



**UNIVERSITY OF PADOVA**

**Department of General Psychology**

**Bachelor's Degree Course in Psychological Science**

**Final dissertation**

**Inside the Anxious Mind: Cognitive Mechanisms  
in Youth Anxiety**

*Supervisor*  
**Professor Simone Cutini**

*Candidate: Carlotta Debiasi*  
*Student ID number: 2067418*

Academic Year 2024/2025

# Table of Contents

<b>ABSTRACT</b> .....	<b>1</b>
<b>INTRODUCTION</b> .....	<b>2</b>
<b>CHAPTER 1: ANXIETY</b> .....	<b>4</b>
DEFINITION .....	4
ANXIETY DISORDERS IN ADOLESCENTS .....	6
<i>Prevalence</i> .....	6
<i>Key Characteristics of Anxiety in Youth</i> .....	7
<i>Social and academic functioning of anxious youths</i> .....	10
<i>Prevention in schools</i> .....	10
<i>Inside out 2 Movie: the role of Anxiety</i> .....	11
<b>CHAPTER 2: COGNITIVE CONSTRUCTS OF ANXIETY</b> .....	<b>13</b>
INTRODUCTION .....	13
REPETITIVE NEGATIVE THINKING (RNT) .....	13
<i>Catastrophic thinking</i> .....	15
FEAR OF ERROR OR PATHOLOGICAL PERFECTIONISM .....	16
INTOLERANCE OF UNCERTAINTY .....	17
NEGATIVE SELF-ASSESSMENT .....	18
NEED FOR CONTROL .....	20
<b>CHAPTER 3: THE RESEARCH</b> .....	<b>22</b>
INTRODUCTION AND OBJECTIVE .....	22
HYPOTHESIS.....	22
METHODS.....	23
<i>Participants</i> .....	23
<i>Materials</i> .....	23
PROCEDURE .....	24
<i>Statistical Analysis</i> .....	24
RESULTS .....	25
<i>SCARED – results</i> .....	25
<i>ANOVA – results</i> .....	26
DISCUSSION .....	31
<i>Limitations and implications</i> .....	33
<b>CONCLUSION</b> .....	<b>34</b>
<b>BIBLIOGRAPHY</b> .....	<b>36</b>
<b>APPENDIX</b> .....	<b>40</b>

## **Abstract**

Anxiety disorders are some of the most prevalent psychiatric conditions, affecting about 1 in 12 children and 1 in 4 adolescents. In particular, anxious adolescents are characterized by impaired social and academic functioning. This thesis aims to study the relationship between anxiety and five cognitive constructs: repetitive negative thinking (RNT), drive to control, intolerance of uncertainty, concern over mistakes and negative self-evaluation. Seven questionnaires were administered to high school students at Istituto Artigianelli in Trento (TN), Italy. The results indicate a high prevalence of anxiety among students and reveal age-related effects on obsessive-compulsive symptoms and self-esteem. Anxiety remains a topic of significant concern, and further research is needed to reduce its burden.

### **Key words**

Anxiety, Adolescence, Cognition

# Introduction

Almost all of us have felt anxious at times. The feeling of uneasiness when thinking about the future. The uncertainty about what is to come. Anxiety is an evolutionarily adaptive mechanism, and its role is to prepare us to face a future event, for example before a job interview, a social interaction or a test at school. However, when anxiety exceeds normal levels, it may hinder our daily life, preventing us to live fully. For instance, it might prevent us to go out and enjoy the company of some friends, or to experience something new. Its paralysing effect is just one of the numerous consequences of a disruptive anxiety. Adolescence, in particular, is a period marked by significant physical and psychological changes and anxiety can take on various forms, negatively affecting young people's emotional well-being, social functioning and academic performance. The goal of this dissertation is to analyse the cognitive component of anxiety in order to better understand the underlying mechanisms that help sustain its disruptive cycle.

For this project, I have collaborated with Istituto Artigianelli: a true “ecosystem” in the heart of Trento, dedicated to supporting high school students in their growth – both professionally and personally. I collaborated with their team of psychologists and teachers to deeply explore the phenomenon of anxiety in adolescence. In particular, I had the opportunity to collect personal reflections directly from the students on this topic. Additionally, I was able to administer several questionnaires to gain deeper insights into the various cognitive constructs involved. Thanks to my practical internship, I was able to fully immerse in the academic context and to observe directly the students during their schooldays for three months.

The thesis is structured into four chapters. The first chapter aims to provide a general definition of anxiety and explore its implications in adolescents. The second chapter then focuses on a specific component of anxiety: cognitive constructs. In particular, the discussion centres on repetitive negative thinking (RNT), the drive for control, intolerance of uncertainty, concern over mistakes (or pathological perfectionism), and negative self-evaluation. Lastly, the third chapter presents the results obtained from the empirical research, discusses the practical implications of the findings and outlines potential directions for future research in this field.

This research aims to provide new insights for the treatment and management of adolescent anxiety, with the goal of developing more targeted intervention strategies and supporting the healthy development of adolescents. Additionally, raising awareness and reducing stigma surrounding

anxiety disorders can encourage more people to seek help, ultimately fostering a more compassionate and supportive society.

