INTERNATIONAL JOURNAL OF SOCIAL SCIENCE HUMANITY & MANAGEMENT RESEARCH

ISSN (print) 2833-2172, ISSN (online) 2833-2180

Volume 04 Issue 12 December 2025

DOI: 10.58806/ijsshmr.2025v4i12n21, Impact Factor: 6.79

Page No. 2392-2401

Reasons for the Emergence of Pessimistic Thoughts in Adolescence and Their Effects on Psychological Development

Prof. Dr. Pamir DİRİL[1], Ayşegül Yetkin[2]

[1]St. Clements Üniversitesi/Psikoloji A.B.D. Öğretim Görevlisi/Türkiye ORCİD ID: 0000-0001-8913-343X

[2]St. Clements Üniversitesi/Psikoloji A.B.D. Yüksek Lisans Ögrencisi ORCID ID: 009-0001-4191-8526

ABSTRACT: Adolescence, like childhood, adulthood, and old age, is a crucial developmental stage and deserves to be examined from various perspectives. This study examines the effects of pessimistic thoughts on adolescent psychological development and identifies the various dimensions of pessimism during adolescence from a psychological perspective. First, adolescence is briefly described. Then, pessimism is examined from various perspectives, including physical and sexual development, emotional development, moral development, social development, personality development, and mental health. Additionally, the special importance of personality and mental health development in this period, within the context of identity formation, is emphasized, and developmental tasks related to mental health are briefly discussed. The study concludes with some recommendations for parents and educators regarding this period.

KEYWORDS: Adolescence, Pessimism, Adolescent Pessimism, Psychological Effects

.

INTRODUCTION

Adolescence is a period when individuals experience significant physical, emotional, and social changes. The pessimistic thoughts seen during this period are often influenced by a number of factors. Here are the reasons for these thoughts and their impact on psychological development:

Causes of Pessimistic Thoughts:

Biological Changes: Adolescence is a period of significant shifts in hormone levels. These changes can cause mood swings and anxiety.

Reasons for the Emergence of Pessimistic Thoughts:

Biological Changes: Adolescence is a period of significant hormonal fluctuations. These changes can lead to mood swings and anxiety.

The Search for Identity: During this period, young people strive to shape their identities. Uncertainty and uncertainty can lead to pessimistic thoughts.

Family and Social Relationships: Family conflicts, complexities in peer relationships, and social pressures can lead to feelings of anxiety and pessimism in adolescents.

Academic Pressures: Pressures related to academic success, anxieties about the future, and the pressure of goals can cause adolescents to feel inadequate and experience pessimistic thoughts.

Media and Society: Media representation and constant comparisons on social media can create a sense of inadequacy in individuals, leading to a pessimistic outlook.

Effects on Psychological Development:

Emotional Health: Pessimistic thoughts can trigger the development of mental health problems such as depression and anxiety. Adolescents can become isolated in these situations and seek support.

Social Relationships: Pessimism can negatively impact individuals' social interactions. Young people may withdraw from friends and experience social anxiety due to negative feelings.

Self-Esteem: Pessimistic thoughts can undermine young people's self-confidence. Feelings of inadequacy can lead to lowered self-esteem.

Decision-Making Skills: Negative thoughts can influence adolescents' decision-making processes. Pessimism can make it difficult to cope with uncertainty about the future, which can prevent adolescents from seizing opportunities.

Academic Performance: Having pessimistic thoughts during adolescence can impact academic motivation. This can be linked to anxiety about studies and fear of failure, thus negatively impacting overall academic performance.

Supportive Strategies:

There are various strategies and supportive methods for coping with pessimistic thoughts:

Family Support: Family members should be sensitive to the emotional needs of adolescents and create an environment of open communication.

Social Support: Strengthening friendships and establishing social support systems is important. Engaging young people in positive social interactions can help reduce pessimistic thoughts.

Professional Help: A psychologist or counseling services can help adolescents cope with pessimistic thoughts. Individual or group therapy can be beneficial.

Reframing Negative Thoughts: Identifying negative thoughts and replacing them with a more positive perspective can help adolescents feel better about themselves.

Engaging in Activities and Hobbies: Physical activities, art, and other creative pursuits can help improve adolescents' emotional well-being. These activities play a role in supporting mental health.

METHODS

Document review was used to analyze various research articles on the subject conducted in Turkey and around the world. Before beginning the analysis, research selection criteria were defined. First, a keyword-based search strategy was created to collect the conducted studies. These searches used keywords such as "adolescence," "family relationships," "adolescent pessimism," and "psychological effects."

When selecting studies, we focused on articles published within the last decade, as adolescence is considered a period of rapid growth in the scientific literature. Many research articles that met the selection criteria were then evaluated for a detailed document review.

During the document review, the methods section of each article was examined in detail. Methodological details such as which measurement tools were used, how data were collected, how analyses were conducted, and how conclusions were drawn were extracted from the documents. Consequently, this research article examines the effects of adolescent pessimism and rumination on psychological development by analyzing numerous research articles from the last decade using the document review method.

