicide attempts.

Prevalence

[1] **Direct self-injury** is particularly common among adolescents and young adults. Research shows that the incidence of this behavior in these age groups ranges from 18% to 45%, with a peak between the ages of 12 and 14. Although the true prevalence of **indirect self-injury** is unknown and may be much higher, longitudinal studies show a natural progression from direct to indirect forms of **self-injury** with age. Among adults, the prevalence of self-injury is actually lower, at about 6%. All of these may be sporadic behaviors (less than five episodes per year), without prior risk factors, without clinical symptoms of mental disorder and without impairing the person's ability to function.

However, in a much smaller number of cases exposed to specific risk factors, the behaviors are repeated over time and are associated with the presence of comorbid psychiatric symptoms, including suicidal behaviors, during or at a later stage. Population studies show that 9-11% of adolescents and up to 3% of adults meet the diagnostic criteria for repeated non-suicidal self-injury. And in the population with mental disorders, 60% may be associated with any psychiatric diagnosis, with a higher prevalence of eating disorders in those younger than 18 and personality disorders in those older than 18, particularly borderline personality disorder.

[2] Traditionally, self-injury has been considered a predominantly female phenomenon. There are many prevalence and incidence studies that support this view. However, there are also more recent studies that discredit data from older studies, and some research shows small differences in incidence by sex and gender.

One aspect that has been widely demonstrated is the **use of different methods by boys and girls** to engage in non-suicidal self-injury. While girls tend to cut, scratch and bleed, boys tend to hit and burn.

8.2 TYPES OF SELF-INJURIOUS BEHAVIORS

The different faces of self-injurious behavior

[1] Self-injurious behaviors can take several forms, each with specific characteristics. Here is an overview of the main types of self-injury:

- ***Cutting.*** This is one of the most common self-injurious behaviors and involves cutting the skin with sharp objects such as knives, razor blades or glass.

- ***Burning.*** Some people burn themselves with cigarettes, lighters or other hot objects.
- ***Scratching or Biting.*** These behaviors include scratching deeply into the skin or biting enough to cause injury.
- ***Hitting.*** punching oneself, banging one's head against a wall or other hard surface are other forms of self-injury.
- ***Pulling hair.*** This behavior, also known as "trichotillomania," involves pulling one's own hair.
- ***Ingesting Toxic Substances.*** such as drugs in non-lethal doses or inedible objects.
- ***Self-poisoning.*** using substances such as drugs or alcohol in a way that causes harm to one's body.
- ***Compulsive behaviors.*** Some self-injurious behaviors may be compulsive, such as biting one's nails until they bleed or sticking needles into the skin.
- ***Indirect self-injury.*** this type of self-injury includes behaviors such as promiscuous sexuality, gambling or substance abuse.

Causes that contribute to Sel-Injury

[1] 27.6 per cent of European adolescent's report having intentionally injured themselves at least once in their lives (Brunner et al., 2014). But why is it that once adolescents start self-injury, they tend to continue the behavior?

It is important to remember that when people hurt themselves, it is not an attempt to end their lives, but a mechanism for coping with a problem or difficulty. Many people who hurt themselves explain that they do so because **they feel unable to cope with an intense emotion** (such as sadness or anger) and they resort to self-injury in an attempt to reduce, manage or escape these feelings. Physical pain can distract from emotional pain by providing temporary relief.

The emotional relief that follows self-injury may lead to the use of the same strategy to cope with difficult emotions in the future. However, this effect does not last long, and in the medium to long term it is very likely that even worse feelings, such as guilt or fear, will emerge. Another cause may be self-**punishment**, i.e., going the point of self-injury to punish oneself for guilt or excessive self-criticism.

[2] In addition, people who self-injure tend to experience **greater emotional distress, relationship difficulties and lower academic performance** at the same time. In some ways, self-injury may be a cry for attention and help.

[3] In summary, self-injurious behaviors may begin as a result of:

- **Negative reinforcement**. The adolescent may have learned that this behavior is an effective short-term way to avoid the negative emotions (anxiety, sadness, guilt, anger, despair, etc.) that cause great psychological distress, or to achieve seemingly effective emotional regulation at times when these emotions arise. In this case, the goal of self-injury is to avoid or disconnect from what is causing intense emotional pain by focusing on the physical harm rather than on the aspects of the person that are causing suffering.

Some of the underlying traumas may be emotional (traumatic events such as the loss of a loved one, emotional abuse, or experiences of abandonment), physical (experiences of physical violence or sexual abuse), or media (exposure to content that normalizes or glorifies self-injury through social media, television or video games).

- **Positive social reinforcement**. The adolescent may have learned that engaging in this behavior provides a much greater and more immediate level of social attention or social reinforcement from peers or adults than other behaviors they have adopted or when they do not self-injure. In other words, they feel that this behavior produces positive social changes (e.g., they feel that they receive more affection, support and group acceptance since they have been practicing self-injury).
- **Evocation of environmental changes**. The adolescent may have learned that by engaging in this behavior, changes occur in their environment that make them feel good and satisfied. The reinforcement received from self-injury in this case is not social attention from others, but the secondary responsive benefits from the environment (e.g., after self-injury, adults decide that the adolescent no longer needs to cope with age-appropriate demands, such as going to school and taking exams, or they are exempted from taking responsibility).
- **Identity construction.** The adolescent may find in this behavior a form of identity and a sense of belonging to the group. In this case, the behavior conveys an ideology of or is identified with urban subcultures (e.g., the emo subculture), or it expresses philosophical and emotional discourses that convey a tragic view of human existence. In this case, self-injury is usually practiced in a group context and is socially reinforced by the rest of the people who participate in this form of identity.

8.3 WARNING SIGNS OF SELF-INJURY

In many cases, self-injurious behavior may be sporadic and therefore may not meet the severity criteria for a clinical or medical diagnosis. However, increased frequency and use of different methods may be variables of poor prognosis. Therefore, **early identification and intervention can be very helpful** in preventing sporadic self-injurious behavior from becoming a health problem.

In this context, it is important to be aware of some **warning signs** that may indicate that a person is self-injuring in order to identify the problem in its early stages. Some of these signs are:

- Persistent injuries that cannot be explained (cuts, burns, scratches or unexplained bumps).
- Wearing clothing that is not appropriate for the season or temperature, such as sweaters in the summer.
- Refusing to participate in activities that require changing clothes (fitness, swimming).
- Wearing bandages regularly.
- Displaying or verbalizing ideas related to self-injury (drawings, conversations with peers, etc.).
- Frequent need for privacy.
- Carrying or hiding objects that cut (razor blades, pieces of glass, scissors, knives, etc.).
- Spending a lot of time in the bathroom or bedroom.
- Finding traces of blood in the garbage.

It is important to note that warning signs are useful in identifying possible self-injury situations, but their presence does not necessarily mean that the person is self-injuring. It is considered a problem when self-injurious behavior becomes a frequent routine.

8.4 MAIN MYTHS AND MISCONCEPTIONS ABOUT SELF-INJURIOUS BEHAVIOR

Some of the misconceptions about self-injurious behaviors include:

Self-injurious behavior is an attempt to manipulate. FALSE

Although some people have learned that the only way to get attention from others is to engage in behaviors such as non-suicidal self-injury, the fact that they self-injure does not mean that they are manipulative. What it means is that they need a certain kind of attention and have not yet learned more adaptive strategies to get it.

Non-suicidal self-injury is pathological and irrational behavior. FALSE

Although self-injury may seem incomprehensible to some people, it always has an important purpose when it occurs and is therefore not an irrational action. People who self-injure usually do so to feel better or for immediate emotional relief, although it can have long-term negative consequences.

Self-injury is a warning sign that a person may be considering suicide. FALSE

Non-suicidal self-injury is behavior that is performed without personal intent, that is, without the intention of causing death. It is an unhealthy way of coping with distress in the absence of healthier and more beneficial strategies. It is true, however, that there are many studies that confirm that non-suicidal self-injury is a risk factor for suicide, i.e., if a person frequently and severely injures themselves, they are usually at risk of developing suicidal thoughts that may lead them to a suicide attempt.

