International Journal of Multidisciplinary Research and Growth Evaluation.

Anxiety During Adolescence: Normal or Pathological?

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Article Info

ISSN (Online): 2582-7138
Impact Factor (RSIF): 7.98
Volume: 06
Issue: 06
November - December 2025
Received: 21-10-2025
Accepted: 22-11-2025
Published: 19-12-2025
Page No: 1143-1148

Abstract
Adolescence is a fundamental period of development that encompasses the transition from childhood to adulthood, and is characterized by profound biological, psychological, and social transformations, associated with many doubts and challenges, which make adolescents more vulnerable to the emergence of emotional problems. During this phase of life the process of puberty occurs, modulated by hormones responsible for changes in the form and structure of the body and also due to the neurological and emotional development typical of this period, it causes repercussions on the formation of self-concept, self-image, and behavioral patterns so necessary for adaptation to more complex environments and situations. Anxiety is an inherent characteristic of human beings and can be considered a normal reaction to stress, the development of good skills, coping, and adaptation for survival, as long as it manifests itself in a tolerable manner and proportional to daily events. However, when the manifestations become frequent, persistent, and disproportionate to the stimuli, causing interference in activities and lifestyle, anxiety should be recognized as a disorder. Because it is a very prevalent disorder among adolescents, undiagnosed and untreated anxiety can interfere with emotional development and impact quality of life, well-being, and even lead to a high probability of developing comorbidities. This narrative review presents some characteristics of adolescent development and aspects related to the onset of anxiety, highlighting its clinical manifestations, associated factors, consequences, screening and diagnostic methods, as well as currently recommended therapeutic approaches and preventive actions.

DOI: https://doi.org/10.54660/.IJMRGE.2025.6.6.1143-1148

Keywords: Anxiety, Adolescent, Emotional Disorders, Adolescent Anxiety

1. Introduction

Adolescence is a fundamental, complex, and dynamic period of development that occurs in the age range of 10 to 19 years, when the transition from childhood to adulthood is evolving, and is characterized by profound biological, psychological, and social transformations, associated with many doubts and challenges, which make the human being more vulnerable to the emergence of emotional problems, particularly anxiety disorders (AD). During this phase of life puberty also occurs triggered by hormonal activities responsible for changes in the shape and structure of the body, sexual maturation, and, also due to the neurological and emotional development typical of this period, causes repercussions on the formation of self-concept, self-image, and behavioral patterns so necessary for adaptation to more complex environments and situations [1]. In the social context, challenges arise with intra-family relationships, between peer groups, academic performance, and general well- being, which contribute to the emergence of excessive worries, fears, and eventual difficulties in daily life, as a source of stress that is generally not well managed, making the adolescent a person of greater cognitive and emotional vulnerability [2, 3]. During adolescence, the emotional control system tends to be less active, cognitive control is not yet developed, and the reward and stress response systems are hypersensitive. These brain characteristics at this stage of life may partially explain the vulnerability of adolescents to anxiety disorders (AD) [4].

Emotions play an important role in social adaptation and well-being in adolescents, helping to increase the ability to overcome challenges and barriers, idealize dreams, and plan their future life [5].

Anxiety is an inherent characteristic of human beings and can be considered a normal condition or reaction to stress, the development of good skills, coping, and adaptation for survival, as long as it manifests itself in a tolerable and proportionate manner to daily events. However, when manifestations become frequent, persistent, and disproportionate to stimuli, causing interference in activities and lifestyle, anxiety should be recognized as a disease [6-9]. Because it is a very prevalent disorder among adolescents, undiagnosed and untreated anxiety can interfere with emotional development and impact quality of life, well-being, and even lead to a high probability of developing anxiety and depression in adulthood [10-12]. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) presents some types of anxiety disorders observed in adolescents, namely [5, 10, 13-15]:

Generalized anxiety disorder: excessive, persistent, irrational, and difficult-to- control fears and worries about various nonspecific situations.