*“When I enter a classroom where I don't know anyone, I wonder: where should I sit?  
I find an empty seat and try to approach. I ask if I can sit there.  
Will I be a bother? Will these people like me?  
I sit down. And now? What should I talk about?  
I don't know — I'm anxious, my heart is racing, I have a lump in my throat.  
The teacher asks me a question, but I don't know the answer.  
What do I do? Should I stay silent? I blush and get confused. I feel embarrassed.  
During the next class, we go to the gym. We have to form teams.  
Where should I go? Should I go with them? No, they'll probably think I'm not good enough.  
I panic and don't know what to do, so I end up standing alone in the middle of the room while everyone  
stares at me.  
I feel judged. Am I not good enough?” — student, 1<sup>st</sup> year<sup>12</sup>*

---

<sup>1</sup> Original quote in Italian: *“Quando entro in una classe in cui non conosco nessuno mi chiedo: dove mi siedo? Trovo un posto libero e provo ad avvicinarmi. Chiedo se posso sedermi. Darò fastidio? Starò simpatica a queste persone? Mi siedo. Ed ora? Di cosa parlo? Non lo so, sono in ansia, mi batte il cuore, ho un nodo alla gola. La prof mi fa una domanda ma non so la risposta. Cosa faccio? Sto zitta? Divento rossa e vado in confusione. Sono imbarazzata. L'ora dopo andiamo in palestra. Dobbiamo decidere le squadre. Dove vado? Con loro? O no, gli sembrerò troppo scarsa. Vado in ansia e non so cosa fare, finisco per stare in mezzo alla stanza sola e tutti mi fissano. Mi sento giudicata. Sono sbagliata?” – studente, 1° anno*

<sup>2</sup> All translations from Italian are mine unless otherwise noted.

# Chapter 1: Anxiety

## *Definition*

There are varying definitions of anxiety in the literature (Rachman, 2004). However, some key characteristics are unequivocally associated with the concept of anxiety and its several forms, starting from a non-pathological condition to a severe form of the disorder.

The American Psychiatric Association (APA) defines anxiety as “an emotion characterized by apprehension and somatic symptoms of tension in which an individual anticipates impending danger, catastrophe, or misfortune” (APA, 2018a). Worry and negative thinking are key characteristics of an anxious state. Repetitive thinking about future threats is seen as a way to avoid harm, prepare for the worst, and solve problems (Watkins, 2022). APA continues specifying that “Anxiety is considered a future-oriented, long-acting response broadly focused on a diffuse threat.” Therefore, it can be defined as the “anticipated expectancy of future danger or negative events” (Perrotta, 2019). The idea is that the body starts a response of alarm and fear toward an event, creating a state of psychophysical arousal. Such states arises either in absence of real danger or produces a response disproportionate to the stimuli.

Moreover, anxiety is described by many authors, including Nisita and Petracca (Colombo G., 2001) as an “objectless fear”. This term underlines the nature of anxiety as a diffuse and persistent sense of apprehension that lacks a specific, identifiable source. Unlike fear, which is typically triggered by a concrete and immediate threat, anxiety often arises without a clear external stimulus. This characteristic makes it more challenging to manage, as the individual may struggle to pinpoint the exact cause of their distress.

Another important aspect of anxiety cited in the APA definition is the appearance of somatic symptoms: “The body often mobilizes itself to meet the perceived threat: muscles become tense, breathing is faster, and the heart beats more rapidly.” This type of response is called “fight or flight”, and it prepares the body to face a potential danger (Hoehn-Saric & McLeod, 2000). The sympathetic system activates and starts a sequence of changes in heart rate, blood pressure, sweat gland activity, and respiration, gastrointestinal and bladder activity. This creates a rush of energy through our body that is usually freed by tapping your foot, fidgeting with your fingers and hands, twirling your hair, and similar movements.

To sum up, anxiety can be divided into three interrelated components: cognitive, emotional and physiological (Luana Marques, 2020). Firstly, the cognitive component is characterized by worry and negative thinking. Secondly, the emotional component comprehends the feelings of fear and alarm. Lastly, bodily sensations and other somatic symptoms make up the physiological component. Anxiety, in its non-morbid condition, is a part of the nature of humankind (Perrotta, 2019). The unpleasant feelings of worry and uneasiness are an evolutionary response which is fundamental for one's life. It is a natural reaction of our body that gets us ready to confront what it considers a threat.

Anxiety, therefore, exists on a continuum: from an adaptive process to a mental disorder. At normal levels, it is useful to avoid dangers and continue one's existence. However, as soon as it exceeds such levels, it can become problematic. One of the main consequences of an anxiety disorder is, in fact, an impairment in daily functioning. Understanding this spectrum is crucial for early identification and intervention in cases where anxiety transitions from an adaptive mechanism to a disorder requiring professional help.

*"What is anxiety to me? A parasite. Something that gnaws at you from the inside. An empty feeling in the stomach that spreads through every cell of the body, traveling from the nervous system to the bones. A civil war within my organism, where the impulsive side overpowers the rational one.*

*We know that negative emotions are more likely to defeat positive ones, yet we still struggle to accept it. Even though I know that this is a feeling I should not pay attention to, I always find myself swallowed by a vortex of torment that refuses to let me go. It clings to me, whispering wicked words, telling me that everything will go wrong and there is nothing I can do to prevent it. A stabbing pain hits my stomach, nausea pervades me, and my bones weaken. My legs seem to betray me, along with my consciousness.*

*A whirlwind of thoughts delays my ability to recover—indeed, it cancels it (at least for a limited time, depending on the seriousness of the situation).*

*Perhaps I shouldn't even say "seriousness," because after all, my body betrays me even for the smallest things, not allowing me to live in peace." – student, 3rd year<sup>3</sup>*

