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ADOLESCENT ANXIETY: FAMILY PERCEPTION AND REALITY

ANSIEDADE EM ADOLESCENTES: PERCEPÇÃO FAMILIAR E REALIDADE

ANSIEDAD EN ADOLESCENTES: PERCEPCIÓN FAMILIAR Y REALIDAD

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ABSTRACT: This study aimed to analyze family members' perceptions of anxiety in adolescents, as well as to investigate the self-perception of these young people regarding their own levels of anxiety. The research adopted a quantitative approach, exploratory and descriptive in nature, and was conducted through the application of two instruments: a questionnaire for family members and another for adolescents, both linked to a programming and entrepreneurship school within a social project. The sample consisted of 36 families and 212 students, aged between 12 and 19 years. Data were collected through an online form administered by the institution's teachers and analyzed using the statistical software JASP (version 17.1). The results indicate a discrepancy between adolescents' and families' perceptions of the students' anxiety levels.

KEYWORDS: Adolescents. Self-Perception. Anxiety. Social Project. Family.

RESUMO: *Este estudo teve como objetivo analisar a percepção de familiares acerca da ansiedade em adolescentes, bem como investigar a autopercepção desses jovens em relação aos próprios níveis de ansiedade. A pesquisa adotou uma abordagem quantitativa, de natureza exploratória e descritiva, e foi conduzida por meio da aplicação de dois instrumentos: um questionário voltado aos familiares e outro direcionado aos adolescentes, ambos vinculados a uma escola de programação e empreendedorismo inserida em um projeto social. A amostra foi composta por 36 famílias e 212 estudantes, com idades entre 12 e 19 anos. Os dados foram coletados por meio de formulário online, administrado pelos professores da instituição, e analisados com o auxílio do software estatístico JASP (versão 17.1). Os resultados apontam uma discrepância entre a percepção dos adolescentes e das famílias sobre os níveis de ansiedade dos estudantes.*

PPALAVRAS-CHAVE: *Adolescentes. Autopercepção. Ansiedade. Projeto Social. Família.*

RESUMEN: *Este estudio tuvo como objetivo analizar la percepción de los familiares acerca de la ansiedad en adolescentes, así como investigar la autopercepción de estos jóvenes con respecto a sus propios niveles de ansiedad. La investigación adoptó un enfoque cuantitativo, de carácter exploratorio y descriptivo, y se llevó a cabo mediante la aplicación de dos instrumentos: un cuestionario dirigido a los familiares y otro a los adolescentes, ambos vinculados a una escuela de programación y emprendimiento integrada en un proyecto social. La muestra estuvo compuesta por 36 familias y 212 estudiantes, con edades entre 12 y 19 años. Los datos fueron recolectados a través de un formulario en línea, administrado por los docentes de la institución, y analizados con la ayuda del software estadístico JASP (versión 17.1). Los resultados muestran una discrepancia entre la percepción de los adolescentes y la de las familias sobre los niveles de ansiedad de los estudiantes.*

PALABRAS CLAVE: *Adolescentes. Autopercepción. Ansiedad. Proyecto Social. Familia.*

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INTRODUCTION

Throughout human development, individuals undergo numerous physical, sociocultural, and psychological processes that can directly affect the quality of life and expose them to various health risks (Miliauskas & Faus, 2020). During adolescence (ages 12 to 18), individuals experience major developmental transitions, ranging from physical changes to behavioral, psychological, and sociocultural shifts, often accompanied by periods of heightened vulnerability (Mühlen & Câmara, 2021; Miliauskas & Faus, 2020).

Anxiety disorders are among the most common mental health problems affecting children and adolescents, frequently leading to significant impairments in social behavior, academic performance, and family relationships (Lopes et al., 2024; Pereira et al., 2024). Early identification and effective intervention are crucial, as untreated anxiety can persist into adulthood and increase the risk of additional mental health issues. Anxiety disorders are commonly diagnosed in adolescents, with prevalence rates ranging from 2.6% to 41.2% (Cartwright-Hatton et al., 2006; Wehry et al., 2015).