Social Phobia: persistent and intense fear of social situations involving possible evaluation by other people, in which one imagines being exposed to evaluation or behaving in a shameful way, and concern about humiliation or rejection.

Specific Phobias: excessive and persistent fear related to a particular object or situation, characterized by intense anxiety in relation to various discrete events of daily life.

Agoraphobia: intense fear or anxiety in specific situations such as using public transport, being in open or closed spaces, standing in lines or in crowds, and going out alone.

Post-Traumatic Stress Disorder: intense fear, feelings of helplessness or horror resulting from exposure to extreme trauma or a frightening event experienced or witnessed directly.

Panic Disorder: a discrete, intense period of anxiety, lasting a few minutes, characterized by increased heart rate, chest pressure, difficulty breathing, and other physiological symptoms of anxiety.

Obsessive-Compulsive Disorder: obsessions, intrusive thoughts or images that cause anxiety, distress, compulsions, or repetitive behaviors used to reduce anxiety or distress.

Separation anxiety disorder: excessive and/or inappropriate anxiety for age and development regarding separation from attachment figures.

Prevalence and pathophysiology

AD is the most common category of mental illness affecting adolescents, appearing after the age of 11 or 12 and increasing in recent decades, with prevalences reaching millions of individuals worldwide, equivalent to about 20% of this population, mainly in females [2, 16]. Some regions have a higher prevalence of AD, with higher rates in Latin America, the Caribbean, high- income regions of North America, and Western Europe. Although some authors have found prevalences of up to 20%, other studies have found some countries with lower prevalences such as Portugal (3.6%), Sweden (4.4%), Malaysia (8%), Brazil (9.3%), Qatar (12.7%), USA (13%), and India (19.6%) [1, 7, 8, 11, 14, 17, 18]. The variations found between different studies occur due to the use of different measurement tools, methods and time periods, making it difficult to compare the results, which demonstrates the need for the use of a standardized and validated instrument to improve comparability [9, 19].

AD emerge in early adolescence, which may demonstrate their relationship with the adolescent brain development process, which undergoes transformations such as myelination and synaptic pruning. Hormones that begin to manifest from the onset of puberty, associated with the demands of the external environment, also contribute to the remodeling of the central nervous system. These processes can trigger and/or mediate the onset and progression of AD among adolescents [4, 20, 21]. Also, it is recognized that structures such as the prefrontal cortex, hippocampus, amygdala, and hypothalamus, among others, are related to AD and can contribute to the development of the cognitive and emotional capacities of adolescents. The hypothalamus, as a central part of the hypothalamic-pituitary-adrenal axis, acts in the regulation of emotions, defensive behavior, aggression, and stress responses, controlling aggressive and anxious behaviors and influencing hormone synthesis in adolescence [4].

Associated factors [5, 10, 19, 22-26]

The emergence of AD in adolescents is related to complex interactions between multiple developmental, neurobiological, cognitive, genetic, and socio- environmental factors that contribute throughout the second decade of life to shaping the adolescent's evolution. Among the main factors related to anxiety, the following can be highlighted:

Genetic Factors: it is estimated that the heritability of the anxiety trait can vary between 30% and 60%. Children of one parent with AD have a higher risk of developing the same disorder.

Biological Factors: the physical changes that occur during puberty due to hormonal action are at the beginning of the process, resulting in increased body size and composition and maturation of the reproductive system. These changes have a decisive influence on the representation of body image, leading to a state of stress in the face of the establishment of self-esteem. Also, the maturation of the central nervous system, mainly the limbic system and prefrontal cortex, plays an important role in emotional development. Poor sleep habits.

Intrafamily Relationships: an important factor in the development of AD has been the functioning of the relationship between parents and children. Parenting styles and behaviors such as rigidity, control, overprotection, abuse, rejection, neglect, and lack of affection contribute to increased stress and anxiety. Having a caregiver with a psychiatric disorder represents both a genetic and environmental risk.