---

<sup>3</sup> Original quote in Italian: *"Cos'è per me l'ansia? Un parassita. Un qualcosa che ti logora dall'interno. Una sensazione di vuoto nello stomaco che si propaga in tutte le cellule del corpo, che viaggia dal sistema nervoso alle ossa. Una guerra civile nel mio organismo, dove la parte più impulsiva sovrasta quella lucida. Si sa che le emozioni negative sono quelle più propense a vincere contro quelle positive, eppure non riusciamo ad accettarlo. Nonostante io sappia che è un sentimento a cui non devo dare peso, mi ritrovo sempre inghiottita da un vortice di tormento, che non osa lasciarmi andare. Mi tiene stretto a se, sussurrandomi parole scellerate, dicendomi che tutto andrà male e non posso fare niente per impedirlo. Una fitta allo stomaco mi colpisce, il senso di nausea mi pervade e le ossa si indeboliscono. Le gambe sembrano tradirmi, e con loro la mia coscienza. Turbine di pensieri differiscono la mia possibilità di ripresa, anzi, la annullano (almeno per un limitato periodo di tempo, che varia dalla gravità della situazione). Forse non faccio bene a dire "gravità", perché dopo tutto il mio corpo mi tradisce anche per le minime cose, non permettendomi di vivere in pace." – studente, 3° anno*

## *Anxiety disorders in adolescents*

### *Prevalence*

Anxiety disorders are some of the most common conditions which can arise in childhood and adolescence. Research suggests that over 7% of adolescents aged 13 to 17 have received an anxiety diagnosis, while more than 36% of children with behavioural issues have been diagnosed with anxiety disorders (Ghandour RM, 2019). Additionally, a systematic review of studies across 27 countries estimates the global prevalence of anxiety disorders in children to be 6.5% (Polanczyk GV, 2015). Data on the prevalence of this disorder states that nearly 1 in 12 children and 1 in 4 adolescents is affected (Ghandour RM, 2019).

The true prevalence of anxiety disorders is likely even higher, as many children and adolescents go undiagnosed and untreated (Neil, 2009). Unfortunately, the consequences of a missing or untreated diagnosis can lead to severe academic and social dysfunction (Chiu et al., 2016). Similarly, it can cause problems in the family environment (Chiu et al., 2016). Neglected anxiety disorders during childhood and adolescence can result in limited career opportunities due to absenteeism and lower academic performance, increased medical visits, and a higher risk of developing depression and substance abuse in adulthood (Donovan, 2000; Rapee, 2005). Given the high prevalence, the costs associated with paediatric depression, and the challenges of treating depression once it has developed, proactive efforts to prevent anxiety and depression in young people are essential (Gladstone, 2009). Moreover, research states that youth anxiety increases the probability that children and adolescents will suffer from anxiety in adulthood (Mattison, 1992).

Despite all these consequences, many cases are either unrecognized or unmanaged (Essau CA, 2005). In general, one of the main reasons for this deficiency is the fine boundary between an adaptive mechanism and a disease. Fear in children and adolescents, as in adulthood, is a natural response to a perceived threat and can be beneficial when it helps them avoid potential danger (Chiu et al., 2016). In addition, anxiety is seen as a transitory and nonthreatening phase of adolescence. Therefore, such diagnostic challenges constitute an important consideration for clinical practice and future research. To prevent these complications, the most effective approach would be to develop and implement early intervention strategies (WHO, 2004).

## *Key Characteristics of Anxiety in Youth*

While the DSM-5 offers essential symptom criteria for diagnosing anxiety disorders, recognizing the core features of anxiety can assist clinicians in identifying anxiety in young individuals.

At least seven key characteristics define anxiety in children and adolescents (Chiu et al., 2016):

- hypervigilance,
- reactivity to novel or changes in stimuli,
- heightened sensitivity to threat,
- avoidant coping,
- somatic complaints,
- catastrophic reactions,
- parental accommodation.

Anxious children are often hypervigilant. Therefore, they tend to scan the environment in order to detect some sign of danger or threat. This heightened awareness can make them overly sensitive to subtle cues, leading to misinterpretations of harmless situations as threatening. Depending on the source of threat, anxiety disorders can be differentiated. For instance, a boy who is constantly worrying about judgement and social interactions might suffer from social anxiety. Similarly, a girl who is fears that her friends might leave her at some point might have separation anxiety. Other types of sources are listed in Table 1.

Moreover, children with anxiety are usually hypersensitive to change in their surroundings. Even minor alterations in their routine or environment can cause significant distress, leading to feelings of uncertainty and discomfort. This heightened sensitivity may result in avoidance behaviours, difficulty adapting to new situations, or excessive reassurance-seeking from caregivers and teachers.

Another core characteristic in anxiety in childhood and adolescence is indeed an avoidant coping style (Zhang, 2024). Children and adolescents with anxiety often cope by avoiding situations that trigger their fears. They may attempt to delay or escape these experiences through behaviours like negotiating, complaining, delaying, or becoming visibly distressed. For example, children with separation anxiety struggle with being away from their loved ones and may resist going to school, attending camp, sleeping alone, or staying with a new caregiver, sometimes even feeling uneasy when in a different room from a family member (NHS, 2025). In contrast, those with social anxiety may dodge social interactions and performance-based activities, such as speaking in class, taking tests,

participating in sports or creative pursuits, making phone calls, or even eating in public (Voncken et al., 2012).

Following a more physiological point of view, anxiety is characterised by somatic symptoms. Common somatic complaints include tension headaches, stomach-aches, dizziness, nausea, hyperventilation, palpitations, muscle tension, sweating, shaking, tingling in extremities, bladder or bowel urgency, chest pain or discomfort, problems swallowing, difficulty falling or staying asleep, and chills or hot flashes. These symptoms arise due to the activation of the autonomic nervous system, particularly the sympathetic branch, which prepares the body for a perceived threat. As mentioned before, this response is commonly known as "fight or flight." (Perrotta, 2019). This physiological state results in increased heart rate, rapid breathing, and heightened muscle tension, all of which contribute to the physical manifestations of anxiety. Moreover, chronic anxiety can lead to long-term health effects, such as gastrointestinal issues, cardiovascular strain, weakened immune function, and disruptions in sleep patterns. The persistent activation of stress hormones, including cortisol and adrenaline, may contribute to fatigue, irritability, and cognitive difficulties such as problems with concentration and memory. Understanding the somatic symptoms of anxiety is crucial for distinguishing it from other medical conditions and for developing effective coping strategies, including relaxation techniques, cognitive-behavioural interventions, and, in some cases, medication.