Studies Reviewed

The studies reviewed in this article reveal that a positive, loving, and supportive environment provided by families for adolescents can boost their self-esteem (Özdemir & Adıgüzel, 2021). Furthermore, families that prioritize gender equality and accept emotional expressions from both genders have been identified as having positive effects on adolescents (Sezer, 2010). By emphasizing the importance of family relationships during adolescence, the research provides valuable insights into how parents can help their children build self-esteem and reduce pessimism and social anxiety.

FINDINGS

This research study examined various research articles to assess the interaction between adolescents' pessimistic thoughts, their psychological development, and family relationships, the link between social anxiety and family communication, and the effects of gender norms on

social anxiety.

Pessimism and Family Relationships: The Role of Interactions During Adolescence

Adolescents' identity development is based on their relationships with their families. This study demonstrates that the emotional bonds adolescents form with their families and their environment are an important component of self-esteem and pessimistic thoughts (Günay, 2022). The findings demonstrate that positive family relationships increase adolescents' emotional security and positively support pessimistic thoughts. On the other hand, negative situations such as conflict and excessive criticism within the family can harm adolescents' self- esteem. It has been observed that when adolescents feel accepted by their families, their self-esteem increases and their sense of social standing strengthens (Onur, 2023).

Social Anxiety and Family Communication

Social anxiety is a common problem among adolescents, and the family's role in this issue is critical. Data shows that the quality of communication within the family has a significant impact on adolescents' social anxiety levels (Kaya & Öz., 2020). By encouraging open communication and supporting their children's social interactions, families have the potential to reduce the risk of pessimistic thoughts and social anxiety. Furthermore, a supportive and understanding atmosphere has been found to contribute to adolescents' development of social skills.

Reasons for the Emergence of Pessimistic Thoughts in Adolescence and Their Effects on Psychological Development

The impact of gender roles and gender norms on adolescents' self-perception and social anxiety is well-known. Research suggests that families that do not discriminate against gender and embrace gender-neutral emotional expression have more positive outcomes for adolescents' self-esteem (Karamanoğlu & Elmas, 2021). These findings suggest that families can serve as role models for their children regarding gender equality and freedom of emotional expression, thereby contributing to adolescents' development of a more flexible perspective on gender norms.

What is Adolescence?

Adolescence is a period when pessimistic thoughts can arise; providing the necessary support mechanisms to navigate this process in a healthy way is crucial. Adolescence, defined as the transition from childhood to adulthood, is actually a sign of children's health. This period is when children grow physically, begin to develop gender-specific characteristics, and acquire reproductive abilities. The age of onset of puberty is generally linked to bone age; in girls, this becomes apparent at age 10 and in boys at age 11. In girls, this process is generally expected to begin between ages 10 and 11, while in boys, the first signs appear between ages 11 and 12. Each child's puberty is unique and should be addressed individually.

While the onset of puberty varies among ethnic groups, it can be said that it is fundamentally related to the child's bone age. Discussions about early puberty in children have increased in recent years. With improving socioeconomic conditions, particularly in Europe and America, it has been observed that the onset of puberty in girls has shifted earlier; however, there is no clear data demonstrating that this is reflected in the menstrual cycle. Rising obesity rates worldwide and increased parental awareness play a significant role in shaping this perception. In Turkish society, on average, puberty in girls generally begins around the age of 10-11; in boys, it generally occurs 1-2 years later. On average, girls complete puberty by menstruating between the ages of 12.5-13, while boys complete it between the ages of 14-15. The period between first breast development and menstruation lasts an average of 2-4 years, and the transition between these stages should last at least six months. In some cases, puberty can begin normally and progress rapidly; therefore, monitoring children during this period is crucial because it allows us to determine whether the transition periods are occurring at normal lengths.

Factors influencing the onset and end of puberty:

Gender Race

Parents' own pubertal experiences Birth weight

Nutrition Exercise Weight

Social and psychological factors can influence changes in an individual's mood. Adolescence, which typically occurs between the ages of 10 and 14, is characterized by mood swings; the effects of hormonal changes become more pronounced during this period. The timing of adolescent mood stability is an important consideration; hormonal balance generally occurs towards the end of puberty or the beginning of the twenties, and emotional regulation begins to develop, leading to a stabilization of moods. However, some young people may exhibit more consistent emotional states between the ages of 16 and 18.

Adolescence is also a critical stage for individuals' identity development. During this period, young people begin to question their own values, beliefs, and identities, while the importance of social relationships increases and their interactions with their environment increase. Therefore, it can be said that adolescence is a decisive period in individuals' identity discovery and definition.

This research aims to examine the self-perception and social anxiety levels of individuals during adolescence, based on studies conducted in Türkiye. Adolescents' self-perception is related to how they evaluate themselves, which is directly linked to their self-esteem and self-esteem. These two elements have significant impacts on adolescents' psychosocial well-being.

Pessimism Pessimism is often associated with a negative outlook. Pessimistic individuals tend to approach events from a negative perspective and may overlook positive aspects. They may feel hopeless about their future plans and focus on this situation, frequently conjuring up negative scenarios.