Social and Environmental Factors: family economic insecurity, difficulties in social relationships, exposure to violence and bullying, trauma, victimization, negative events (living in areas at risk for violence), school difficulties, academic pressure, negative evaluation by friends and teachers [2, 10, 27], excessive use of social networks and substance abuse [14, 17, 28].

Protective factors

Several protective factors have proven effective in both preventing and reducing anxiety symptoms in adolescents. Adequate family functioning is one of the main protective factors, as it provides an environment with safety, trust, emotional support, and stability. Regular physical activity also plays a significant role in promoting mental health, contributing to improved mood, increased well- being, and reduced sedentary behavior and stress [7, 29, 30].

Clinical manifestations [7, 10, 14, 19, 31].

The physical symptoms of anxiety in adolescents manifest as a response to the activation of the autonomic nervous system and include sweating, palpitations, chest tightness, nausea, chills, and muscle stiffness. Most adolescents may also experience restlessness, fatigue, dizziness, headache, stomach aches, myalgia, dysphagia, tingling in the extremities of the hands and feet, urgency to urinate and defecate, difficulty sleeping, and night awakenings. On the other hand, few patients may present with psychiatric complaints such as behavioral inhibition, avoidance, irritability, explosive and oppositional behaviors, need for reassurance, eating disorders, and suicidal thoughts or behaviors.

AD can occur concomitantly with physical or emotional illnesses or substance abuse, which can mask or worsen anxiety symptoms. Approximately 15% of adolescents diagnosed with anxiety have other comorbid psychiatric disorders, both homotypic (within the group of anxiety disorders) and heterotypic (between groups of disorders). Untreated anxiety increases the risk of depressive episodes by up to four times and tends to have a chronic course. Other disorders such as attention deficit hyperactivity disorder, oppositional defiant disorder, obsessive-compulsive disorder, eating disorders, and drug use may also be observed.

Screening and diagnosis [14, 31, 32].

Anxiety symptoms can present in a multidimensional way, ranging from an expected reaction to stress to exacerbated reactions. AD is considered to occur when symptoms persist for at least 6 months, are very intense, and cause impairment to the individual. To this end, some warning signs should be considered, such as: isolation, behavioral inhibition, difficulties in social relationships, and eye contact. The main diagnostic guidelines for mental health disorders are the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the WHO's International Classification of Diseases (ICD) [10, 33]. Routine screening for anxiety and other mental health symptoms should preferably be performed annually, associated with routine care for adolescents. In this context, the use of appropriate screening instruments is fundamental for early detection.

AD diagnosis is established through a clinical assessment, which requires the integration of information from multiple sources, including the adolescent, their parents, and, when possible, teachers and other people who have close contact with the patient, since changes in behavior may be difficult to recognize, requiring more observers to assist in identifying less expressive signs and symptoms or those eventually associated with normal adolescent syndrome [34]. Anxiety can be considered as a set of emotional, cognitive, behavioral, and physiological components that provide information obtained through clinical interviews, direct behavioral observation, monitoring protocols, questionnaires, and assessment scales. The psychiatric evaluation is carried out by the specialist through a thorough and complete diagnostic interview with the patient and family, where information will be obtained about the symptoms, frequency, duration, severity, and degree of interference in daily life [34].