Self-injury implies a mental disorder. FALSE

These behaviors do not always occur in the context of a mental disorder. In fact, they are increasingly common in the non-clinical population and in many cases can be intervened in a non-psychiatric context. In recent decades, there has been an increase in non-suicidal self-injury among boys and girls without a mental health diagnosis as a way of expressing distress.

Self-injury is not a problem; many people do it. FALSE

Many people can self-injure – you may know some who do – and have no mental health disorders or problems, but self-injury is not a healthy way to cope with distress. Although it may seem to work in the short term, relying on this strategy in the medium and long term can have very problematic consequences and prevent the person from learning healthier strategies.

It is necessary to resolve past problems in order to stop being self-injuring. **FALSE**

There is no reason to believe that one should wait to resolve all past negative experiences before stopping self-injury. In fact, stopping self-injury can help you begin to resolve the rest of your problems.

Non-suicidal self-injury is a way to get attention. **FALSE**

People hurt themselves for many different reasons, and many people hide their self-injury to avoid showing it. Even within the same person, the reasons for and forms of self-injury can vary over time.

Self-injury is a teenage thing. **FALSE**

No, non-suicidal self-injury as a coping mechanism can occur at any age, but it is true that it is more common among adolescents and young adults.

Self-injury has no short-term consequences. **FALSE**

The consequences of self-injury can be both short-term and long-term, and the latter can be the most serious. In the short term, it is a behavior that can be stigmatizing and interfere with social and interpersonal relationships, leading to, among other things, isolation, feelings of misunderstanding, worry and discomfort in social and family settings. Long-term consequences, in addition to the chronicity of these immediate consequences, include the fact that self-injury may become a habitual way of coping with distress, preventing the learning of more adaptive strategies, with all that this entails. On the other hand, there is a risk that this self-injurious behavior may be associated with more serious problems, such as the development of thoughts of death.

8.5 HOW TO DEAL WITH SELF-INJURIOUS BEHAVIOR IN EDUCATIONAL SETTINGS

The importance of building resilience in youth development

[1] Protective factors for self-injurious behavior are the same as for any emotional disorder or problem and refer to **people's abilities or skills to cope with negative or stressful life events** without developing dysfunctional or pathological behaviors.

In this sense, **resilience** is the ability to cope with negative life events (Dray et al., 2017). It has also been defined as a person's ability to adapt to difficult situations and persevere in the face of adversity, or the ability to recover after a traumatic or stressful event (Norris et al., 2009). The development of resilience during adolescence (between the ages of 12 and 18) is considered an effective coping alternative for some of the mental disorders present in today's society.

Evidence suggests that not all adolescents who experience adverse situations develop mental disorders. Some studies have shown that the key appears to be resilience, which is **central to recovery from trauma and adverse events** (Rutter, 2013). It is also often defined as the ability to recover after a traumatic or stressful event. This resilience may act as a protective factor against the development of mental disorders, and consequently its absence may be a risk factor for a range of clinical conditions (Srivastava et al., 2019).

> Resilience is directly related to psychological well-being. Emotional well-being and resilience are closely related concepts. The more resilient we are, the less likely we are to develop mental disorders and the more likely we are to have a state of psychological well-being.

Resilience is the ability to cope with and adapt to new situations. Resilient people adapt to change. They have the ability to cope with the difficulties, frustrations and stress that are part of our daily lives. This is why many experts see resilience as the antidote to the mental health epidemic and the pathway to psychological well-being.

[2] What skills can we work on to foster resilience in youth?

The skills that make up **emotional learning** will be some of the key components to work on. There are some specific skills that studies have identified as critical to fostering resilience:

- Emotional self-regulation.
- Self-awareness (*intuition*).
- Social awareness (related to the ability to empathize with others and understand their feelings and thoughts).
- Relational skills (establishing and maintaining relationships, active listening, offering and asking for help, etc.)
- The ability to make responsible decisions.

It will also help them, in this society of overstimulation, to acquire the ability to connect with the present moment and with emotions without judging them, that is, to **acquire the practice of mindfulness.** This involves training them to keep their attention in the present moment by simply observing the experience, describing it in words, and letting themselves be carried away by it. This, in turn, would help to avoid impulsiveness in actions or decisions.

Another aspect to work on is **self-efficacy**. Self-efficacy is the self-perception of our ability to achieve the things we want. When we work on self-efficacy, adolescents perceive themselves as more capable of achieving their goals. To achieve their life goals, they will need to take action, and it is critical that they feel they can achieve whatever they want. If they do not feel capable of achieving their goals, they tend to set limits for themselves and give up before they even try. For this reason, it is essential to ensure that adolescents develop the belief that: «I can reach my goal, I will try, why not?

"You never know how strong you are until being strong is your only choice", Bob Marley.

At this point we see the importance of the relationship between resilience and our self-esteem. When we have a strong and healthy self-esteem, we are better able to cope with the difficulties we face. As a result, resilience will manifest itself as a greater ability to overcome obstacles. Cultivating a resilient attitude will simultaneously strengthen our self-esteem and improve our self-awareness.

So how do we become resilient? By sowing and nurturing these attitudes, we can succeed:

- Not be afraid of changes that we feel are necessary.
- Understand that the crises we are sure to experience are not insurmountable.
- Be determined, make decisions without fear; failure because of our actions should not stop us.
- Remember the experiences that have allowed us to overcome difficulties.

We, our decisions and our optimism in dealing with them will be crucial in continuing to grow and making sure that obstacles do not stop us.

Teaching them effective **coping strategies** to deal with the many situations they will face will also be crucial, keeping in mind that adolescents are constantly faced with challenges and novelties. Being able to develop effective coping strategies will help them reduce the stress caused by new situations, or even situations that are not

new but stressful. These strategies, but are not limited to, communication skills, assertiveness and problem solving.

[3] What can educators do to promote resilience?

Educational institutions can do much to promote the psychological well-being of their young people. Moreover, they are privileged contexts because they are spaces that offer opportunities to implement universal prevention programs (i.e., for all young people and not just those who show difficulties) to promote adolescents' psychological well-being by teaching them skills that foster their resilience. The classroom can become the ideal place to put all of the above skills into practice.

In addition to implementing universal prevention programs that promote resilience, educational centers could implement various **measures that promote resilience** and, consequently, psychological well-being. Measures such as:

- Providing guidelines for healthy relationships.
- Shaping and reinforcing appropriate behaviors and attitudes
- Providing opportunities to set life goals.
- Providing space for discussion and reflection on important adolescent issues.
- Building positive relationships, both among youth and between adult professionals and youth.
- Raise awareness and reduce stigma about mental health.
- Promote young people's sense of belonging to the educational community.
- Encourage the active participation of young people in activities that promote a resilient school.

CHAPTER

9 Suicide

9.1 SUICIDE. RECOGNIZING SUICIDE AS A SERIOUS PROBLEM

Suicide is a private decision and a problem for everyone

This chapter summarizes the most important information about suicide: the warning signs, risk factors and protective factors in adolescents, adults and the elderly; various educational interventions; key recommendations for survivors during bereavement; and the most common myths about this serious problem that we must address together.

[1] Talking about suicide is the great unfinished business of understanding the phenomenon, learning about its causes, how to help prevent it and how to help end its stigma. Suicide is a serious public health problem and is generally the leading external cause of death. According to 2019 data from the World Health Organization (WHO), one person dies by suicide every 40 seconds, which translates to approximately 700,000 preventable deaths per year worldwide. Suicide is still stigmatized, and the numbers are thought to be underestimated because many deaths are not recorded as suicides. Not to mention the consequences of many suicides attempts that do not result in death, for which there are or will be no records.