Pessimism has many causes, and these can vary from person to person. Factors such as a person's past experiences, the influence of those around them, and their stress and anxiety levels can all contribute to feelings of pessimism. This feeling can negatively impact not only a person's outlook on life but also their mental and emotional state.

A pessimistic person may have difficulty seeing things positively; they often focus more on the negative aspects. They even run the risk of having difficulty celebrating even the smallest successes.

Constantly evaluating oneself negatively can lead to long-term depression, excessive anxiety, and hopelessness.

What is Pessimism During Adolescence?

Risk factors during adolescence are highly sensitive to genetic, environmental, and cultural factors. The transmission of a family history of mental disorders to subsequent generations makes future generations of children and adolescents genetically more prone to mental disorders, making them vulnerable to certain risks.

Adolescence is characterized by rapid physiological growth; this process involves changes in the body and hormones. In addition to these hormonal and metabolic changes, one of the most significant events of adolescence is self-development. Conflicts related to identity formation, a sense of belonging, and sexual orientation, if not resolved healthily, can escalate into an identity crisis and

lead to various mental health problems.

Not only genetic predisposition but also environmental factors are important risk factors. Stress or previous trauma can predispose children to anxiety disorders, depressive symptoms, or somatic complaints. Chronic illnesses or family attitudes (e.g., domestic violence, neglect, or abuse) are also environmental risk factors that can trigger mental health problems.

Living in low socioeconomic conditions, being in at-risk adolescent groups, and poverty are among the most significant cultural/societal risk factors.

Emotional fluctuations during adolescence are a common occurrence, characterized by emotional instability and mood swings common in young people. Increased emotional sensitivity, increased reactivity, and a desire to intensely experience both positive and negative emotions are a natural part of adolescent development.

According to the National Institute of Mental Health (NIMH), approximately 14.3% of adolescents have some form of mood disorder, while 11.2% experience severe disorders. While these rates are common among adolescents, they can be alarming.

Adolescent mood swings can pose challenges for both adolescents and their parents; understanding and supporting adolescents during this time is crucial for their overall well-being and healthy development.

Moodiness in teenagers can be caused by a variety of controllable and uncontrollable factors, from hormonal changes to environmental challenges. Some common causes of moodiness during adolescence are listed below:

Hormonal Changes: During puberty, levels of hormones such as estrogen and testosterone increase; this can affect neurotransmitter levels in the brain, leading to mood swings.

Brain Development: Adolescent brain structure undergoes significant changes, particularly in areas related to emotional regulation and impulse control. These ongoing developments can lead to increased emotional sensitivity and heightened reactivity.

Identity Formation: Adolescents explore and shape their identities; this process can involve a range of emotions, lack of self-confidence, and confusion. The process of understanding who they are and their place in the world can contribute to mood swings.

Social Pressures: Adolescents often face pressures to fit in, meet societal expectations, and navigate complex social dynamics. These pressures can lead to feelings of stress and anxiety, which can manifest as mood swings.

Academic Demands: Increasing academic workload, expectations for good performance, and the pressure of expectations can lead to mood swings in teens, creating stress and frustration.

Family Dynamics: Changes in family dynamics, conflict, or difficulties in parent-child relationships can impact a teen's emotional well-being and contribute to mood swings.

Sleep Deprivation: Many teens struggle with inadequate sleep due to factors such as schoolwork, extracurricular activities, and the influence of technology. Sleep deprivation can negatively impact mood regulation and exacerbate mood swings.

Stressful Life Events: Major life events such as divorce, the loss of a loved one, or moving to a new school can cause emotional distress and lead to mood swings.

Peer Influence: Adolescents are highly influenced by their peers, and social interactions can have a significant impact on their emotional well-being. Peer pressure, conflict, or the desire for acceptance can contribute to mood swings.

Mental Health Issues: Mood swings can sometimes be an early sign of underlying mental health issues such as depression or anxiety. These conditions can disrupt mood regulation and intensify emotional swings. It's important to remember that these factors can contribute to mood swings in adolescents, but each individual is different, and specific causes and experiences may vary.

What Symptoms Does a Moody Teen Exhibit?

A moody teen exhibits a variety of symptoms that indicate fluctuating moods and emotional states. Here are some common signs and symptoms:

Emotional Instability: Mood swings are a hallmark of teenage mood swings. A moody teen may experience sudden and intense emotional shifts, such as going from happiness to anger or sadness in a short period of time.

Irritation: They may be easily irritated, frustrated, or irritable, often reacting more strongly than usual to minor annoyances or triggers.

Increased Sensitivity: Moody teens may exhibit increased emotional sensitivity, feeling hurt or offended by comments or situations they might normally handle with more resilience.

Withdrawal and Isolation: They may withdraw from social interactions, preferring to spend more time alone, or isolate themselves from family and friends.

Lack of Interest: A moody teen may exhibit a loss of interest in activities they previously enjoyed, such as hobbies, sports, or social events.