Catastrophic reactions may also be included in the description of youth anxiety. When the feared situation cannot be avoided, children with anxiety tend to respond disproportionately, like crying, excessive reassurance-seeking, whining or yelling. These reactions can be triggered by a specific condition: the anticipation of the feared situation. To support healthy development, parents should encourage their children to face their fears instead of shielding them from discomfort. This practice, known as parental accommodation, may seem helpful in the short term but can actually reinforce anxiety. When children rely on avoidance, they miss the opportunity to develop self-efficacy and learn effective coping strategies (Jones et al., 2019).

While talking to students at Istituto Artigianelli, several contexts emerged as common sources of anxiety. School, in particular, is a key setting. Many students reported feeling anxious during tests, when receiving their grades, or while presenting in front of the class. The social sphere also plays a significant role in youth anxiety. Students often experience discomfort when meeting new people, fearing judgment or feeling uneasy in everyday social situations, such as taking public transport. Another context that frequently came up is sports. Performance anxiety is especially common among

adolescents during competitions, when the pressure to perform perfectly and avoid mistakes becomes overwhelming.

*Table 1: Threat Bias by Anxiety Disorder (Chiu et al., 2016)*

<b>Disorder</b>	<b>Source of Threat</b>	<b>Common Presentations</b>
<b>Separation anxiety disorder</b>	Excessive fear or anxiety about losing major attachment figures or persistent worry about an untoward event (e.g., getting kidnapped, getting lost) that will cause separation from major attachment figures	Co-sleeps; follows caregiver around the home; avoids being in separate room from caregiver; repeatedly calls caregiver when separated; avoids school, camp, and other activities requiring separation
<b>Social anxiety disorder</b>	Fear of humiliation or embarrassment in situations involving performance or scrutiny by others	Avoids raising hand or speaking in class; avoids eye contact; avoids ordering food in restaurants; avoids talking on the phone, texting, or e-mailing peers; refuses to initiate conversations with peers
<b>Panic disorder</b>	Fear of recurrent panic attacks or their consequences (e.g., "going crazy," "dying," "losing control")	Avoids places where panic attacks have occurred before; avoids activities that create strong physical sensations (e.g., heavy exercise)
<b>Agoraphobia</b>	Fear of places where immediate escape may be embarrassing or difficult or help not available	Avoids leaving home or relies on adult to leave home; avoids crowded and enclosed spaces
<b>Specific phobia</b>	Marked fear or anxiety about a specific object or situation (e.g., animals, natural environment, needles, transportation)	Has intense fear and avoidance of insects, animals, storms, blood, needles, medical procedures, subways, planes, or buses
<b>Generalized anxiety disorder</b>	General feeling of dread or unease associated with the perception of uncontrollability and unpredictability about a number of events or activities such as school performance, health, financial matters or family problems	Constantly seeks reassurance; has disrupted sleep, fatigue, irritability, restlessness, and/or difficulty focusing due to worries
<b>Obsessive-compulsive disorder</b>	Fear of intrusive and unwanted thoughts, urges, or images	Constantly worries about dirt or germs; fears harm or danger to a loved one or to self; practices ritualized washing; arranges or orders objects; repeats, rereads, or rewrites; checks and rechecks;

## *Social and academic functioning of anxious youths*

Adolescents undergo very rapid changes during the transition from childhood to early adulthood. During this changes they face different challenges: social interactions become more complex, and they spend more time with their peers (de Lijster et al., 2018; see for review). Moreover, the level of commitment and effort required in school grows. All these challenges can be detrimental for an adolescent's mental health and can contribute to the development of anxiety disorders in youth.

The opposite is also true: anxiety can affect social and academic functioning. As we already know, such disorders are preponderant in adolescence. Therefore, an effective study on how social and academic functioning can be influenced by anxiety levels could be fundamental in order to develop effective preventive measures.

Overall, research shows that anxious students encounter more social challenges, such as reduced social skills and negative interactions in relationships. Moreover, youth anxiety can cause difficulties in concentration and performance anxiety – for example, fear of public speaking and of interactions with teachers and peers (Kajastus et al., 2024; for review see). Additionally, this social anxiety can be alimented by episodes of bullying and isolation. Anxious students also have problems with teamworking, as they experience problems in communication and negative self-evaluations.

Furthermore, anxiety affects their academic abilities, leading to difficulties in focusing on tasks, achieving high grades, completing homework, and performing during exams. Not only it can compromise academic performance, but it also increments school refusal, premature withdrawal from higher education and failure to attend university. The presence of school-related difficulties in adolescents with an anxiety disorder is expected, as excessive worry – a core characteristic of anxiety – has been linked to cognitive impairments, particularly in concentration, when anxiety levels remain high over time. Such deficit also expands to other executive functions like attention, visual memory, working memory, and learning – fundamental for academic performance.

## *Prevention in schools*

Schools could play a crucial role in the prevention of anxiety in children and adolescents. Since students spend a significant amount of time at school, it is essential for educational institutions to implement universal prevention programs to address this issue effectively. Early interventions are fundamental to prevent the onset of anxiety disorders in adolescents, which can be achieved, for example, by increasing emotional resilience and promoting positive coping skills.