[2] Suicide prevention is considered a public health priority and one of the priority conditions of the Mental Health Gap Action Program established in 2008. In the Mental Health Action Plan 2013-2020, WHO Member States pledged to work towards the global target of a 10% reduction in national suicide rates, but the numbers have changed little.

> In order to talk about suicide, rather than give a precise definition, we **can establish a grouping of behaviors** that constitute suicidal behavior, from low to high intensity. The presence of these behaviors then determines the severity and risk profile of the individual's behavior.

The symptoms of suicide

[1] Suicidal behavior consists of the following behaviors:

- ***Suicidal ideation.*** Ranging from passive thoughts about wanting to die to active thoughts about killing oneself, including planning the attempt itself. There is broad consensus that suicide planning identifies a person as being at high risk for suicide. When we talk about suicidal ideation, we are referring to people who have active suicidal thoughts, a desire to die, and therefore a high risk of committing suicide. This «high risk» is assessed by a psychiatrist or psychologist, either in a doctor's office or in a hospital emergency room.
- ***Suicide threats.*** Are understood as the verbalization of these thoughts and are therefore indicators of high risk.
- ***Suicidal gestures.*** All the preparatory actions that precede the self-initiated suicide attempt, without the attempt itself being initiated. We know it is a suicidal gesture when we understand what is happening, without the need for the person to verbally tell us what they are doing.
- ***Self-initiated suicide attempt.*** Is a sequence of actions initiated by a person who plans to end their own life as a result of those actions.
- ***Completed suicide.*** An attempt that results in the death of the person.

Prevalence

[1] Over the past decade, the prevalence of suicide has shown significant trends worldwide, influenced by various factors, including age, gender and socio-economic characteristics. Data indicate that suicide remains one of the leading causes of death worldwide, with an estimated 700,000 suicides per year, according to World Health Organization (WHO) statistics.

[2] The age group most affected by suicide is adolescents and young adults, particularly those between the ages of 15 and 29. This age group has increasing rates of suicide, often related to factors such as mental health, social pressures, and experiences of discrimination. It is interesting to note that suicide rates among the elderly, particularly those over the age of 70, are also significant, highlighting the challenges associated with social isolation, the loss of loved ones and declining health.

[3] There is a clear gender difference in the prevalence of suicide. Men have significantly higher rates of suicide than women, with the overall average showing that men are almost three times more likely to die by suicide than women. However, women tend to have a different pattern of suicidal behavior, with higher rates of suicide attempts due to several factors, including the use of less lethal methods.

[4] Geographically, the incidence of suicide varies around the world. Regions with the highest suicide rates include East Asia, with countries such as South Korea and Japan, where cultural factors, work pressures and social expectations contribute to the phenomenon. Some Eastern European countries, such as Latvia and Lithuania, also have worryingly high suicide rates, often linked to economic crises, unemployment and problematic lifestyles.

In contrast, some areas of Africa and the Middle East have relatively lower suicide rates, but this does not mean that the problem does not exist; rather, it may be underestimated due to the stigma and cultural taboos surrounding suicide. In many of these areas, lack of access to mental health services and fear of social retribution makes it difficult to identify and treat mental disorders.

9.2 CAUSES THAT CONTRIBUTE TO SUICIDE

There are experiences that place adolescents and young people in a vulnerable situation, either because of the severity of the situation, its long-term nature or because they have accumulated a series of stressful or distressing life experiences during childhood. There may be several different situations:

- Relationship conflicts with peers, problems with bonding and acceptance in groups.
- Conflicting family problems or family breakdown.
- Academic problems.

- Financial problems.
- Problems related to organic or mental illness.
- Death of a family member or a significant person.
- Experiences of loneliness, discrimination, violence or abuse.

It is among these vulnerable youth that death-related behaviors may be most common. When we talk about suicidal behavior, we are referring to any act that involves some degree of intent to die. This can manifest itself in a number of ways: having death-related thoughts, planning how to die, making some kind of preparation or even carrying out the act with suicidal intent.

9.3 WARNING SIGNS OF SUICIDE

[1] There are several signs that can alert us to the risk of suicide. One is **any verbalization of a negative self-image**. This includes expressions such as «I am worthless,» «My life is meaningless". We must also look for **behavioral changes** that indicate a loss of interest in things that used to be enjoyable.

> Death by suicide **is the leading cause of unnatural death among adolescents and young adults**, and the number of suicides attempts and suicides we know about has raised a red flag around the world. Suicide remains an uncomfortable and silent death, especially when it affects adolescents and young people. Epidemiological data on suicide deaths speak for themselves: worldwide, an estimated one-quarter of suicides are committed by people under the age of 25.

In the case of adolescents, here are some warning signs:

- Lack of hope for the future, catastrophic thoughts such as «life is not worth living» or «nothing will change.
- Lack of short-/medium-term life plans.
- Bad mood, feelings of sadness, disability and low self-esteem.
- Changes in lifestyle, sleeping and eating habits, and decreased academic performance.
- Difficulty sharing distress or suffering with family and friends.
- Isolation at home and poor communication with family and friends.
- Interruption of or inability to enjoy previous activities.

- Self-injury (cuts on forearms, thighs, etc.), usually to regulate negative emotions.
- Suffering from bullying or difficulties in forming lasting social relationships.
- The discovery or expression of traumatic experiences (sexual abuse, mistreatment, etc.) that cause great suffering.
- Disproportionate emotional excesses in conflict situations or lack of resources to deal with them.

9.4 MAIN MYTHS AND MISCONCEPTIONS ABOUT SUICIDE

Lurking in the collective unconscious are several myths, misconceptions and prejudices related to the taboos and stigmas associated with suicide, which we must combat. They do not help or protect and are just unhelpful attempts to explain why it is so terrible.

The person who commits suicide wants to die. **FALSE**

People who attempt and commit suicide are often ambivalent about life and death. Some people die in a suicide attempt but would have preferred to live. They want permanent relief from their emotional distress.

People who have attempted suicide never stop trying. **FALSE**

It is true that some people attempt suicide several times in a short period of time, but suicidal thoughts are not permanent. In some cases, they never return.

People who say they want to kill themselves will not do so. **FALSE**

About 75% of people who commit suicide have given some warning. These people do not want to draw attention to themselves. These warnings should not be ignored. Talking about them can be a way to get help.

Talking about suicide may encourage someone to commit suicide. **FALSE**

There is a lot of stigmata attached to suicide. Most people who are thinking about suicide do not know who to talk to about it. Talking about it can be a way to prevent it by offering a new and alternative view of the situation.

Suicide cannot be prevented because it is an impulsive act. FALSE

The percentage of cases in which no symptoms, risk factors or previous indicators have been observed is very small. These cases are certainly very difficult to prevent, but in most cases, there are many indicators of suicidal behavior. Prevention is therefore the best way to help these people.

9.5 HOW TO DEAL WITH SUICIDAL IDEATION IN EDUCATIONAL SETTINGS

Promoting socio-emotional skills and safe environments

[1] One of the most important educational actions is to create **a safe and welcoming space** where young people can talk freely about their feelings and difficulties without fear of being judged. Educators acts as figures of active listening, empathy, trust and understanding without judgment. To achieve this, they can organize individual or group dialogue sessions, structured in an informal way, perhaps in a welcoming and non-judgmental environment.

For example, the educator can set up a "Listening Week" where young people can book one-on-one interviews in a comfortable setting, such as a library or common room, to talk about their experiences and emotional challenges. During these sessions, the educator could ask open-ended questions such as «Is there anything you would like to talk about today?" or «How have you been feeling this week?» to encourage communication and authentic reflection.

[2] It is important to emphasize **factors that may protect against suicidal thoughts**, such as

Reduce pain or increase coping skills:

- Increasing conflict resolution skills.
- Engaging in mental health treatment, especially for drug and alcohol abuse.

Active religious affiliation or belief:

- In the face of so much suffering, believing hope helps to grasp the beauty of one's own life and the beauty of sharing it with others.
- Having personal and group religious practices.
- Believing in the healing of disorders.