Fatigue and changes in sleep patterns: Mood swings may be accompanied by changes in sleep patterns, such as difficulty falling asleep, excessive sleepiness, or irregular bedtimes.

Appetite Changes: Some moody teens may experience changes in their appetite, such as increased or decreased food intake or a preference for certain types of foods.

Poor Concentration and Academic Performance: Mood swings can affect a teen's ability to concentrate, leading to poor academic

performance or decreased motivation and focus.

Physical Symptoms: In some cases, depression may be accompanied by physical symptoms such as headaches, stomach aches, or a general feeling of tension and discomfort.

Increased Risk-Taking Behavior: Some mood-stable teens may engage in impulsive or risky behaviors, seeking new experiences as a way to cope with their changing emotions.

Remember that mood swings are normal during adolescence; however, if these symptoms significantly impact a teen's daily functioning, persist for a long time, or occur alongside other concerning symptoms, it may be advisable to seek professional help from a healthcare professional or mental health professional.

When Does Mood Swings in Adolescence Become Abnormal?

Adolescent mood swings become abnormal when they significantly impact an adolescent's daily functioning, relationships, and overall well-being. Here are some indicators that mood swings may be more than just typical teenage behavior:

Duration and Intensity: If mood swings and emotional instability are persistent, intense, and occur for a period beyond what is considered normal for adolescence, they become abnormal.

Impairment in Functioning: If mood swings negatively impact the adolescent's ability to perform daily functions such as attending school, completing homework, maintaining social relationships, or participating in extracurricular activities.

Social Withdrawal: If the adolescent consistently withdraws from friends, family, and social activities, and shows a lack of interest in activities they previously enjoyed.

Excessive Behaviors: If there are significant changes in behavior, such as engaging in risky activities, developing substance abuse, expressing thoughts of self-harm or suicide.

Physical Symptoms: If persistent physical symptoms, such as chronic headaches, unexplained weight fluctuations, frequent stomach aches, or sleep disturbances, accompany mood swings.

Impact on Relationships: This occurs when the adolescent's mood swings create significant strain on relationships with family members, friends, or romantic partners, leading to frequent conflict or weakening meaningful bonds.

Other Mental Health Symptoms: If mood instability is accompanied by other concerning symptoms such as persistent sadness, excessive anxiety, changes in appetite or sleep patterns, a sense of hopelessness, or thoughts of self-harm, it is important to remember that adolescence is a challenging period and that mood swings experienced during this period can be a natural part of the developmental process.

What Mental Health Issues Can Cause Pessimism During Adolescence?

There are a variety of mental health issues that can cause or accompany mood swings during adolescence. Here are some issues that may be linked to mood swings during adolescence:

Major Depressive Disorder: Teens experiencing depression often experience a persistent feeling of sadness, hopelessness, and a loss of pleasure in activities. Symptoms of depression may also include changes in appetite and sleep patterns, fatigue, difficulty concentrating, and thoughts of self-harm.

Generalized Anxiety Disorder: Teens with this disorder often experience intense anxiety, restlessness, and irritability, which can make it difficult to manage their emotions. This constant state of worry can negatively impact their daily lives and lead to mood swings.

Bipolar Disorder: Bipolar disorder encompasses a wide spectrum of moods, ranging from periods of mania or hypomania to depression. Young people with this disorder exhibit complex symptoms. While older individuals exhibit symptoms similar to those of adults, adolescents may experience symptoms such as excessive energy, a sense of self-importance, increased sexual urges, substance or alcohol abuse, and a tendency toward criminal activity in their social circles. Suicidal thoughts are also common. Traumatic events can trigger bipolar disorder; therefore, it is important to carefully monitor children and adolescents who exhibit addictive or suicidal thoughts.

This situation should be taken seriously and evaluated for a mood disorder. With appropriate treatment, it is possible to overcome suicidal thoughts and other problems. It is important to investigate other psychiatric conditions that exhibit symptoms of bipolar disorder. Attention Deficit Hyperactivity Disorder (ADHD), other disruptive behavior disorders, intellectual disability, and metabolic causes should be considered. ADHD can often present symptoms before the onset of bipolar disorder symptoms; however, this does not mean that every child with ADHD has bipolar disorder. However, having a relative with a history of bipolar disorder in a child with ADHD increases the risk of developing bipolar disorder. If symptoms of mania are observed in children taking antidepressants or psychostimulants, a thorough evaluation for bipolar disorder is appropriate.

Attention Deficit/Hyperactivity Disorder (ADHD): ADHD can cause emotional dysregulation, impulsivity, and difficulty coping with frustration. These symptoms can lead to mood swings and irritability in adolescents with ADHD.

Substance Use Disorders: Substance abuse can cause mood swings in adolescents or worsen existing moods. Substances that affect mood can alter brain chemistry, leading to mood swings, irritability, and behavioral changes.