Integrating mental health programs into the school curriculum or offering them as extracurricular activities can help overcome common obstacles to accessing treatment, such as scheduling conflicts, transportation issues, financial barriers, stigma, and accessibility. By providing easily accessible, affordable, and encouraging support, schools can create a more inclusive environment for students in need (Iizuka et al., 2012).

A review by Schoenfeld and Janney (2008) highlights the effectiveness of school-based interventions for anxiety disorders. Mental health professionals play a crucial role in equipping both students and school staff with the knowledge and resources necessary to address anxiety and promote emotional well-being in educational settings.

There are three types of prevention programs:

1. Universal programs are presented to all students regardless of symptoms and are often designed to build resiliency or enhance general mental health.
2. Selective programs target children and adolescents at risk of developing a disorder.
3. Indicated programs are provided to students who show early or mild symptoms.

Universal programs are more suitable in a school, as they include all children. As a consequence, it avoids the possibility of stigmatization and labelling, enhancing resilience in all children regardless of risk status. Moreover, this model supports peer cooperation and modelling.

### *Inside out 2 Movie: the role of Anxiety*

The sequel to *Inside Out*, *Inside Out 2*, was released in 2024 and introduced new characters to headquarters. Among the new emotions, one plays a central role in the story: Anxiety. Meanwhile, Riley, the protagonist, starts a new phase of her life – puberty. She faces new challenges, such as starting high school and making new friends.

Anxiety is portrayed as a small, orange character with messy hair, arriving at headquarters with her "baggage." From the very beginning, her dual nature is evident. At first, we see the benefits of her arrival. For instance, she helps Riley in social interactions and meticulously plans for every possible outcome. She genuinely believes she is helping. In one scene, Anxiety compares herself to Fear, highlighting a key distinction: "Fear keeps Riley safe from the things she can see. I keep Riley safe from the things she can't see. I plan for the future."

A crucial aspect of her character is that, like the real emotion, she is not a villain. As mentioned earlier, anxiety has an adaptive function as it prepares us for the unknown. However, although Anxiety never turns evil or intentionally harms Riley, she becomes overwhelming and eventually loses control. The film also effectively illustrates a cognitive concept related to anxiety: catastrophizing. Anxiety takes over the “imagination centre”, forcing its workers to visualize only worst-case scenarios in Riley’s mind. She plans obsessively every single move and always fears that everything might go wrong.

This all leads to a powerful depiction of a panic attack. Anxiety runs chaotically around the control console, desperately trying to restore order. This scene vividly portrays the experience of a panic attack. In fact, Anxiety is trapped in the eye of a storm she created herself. A single tear rolling down her cheek expresses the pain and distress of the moment. The other emotions try to intervene, but Anxiety has completely taken over.

In the end, Anxiety realizes she cannot control everything and that sometimes she must step back and allow other emotions to take the lead. In the final scene, she is drinking tea under a cozy blanket, and sometimes she is assigned tasks which are concrete and close in time – symbolising the need to concentrate on the present rather than only thinking about the future possibilities. This funny yet meaningful image teaches an important lesson: anxiety is always present in our minds, but when managed with the right coping strategies, it can be highly beneficial, motivating us, boosting our energy, and helping us perform at our best.

The film presents Anxiety as both a protector and a source of distress, offering a nuanced view of this complex emotion. By giving anxiety a concrete form, the audience is encouraged to develop a deeper, more empathetic and diverse understanding of the emotion, viewing it not as an enemy to be defeated but as an integral part of oneself that needs understanding and controlling. Moreover, the centrality of this orange character in the story symbolises the prevalence of anxiety disorder in adolescence. Through creative storytelling and metaphors, this film provides useful insights about mental health and promotes a scientific knowledge through a language accessible to all, young and old people. By portraying anxiety as a normal part of life, it helps to reduce stigma while emphasizing the importance of healthy coping mechanisms.

## **Chapter 2: Cognitive constructs of anxiety**

### ***Introduction***

Sassaroli and Ruggiero (2002) have identified five cognitive constructs which are associated with anxiety:

1. Catastrophic thinking is defined as the tendency to expect a wider range of negative consequences and conceiving such situation as an unavoidable threat.
2. Fear of error or pathological perfectionism is the tendency to concentrate on errors and mistakes and ignore positive results.
3. Intolerance of uncertainty is the thought of not being able to face physically or tolerate emotionally unexpected future events.
4. Negative self-assessment is characterized by a negative evaluation of one's performance, emotional self-control and ability to cope.
5. Need for control is the illusory search for absolute knowledge. The anxious person is convinced that knowledge and control will suffice to prevent negative events from happening.

In the current literature, another construct associated with anxiety has been explored: repetitive negative thinking (RNT) (Hijne et al., 2020; Spinhoven et al., 2018; Taylor & Snyder, 2021). In particular, they refer to the concept of worry – defined as “as a state of mental distress or agitation due to concern about an impending or anticipated event, threat, or danger” (APA, 2018). This construct can be included in what Sassaroli defined as “catastrophic thinking”, as they both involve a cognitive pattern common in anxious people – they expect negative (with a tendency to the catastrophe) outcomes. What RNT adds to the previous construct is the persistent and cyclical nature of these thoughts.

### ***Repetitive negative thinking (RNT)***

Feeling worried from time to time is a normal part of life. Many people worry about things like their health, social relationships, finances, or work/academic performance. In most cases, these worries are temporary and eventually fade away. However, when worry lasts for six months or more – even without any major life changes – and begins to interfere with daily activities such as work, school, or relationships, it may be a sign of an anxiety disorder.