The gold-standard semi-structured diagnostic interview is the Structured Interview for Anxiety Disorders, versions for adolescents and parents, which can identify each anxiety disorder, as well as possible comorbidities. Other instruments that can be used are: Kiddie Schedule for Affective Disorders and Schizophrenia, Screening for Childhood Anxiety-Related Disorders (SCARED), Multidimensional Anxiety Scale for Children (MASC), Generalized Anxiety Disorder Assessment (GAD-7), Pediatric Anxiety Rating Scale, Patient Reported Outcomes Measurement Information System, Pediatric Anxiety Rating Scale, Youth Anxiety Measure for DMS-5, Kiddie-Computerized Adaptive Tests, Patient Reported Outcomes Measurement Information System, Beck Anxiety Inventory, Phobia and Anxiety Inventory for Children (SPAI-C), DASS-Y (Depression, Anxiety and Stress Scale - Youth Version), S-R Inventory of Anxiousness, Multifactorial Scale of Anxiety, Penn State Worry Questionnaire-Children (PSWQ-C), Physical Indicators Measuring Heart Rates, Behar Preschool Behavior Questionnaire, Behavioral Rating Scale for Blood Sampling and Child Behavior Checklist (CBCL) [11, 13, 14, 35, 36].

Although these instruments cannot be used in isolation to diagnose an AD, they are important for screening and monitoring the severity of symptoms throughout the course of the illness. Anxiety screening is also important among young people who have experienced or are experiencing distressing or challenging life situations, such as chronic or debilitating illnesses, painful medical procedures, family separation, natural disasters or wars, situations in which such a reaction would be relatively normal [34].

Differential Diagnosis

Some clinical conditions should be considered in the differential diagnosis of anxiety, although they may occasionally manifest in comorbid settings, such as [5, 14, 17]:

1. **depressive disorders:** differentiated from anxiety symptoms by the presence of difficulty concentrating, anhedonia, dysphoria, feelings of worthlessness, and suicidal thoughts, which are more common in individuals with depression.
2. **attention deficit hyperactivity disorder:** persistent difficulty paying attention and concentrating in various situations and contexts.
3. **obsessive-compulsive disorder:** presence of obsessive ideas that manifest as intrusive or unwanted thoughts, impulses, or images.
4. **post-traumatic stress disorder:** arises after experiencing or witnessing a terrifying event, manifesting as reliving the trauma, avoidance of triggers, mood swings, and hypervigilance.
5. **somatic symptom disorder:** the target of anxiety is symptoms or concerns about health or the fear of having or acquiring a serious illness.
6. **Medical and substance use disorders:** diseases such as asthma, cardiac arrhythmias, diabetes mellitus, hyperthyroidism, adverse effects of medications or substances (caffeine, nicotine, alcohol, sedatives, stimulants), migraine, pheochromocytoma, systemic lupus erythematosus, vestibular disorders.

Consequences

AD significantly compromise the individual's overall functioning, interfering with family relationships and socialization, school performance, and emotional development. As a result, family conflicts, social isolation, early substance use [16], reduced academic performance, school dropout, bullying, reduced quality of life, and increased vulnerability to other emotional disorders [1, 2, 8, 11, 17, 19, 37, 38] can be observed. If not adequately treated, the difficulties associated with AD can persist into adulthood, following a typically chronic and debilitating course [8, 39].

Treatment

Treatment is based on psychoeducation and psychotherapeutic interventions (particularly cognitive-behavioral therapy - CBT) and, in moderate to severe cases, pharmacotherapy, preferably combined with psychotherapy. Early identification is essential to reduce morbidity, prevent recurrences, and promote healthy development [16]. Treatment for anxiety should be prescribed by a qualified professional and take into account the patient's age, severity of the clinical picture, history of previous treatment, presence of comorbidities, availability of the therapeutic proposal, and the decision should be shared with the patient and family members, who need to recognize the importance of the problem and the need for specialized treatment [8, 40]. In mild and moderate cases, the first indication is psychoeducation combined with CBT, individually or in groups, which is the modality with the most proven evidence of effectiveness [19]. This treatment modality seeks to help in understanding how thoughts affect mood and behavior. It is a directive approach with a limited duration, which addresses the factors that maintain anxiety symptoms. CBT has two components: modifying thought patterns (cognitive) and modifying behavioral patterns (behavioral). Cognitive restructuring is an essential aspect of CBT that helps adolescents become more aware, providing opportunities to examine the accuracy of their thoughts and replace them with more appropriate ones. The behavioral component uses strategies such as social skills training, relaxation techniques, and exposure to modify behavior [14, 27].