Eating Disorders: Characterized by loss of appetite and weight loss, like anorexia nervosa, this psychiatric disorder is quite

dramatic and presents with symptoms frequently encountered in general medicine. Insufficient understanding of the characteristics of anorexia nervosa can lead to some differential diagnostic challenges. Symptoms include excessive fear of gaining weight, inaccurate assessment of body weight, and a feeling of being overweight despite being very thin.

Anorexia nervosa generally occurs between the ages of 10 and 30, with a prevalence of 95% higher in women than in men. The disorder was first described by Gull and Laseque in 1873. Anorexia nervosa, which can lead to high mortality rates if left untreated and is increasingly prevalent in Western countries, has increased interest in the condition. Individuals suffering from anorexia nervosa have excessive preoccupations with their body weight and shape. These patients engage in strenuous exercise (e.g., walking, cycling, swimming) and strict diets to prevent weight gain. Following weight loss, 30-50% of these patients experience episodes of binge eating within approximately 1.5 years.

Due to anxiety about excess weight, individuals often tend to induce vomiting or use laxatives and diuretics after these binge eating episodes. Therefore, anorexic patients are divided into two subgroups: those who practice dietary restriction, known as the "restrictive type," and those who experience binge eating episodes, known as the "bulimic type." Both those who restrict their diet and those who experience binge eating episodes make significant efforts to remain thin and avoid foods containing carbohydrates and fats.

Depressive symptoms are known to be common with anorexia nervosa. In addition to depression, other mental disorders such as obsessive-compulsive disorder, histrionic features, anxiety, and hypochondriasis are also common. One study found anorexia nervosa in 26% of women diagnosed with obsessive-compulsive disorder. In another study, 60% of 30 patients with eating disorders had avoidant personality traits, while 7% had borderline personality traits. Thirty percent of individuals with eating disorders were found to have been sexually abused in
childhood.

The onset of the disease is often associated with stressful events. Anorexia nervosa has been observed to be more prevalent in models and ballerinas from middle and upper socioeconomic classes, where slimness is encouraged. Family dynamics and biological factors play a significant role in the development of this condition; it is also thought that these individuals have poor coping skills with the challenges of adolescence; the perception of thinness as a criterion of success in the social environment contributes to the development of anorexia nervosa.

Psychoanalysts argue that the inability to accept sexuality leads the individual to starve themselves and reject pregnancy, while theorists focusing on the mother-child relationship argue that anorexia nervosa stems from an inability to cope with conflicts during the individuation process. Although these individuals are assertive and competitive, they lack the ability to cope with the challenges of competition; this leads to a decline in their self-esteem, and they are reported to seek solutions in appearance. Cultural factors are emphasized as playing a critical role in this; anorexia nervosa is more common in young girls growing up with Western values.

While 40% of patients recover completely, 30% recover partially, and the remaining 30% become chronic. The mortality rate has been reported as 22%, and the suicide rate in chronic cases varies between 2-5%. The primary goal of treatment is to restore the patient's body weight, while the secondary goal is to reduce the individual's concerns about weight loss. Furthermore, increasing self-confidence and fostering individuality are also important. Other goals of treatment include alleviating physical complications (hypokalemia, dehydration) and treating existing psychiatric disorders (major depression, etc.).

While mild cases can be treated on an outpatient basis, this can be crucial when anorexia requires hospitalization. The primary goal of hospitalization is to ensure the individual learns appropriate nutrition to achieve healthy weight gain. Weight management strategies include nursing services, high-calorie diets, rest, behavioral modification techniques, mandatory treatments such as hyperalimentation and tube feeding, psychotherapy, and pharmacotherapy.

Borderline Personality Disorder

Borderline personality disorder (BPD) is characterized by unstable moods, intense emotional experiences, and difficulties with identity and relationships. Emotional fluctuations and instability are hallmarks of BPD. Only a qualified healthcare professional or mental health professional can diagnose these disorders. Before assessing whether your child is experiencing mental health problems, it is important to refer them to a specialist for a comprehensive evaluation.

ASSESSMENT

Adolescents between the ages of 10 and 19 undergo numerous developmental stages in physical, sexual, and psychosocial areas. These changes put them at risk of encountering various challenges.

Adolescents are challenged to cope with stress. During this period, young people adapt to the rapid changes occurring in their bodies, strive to become independent individuals by restructuring their relationships with their parents, fulfill academic requirements, and choose a career. They also interact with peers and other individuals, attempting to adopt appropriate social roles in social settings, and attempting to answer the question "Who am I?" by developing a unique value system. Each of these stages can create a different source of stress for adolescents. Developing effective stress coping skills provides significant advantages for

young people in both adolescence and adulthood. While adolescents who manage stress can achieve physical and psychological benefits, long-term stress can lead to numerous physical, emotional, and behavioral problems in adolescents who haven't mastered these skills. Serious problems can arise, ranging from headaches, stomachaches, and backaches to angry outbursts; from excessive anxiety to sleep disturbances; and from violent tendencies to depression and even suicidal thoughts. Because adolescents' stress coping skills are not yet fully developed, they need the experience and support of their parents to develop effective coping skills. Every child is unique; therefore, it's important to accept the fact that they may excel in certain areas and avoid comparing them to their peers.