Repetitive Negative Thinking (RNT) is a transdiagnostic construct typically associated with emotional disorders. It is characterised by a recurrent thinking pattern, passive and difficult to control, which focuses on negative content. RNT describes a cognitive pattern which characterises depression and anxiety. In particular, it can be divided into: worry and rumination. Worry and rumination are both forms of repetitive negative thinking characterized by repetitive and often uncontrollable thinking about negative content (Watkins, 2022).

- Rumination is typically defined as “repetitive thinking about the symptoms, causes, circumstances, meanings, and consequences of negative mood, personal concerns, and upsetting experiences.” (Watkins, 2022)
- Worry is typically defined as “repetitive thinking about future potential threat, imagined catastrophes, uncertainties, and risks and is conceptualized as an attempt to avoid negative events, prepare for the worst, and problem-solve.” (Watkins, 2022)

Therefore, the main difference between these two types of repetitive thinking patterns is actually the time orientation of those thoughts. In particular, rumination is past-oriented, focusing on past experiences and emotions. On the other hand, worry is future-oriented, and its aim is to avoid potential future danger. Worrying is most typically associated with anxious symptoms, while rumination tends to occur in the context of depression and low mood.

*"Thoughts that torment me during the night: I think about the future, the present, the past, and what I should have done or could have done in certain situations." – student, 1<sup>st</sup> year <sup>4</sup>*

*"For me, anxiety is like a mosquito that always buzzes around you, annoying you with negative thoughts about things that could happen in the future." – student, 1<sup>st</sup> year <sup>5</sup>*

---

<sup>4</sup> Original quote in Italian: “Pensieri cha mi tartassano durante la notte, penso al futuro, al presente, al passato, cos’avrei dovuto o potrei fare in certe situazioni.” – studente, 1° anno

<sup>5</sup> Original quote in Italian: “Per me l’ansia è una zanzara che ti ronza sempre intorno e che ti infastidisce con pensieri negativi che potrebbero accadere in futuro.” – studente, 1° anno

## *Catastrophic thinking*

Catastrophic thinking is strictly related to a particular emotion: fear. This emotion can be described with two keywords: danger appraisal and immediate harm (Sassaroli & Ruggiero, 2002). This means that fear involves appraisal and evaluation of a danger, which is thought to create instant harm to the person. In order to protect ourselves and prevent any harm, we enact protective and coping mechanisms, such as avoidance.

The feeling of anxiety, however, comes from an evaluation of the risks which is disproportionate to the situation or to the stimulus. Anxious people fear that something terrible might happen to them, even with little or no evidence. For example, they tend to evaluate neutral or ambiguous stimuli as threatening or as having negative consequences. They tend to use more negative or catastrophic terms when describing a stimulus and have more negative predictions related to a certain event than non-anxious people. All of these mental processes lead the person to think that everything in his life will go inevitably wrong and he cannot do anything about it. Clearly, an anxious individual lacks – or, at least, this is what he believes – coping mechanisms which help remove and/or change the threatening event. This inability leads to a sense of resignation and helplessness, feeding into thoughts of catastrophe.

Another important aspect of this pattern of thinking is its lack of modulation and detail. This means that the anxious individual simply acknowledges the “negativity” of an event, without a more specific evaluation of the danger. From a representational-iconic perspective, the threatening agent is represented in a static and abstract way, and the person does not take into consideration a scenario in which the person and the threat interact. This creates a stationary, inflexible mental image of the threat: the frightening agent looms over the individual, remaining large and menacing, endlessly perpetuating fear in a catastrophic manner. Therefore, the subject feels incapable of facing it. From a verbal-propositional viewpoint, the threatening agent is described using fixed negative predicates, like “catastrophic” and “invincible”. These negative connotations are repeated over and over again, fuelling a cyclic thinking style. In summary, our mind forms a fixed image of an invincible threat, unable to shift and change, which is looming on us and makes us feel helpless.

*"For me, anxiety makes me anxious. It's such an annoying feeling that leads to imagining even senseless things, but things that are still frightening." – student, 1st year*<sup>6</sup>

---

<sup>6</sup> Original quote in Italian: “A me l’ansia fa ansia. È proprio una sensazione odiosa, che porta ad immaginare cose anche insensate, ma che fanno paura”. – studente, 1° anno

## ***Fear of error or pathological perfectionism***

Fear of error, or pathological perfectionism, is a multidimensional construct, characterised by:

1. Excessively high standards and expectations
2. Concern over mistakes
3. Uncertainty about their abilities
4. Strong need for order and certainty
5. Overestimation of criticisms from others

Even though some level of perfectionism is adaptive, as it helps us striving and putting effort on our tasks and aims, an imbalanced level can actually be detrimental for one's mental health (Lunn et al., 2023). In fact, excessive perfectionism has been linked to increased stress and burnout (D'Souza et al., 2011), but also anxiety and depression (Egan et al., 2011), ultimately hindering personal and professional growth.

The “concern over mistakes” dimension of perfectionism describes how people react to mistakes. In particular, it involves negative reactions such as “a tendency to interpret mistakes as equivalent to failure and believe that one will lose the respect of others following failure” (Frost et al., 1995). In fact, their self-imposed standards are often not only unattainable but also leave no room for error. Anything that deviates from the original plan, even if eventually successful, is perceived as a complete failure. His concern over mistakes describes a very rigid cognition, which precludes any last-minute change.

A perfectionist is characterized by a pervasive sense of uncertainty about their work and frequently doubts their abilities. They rarely believe that anything is done completely enough or well enough. At the same time, they have a strong need for order and certainty. For instance, his plans must be executed in their entirety. Lastly, they tend to overestimate criticism from others, including parents, teachers, and peers. Burns (1990) defines this aspect of perfectionists as “disclosure phobia”, as they fear how people will assess them. Other people are perceived as very critical and demanding, and perfectionists fear their evaluation.