Adolescent anxiety is associated with difficulties in peer relationships, school performance, and family life, often resulting in increased use of healthcare services and comorbidity with other emotional disorders.

Anxiety disorders may manifest as phobias, generalized anxiety disorder, separation anxiety, excessive screen use, apathy, and aggressiveness, among other symptoms. Without appropriate treatment, these disorders tend to persist and are associated with a higher risk of suicide, depression, and substance abuse in adulthood. Traditional therapeutic approaches, such as Cognitive Behavioral Therapy (CBT) and the use of selective serotonin reuptake inhibitors, have demonstrated effectiveness, particularly when initiated early (Storch et al., 2024).

Despite the proven efficacy of CBT, its application among adolescents faces barriers, including resistance to therapy and difficulties with adherence. Many adolescents refuse to participate due to fear, denial of the problem, or dependence on family accommodations. In this context, parental involvement has been suggested as an effective alternative, especially when the child is resistant to individual therapy. Intervention models such as Supportive Parenting for Anxious Childhood Emotions (SPACE)[1], for example, are entirely parent-based and aim to modify parental behaviors that maintain child anxiety, such as overprotection and avoidance of anxiety-provoking situations (Lebowitz et al., 2014).

"Family accommodation" refers to parental behaviors that, although well intentioned, reinforce avoidance and perpetuate anxiety disorders. Examples include allowing the

1 The objective of the SPACE program is to modify parental responses to children's anxious states by gradually reducing the accommodation behaviors on which the child has come to rely (Omer et al., 2013). The term can be translated as "Supportive Parenting for Anxious Childhood Emotions."

adolescent to sleep with the parents out of fear or repeatedly answering reassurance-seeking questions. The literature shows that high levels of accommodation are associated with poorer therapeutic outcomes. Systematically reducing these accommodations is one of the core components of the SPACE intervention (Rozenblat et al., 2023), with promising results even among children who resist traditional treatments (Lebowitz et al., 2014; Storch et al., 2024).

Despite the growing recognition of the family's role in adolescent anxiety, a gap remains in understanding perceptual discrepancies between parents and adolescents in Brazil, particularly in contexts of social vulnerability. Although parent-based interventions such as SPACE show promising international results, the underestimation of adolescents' anxiety by family members is a real barrier that may contribute to feelings of loneliness and misunderstanding among youth. Examining this perceptual gap is essential for improving strategies that foster communication and awareness within the family environment.

Health-related anxiety may begin in early childhood and persist into adulthood, with risk factors including exposure to severe illnesses and the intergenerational transmission of anxiety-related beliefs (Rask et al., 2024). Anxious adolescents tend to have lower emotional awareness, acceptance, and self-efficacy, and are more likely to use maladaptive coping strategies (Mathews et al., 2016).

Adolescent anxiety is also understood as a relational phenomenon, particularly within parent–child dynamics. When anxiety activates the attachment system, adolescents typically seek comfort from their parents, who respond with protective behaviors. This reciprocal dynamic may become entrenched in dysfunctional patterns. The SPACE model, inspired by principles of nonviolent resistance, trains parents to maintain a firm yet empathetic stance even in the face of oppositional or aggressive reactions from their children (Lebowitz et al., 2014).

Brazilian studies consistently highlight CBT as the psychotherapeutic treatment of choice, with strong evidence supporting its effectiveness in managing anxiety symptoms in children and adolescents. CBT focuses on teaching therapeutic strategies and techniques to help manage automatic negative thoughts, cognitive distortions, anticipatory worry, and irrational fears. Active parental participation is considered essential for treatment success, involving guidance on how parents can better support their children and manage anxiety symptoms (Almeida et al., 2023; Flôr et al., 2022; Martins & Cunha, 2021; Rodrigues, 2023).