Psychiatric disorders (depression, eating disorders, conduct disorder, alcohol and substance abuse and dependence, psychotic disorders, or suicide attempts) may occasionally occur during adolescence. This period is challenging for both the youth and the family. The way to cope with some problems is to seek professional help and implement the treatment methods listed below.

Behavioral and Pharmacological Treatments The American Academy of Child and Adolescent Psychiatry (AACAP) recommends that primary care clinicians collaborate with caregivers to assess the child's anxiety symptoms. Following the assessment, psychological or pharmacological treatment options should be considered depending on the severity of the symptoms; this decision should be based on the availability of psychosocial treatment options, as well as patient and parent preferences.

Psychological Therapies

Randomized trials for mild to moderate symptoms provide strong evidence supporting the use of cognitive behavioral therapy (CBT) as a first-line treatment, either individually or in a group setting. The number of treatments needed to achieve remission (NNT) for patients diagnosed with an anxiety disorder is 6, compared to waitlist controls. CBT focuses on the influence of thoughts on mood and behavior; it is a directive, time-limited approach to addressing the factors that maintain anxiety symptoms. Sessions can be conducted either with the child alone or with the child and their parents; they may also include homework assignments that provide the child with opportunities to practice outside of therapy. CBT treatment for childhood anxiety disorder typically lasts 12 to 20 weeks, with occasional booster sessions over several months to reinforce skills.

Cognitive Behavioral Therapy has two components: changing thought patterns (i.e., cognitive) and changing behavior patterns (i.e., behavioral). Cognitive restructuring is a core element of Cognitive Behavioral Therapy (CBT) that helps children or adolescents become more aware of their own self-talk and provides an opportunity to examine the accuracy of their thoughts and replace them with more adaptive ones. The behavioral component uses strategies such as social skills training, relaxation strategies, and exposure techniques to modify behavior. Exposure techniques are used to address avoidance behavior, which is known to maintain or worsen anxiety over time. A commonly used exposure technique is systematic desensitization, which is the gradual and progressive exposure to feared stimuli.

Pharmacological Therapy

While cognitive behavioral therapy (CBT) is the preferred treatment for symptoms of mild to moderate anxiety disorders, pharmacological treatment may be considered when the child or adolescent exhibits moderate to severe symptoms (e.g., panic attacks, inability to attend or refusal to attend school), is unwilling or unable to participate in psychotherapy, or responds poorly to CBT. Selective serotonin reuptake inhibitors (SSRIs) are considered first-line medications for anxiety disorders and are generally well tolerated. Fluoxetine (Prozac), sertraline (Zoloft), and escitalopram (Lexapro) are antidepressant medications that effectively treat childhood anxiety disorders. Serotonin-norepinephrine reuptake inhibitors (SNRIs) have also been shown to be effective.

Duloxetine (Cymbalta) is the only medication approved by the U.S. Food and Drug Administration (FDA) for generalized anxiety disorder in children aged seven years and older. In a 10-week randomized, placebo-controlled trial in adolescents aged seven to 17 years, duloxetine-treated patients were more likely to have a significant improvement in Pediatric Anxiety Rating Scale scores, remission (NNT = 6), and functional recovery compared to placebo. 16 In a large, multicenter, double-blind, randomized, controlled trial, patients aged six to 17 years receiving extended-release venlafaxine for generalized anxiety disorder and social phobia showed a significant improvement in symptoms compared to placebo over the eight-week trial period. 8 A Cochrane systematic review of 22 randomized trials concluded that the likelihood of treatment response was significantly greater with pharmacotherapy compared to placebo (58.1% vs. 31.5%; NNT = 4). The drugs were less well tolerated than placebo, but only 5% of participants withdrew from the studies due to side effects.

Antidepressants, such as SSRIs and SNRIs, have an FDA boxed warning indicating an increased risk of suicidal thoughts and behaviors in children and adolescents. Family physicians should discuss this risk with patients and their caregivers when obtaining informed consent and use medications selectively. Pharmacological treatment should be initiated at the lowest available dose of the selected drug and increased after the first week if tolerated. Symptoms should be monitored regularly after initiating pharmacological treatment. Typical therapeutic dose ranges are similar to those in adults because children tend to metabolize medications rapidly. 18–20 The long-term effects of antidepressant use in children and adolescents are unknown; therefore, the FDA recommends limiting the duration of use. AACAP recommends that children and adolescents continue taking medications for six to 12 months after anxiety symptoms improve and, if possible, begin tapering and stopping the medication at a less stressful time (e.g., at the end of school, early summer).

Combination Therapy

Cognitive behavioral therapy (CBT) and CBT combined with medication have been shown to be the most effective treatment for childhood anxiety disorders. A randomized controlled trial of 488 children with social anxiety disorder, generalized anxiety disorder, or separation anxiety disorder found that the combination of CBT and sertraline was more effective than CBT or sertraline alone (81% vs. 60% and 55%, respectively; NNT = 2, 3, and 3, respectively).