There are three subtypes of perfectionism (Hewitt, 1991):

- Self-oriented perfectionism: high standards for the self
- Other-oriented perfectionism: massive expectations of the others
- Socially prescribed perfectionism: excessively high standards of the others on the self

High standards, unrealistic expectations, the fear of making mistakes, overestimating others' expectations, high cognitive rigidity, and a lack of trust in one's own abilities and qualities create a fundamental vulnerability that predisposes individuals to various forms of psychopathology. Nevertheless, this construct appears only sometimes in anxiety, and it is typically detected in performance-related situations, like in sports or at school. The pathological perfectionist is unable to positively appreciate their own performance because they tend to perceive a final failure behind every partial or imperfect success. A suitable example in youth anxiety is related to academic performance. For instance, individuals with perfectionistic tendencies may believe that receiving anything less than a perfect grade is a failure. This rigid thinking pattern increases anxiety, leading to excessive studying and intense self-criticism, ultimately reinforcing distress and academic burnout in adolescence.

Beyond this inability to recognize a partial success, there is a global assessment of failure, which in turn leads to a series of further catastrophic, negative predictions. The fear of making mistakes can, therefore, be conceptualized as a belief following the fear of harm and the tendency to control.

*“It feels as if every mistake were a blow to my shins, making me collapse more and more. As if every criticism were an iron thrown at me.” – student, 1<sup>st</sup> year<sup>7</sup>*

### ***Intolerance of uncertainty***

Anxious people do not often consider the probability of a risk. For example, they may fixate on the possibility of failure in an exam, a social rejection, or a health issue without realistically assessing how likely these events are to occur. Instead of weighing evidence or considering alternative outcomes, their mind latches onto the worst-case scenario as if it were a certainty. This tendency leads to excessive worry and avoidance behaviours, reinforcing the belief that danger is imminent and inevitable. Over time, this pattern can make it difficult for them to engage with challenges or cope with uncertainty in a balanced way.

Intolerance of uncertainty is, in fact, the inability to cope with the simple existence of a risk. Rather than accepting that some degree of unpredictability is a natural part of life, anxious individuals feel obligated to seek absolute certainty, even when it is unattainable. This need for certainty can lead to excessive reassurance-seeking, compulsive checking, or avoidance behaviours, all aimed at

---

<sup>7</sup> Original quote in Italian: “È come se ogni errore fosse una mazzata negli stinchi, che mi fa crollare sempre di più. Come se ogni critica fosse un ferro da stiro tiratomi addosso.” – studente, 1° anno

reducing discomfort. However, these strategies often backfire, reinforcing the belief that uncertainty is dangerous and must be eliminated. As a result, the individual becomes trapped in a cycle of anxiety, where any ambiguous situation triggers distress and the urge to control what cannot be fully controlled.

According to Dugas, Freeston, and Ladouceur, (1997) this construct can be explained by a difficulty in problem orientation. Problem orientation refers to a person's general response range when faced with a challenge. Indeed, an anxious individual struggles to plan and develop coping strategies to address a threat (Dugas et al., 1997; Georgeta & Nicoleta, 2019). Moreover, intolerance of uncertainty is based on an anxiogenic assumption, where – from a given situation – failure is expected to occur (Shihata et al., 2016). This attentional bias causes the individual to focus solely on the negative possibilities of an outcome, thereby increasing the worry related to the event (Burns et al., 2025). Therefore, the individual cannot tolerate even the mere possibility of an event. Consequently, the uncertainty (or possibility) of an event can be similarly defined as the certainty of a catastrophe (Sassaroli & Ruggiero, 2003).

### *Negative self-assessment*

In addition to threat appraisal, anxious people tend to evaluate themselves as well. Negative-self assessment is usually described as an evaluation of the self as typically incapable to cope with problems. In this case, the fear is not projected onto the object itself, but rather on the ability to control one's behaviours and emotions properly. In fact, this belief can stem from either an alleged material or emotional incapacity. On a material level, one may feel physically unable to confront a problem or danger, thus being unable to control one's behaviour. Similarly, some individuals believe they lack control over their emotions.

Negative self-assessment is fundamentally the opposite of self-efficacy (Sassaroli & Ruggiero, 2003). Self-efficacy is a central concept in the study of anxiety. It is defined by the APA as “an individual's belief in his or her capacity to execute behaviours necessary to produce specific performance attainments (Bandura, 1977, 1986, 1997). Self-efficacy reflects confidence in the ability to exert control over one's own motivation, behaviour, and social environment.”

In fact, we could define it as the belief in one's ability to:

- produce effective behavioural responses when facing problems,
- manage fear and other negative emotions triggered by a challenging situation,
- cope emotionally with a potential escape or failure, while conceiving alternative goals that are subjectively meaningful and rewarding, even in the face of significant defeats.

As for catastrophic or repetitive negative thinking, also negative self-assessment has two forms of thought: representational-iconic and verbal-propositional. From a representational-iconic point of view, the person depicts himself as a permanent loser who is mocked, ignored, bullied, criticised or excluded. This mental image is unchanging, and the person cannot image a different scenario. From a verbal-propositional viewpoint, the person describes himself with derogatory comments, like “fragile”, “inadequate”, “incapable”. Therefore, he gets involved in a spiral of negativity and self-hatred.

Persistent negative self-evaluations involve specific fears, for instance doing or saying something wrong (“I’ll babble”, “I’ll fail the exam”). Moreover, they include more general statements like “I am foolish”, “I am a loser”, “I am incapable” (Warnock-Parkes et al., 2022). This construct is fairly persistent in social anxiety disorders (SAD). In particular, socially anxious people need to make a favourable impression of oneself to others and marked insecurity in one’s ability to do so.