Improve bonding with groups or membership projects (even individual ones):

- Increasing social relationship skills.
- Good family communication and participation in family activities.
- Self-confidence.
- The presence of dependent children.
- Having family and social support, i.e. feeling useful and valued by important people, both in the family and in peer groups.
- Having projects/tasks that need to be completed.

Practical techniques for working in depth on various aspects of suicide

The activities are designed to provide concrete tools for dealing with difficult emotions and building trusting relationships. Some practical activities and specific techniques that can be used in school or community settings are described below.

Peer support groups. Create a space for discussion and support where young people can talk freely about their experiences and feel understood and less alone. Specifically, educators organize group meetings, led by a facilitator, where young people are invited to share their thoughts and experiences respectfully and anonymously if they wish. The emphasis is on listening and supporting each other without judging.

> ***Materials.*** Chairs are arranged in a circle to encourage interaction; the educator can hand out cards with questions or prompts, such as "Talk about a time when you felt under pressure" or "What is one thing that makes you proud of yourself?"
>
> ***Frequency.*** Weekly or bi-weekly meetings, lasting approximately one hour.

Conflict Management Role Playing. To develop skills for dealing with conflict and everyday difficulties by simulating problem situations. Participants are divided into pairs or small groups and given scenarios that reproduce common conflict situations (e.g., a disagreement with a friend or a criticism received). During the activity, they play different roles and search for solutions, after which the educator leads a discussion to analyse the strategies used.

> ***Materials.*** Cards with conflict scenarios, any accessories to enrich the setting.
>
> ***Frequency.*** Monthly meetings or every other week, for one hour.

Tree of Life Exercise. Strengthens self-esteem and promotes self-awareness by helping young people visualize their resources and goals. The young people draw a tree that represents themselves: the roots represent their personal resources (e.g. family, friends, personal qualities), the trunk represents their values and strengths, the branches indicate future goals, and the fruits symbolize positive experiences or achievements.

Materials. Paper and coloured pencils, any diagrams to help build the tree.

Frequency. One-time or periodic activity to be repeated every 3-6 months to monitor changes.

Show and discuss films with emotional themes. Encourage dialogue and reflection on emotional and relationship issues by analysing films that deal with themes related to emotions, adolescent problems, and overcoming difficult times by asking teens to suggest films or series that deal with this theme. This means that educators organize the viewing of films that deal with emotional themes (e.g., friendship, courage, suffering), followed by a guided discussion. During the discussion, questions such as «Which character stood out to you the most and why?» or «How did the story develop from the initial problem?"

Materials. Projector or TV, list of appropriate and reflective films, reflection questions for participants.

Frequency. Once a month, for a total of 2 hours (film + discussion).

Film suggestions:

***«Scialla!* (Be Calm)»** (2011) by Francesco Bruni. This film deals with the difficulties of the father-son relationship, the challenges of adolescence, and life choices. It can open a dialogue on issues of personal growth and how to deal with family and social conflicts.

«Quasi amici – Untouchables» (2011). The film explores issues of disability and friendship, showing how differences can be enriching and lead to personal discoveries.

«Bianca come il latte, rossa come il sangue» (2013) by Giacomo Campiotti. The film tells the story of a teenager who falls in love with a sick girl. The film explores the discovery of love, suffering and overcoming difficulties, important themes for young people growing up.

«The Perks of Being a Wallflower» (2012) by Stephen Chbosky. The film explores friendship, trauma, and mental health by following the life of a teenager struggling with his inner demons. Great for talking about self-esteem, resilience and the power of personal connections.

«Good Will Hunting» (1997) by Gus Van Sant. The story of a young genius tormented by trauma and insecurity. Through an encounter with a therapist, he faces his fears and discovers his own worth. Useful for talking about self-esteem and personal growth.

«It's Kind of a Funny Story» (2010) by Anna Boden and Ryan Fleck. Set in a psychiatric hospital, the film tells the story of a teenager who seeks help for his suicidal thoughts. It is an interesting work that explores the theme of depression and the importance of support.

Emotional Well-Being Self-Assessment Questionnaire. To regularly assess emotional well-being and identify signs of distress in young people so that they can monitor their mood and intervene if necessary. Educators distribute an anonymous questionnaire with questions to help young people reflect on their emotional well-being. Questions might include, «How often do you feel sad or frustrated?» or «When you feel distressed, what do you do to feel better?»

Materials. Paper or digital questionnaires, anonymous responses to protect privacy.

Frequency. Every three months or as needed.

Personal Storytelling Sessions. Encourage openness and sharing of personal experiences in a safe and respectful environment where youth can listen to and share stories of personal growth and overcoming difficulties. Specifically, in small groups, youth are invited to share a meaningful personal story, such as a difficult time they overcame or a situation in which they felt valued. After each sharing, the group offers positive comments and supportive questions, always respecting the sharing limit that each participant wants to maintain.

Materials. Welcoming atmosphere, voice recorder (if participants agree, to listen to and discuss later).

Frequency. Monthly meetings or at the request of the group.

Vision of the Future Activity (Vision Board). To help young people create a positive and motivating vision of their future by increasing their hope and motivation to achieve their goals. This means that participants create a «Vision Board» with pictures, words or symbols that represent their future dreams and goals. They can cut out pictures from magazines or draw symbols that represent what they want to achieve.

Materials. Magazines, scissors, glue, cardboard, markers, and drawing materials.

Frequency. Annual or bi-annual activity, useful for reevaluating and updating their aspirations.

CHAPTER

10 Bullying

10.1 HOW TO RECOGNIZE BULLYING

Bullying is an expression of violence

The Universal Declaration of the Rights of the Child states in its articles the right to education and to be protected from practices that may encourage racial, religious or any other kind of discrimination … to be educated in a spirit of understanding, tolerance, friendship among peoples, peace and universal brotherhood, etc. Healthy coexistence in the school is a right and a duty of all members of the educational community, the main basis of which is the dignity of the individual.

> Bullying behavior can be defined as **repeated and intentional negative (unpleasant, offensive) behavior by one or more persons directed against a person who has difficulty defending himself or herself.**

According to this definition, bullying can be described as:

- Aggressive or intentionally hurtful behavior.
- Repeated over a period of time.

- In an interpersonal relationship characterized by an actual or perceived imbalance of power or strength.

Bullying appears to occur without any apparent provocation by the target. This definition makes it clear that bullying can be understood as a form of peer abuse. What distinguishes it from other forms of abuse is the context in which it occurs and the characteristics of the relationship between the interacting parties.

Bullying is any form of intimidation or physical, psychological or sexual aggression against a person of school age in a repeated manner that causes harm, fear and/or distress to the victim or the group of victims (WHO and the international NGO Bullying Without Borders).

The players involved in bullying situations

In addition to the bully and the victim, there are other people involved, even if indirectly. Let us briefly describe the players involved:

[1] The most common type of *victims* are the passive or submissive victims, who usually have some of the following characteristics:

- They are cautious, sensitive, quiet, withdrawn and shy.
- They are anxious, insecure, unhappy and have low self-esteem.
- They are depressed and have suicidal thoughts much more often than their peers.
- They often have no friends and relate better to adults than to peers.
- If they are male, they tend to be physically weaker than their peers.

There is also another, less numerous group of victims: the provocation or bullying victims, who are characterized by a combination of both anxious and aggressive response patterns. These students often have difficulty concentrating and may have learning difficulties. They may behave in ways that create irritation and tension around them. Some of them are characterized as hyperactive: it is not uncommon for their behavior to be provocative to many students in the class.

[2] On the other hand, let us say *a word about bullies*, who often exhibit some of the following characteristics:

- Strong need to dominate and control other students and get their own way.
- They are impulsive and get angry easily.

- They show little empathy for peers who are being bullied.
- They are often rebellious and aggressive towards adults, including teachers and parents.
- They are often involved in other antisocial or transgressive activities, such as vandalism, delinquency, and drug use.
- If they are male, they are often physically stronger than their victims.