The literature also underscores the importance of early diagnosis and intervention to ensure better prognoses and prevent the progression or worsening of anxiety among children and adolescents. Accurate diagnosis requires a careful clinical assessment by a mental health professional, using validated psychometric instruments and examining environmental factors and family history. It is crucial to distinguish between normal and pathological anxiety, the latter requiring clinical diagnosis (Almeida et al., 2023; Brito, 2011; Tavares et al., 2022).

In this context, the present study aimed to deepen the investigation of anxiety among adolescents enrolled in a social project, analyze parents' perceptions of adolescent anxiety levels, examine adolescents' self-perceptions regarding their own anxiety, and identify potential discrepancies between parental perceptions and adolescents' self-reported anxiety symptoms.

METHOD

This quantitative study sought to assess parents' perceptions of the anxiety levels of students enrolled in a Programming and Entrepreneurship school. To this end, the Childhood Trait Anxiety Scale (Assumpção Junior & Resch, 2006) was administered. This instrument evaluates manifestations of anxious reactions in children and adolescents and uses a cutoff score of 41:

- Score below 41: does not indicate a clinically significant anxious trait; may reflect situational or transient anxiety;
- Score equal to or above 41: indicates the presence of an anxious trait at a concerning level, although not necessarily diagnostic of an anxiety disorder.

The scale comprises 34 items, each rated according to the frequency or intensity of the behavior on a 4-point scale: 0 = Absent, 1 = Rarely, 2 = Frequently, 3 = Always. The Childhood Trait Anxiety Scale shows a sensitivity of 0.733 (73.3%) and specificity of 0.733 (73.3%).

These indicators reflect the instrument's capacity to adequately distinguish between children with and without anxious traits. Sensitivity refers to the proportion of true positive cases correctly identified—meaning that 73.3% of children with anxious traits are detected by the scale. Specificity refers to the proportion of true negative cases correctly identified—73.3% of children without anxious traits are accurately classified. These values indicate good performance as a screening tool, enabling reasonably precise identification of anxiety symptoms, although its use should be complemented with additional assessment procedures.

For the adolescents, the Multidimensional Anxiety Scale for Children (MASC) (Nunes et al., 2021) was applied. Developed to assess anxiety symptoms in children and adolescents, the MASC is a highly practical instrument. With an administration and scoring time of under 25 minutes, it serves as a valuable tool for routine identification of anxiety-related problems in this population.

Parents invited to participate were responsible for students enrolled in a social project offered by the Programming and Entrepreneurship School of the Municipality of Saquarema, which teaches digital technology to adolescents. Although nearly 300 families were involved, only 36 responded to the survey. Among the students—totaling 300—the scale was

administered by their teachers using an online form. A total of 212 responses were obtained, as participation was voluntary and not all students opted to take part. Participants' ages ranged from 12 to 19 years.

This study was approved by the UNASP Research Ethics Committee, CAAE: 80618324.6.0000.5377, approval number 7.028.982.

RESULTS

The findings of this study are presented below. First, the responses from family members are reported, followed by the results of the scale administered to students.

The parent-administered scale includes response options ranging from 0 to 3 (0 = Absent, 1 = Rarely, 2 = Frequently, 3 = Always). For analytical purposes, the mean values for responses 1, 2, and 3 were considered indicative of some level of anxiety for each item. The maximum possible score was therefore 6 points, divided by the four response options. Items with mean values of 1.5 or higher were highlighted. The median was 2 points, and the modes were 2 and 3 points.

Items with the highest mean scores are presented in Table 1.

Table 1
Items with the highest scores

Item	Mean
Q17 – Is afraid of the dark.	1.667
Q15 – Cries easily.	1.556
Q1 - Tends to be restless or worried about anything (exams, competitions, illnesses of close people, fights between parents...).	1.500

Note. Research data (2024).

For item Q15 ("Cries easily"), the option most frequently chosen by parents was "always" (3 points). In item Q1 ("Tends to appear restless or worried about anything…"), although the mean was 1.5, the most frequent response was "rarely." The same occurred for item Q17 ("Afraid of the dark").