Interpersonal psychotherapy (IPT) posits that some people have risk factors, such as inappropriate interpersonal behaviors, that cause negative emotions, making situations or social relationships anxiety-inducing, which can lead to anxiety. IPT focuses on modifying these personal interactions to make them less stressful. Studies have shown that the combination of psychotherapy with pharmacotherapy yields the best results in reducing anxiety in adolescents [10]. Psychodynamic adolescent psychotherapy is a limited-duration therapeutic option designed to help improve the ability to reflect and better investigate and understand symptoms, beginning to articulate and explore the underlying psychological meanings associated with them [27].

The second option is pharmacological treatment, which may use medications from the class of selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), or tricyclic antidepressants [3], which requires frequent and rigorous monitoring due to its adverse effects such as worsening anxiety, headache, gastritis, sleep disorders, increased suicidal ideation and attempts. Although CBT is the preferred treatment for mild to moderate symptoms of AD, pharmacological treatment may be considered when the adolescent presents moderate to severe symptoms, is unwilling or unable to participate in psychotherapy, or has shown an unsatisfactory response to CBT [14]. In some situations, the use of combined psychiatric and pharmacological treatment, recommended by qualified professionals for patients with such conditions, may be considered by qualified professionals for patients with more severe conditions [10, 14].

Prevention

Due to the high prevalence and the various changes it causes in the lives of adolescents, it is of great importance that measures be adopted to help prevent anxiety disorders, in addition to the early detection of subclinical cases, which should be considered a public health priority [31, 41]. Prevention interventions aimed at modifying risk factors and/or strengthening protective factors can reduce the prevalence and impact of the disease and decrease the need for treatment. In this context, selective interventions indicated for groups of adolescents at high risk or universal interventions that can benefit the entire community should be highlighted [31]. Parental education and school program initiatives aimed at improving socio-emotional learning, as well as coping mechanisms that address cognitive, physiological, and behavioral processes, constitute excellent community strategies for the prevention of anxiety [19]. Physical conditioning programs can also mitigate anxiety disorders and be associated with other initiatives [2, 3].

Conclusion

Anxiety is a common mental disorder among adolescents and requires attention and recognition from health professionals and society as a whole. Early identification and appropriate management are essential to reduce negative impacts at any time, promoting the resumption of healthy development and improving prognosis. In this context, understanding clinical manifestations, diagnostic strategies, and possible treatments is a fundamental skill for healthcare professionals, especially those working on the front lines of pediatric care. Pediatricians, adolescent medicine specialists, and physicians working in primary healthcare play a key role in the initial diagnosis of anxiety in adolescence, as they are the healthcare professionals with the most regular contact with this population. This allows for a greater understanding of the adolescent's history and family dynamics, enabling the early identification of mild changes in behavior, mood, or patterns of social functioning, which often represent the first signs of these disorders. This allows suspected cases to be referred to mental health professionals earlier, enabling more effective interventions and reducing the negative impact of these conditions on emotional, academic, and social development.

References

1. Putri BK, Noer AH, Purba FD. Psychological factors influencing appearance anxiety among adolescents: a systematic literature review. Psychol Res Behav Manag. 2025;18:487-504.
2. Islam MA, Islam T, Saha BR, Al Hassan S, Hasan N, Rahman A. Prevalence of and factors associated with anxiety among school going adolescents analysis from 59 countries. J Affect Disord. 2026;93(Pt A):20315.
3. Chaturvedi DS. Perception on anxiety among adolescents and mental health professionals and development of comic strip. Indian J Psychol Med. 2023;45:271-276.