> Underlying psychological characteristics of bullying can be identified. First, bullies have a strong need for power and dominance; they seem to enjoy being in control and oppressing others. Second, given the family circumstances in which many of them have grown up (Olweus, 1993), it is natural to assume that they have developed a degree of hostility towards the external environment; such feelings and impulses may lead them to find satisfaction in inflicting harm and suffering on others. Third, there is an «instrumental or utilitarian component» to their behavior: bullies often force their victims to give them money, cigarettes, beer, and other valuables.

[3] *Witnesses:*

- Are bystanders who may side with the aggressor or defend the victim.
- Could increase the harassment.
- Defend the bullies.
- Ignore the situation.

[4] *Schools can* be:

- The internal organization
- The scenario
- The active agent of abuse
- The one who takes a stand
- The one who implements prevention and case management policies
- The one who is able to resolve conflicts

[5] *Society* has a responsibility because:

- Social vulnerability makes vulnerability in schools more likely, which becomes a reflection of society.
- It denies the problem.

The symptoms of bullying

Victims of bullying show **a variety of symptoms and signs** that can take different forms: physical, psychological, emotional, verbal, sexual harassment or cyberbullying. We will provide three main categories: physical, behavioral and emotional.

«We cannot achieve inclusive and equitable education for all if children cannot learn in schools that are safe and free from violence, including violence perpetrated by students, teachers and other school staff, and corporal punishment.» UNESCO 2020.

[1] People who are bullied may experience physical effects (**physical symptoms**), often related to the chronic stress and anxiety that bullying causes. Common physical symptoms include frequent headaches, stomach-aches, and other gastrointestinal problems for no apparent reason. In addition, the constant state of tension may manifest through sleep disorders, such as insomnia, nightmares, or difficulty falling asleep. Chronic fatigue related sleep deprivation or anxiety is also a common symptom. In some more extreme cases, there may be bruises or physical injuries that the boy/girl may try to hide out of fear or shame.

[2] Bullying often leads to **behavioral symptoms**, i.e., significant changes in the victim's behavior. There may be a sudden drop in academic performance as the person loses interest or has difficulty concentrating. The associated anxiety and stress may also lead to increased absenteeism as the victim tries to avoid school or other environments where bullying occurs. Another behavioral manifestation is social isolation: the victim may begin to avoid social activities, preferring to be alone or avoiding friends and family. Some develop a phobia of certain places or situations associated with bullying, such as going to school or riding the bus.

In addition, self-destructive behaviors may be observed, such as attempts to physically harm oneself or the use of substances such as alcohol and drugs to relieve emotional distress. Changes in eating habits, such as a loss of appetite or compulsive binge eating, may be another indicator of psychological and behavioral distress.

[3] Victims of bullying often develop signs of depression and anxiety, which can vary in severity. These are **emotional symptoms**. They may seem sad or melancholy most of the time, with a strong sense of helplessness and low self-esteem. They often feel inadequate or guilty and come to believe that the bullying is somehow their fault. In prolonged situations, suicidal thoughts may arise, which is a serious warning sign. The person may also be easily irritated, have temper tantrums or have emotional outbursts that seem out of proportion to the situation.

Victims may also have difficulty expressing their feelings clearly and may try to hide their pain. This can lead to an apparent lack of interest or apathy towards many activities that were previously a source of pleasure, a condition known as anhedonia.

Prevalence

Bullying has become a public health problem that affects children and adolescents regardless of their social status, age, race, gender, or religion. The United Nations Educational, Scientific and Cultural Organization (UNESCO) found that approximately 246 million children and adolescents worldwide experience some form of violence at school, the most common of which is bullying.

According to the official study by the international NGO *Bullying Without Borders* for the Americas, Europe, Asia, Oceania and Africa (January 2022 – April 2023):

- 6 out of 10 children experience some form of bullying and cyberbullying every day.
- Bullying and cyberbullying have worsened in Mexico, the United States and Spain.

UNESCO study in 144 countries (2020):

- One in five students in the world is bullied.
- One of the main consequences for victims is seen in educational outcomes: they are twice as likely to miss school.
- Bullying also affects health.
- UNESCO also warns of the potential negative impact on well-being and health.

200,000 children and adolescents worldwide lose their lives each year due to bullying and cyberbullying (5).

"Young people who suffer are twice as likely to feel lonely, to have trouble sleeping at night and to have contemplated suicide," the agency warned.

In addition to these data, we know that:

- 85% of cases occur at school.
- 82% of children with disabilities are bullied at school.
- 74% of children between the ages of 8 and 14 have been bullied at least once.

- More than 90% of bullying is not reported to educators.
- 60% or more of bullies will have at least one criminal episode in adulthood.
- 3 million children miss school every month because of bullying.
- 9 out of 10 homosexual youth experience harassment because of their sexual orientation.

Regarding cyberbullying:

- According to data from 7 European countries, between 2010 and 2014 the percentage of young people aged 11-16 who were victims of cyberbullying increased from 7 per cent to 12 per cent.
- "Although it happens in the "virtual" universe, cyberbullying has very real consequences for children's health…."
- Bullying and cyberbullying are directly responsible for more than 200,000 deaths.
- Networks such as Facebook, Twitter, Instagram and WhatsApp create a sick and dangerous environment for children, adolescents and young people.
- Harassment on social media is difficult to control and there are no national or international laws to protect the victims.

10.2 CAUSES THAT CONTRIBUTE TO BULLYING

There are many **triggers and motivations** that lead an individual to engage in bullying and they can vary from case to case. Some of the main motivations include:

[1] Need for power and control. Many bullies seek to exert power over others in order to feel strong and dominant. This may be the result of personal insecurities or an environment where power is seen as a sign of success and superiority. In these cases, bullying becomes a means of asserting one's social position and controlling others.

[2] Group conformity and peer pressure. Bullying often occurs within groups that members join in order to feel accepted and respected by their peers. In these contexts, the bully acts to conform to the group's expectations, especially during adolescence when social approval is particularly important. Even those who do not initiate bullying may be drawn into participating in order to avoid being ostracized.

[3] Envy and jealousy. Some incidents of bullying result from feelings of envy or jealousy. If an individual perceives that a peer is more successful in school, social or even family life, they may use bullying as a way to humiliate the other person and feel less inadequate.

[4] Personal experience with violence or exclusion. Many bullies have experienced trauma or marginalization themselves. In these cases, bullying may be an attempt to regain control or to take out their frustration and anger on someone perceived as weaker. In some cases, those who have been bullied in the past may become bullies to avoid reliving those experiences or to seek revenge.

[5] Lack of empathy and emotional problems. Some people bully because they are unable to perceive the pain and suffering, they inflict on others. Lack of empathy, combined with poor emotional management, can lead to aggressive behavior. In particular, young people who have difficulty managing anger or frustration may act impulsively and aggressively.

[6] Amusement and desire for entertainment. In some cases, bullying may be motivated by a simple desire for entertainment. Some bullies, especially younger bullies, may see the suffering and humiliation of others as a source of entertainment. This motivation is often accompanied by a lack of awareness of the consequences of their actions and a lack of responsibility.

[7] Feeling of impunity. Finally, bullying may be motivated by a sense of being able to act without consequence. In contexts where there are no clear sanctions or where adults do not intervene promptly, bullies may feel that their actions will not be punished, which encourages further aggressive behavior.

10.3 WARNING SIGNS OF BULLYING

The signs we saw earlier can be observed in a person's behavior, social relationships, technology habits and general health.

[1] The use of technology plays a crucial role in modern bullying, especially with the spread of cyberbullying. It is therefore possible to speak of **technological indicators**. Victims may show various signs related to their use of electronic devices. For example, there may be a dramatic increase or decrease in the use of their phone, tablet or com-

puter. In some cases, the victim may become obsessed with constantly checking notifications, fearing further attacks or offensive messages. On the other hand, others may avoid technology altogether, fearing further abuse via social media or messaging platforms.