The items Q28 to Q31—complains of chest tightness or difficulty breathing (regardless of physical exertion); has sleep difficulties (refuses to lie down, has bedtime rituals, requires company); difficulty swallowing (complains of a lump in the throat); startles easily with noises—showed very low mean scores, ranging from 0.139 to 0.250. These results suggest that such symptoms occur infrequently in the assessed group.

The descriptive analysis of the 32 items of the Childhood Trait Anxiety Scale, applied to 36 participants, reveals an overall mean score below the clinical cutoff (mean ≈ 29.4). Since

the cutoff point is 41, the group's average lies below the threshold for a clinically significant anxious trait. Nonetheless, some items registered higher mean scores, indicating frequent manifestations of anxiety symptoms in specific domains such as emotional self-regulation and fear of evaluation. These findings highlight the presence of relevant signs of anxiety in part of the group, underscoring the need for individual analyses to identify cases with heightened risk. As shown in Table 2, four students were identified by their families as having high anxiety levels.

Table 2
Individual scores

Family	Total scores	Family	Total scores
1	6	19	27
2	18	20	14
3	33	21	8
4	11	22	31
5	35	23	31
6	20	24	14
7	10	25	93
8	43	26	47
9	29	27	11
10	40	28	34
11	27	29	22
12	10	30	25
13	14	31	31
14	20	32	23
15	38	33	30
16	32	34	52
17	34	35	18
18	11	36	48

Note. Research data (2024).

Student Results

The scale applied to students consists of 37 items (numbered 1 to 39, with items 10 and 11 removed in the Brazilian adaptation). A commonly used cutoff point indicating elevated anxiety on the MASC is a score above 65. The items are organized into major factors and subfactors that assess different dimensions of anxiety, including:

- Physical Symptoms (Tension/Restlessness and Somatic/Autonomic)
- Social Anxiety (Humiliation/Rejection and Public Performance)
- Harm Avoidance/Danger Avoidance (Perfectionism and Anxious Coping)
- Separation Anxiety

The participating students were enrolled in a social project of the Municipality of Saquarema, Rio de Janeiro. Of the 300 enrolled students, 212 completed the scale. The average age of respondents was 14 years, with ages ranging from 12 to 19.

The student scale uses a 0–3 scoring system: 0 (Absent), 1 (Rarely), 2 (Frequently), and 3 (Always). For interpretation, scores of 2 or 3 on an item were considered indicative of anxiety. Based on this rationale, we highlight average scores of 2 or higher, as they denote the presence of the condition. The items with the highest scores were items 2, 6, 9, 13, 28, 33, and 39 (Tables 3 and 4).

Table 3
Items with the Highest Mean Scores

Questions	Mean
2. I usually ask for permission before doing things	1.667
6. I stay alert in case there is any danger	1.556
9. I try hard to obey my parents and teachers	1.500
13. I check things before doing them	1.976
28. I try to do everything exactly the right way	2.005
33. I get nervous when I have to do something in public	1.825
39. I feel ashamed	2.009

Note. Research data (2024).

Table 4
Students' Mean Scores

Questions	Mean	SD	Questions	Mean	SD	Questions	Mean	SD
q1	1.807	0.916	q15	1.208	1.073	q27	1.462	1.107
q2	2.193	0.879	q16	1.392	1.217	q28	2.005	0.956
q3	1.708	1.143	q17	0.679	1.022	q29	1.684	1.088
q4	0.665	0.818	q18	0.934	1.000	q30	0.528	0.823
q5	1.014	1.046	q19	0.986	1.042	q31	0.741	1.041
q6	2.292	0.865	q20	1.297	1.153	q32	0.953	0.982
q7	0.991	0.949	q21	1.877	1.068	q33	1.825	1.090
q8	1.354	1.145	q22	1.679	1.148	q34	1.052	1.040
q9	2.231	0.973	q23	1.009	1.135	q35	1.009	1.039
q12	0.958	1.085	q24	0.825	1.027	q36	1.774	0.986
q13	1.976	0.926	q25	1.920	0.997	q37	1.292	1.192
q14	1.406	1.129	q26	0.868	1.177	q38	1.500	1.182
						q39	2.009	1.026

Note. Research data (2024).