4. Xie S, Zhang X, Cheng W, Yang Z. Adolescent anxiety disorders and the developing brain: comparing neuroimaging findings in adolescents and adults. Gen Psychiatry. 2021;34:e100411.
5. Mallet P, Vignoli E, Lallemand N. Adolescent educational and occupational anxiety: a three-dimensional model to fit into an attachment framework. Int J Educ Vocat Guid. 2025;25:1005-1026.
6. Zeytinoglu S, Neuman KJ, Degnan KA, Almas AN, Henderson H, Chronis-Tuscano A, *et al*. Pathways from maternal shyness to adolescent social anxiety. J Child Psychol Psychiatry. 2022;63:342-349.
7. Sousa KS, Silva PO. Anxiety disorder in adolescents: impact on the development and worsening of other pathologies. Arq Ciên Saúde. 2023;27:1962-1973.
8. Alves F, Figueiredo DV, Vagos P. The prevalence of adolescent social fears and social anxiety disorder in school contexts. Int J Environ Res Public Health. 2022;19:12458.
9. Shen W, Zhang W, Ye M, Tan S, Yuan S, Wang S, *et al*. Profile of anxiety symptoms in adolescents in Zhejiang, China. J Affect Disord. 2026;395(Pt B):120787.
10. Garcia I, O'Neil J. Anxiety in adolescents. J Nurs Pract. 2021;17:49-53.
11. Casares MA, Lucas-Molina B, Díez-Gomez A, Perez-Albeniz A, Fonseca-Pedrero E. Screening for anxiety in adolescents: validation of the generalized anxiety disorder assessment-7 in a representative sample of adolescents. J Affect Disord. 2024;354:331-338.
12. Bao C, Han L. Gender difference in anxiety and related factors among adolescents. Front Public Health. 2025;12:1410086.
13. Baptista MN, Soares TFP. Revisão integrativa da ansiedade em adolescentes e instrumentos para avaliação na base Scientific Electronic Library Online. Av Psicol. 2017;16:97-105.
14. Kowalchuk A, Gonzalez SJ, Zoorob RJ. Anxiety disorders in children and adolescents. Am Fam Physician. 2022;106:657-664.
15. Spence SH. Assessing anxiety disorders in children and adolescents. Child Adolesc Ment Health. 2028;23:266-282.
16. Linan CA, Rocha GMP, Lucion MK. How to identify depression and anxiety in children and adolescents. J Pediatr (Rio J). 2026;102 Suppl 1:1-6.
17. Kerr B, Garimella A, Pillarisetti L, Charlly N, Sullivan K, Moreno MA. Associations between social media use and anxiety among adolescents: a systematic review study. J Adolesc Health. 2025;76:18-28.
18. Gupta SK, Prabhakar A, Kumar A, Arif N, Yadav SS, Ganta SR. Burden of anxiety in adolescent: a community-based study in Western Uttar Pradesh. Indian J Comm Health. 2023;35:441-447.
19. Rapee RM, Creswell C, Kendall PC, Pine DS, Waters AM. Anxiety disorders in children and adolescents: a summary and overview of the literature. Behav Res Ther. 2023;168:104376.
20. Duchesne S, Ratelle CF. Patterns of anxiety symptoms during adolescence: gender differences and sociomotivational factors. J Appl Dev Psychol. 2016;46:41-50.
21. Akiki TJ, Jubeir J, Bertrand C, Tozzi L, Williams LM. Neural circuit basis of pathological anxiety. Nat Rev Neurosci. 2025;26:5-22.
22. Anderson TL, Valiauga R, Tallo C, Hong CB, Manoranjithan S, Domingo C, *et al*. Contributing factors to the rise in adolescent anxiety and associated mental health disorders: a narrative review of current literature. J Child Adolesc Psychiatr Nurs. 2025;38:1-10.
23. Kramer L, Francis S. The relationships between adolescent anxiety sensitivity, parent emotional availability, and gender in the context of adolescent anxiety. J Psychopathol Behav Assess. 2025;47:17-29.