Another important indicator is a change in online habits. The victim may suddenly stop participating in social networking sites or delete their profiles altogether. It is also common for the person to frequently change their phone number or account passwords in an attempt to evade attackers. In addition, a sudden and unexplained increase in the amount of time spent online may indicate that the victim is seeking reassurance or support or is facing new incidents of digital bullying.

[2] Bullying often has a strong impact on the victim's social relationships. Therefore, **changes in social relationships** are another warning sign. Many victims begin to avoid friendships that were previously important and develop a strong distrust of peers or people in general. This behavior may be the result of the victim no longer feeling confident in who they can trust, especially if they have been betrayed or ridiculed by friends in the past.

At the family level, the victim may appear distant and uncommunicative, refusing to talk about what is happening or minimizing the problem when asked. In other cases, the victim may seek constant support from parents or family members because they are afraid to face the school or social environment alone.

The effect on peer relationships may also be seen in the victim's tendency to hang out with younger or less popular people in an attempt to avoid unwanted attention. In some cases, the victim may choose to hang out in online environments to seek understanding and support from virtual groups or communities, at the risk of further bullying.

Peer behavior may also include the following:

- bad jokes, insults, etc.
- offensive or threatening notes or emails.
- name calling
- exclusion from parties or activities outside of school.
- isolation
- teasing about clothing, appearance, gestures, etc.

75% of children and adolescents who have been or are being bullied and cyberbullied have situations related to mental illness such as depression, anxiety, bulimia or anorexia.

10.4 MAIN MYTHS AND MISCONCEPTIONS ABOUT BULLYING

Any conflict between students should be considered bullying. FALSE

To be considered as such, the events must be sustained over time (repeated), there must be an imbalance of power between the perpetrator and the actor, there must be an intent to harm on the part of the perpetrator, and the actor must be in a defensive situation.

The victims are young people. FALSE

Bullying is a situation that can affect anyone, regardless of cultural, social or economic level.

It is not common among women. FALSE

Cases of bullying do not differ between the sexes. There are differences in behavior. The male bully uses more physical aggression, while the female bully uses more verbal or social aggression. There is a marked difference in the behavior of females, who are the most vulnerable.

Bullies are always "bad boys". FALSE

Bullies can be children or adolescents with relationship difficulties who try to cope with insecurities or personal problems by controlling others. They are not «bad guys,» but they need help understanding and changing their behavior.

Cyberbullying is not as serious as physical bullying. FALSE

Cyberbullying can be just as devastating, if not more so. Online content travels quickly and remains visible for a long time, adding to the humiliation and isolation of victims.

10.5 HOW TO ACCOMPANY BULLYING IN EDUCATIONAL SETTINGS

Protective factors that can prevent the occurrence of bullying

[1] In order to accompany, it is necessary to start with some factors that can *protect potential victims* from this phenomenon:

- One of the most important protective factors is a **strong self-esteem**. Children and adolescents with a good self-image and confidence in their abilities tend to cope better with conflict situations and are less vulnerable to bullying.
- Another important factor is **family support**. Victims who have caring parents who are there for them, listen to their problems and support them are more likely to seek help and overcome the difficulties caused by bullying.
- **Positive peer relationships** are also an important resource. Having a group of trusted friends, or even just a reference person in the social network, can provide a sense of security and protection and reduce the risk of isolation that often makes it easier to become a target for bullies.
- **Mutual respect and empathy**, which promotes understanding and acceptance of differences. This includes taking individual and collective responsibility, encouraging each young person to look out for others and to intervene in cases of aggressive or discriminatory behavior.
- Finally, a **safe and inclusive school environment** can be a powerful protective factor. When schools have clear anti-bullying policies, a caring staff, and a climate of respect and inclusion, children feel more protected and secure.
- **Emotional management**, given them tools to express their emotions in healthy and positive ways and to avoid violent behavior.
- Awareness and education, as it is important for all young people to understand **what bullying is** and to be able to recognize its different forms.

[2] *Protective factors for bullies*: In order to prevent young people from becoming bullies, it is important to intervene at an early stage in various ways.

One of the most effective factors is the **presence of positive role models**, such as parents, educators or coaches who teach respect, empathy and dialogue as tools for conflict resolution. When young people see constructive behaviors in adults they relate to, they are more likely to emulate them in their relationships with peers.

Another protective factor is the **ability to manage emotions**. Educational programs that help children and adolescents develop social and emotional skills, such as anger management and empathy, can reduce the likelihood that a youth will engage in aggressive behavior. **Careful adult supervision**, both at home and at school, is critical to preventing bullying. In environments where adults closely monitor behavior and intervene promptly, bullies have less opportunity to act without consequences.

[3] In addition, preventing bullying in educational settings **requires an integrated approach that involves not only children, but also educators, parents and the entire educational community**. Educational interventions should aim to create an environment of respect and inclusion and to develop social and emotional skills in youth. Let's look at some effective interventions and their practical applications:

- **Social-emotional education.** One key intervention is to integrate social-emotional education into the school curriculum. This type of education helps children identify and manage their emotions, develop empathy for others and build positive relationships. For example, schools can implement programs that include role-playing activities in which children play the roles of bullies, victims and bystanders to discuss the emotions and consequences of aggressive behavior. In this way, children learn to empathize with others and gain a deeper understanding of the suffering caused by bullying.

- **Training Educators.** Another critical step is to train educators. Educators need to be equipped with strategies for recognizing and dealing with bullying behavior. Training can include simulations of bullying situations, discussions on how to intervene effectively, and how to support victims. For example, a teacher might learn how to recognize signs of distress in their students and how to take immediate action by talking privately with the victims and involving the parents if necessary.

- **Develop anti-bullying policies.** Schools should develop and implement clear and consistent anti-bullying policies. These policies should define what constitutes bullying, consequences for bullies and support for victims. For example, a school might create a code of conduct that all children must sign at the beginning of the school year, which recognizes the importance of a safe and respectful environment. Policies should be visible and accessible, such as through posters in classrooms and hallways.

- **Youth involvement initiatives.** Encouraging young people to become active agents of change is another effective measure. Schools can create task forces or anti-bullying committees made up of youth who have shown interest and commitment. These groups can organize events, such as awareness days, that ad-

dress bullying issues and promote the values of respect and inclusion. A practical example could be a "Kindness Week" where youth are encouraged to practice acts of kindness and share their positive experiences.

- **Team building activities.** Team-building activities can help strengthen bonds among young people and reduce the risk of bullying. Schools can organize field trips, team sports or community projects in which young people work together to achieve a common goal. For example, a community gardening project can encourage children to work together and develop a sense of responsibility and belonging. These shared experiences can improve group cohesion and create an environment where bullying is less likely.

- **Create safe spaces.** Schools should also create safe spaces where children can freely express their concerns. This may include setting up «listening hours» where young people can meet with a trusted psychologist or teacher to discuss issues related to bullying. In addition, establishing an anonymous reporting system for bullying incidents can help young people feel more confident about reporting problematic behavior without fear of retaliation.

- **Work with families.** Family involvement is essential to an effective prevention strategy. Schools can organize meetings or workshops to educate parents about the signs of bullying and how to support their children. One example would be a meeting for parents to discuss the importance of encouraging empathy and respect in the family and to provide information on how to handle reports of bullying that their children may receive. Creating an open line of communication between school and family fosters a broader support network.

- **Monitoring and evaluation.** Finally, it is important to monitor and evaluate the effectiveness of the interventions implemented. Schools can conduct surveys of children to gather feedback on the school climate and attitudes towards bullying. This information can guide any changes to existing programs and policies. For example, if a survey shows that children do not feel safe reporting incidents of bullying, the school can revise its approach to reporting and improve support systems.