When summing students' scores—where individual totals across the 37 items could range from 0 to 111, with a cutoff score of 65 as defined by the instrument's author—it became evident that several students exhibited high levels of anxiety. The data also indicated that younger students tended to present higher scores (Tables 5 and 6). Among them, 12-year-olds showed the highest anxiety levels, followed by those aged 13 to 15, who had similar mean scores. Only at age 16 was there a slight decrease. However, when analyzing the mean scores:

Table 5
Ages and Mean Scores on the Trait-Anxiety Scale

Age	Mean	Age	Mean	Age	Mean	Age	Mean	Age	Mean
12	68	13	51,83	14	51,04	15	51,36	16	42,11

Note. Research data (2024).

Table 6

Ages and Individual Scores on the Trait-Anxiety Scale

Age	Total	Age	Total	Age	Total	Age	Total	Age	Total
12	84	13	100	14	83	15	88	16	87
12	52	13	94	14	83	15	79	16	61
		13	91	14	80	15	76	16	53
		13	89	14	79	15	70	16	47
		13	88	14	78	15	69	16	31
		13	87	14	77	15	68	16	28
		13	87	14	77	15	68	16	26
		13	82	14	76	15	67	16	26
		13	81	14	75	15	66	19	20
		13	79	14	74	15	65		
		13	75	14	73	15	64		
		13	75	14	72	15	64		
		13	74	14	72	15	63		
		13	72	14	70	15	63		
		13	70	14	69	15	62		
		13	67	14	69	15	62		
		13	66	14	67	15	61		
		13	62	14	67	15	61		
		13	62	14	67	15	60		
		13	62	14	66	15	59		
		13	61	14	66	15	57		
		13	61	14	66	15	55		
		13	59	14	65	15	54		
		13	57	14	65	15	54		

Note. Research data (2024).

Table 7 presents the analysis of affirmative responses by age group for 39 items of a self-report instrument focusing on emotional and behavioral aspects such as anxiety, fear, avoidance, shame, and physical symptoms. The highlighted items correspond to those with the highest scores within each age group.

Table 7
Items with the highest values by age group

	n = 2	n = 56	n = 98	n = 47	n = 8 + 1	ntotal = 212
Question	12 years	13 years	14 years	15 years	16 and 19 years	
1. I feel tense or nervous	5	98	180	86	12	381
2. I usually ask permission to do things	6	129	211	103	13	462
3. I worry that others will laugh at me	4	92	171	80	12	359
4. I get scared when my parents go out	2	35	69	29	5	140
5. I feel short of breath	4	50	105	49	6	214
6. I stay alert in case there is danger	4	130	227	106	17	484
7. The idea of being far from home scares me	2	51	108	43	5	209
8. I feel shaky or restless	3	78	132	66	7	286
9. I try hard to obey my parents and teachers	6	127	206	118	13	470
12. I feel dizzy or faint	4	51	97	43	7	202
13. I check things before doing them	5	118	180	96	18	417
14. I worry about being called on in class	3	83	144	59	8	297
15. I feel restless (startled)	3	75	114	58	5	255
16. I am afraid others will think I am silly	4	86	126	71	6	293
17. I leave the lights on at night	0	49	63	25	7	144
18. I feel chest pain	4	61	87	39	6	197
19. I avoid going out without my family	3	70	89	39	7	208
20. I feel strange or unreal	6	68	133	54	13	274
21. I try to do things that will please others	5	99	187	91	14	396
22. I worry about what others think of me	4	92	162	85	11	354
23. I avoid watching scary movies or TV shows	3	57	93	52	7	212
24. My heart races or “skips”	6	45	78	35	10	174
25. I avoid things that upset me	4	110	180	101	10	405
26. I sleep next to someone in my family	3	47	83	47	4	184
27. I feel restless and nervous	3	81	146	69	10	309
28. I try to do everything exactly right	5	119	189	98	12	423
29. I worry about doing something silly or embarrassing	5	104	155	81	10	355
30. I get scared when riding in a car or bus	2	26	64	18	2	112
31. I feel sick to my stomach on the bus	1	41	86	25	4	157
32. If I get upset or scared, I tell someone right away	0	61	87	51	2	201
33. I get nervous if I have to do something in public	4	109	175	88	9	385
34. I am afraid of storms, darkness, heights, animals, or insects	5	55	106	51	4	221