Prognosis

There is substantial empirical evidence demonstrating that psychotherapy or pharmacotherapy significantly improves childhood anxiety disorders, and that a combination of these therapies provides the most benefit. Despite effective treatments, some childhood anxiety disorders persist into adulthood. In a longitudinal study examining anxiety remission rates among 319 youth, researchers found that after four years, only 22% of study participants were in stable symptom remission, 48% had relapsed, and 30% were chronically ill. 23 Evidence-based treatments, early intervention, caregiver support and modeling, professional collaboration, and care coordination are important factors leading to a better prognosis.

Cognitive Behavioral Therapy has two components: changing thought patterns (i.e., cognitive) and changing behavior patterns (i.e., behavioral). Cognitive restructuring is a core element of Cognitive Behavioral Therapy (CBT) that helps children or adolescents become more aware of their self-talk and provides an opportunity to examine the accuracy of their thoughts and replace them with more adaptive ones. The behavioral component uses strategies such as social skills training, relaxation strategies, and exposure techniques to modify behavior. Exposure techniques are used to address avoidance behavior, which is known to maintain or worsen anxiety over time. A commonly used exposure technique is systematic desensitization, which is the gradual and progressive exposure to feared stimuli.

CONCLUSION

Family and school collaboration is critical when dealing with adolescent problems. A mental health professional conducts a comprehensive assessment and gathers information regarding the family's reason for referral; various scales and tests may be utilized during this process. In some cases, the source of the complaints may not be the youth but the family. Based on this assessment, an appropriate treatment plan should be developed that addresses the problem area, severity, onset, and the extent to which it impacts the functioning of the youth or family.

Medical treatment can be used to alleviate or eliminate the symptoms of the problems experienced by young people. It is crucial that medications are prescribed by a mental health professional (psychiatrist) in all cases. Psychotherapy can be administered in addition to or in conjunction with medical treatment. Appropriate psychotherapy methods are used to develop coping skills for family members and the adolescent, increase functionality, and reduce symptoms. The family is informed about their attitudes throughout the process, and parents are provided with psychoeducational support. Additionally, social and physical activities (meditation, breathing exercises, sports, and quantum drama) are recommended to complement these treatments.

REFERENCES

1) Çaçan, Ö. (2020). Examining the mediating role of cognitive emotion regulation strategies in the relationship between fear of negative evaluation and social anxiety symptoms. Published master's thesis,Istanbul Kent University, Istanbul.
2) Ergün, N. (2020). Identity development: narrative identity and intergenerational narrative identity. Current Approachesin Psychiatry, 12(4), 455-475.https://doi.org/10.18863/pgy.676439Erikson E. H. (1968). Identity: Youth and crisis (First). W.W. Norton.
3) Eriş, Y. & İkiz, F. E. (2013). The relationship between self-esteem and social anxiety levels of adolescents and the effects of personal variables. Journal of Turkish Studies. https://doi.org/10.7827/TurkishStudies.4726
4) Günay, B. (2022). Examining the relationship between adolescents' childhood psychological trauma, perceived parental attitudes, and their self-perception. Published master's thesis, Istanbul Gelişim University, Istanbul.
5) Harter, S., & Leahy, R. L. (2001). The construction of the self: A developmental perspective. https://doi.org/10.1891/0889-8391.15.4.383
6) Karamanoğlu, T. & Elmas, P. (2021). The mediating role of attitudes toward violence in the effect of self-esteem on ambivalent sexism. Notion: International Journal of Society and Culture Studies, 8, 116-128. 7.
7) Kaya, Y., & Öz, F. (2020). The role of perceived parental attitudes and attachment styles on adolescents' self-perception: A structural equation modeling. Journal of Psychiatric Nursing, 11(2), 106-114. https://doi.org/10.14744/phd.2020.74429
8) Onur, T. (2023). Examining the relationship between attachment styles and social anxiety in adolescents. Published master's thesis, Istanbul Gelişim University, Istanbul.
Özdemir, N., & Adıgüzel, V. (2021). The relationship between social intelligence, self-esteem, and resilience in healthcare professionals and the affecting factors. Journal of Psychiatric Nursing.