24. Romero-Acosta K, Gómez-de-Regil L, Lowe GA, Lipps GE, Gibson RC. Parenting styles, anxiety and depressive symptoms in child/adolescent. Int J Psychol Res. 2021;14:12-21.
25. Vallance AK, Fernandez V. Anxiety disorders in children and adolescents: aetiology, diagnosis and treatment. BJPsych Advances. 2016;22:335-344.
26. Kaur A. The roots of anxiety disorder in children and teenagers; what it is in detail. Int J Eng Res Technol. 2022;11:146-151.
27. Chen Y, Li X, Sun C. Causes and intervention of adolescent anxiety. In: Proceedings of 3rd International Conference on Interdisciplinary Humanities and Communication Studies; 2024. doi: 10.54254/2753-7064/51/20242514
28. Choi EJ, Christiaans E, Duerden EG. Screen time woes: social media posting, scrolling, externalizing behaviors, and anxiety in adolescents. Comput Human Behav. 2025;170:1-12.
29. Huishan S, Sheng G, Yuhe W, Linghua R, Hongya Z. Aerobic exercise strategies for anxiety and depression among children and adolescents: a systematic review and meta-analysis. Front Public Health. 2025;13. doi: 10.3389/fpubh.2025.1555029
30. Yang L, Wang N, Li D, Zhao X, Wen M, Zhang Y, *et al*. Social support and anxiety, a moderated mediating model. Sci Rep. 2025;15:29390.
31. Bennett K, Manassis K, Duda S, Bagnell A, Bernstein GA, Garland EJ, *et al*. Preventing child and adolescent anxiety disorders: overview of systematic reviews. Depress Anxiety. 2015;32:909-918.
32. Orgilés M, Méndez X, Espada JP, Carballo JL, Piqueras JA. Anxiety disorder symptoms in children and adolescents: differences by age and gender in a community sample. Rev Psiquiatr Salud Ment. 2012;5:115-120.
33. Atkinson S. Cultural contexts of adolescent anxiety: paradox, ambivalence, and disjuncture. Soc Sci Humanit Open. 2024;10:1-8.
34. Neelakandan A, Wuthrich VM. Anxiety and teacher-student relationships in secondary school: a systematic literature review. Child Psychiatry Hum Dev. 2025;56:1870-1888.
35. Viswanathan M, Wallace IF, Cook Middleton J. Screening for anxiety in children and adolescents: evidence report and systematic review for the US Preventive Services Task Force. JAMA. 2022;328:1445-1455.
36. Mangione CM, Barry MJ. Screening for anxiety in children and adolescents: US Preventive Services Task Force recommendation statement. JAMA. 2022;328:1438-1444.
37. Sasagawa S, Essau CA. Relationship between social anxiety symptoms and behavioral impairment in adolescents: the moderating role of perfectionism and

learning motivation. Eur J Educ Psychol. 2022;15:79-96.
38. Fanga L, Tonga Y, Lia M, Wanga C, Lia Y, Yuana M, *et al*. Anxiety in adolescents and subsequent risk of suicidal behavior: a systematic review and meta-analysis. J Affect Disord. 2024;358:97-104.
39. Galán-Luque T, Serrano-Ortiz M, Orgilés M. Effectiveness of psychological interventions for child and adolescent specific anxiety disorders: a systematic review of systematic reviews and meta-analyses. Rev Psicol Clín Niños Adolesc. 2023;10:1-41.
40. Amsel L, Kortenho J. Understanding adolescent anxiety disorders through the lens of decision science: towards a mathematical psychiatry. Pediatr Med. 2022;5:1-15.
41. Fisak BJ Jr, Richard D, Mann A. The prevention of child and adolescent anxiety: a meta-analytic review. Prev Sci. 2011;12:255-268.

How to Cite This Article
Del Ciampo LA, Del Ciampo IRL. Anxiety during adolescence: normal or pathological? Int J Multidiscip Res Growth Eval. 2025;6(6):1143–1148. doi:10.54660/IJMRGE.2025.6.6.1143-1148