35. My hands shake	3	56	101	47	6	213
36. I need to be sure things are safe	5	98	175	88	8	374
37. I have difficulty inviting other boys or girls to play with me	3	67	138	56	9	273
38. My hands get sweaty or cold	3	79	158	67	10	317
39. I feel ashamed	4	106	197	100	17	424
Maximum possible score by number of respondents in the corresponding age group	**6**	**168**	**294**	**141**	**27**	**636**

Note. Research data (2024).

Items with consistently high frequencies across all ages suggest persistent traits, whereas specific peaks may indicate critical developmental moments.

DISCUSSION

According to parents, although the overall mean of the Childhood Trait Anxiety Scale remained below the clinical cutoff, some symptoms stood out, such as frequent crying, fear of the dark, and excessive worry about everyday situations. These indicators reveal signs of vulnerability, particularly concerning emotional self-regulation—an aspect previously highlighted by Mathews et al. (2016), who identified reduced emotional awareness and less adaptive coping strategies in anxious adolescents. In addition, the presence of isolated cases with high scores reinforces the importance of individualized analysis, as group averages may obscure more severe profiles.

Among adolescents, results were more pronounced: a substantial proportion exceeded the MASC clinical cutoff, indicating a high prevalence of anxiety symptoms. The 13–14 age group emerged as the most vulnerable, corroborating evidence that early adolescence is a critical period for emotional risk (Cartwright-Hatton et al., 2006; Wehry et al., 2015).

This developmental stage, marked by intense physical, cognitive, and social transformations, heightens susceptibility to experiences of misunderstanding, rejection, and social anxiety—factors that often overlap with anxious and depressive symptoms. These manifestations tend to intertwine during this transitional phase, as adolescents encounter contexts that foster negative perceptions of themselves and others. Rask et al. (2024) note that feelings of rejection and loneliness significantly contribute to lower self-esteem, which, in turn, constitutes a key risk factor for the development of anxiety in early adolescence.

The comparison between parents' perceptions and students' self-reports reveals a relevant discrepancy: parents tend to underestimate the intensity of symptoms, whereas adolescents report more pronounced anxious experiences that may trigger feelings of loneliness

and misunderstanding. This mismatch is already documented in the literature (Lebowitz et al., 2014), which highlights how parental behavior can either minimize or reinforce anxiety, whether through overprotective mechanisms or through so-called "family accommodation." The fact that students show higher anxiety levels than those reported by their caregivers reinforces the need for multimodal assessments that integrate diverse perspectives.

Another point to emphasize is the presence of physical symptoms reported by adolescents, such as palpitations, shortness of breath, and chest pain. These findings align with Storch et al. (2024), who underscore the multifaceted nature of anxiety, spanning emotional, cognitive, and somatic manifestations. Such symptoms require heightened attention, as they may be mistaken for medical conditions, delaying access to psychological support.

Overall, the findings of this study confirm the importance of early diagnosis and intervention (Brito, 2011; Tavares et al., 2022), while underscoring the need for strategies that actively involve both schools and families. Approaches such as CBT, widely recognized for its effectiveness (Almeida et al., 2023; Flôr et al., 2022), and parent-focused programs such as SPACE (Lebowitz et al., 2014; Rozenblat et al., 2023) emerge as promising alternatives.