Let us try to quickly and concisely summarize in a decalogue what we should do and think when faced with bullying:

1. Bullying is not a "joke".
2. Anyone can engage in or be subjected to bullying and cyberbullying behaviors.
3. Everyone has a role to play in bullying situations.
4. Boys and girls differ in their aggressiveness.
5. Bullying among young people is a health problem that affects everyone.
6. The bullied boy or girl needs help.
7. The bully needs help too.
8. Firm action is needed to stop the situation.
9. These are basic rights.
10. Family cooperation is essential.

Techniques for working in depth on various aspects of bullying

Educational actions that educators can take include various group and individual activities, assessment tools and targeted educational resources.

[1] Interviews

Interview the victim:

- Communicate that we understand the difficulty, but also the importance, of talking about what has happened or is happening.
- Speak calmly and avoid blaming yourself for what has happened or is happening.
- Do not talk excessively and listen attentively and empathetically.
- Make it clear that we do not want to add to the problem!

? ***Some questions:***
How are you feeling? How do you feel at school/at the center?
What are you worried about?
What has happened?
Where and when?
Who did it?

Why do you think they did it?
Did anyone see it?
Who knows about the situation?
Did you tell anyone? Who did you tell?
Can anyone help you?
How long have these situations been going on?
How do you feel when it happens?
What do you do when it happens?
How do you think this problem can be solved?

Key messages

You are not responsible for what has happened
You are not alone
We believe in you
No one has the right to make you feel guilty
We can help you

Interview the aggressor:

- Speak calmly, using a respectful, non-aggressive tone and avoiding arguments that create resistance.
- Avoid moralizing or making judgments.

Some questions

How do you feel at school/at the center? What is worrying you?
Do you get along with your classmates/colleagues?
I was told that something happened to …. the other day. What happened, where, when, why do you think it happened, how do you feel when these things happen?
How do you think X feels? How do you think this problem can be solved? Do you think that peer aggression is a problem at school?
What do you think are the most common types of peer bullying? How often do they happen? Why do you think some boys and girls do these things? Have you ever done these things? Do you think what happened to X… could be considered bullying and/or cyberbullying?

Key messages

It is important to be aware of your actions.
Try to empathize with those who are suffering.
Others' approval can be gained in other ways.
What can you do to heal and repair the damage?
The ability to change belongs to the strong.

Interview the bystanders:

Raise awareness among peers about the phenomenon of bullying or cyberbullying and promote empathy for those who are being bullied.

Help break the law of silence in order to see bullying or cyberbullying situations that are hidden from the eyes of adults.

Encourage the identification and validation of who is being bullied and by whom.

Seek their involvement by offering to help them change their role from passive bystander to active collaborator.

Ensure confidentiality.

?

Some questions

How did you feel when you witnessed the bullying?

What was your reaction at the time? Did you say or do anything?

What stopped you from doing something (if they didn't do anything)?

Did you ever think about how the victim felt at that moment?

If you were in the victim's shoes, what would you have wanted others to do for you?

Do you think the bully would have acted differently if someone had intervened?

If it happened again, what do you think you could do differently?

Key messages

What is happening is not a joke.

What happens affects you

We are all responsible

How do you think those affected by negative behavior feel?

The power to change things is in the group.

Interview the family:

- These interviews should be conducted separately with the families of the students involved.
- It is important to make a clear presentation and to communicate calmly.
- It is important to use appropriate communication tools (empathy, first-person messages, etc.) so as not to alarm the family.
- It is important to make it clear that the school and the family have the same goal and therefore their cooperation and commitment is needed.
- It is recommended to convey the confidence that things can improve.
- It is recommended to focus on the facts, not the person, and to avoid judging and blaming the family.

[2] Anonymous questionnaires to assess perceptions of bullying. Anonymous questionnaires are an effective tool for gaining insight into the school climate and the presence of bullying incidents. Young people can answer questions that explore perceptions of the phenomenon within the school and direct experiences. Practical questions on various aspects could include:

? ***Questions about general perceptions of bullying:***

- How common do you think bullying is in our school?
- What forms of bullying do you think are most common (physical, verbal, online, exclusion)?
- Do you think that bullying is a serious problem in our school?

Questions about personal experience:

- Have you ever been the victim of bullying? If so, how?
- Have you ever witnessed bullying incidents? If so, how did you respond?
- Do you feel comfortable asking a teacher or adult for help if you are being bullied?
- Do you think educators intervene appropriately to stop bullying?

Questions about school and social environment:

- Do you feel accepted and respected by your friends?
- Do you think there is enough information about what to do if you are bullied?
- Do you think there are activities or projects in our community to prevent bullying?

Questions about group dynamics and peer support:

- Have you ever seen someone intervene to stop a bullying incident? If so, who (friends, other peers, educators)?
- Have you ever supported or defended a friend who was being bullied? If not, what stopped you?
- Do you think there is a good sense of cooperation and respect among young people?

Questions about social media and cyberbullying:

- Have you ever received offensive messages or comments from friends on social media?
- Do you think cyberbullying is more or less serious than «traditional» bullying?
- Do you feel safe using social media without fear of being bullied?

Questions about possible actions and improvements:

- What steps do you think can be taken to prevent bullying?
- Would you like to have special discussion times or projects to talk about bullying?
- Do you think an awareness campaign among young people could improve the situation?

[3] Classroom awareness program. Educators can devote a series of sessions to bullying awareness, exploring key themes such as empathy, inclusion and mutual respect. Each session could include hands-on activities, discussion and group reflection. A practical example: *«Me, the Bully, and the Victim» Activity:* Ask the young people to imagine how they might feel in the roles of the victim, the bully, and the bystander. They can write down their feelings and share them in small groups. This activity helps develop emotional awareness and empathy, which can help them better understand the impact of bullying.

[4] Workshop on emotions and non-violent communication. A special workshop on managing emotions and assertive communication can help children express their feelings without resorting to violence. Nonviolent communication and active listening techniques can be used to teach youth to express themselves while respecting others.

> ***"I talk, you listen» exercise.*** Divide participants into pairs; one talks about their feelings or a difficult experience, and the other listens without interrupting, asking only open-ended questions for clarification. At the end, the second participant repeats what they have understood to make sure they got the message. This technique promotes mutual understanding and builds empathy.

[5] Create a Charter of Values. A charter of values shared by the class can build a sense of community and a commitment to mutual respect and acceptance. The charter of values can be developed with the young people so that they feel an active part in setting social rules and behaviors.

> ***Practical example.*** Begin with an open discussion about what «respect» and «acceptance» mean to them. The young people can then come up with some basic values and guidelines that are written down, signed by everyone and then posted in the classroom for constant reference. This process makes them feel responsible and encourages them to live up to their commitments.

[6] Group projects to create awareness materials. Create group projects in which young people create posters, videos or short presentations to raise awareness about bullying. This type of project develops collaboration among young people and gives them a voice to express themselves and spread positive messages to their peers.

> ***Practical example:*** Divide the class into groups and assign each group a different topic, such as «What is bullying?», «How to combat bullying», and «The importance of empathy». Groups can use posters, videos or digital presentations to express their messages and share their work with the rest of the school or community.

[7] Peer mentoring programs. Create a mentoring system in which older or trained students shadow and support younger students. These peer mentoring programs are effective in creating a welcoming and inclusive environment, especially for newcomers who may be more vulnerable to bullying.

> ***Practical example:*** Train a group of senior students to recognize and intervene in bullying. Mentors can then hold weekly meetings with their «protégés» to discuss daily challenges and offer suggestions for dealing with difficult situations.

[8] Role-playing bullying situations. Role playing is a practical technique that allows young people to experience the phenomenon from different perspectives: that of the victim, the bully and the bystander. This activity helps young people think about the consequences of bullying and how they might react in real-life situations.

> ***Practical example.*** In a role-playing situation, divide students into small groups and give each group a script describing a bullying situation. In each group, one student plays the victim, another plays the bully, one or more students play the bystanders, and one student plays the defender. After the simulation, each group reflects together on how each character felt and possible alternative solutions to improve the situation. This activity raises awareness and encourages young people to take a stand against bullying.