https://doi.org/10.14744/phd.2020.96658

9) Sezer, Y. Ö. (2010). The relationship between adolescents' self-perception and parental attitudes and some factors. Van Yuzuncu Yil University Faculty of Education Journal, 7(1), 1-19. Retrieved from https://dergipark.org.tr/tr/pub/yyuefd/issue/13709/165977
10) Steinberg, L. (2014). Family Structure, Parenting Practices, and Adolescent Adjustment: An Ecological Examination. Coping With Divorce, Single Parenting, and Remarriage: A Risk and Resiliency Perspective, 65. ISBN 9781410602893.
11) Susman EJ, Rogol A. Puberty and Psychological Development. In: "Handbook of Adolescent Psychology". (eds) Lerner RM, Steinberg L. 2nd ed. Hoboken, New Jersey. John Wiley & Sons, Inc. 2004;15-44.
12) Tekgül N, Göktay GA, Dirik N, Karademirci E, Ongel K. Tepecik Training and Research Hospital, Family Medicine Clinic, Alsancak Youth Counseling and Health Service Center Example, ÇİDEM. Smyrna Medical Journal 2012; 2(1-suppl1):33-35.
13) Tekgül N, Dirik N, Karademirci E, Bıçakçı B, Öngel K. Evaluation of the Knowledge and Attitudes of Adolescent Parents About Adolescence. Tepecik Education Hast Derg 2012;22(1):59-62.
14) World Health Organization. Promoting the health of young people in Custody, p. 7. Retrieved from [http://www.euro.who.int/document/e81703.pdf] on November 30, 2012.
15) Republic of Turkey, Ministry of Health, General Directorate of Maternal and Child Health and Family Planning: Youth Counseling and Health Service Centers SRH Education Module, Participant Guide. Ankara, Turkey, 2007.
16) Hacettepe University Institute of Population Studies: Turkey Demographic and Health Survey 2008. Ankara, Turkey, 2009.
17) Kreipe RE, McAnarney ER. Adolescence. In "Nelson of Pediatrics" (trans.ed.) Tuzcu M. 3rd ed. Istanbul, Nobel Medical Bookstores. 2001;226-262.
18) Çuhadaroğlu F. Characteristics of Psychological Development During Adolescence. Contribution to Pediatric Journal Adolescent Issue 2000;21(6):863-868.
19) Eneç Can F. Evaluation of Risky Health Behaviors among High School Students in Edirne City Center. Specialization Thesis. Trakya University Faculty of Medicine, Department of Family Medicine, 2007.
20) Neyzi O, Alp H, Orhon A. Sexual Maturation in Turkish Girls. Annals of Human Biology. 1975;2(1):49-59.
21) Turkey Reproductive Health Program, Strengthening Reproductive Health Services for Youth Aged 10-24. [http://www.tusp.saglik.gov.tr] Retrieved on 01/02/2012.
22) Tekgül BN, Uslu Tek P. Puberty. In: "Adolescent Health" (ed) Tekgül BN. İzmir, Publication of the General Practitioners Association. 2005;23-37.
23) Chambers CV. Childhood and adolescence. In: "Textbook of Family Practice" (ed) Rakel RE 5th ed. Philadelphia: W.B. Saunders Company. 1995;634-659.
24) Patton DD, Harris JR. Adolescent Development and Screening (trans.) Mazıcıoğlu MM. In: "Current Family Medicine Diagnosis and Treatment" (trans.) (Trans. Ed.) Kut A, Tokalak İ, Eminsoy MG. Ankara, Güneş Medical Bookstores. 2007; 129-138.
25) Kınık E. Physical Growth and Sexual Development in Adolescence. Contribution to Pediatric Journal Adolescent Issue 2000;21(6):720-740.
26) Tanner JM. "Growth at Adolescence". With a general consideration of the effects of hereditary and environmental factors upon growth and maturation from birth to maturity. Oxford, Blackwell Scientific, 2nd ed. 1962;325.
27) Jean Emans S., Laufer MR., Goldenstein DP. "Pediatric and Adolescent Gynecology" Philadelphia USA, Lippincott Williams & Wilkins. 1998.
28) Özcebe H. Approach to Adolescent Problems in Primary Care. STED 2002;11(10):374.
29) Gülay M. Health Measures of Adolescents. In "Adolescent Health". (ed) Tekgül BN. Izmir, Publication of the General Practitioners Association. 2005;87.
30) Ercan O. Physical Development of Adolescents. "Adolescent Health, II. IU Cerrahpasa Faculty of Medicine Continuing Medical Education Activities" Symposium Series No: 63. Istanbul, Aksu Publishing House. 2008;13-18.
31) Derman O. Psychosocial Development in Adolescents. "Adolescent Health, II. IU Cerrahpasa Faculty of Medicine Continuing Medical Education Activities" Symposium Series No: 63.2008;9-21.

32) Pataki CS. Normal Adolescence. In "Kaplan&Sadock Comprehensive Textbook of Psychiatry". (Translator) Aydın H, Bozkurt A. Volume 4. 8th edition. Ankara, Güneş Kitabevi. 2007; 3035-3043.
33) Piaget J. The birth of intelligence in the children. Oxford, England. Delachaux and Niestle 1937;429.
34) Göka E, Türkçapar MH. Youth and violence.Retrieved from [http://saglik.tr.net/ruh_sagligi_genclik_siddet_2.shtml] on December 15, 2011.
35) Çuhadaroğlu F, Tüzün Özgüner Z. Gender Identity Development and Disorders, Sexual Abuse. Contribution to the Journal of Pediatrics, Adolescent Issue 2000;21(6):877- 883.
36) Kanbur NÖ. "Preventive Health Services in Adolescents, Adolescent Health". Ankara, Adolescent Health Association Publications 2012;153.
37) Mathey E. This Thing Colled Sport. Y Health Physical 1969;40(2):38.