Therefore, the results indicate that, although not all adolescents exhibit a generalized clinical picture of anxiety, there are consistent manifestations of relevant symptoms that justify preventive and interventional attention. Active collaboration among families, schools, and mental-health professionals is essential for promoting healthy emotional development and preventing the escalation of more severe anxiety disorders.

A central aspect highlighted by the data is the importance of adopting an individualized approach to anxiety assessment. Although group means fall below the clinical cutoff, isolated cases showed elevated scores, indicating substantial risk. This finding demands the implementation of systematic screening and periodic monitoring in school and mental-health settings to identify and promptly support high-risk adolescents, preventing severe cases from being obscured by group averages (Brito, 2011; Tavares et al., 2022).

Furthermore, the results indicate the need to strengthen support and intervention networks. The discrepancy between parental and adolescent perceptions substantiates the urgency of developing Psychoeducation Programs that clearly address signs of youth anxiety—including somatic symptoms—and promote active listening and dialogue within families. For the school environment, we recommend integrating emotional self-regulation skills into the curriculum and ensuring continuous teacher training for crisis management and appropriate referral of vulnerable students (Almeida et al., 2023; Flôr et al., 2022).

Finally, the findings directly align with the urgent need for investment in Public Policies that prioritize adolescent mental health. We recommend that public managers coordinate the development of Intersectoral Mental-Health Protocols linking school networks (for detection) with health networks (for intervention), ensuring early access to evidence-based programs

such as CBT and the SPACE program. Such measures are essential for reducing inequalities in access to care and preventing the chronicity of anxiety into adulthood (Onyeka et al., 2024; Storch et al., 2024).

FINAL CONSIDERATIONS

This study aimed to analyze the perceptions of family members regarding the anxiety of adolescents participating in a social project and to compare these data with the students' self-reports. By applying the Child Trait-Anxiety Scale to parents and the MASC to adolescents, it was possible to identify both convergences and discrepancies between these perspectives.

The results showed that, although the overall parental perception remained below the clinical cutoff, certain emotional symptoms—such as frequent crying, fear of the dark, and excessive worry—were recurrent, indicating meaningful vulnerabilities. In the adolescents' self-reports, a higher prevalence of anxious symptoms emerged, particularly those related to social anxiety, fear of evaluation, and somatic manifestations. The 13–14 age group proved to be more vulnerable, confirming evidence in the literature that early adolescence is a critical period of risk.

These findings contribute to the field of adolescent mental health by demonstrating that anxiety assessment should not rely solely on family perceptions, as this may lead to underestimation of adolescents' distress. The integration of multiple sources of information, coupled with early diagnosis and preventive interventions, is essential for a more effective approach.

From a practical and action-oriented standpoint, this study generates three immediate implications:

1. School Programs: The 13–14 age group, identified as more vulnerable, should be the primary target of universal school-based intervention programs focused on socioemotional skills, stress-management techniques, and reducing social anxiety and fear of evaluation. Schools must adopt multimodal evaluation protocols to avoid relying exclusively on parental perception;

2. Family Psychoeducation: Given the parental underestimation of symptoms, it is recommended that psychoeducational groups be structured using family-based intervention models such as the SPACE Program. These initiatives should equip caregivers to recognize signs of distress—including somatic manifestations—and reduce family accommodation behaviors that may reinforce anxiety;

3. Public Policy: The findings support the need for a youth mental-health policy that integrates the Departments of Education and Health. Such a policy should ensure funding for the inclusion of mental-health professionals in schools and the creation of rapid referral

pathways to CBT, ensuring early diagnosis and intervention as supported by the literature and by the results of this study.

Finally, a key limitation of this study lies in the fact that it was conducted within a single social project, restricting the generalizability of the findings. Future research should broaden the range of contexts investigated, include longitudinal analyses, and explore the influence of factors such as gender, social media use, and socioeconomic conditions on the manifestation of anxiety. Nevertheless, the results presented here offer relevant insights for understanding the phenomenon and for designing more comprehensive care strategies for adolescents.

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