[9] Regular focus group meetings and guided discussion. Holding regular discussion sessions allows young people to speak freely about the school climate and the problems they perceive, while providing a safe space to discuss any bullying incidents. These meetings are led by an educator who facilitates the conversation and encourages constructive reflection.

Practical example. Discussions can include questions such as «What situations at school make you feel uncomfortable?», «What would you like your peers and adults to do to make you feel safer?» and «What could be done to improve the school climate? After the discussion, the students can also make concrete proposals to be implemented together with the educators.

[10] Use a journal of emotions. The journal of emotions is a personal tool that allows young people to reflect on their feelings and record their daily experiences. It encourages self-reflection and helps develop emotional awareness, which is crucial for recognizing and dealing with difficult situations, including bullying incidents.

Practical example. Young people can keep a journal in which they write at the end of the day how they felt, what made them feel that way, and what they think they can do to deal with similar situations in the future. The educator can periodically invite those who wish to share some anonymous or general reflections and use these insights to discuss positive emotional management and conflict resolution strategies.

[11] Create a group of "Ambassadors of Respect". «Ambassadors of Respect" are student volunteers who work to monitor and promote a positive school climate. This group can serve as a resource for young people who are feeling isolated or in distress and can also organize anti-bullying events and awareness campaigns.

Practical example. The ambassadors, selected from the most sensitive and respectful young people, can be trained to recognize and safely intervene in bullying situations. They can work with educators to organize theme days, such as «Kindness Day» or «Inclusion Week,» during which they promote group activities and small events designed to build a sense of belonging.

[12] Meetings with experts and direct witnesses. Inviting experts, such as psychologists or anti-bullying associations, can give young people an outside, authoritative perspective on how to deal with the problem. Testimonies from former victims or people who have overcome bullying situations can inspire young people to seek help or take a stand.

Practical example. During a meeting with an expert, students can ask questions about how to deal with bullying and how to manage their emotions in difficult situations. A guest speaker who talks about his own experience as a victim and how he found the support he needed can motivate young people to open up to adults in difficult situations.

[13] Interactive diversity projects. Projects that celebrate diversity, such as creating a «Wall of Diversity» where each student writes a unique characteristic about themselves, can reinforce inclusion and help them see the value of individual differences.

> ***Practical example.*** Students can create a large poster or mural with drawings, messages and pictures that represent the positive differences of each person. They can also include words such as «empathy,» «friendship,» and «solidarity. This activity helps create a welcoming environment where differences are celebrated and respected.

[14] Screenings and discussions of films with emotional themes. Encourage dialogue and reflection on emotional and relationship issues by analysing films that deal with topics related to emotions, adolescent problems and overcoming difficult moments. Some films are provided, but it may be interesting to have the young people search for other film titles or series on the topic.

Educators arrange for a viewing of films that deal with bullying or inclusion issues, followed by a guided discussion. During the discussion, ask questions such as «Which character affected you the most and why?» or «How did the story develop from the initial problem?

> ***«Come te nessuno mai»*** (1999) – Directed by Gabriele Muccino, this film is about the dynamics and turmoil of adolescence during a school sit-in. The film offers an insight into the typical problems of teenagers, their insecurities and their desire to belong.
>
> ***«Mean Girls»*** (2004) – Although it is a comedy, this film explores the complex power games and exclusionary dynamics among teenagers in an American school. It is a light-hearted but effective way to introduce discussions about bullying, peer influence and the importance of being authentic.
>
> ***«Cyberbully»*** (2011) – A film that addresses the issue of cyberbullying through the story of a teenage girl who is bullied online. Ideal for talking about the challenges and dangers of social media and the importance of being aware of one's actions online.
>
> ***"Después de Lucía"*** (2012) – A film directed by Michel Franco. After the death of his wife Lucía, Roberto moves to Mexico City with his 17-year-old daughter Alejandra. Enrolled in an upper-middle class school in the city, Alejandra has sex with a classmate during a party and is filmed with a cell phone. The next day, the video circulates around the school, and Alejandra becomes the laughingstock of the class, singled out as the easy girl and in-

sulted. Increasingly isolated, Alejandra is physically humiliated by her classmates and raped by a classmate in front of everyone's indifferent eyes during a school trip. At the peak of her endurance, the girl runs away and Roberto, while trying to find his daughter, takes merciless revenge.

«To This Day Project» (animated video, 2013) – An animated short film based on a poem by Shane Koyczan, a former victim of bullying who shares his experiences in a poetic and profound way. Although short, it is a powerful tool for discussing the emotional impact of bullying and the importance of listening to and supporting the victims.

«La classe degli asini» (2016) –Based on a true story, this film tells the story of a teacher who fights for the inclusion of marginalized children with disabilities in public schools. It offers an educational perspective on the fight against discrimination and encourages reflection on schools as places of inclusion.

«Wonder» (2017) – Based on the book of the same name by R. J. Palacio, it tells the story of Auggie, a boy born with a facial deformity, and his difficult experience of inclusion in school. It is a film that promotes the values of acceptance, empathy and respect for differences.

«I ragazzi dello Zecchino d'Oro» (2019) – Set in the 1960s, this film tells the story of the children who participate in the famous choir and their experiences of friendship, solidarity and challenges. It depicts the importance of community and collaboration, as well as inclusion and resilience.

"Il ragazzo dai pantaloni rosa" (2024) by Margherita Ferri – The film is inspired by the true story of Andrea Spezza catena, a 15-year-old victim of homophobic bullying and cyberbullying who took his own life on November 20, 2012.

Conclusion

[1] Our adolescents and young people are warning signs of our wounded world, suggesting that our society and world are in serious trouble. The well-being of the adolescent population highlights an educational priority: the **prevention, recognition, and care/treatment of mental illness.**

As we saw at the beginning, it should also be emphasized that stigma is present in all areas of the lives of people with mental disorders: in the educational environment, but also in the family, with their partner, in friendships, etc. A stigma that perpetuates discriminatory behaviors and is often fuelled by prejudices and stereotypes that still exist in the media, films, books and songs that we consume. For this reason, it is necessary to introduce **awareness-raising processes in our educational institutions** and to train people to work on **«new» educational concerns**, involving all our environments and especially young people, so that they can make real changes to eliminate social and structural stigmas and, consequently, self-stigmas.

In order to begin a process of initial knowledge and accompaniment in the educational field, we have included in this guide some of the most common disorders that affect the world of youth and that are a source of discomfort for so many young people who spend time in our environments. It becomes crucial for us as educators to promote and care for their emotional and mental well-being.

In caring for young people, in addition to observation, there are certain strategies for strengthening the bond and the relationship, for strengthening and nurturing a climate of trust. **Summarizing them in educational concerns, we point out twelve of them:**

1. At the end of each task, ask: "How did it go? Was it very difficult for you?
2. Use a sense of humour: smiling, laughing and sharing relaxed moments with the young people will help them feel calmer and more relaxed in any context.
3. Pay attention to their reactions to understand the situations they are experiencing.
4. Find out what their hobbies and passions are.

5. Personalize educational activities according to the target group.
6. Listen to them and include their opinions in the process.
7. Explain more complex things using metaphors or anecdotes.
8. Always address them by name.
9. Begin the lesson, group meeting, or catechesis by asking if anyone would like to share something that happened to them (5 minutes).
10. Begin each meeting with a happy anecdote or a joke (5 minutes).
11. Share with the class or group when you have a bad day.
12. Play and share music they like.

[2] *«Educating the mind without educating the heart is no education at all".* Aristotle's aphorism is as relevant as ever and supported by empirical evidence. Indeed, there is no learning process that is completely devoid of emotion. Recent scientific literature has found a strong link between emotional and cognitive systems. Indeed, emotions have been shown to play a fundamental role in determining the quality of cognition.

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