There are two key processes that are fundamental in maintaining these negative evaluations. The first one is “self-focused attention”. In fact, an anxious person shifts his attention from the external environment – for example, a conversation or a test – to his internal state – for example, anxious symptoms, bodily sensations, catastrophic thoughts and worry. This internalization heightens his negative evaluations. For instance, a person might concentrate on the sensation of heat and pictures himself sweating. The second process involves reinforcement of safety behaviours. By avoiding the perceived threat, the individual “prevents” negative outcomes, reinforcing the belief that the behaviour is necessary for protection.

*"For me, anxiety means when that little voice in my head starts to come alive and doesn't stop. Maybe everything is going fine, but here it comes, ready to make me question everything! What if I make a mistake? What if I'm not enough? Maybe I'm eating too much! I should start working out! What if tomorrow goes wrong? Why is nobody reaching out to me? It's like an endless loop of thoughts chasing each other relentlessly. Sometimes it felt like school was triggering it, with all the tests, expectations, and the future approaching too quickly. But then I realized it wasn't just that. It was the fear of disappointing, of failing, of not being good enough for what others (or I) expected me to be." – student, 4<sup>th</sup> year <sup>8</sup>*

## ***Need for control***

Seligman (1975) defined control as “the subjective perception of a contingent relationship between the response to a feared event and the outcome of avoidance of the harm.” In other words, control is the belief that by behaving in a certain way, one can achieve the desired outcome – in this case, avoiding danger. This concept plays a crucial role in anxiety, as the anxious mind strives to maintain control over as many aspects of life as possible.

The need for control, often referred to as the illusion of control, is the persistent pursuit of absolute certainty. Anxious individuals attempt to prevent all imagined catastrophic events, which are scenarios they create and reinforce through repetitive negative thoughts. They engage in excessive rumination, mentally rehearsing worst-case scenarios in an effort to anticipate and neutralize perceived threats. However, this quest for total control is inherently ineffective, leading to frustration and heightened anxiety.

When faced with the realization that not everything can be controlled, anxious individuals often redirect their focus to aspects of life where they do perceive control. This tendency is particularly evident in disorders such as eating disorders, where control over food intake becomes a coping mechanism. By meticulously managing their diet, individuals may feel a temporary sense of stability and predictability, compensating for the overwhelming uncertainty in other areas of life.

---

<sup>8</sup> Original quote in Italian: “*Per me ansia vuol dire quando quella vocina nella testa inizia a prendere vita e non si spegne, magari sta andando tutto bene e arriva lei, pronta a farmi venire mille dubbi! E se sbaglio? E se non sono abbastanza? Forse sto mangiando troppo! Devo iniziare ad allenarmi! E se domani va male? Perché nessuno mi cerca? È come un loop infinito di pensieri che rincorrono senza sosta. A volte mi sembrava che fosse la scuola a scatenarla, con tutte le verifiche, le aspettative, il futuro che si avvicina troppo in fretta. Ma poi mi sono accorta che non era solo quello. Era la paura di deludere, di non riuscire, di non essere all'altezza di quello che gli altri (o io stessa) mi aspettavo di essere.*” – studente, 4° anno

The anxious individual perceives absolute control as the only viable alternative to their constant state of fear and apprehension. Since control is the sole imagined escape from anxiety, it becomes an indispensable and non-negotiable condition for achieving a sense of calm. Their rigid perception leaves no room for uncertainty, spontaneity, or adaptability. Any deviation from the expected level of control is experienced as a direct threat, reinforcing the cycle of anxiety. The individual becomes trapped in a paradox: the more they strive for absolute control, the more anxiety intensifies when control inevitably proves unachievable. This mindset can lead to maladaptive behaviours, such as excessive planning, avoidance, compulsions, or rigid routines, as the person seeks to impose order on an unpredictable world. Over time, this rigid need for control can become a barrier to personal growth, emotional resilience, and the ability to navigate life's natural uncertainties.

Moreover, this need for control can also be described as “need for certainty” or “need to know”. The anxious person craves knowledge and certainty in order to avoid the feared situation. He aims to maximise his predictive capacity to increase his knowledge about all future events and to be able to control them.

In conclusion, the ultimate goal anxiety is to predict and control all possible future events. However, this relentless need for control represents a maladaptive coping mechanism of anxiety and ultimately leads to the growth of the anxious state, rather than alleviating it. In fact, it produces just a small and temporary sense of relief, that soon will be taken over by more anxiety and preoccupation. Instead of establishing a sustainable or effective way of managing uncertainty, this pursuit of absolute control reinforces the anxious cycle, making it even harder to develop adaptive strategies for coping with life's unpredictability. Breaking free from this cycle requires learning to tolerate uncertainty, which is a process that involves gradually accepting the unpredictability of life and developing strategies to face challenges without relying on absolute control.

## Chapter 3: The Research

### *Introduction and Objective*

Anxiety is a key issue in today's society, driven by higher standards, increasing performance expectations, and the constant input from external stimuli. As a result, anxiety levels are rising, particularly among adolescents and young adults, as recently reported by the WHO (2022). The fear to let your parents down, to fail school or to not have a plan for the future are just some examples of worries that adolescents experience nowadays. As maladaptive levels of anxiety could be detrimental for their mental health, it is fundamental to study further this current phenomenon in order to implement preventive programs and help young adults to cope with this confusing emotion.

The objective of this research is to investigate the level of anxiety of adolescents and five specific cognitive constructs: catastrophic/repetitive negative thinking, fear of error or pathological perfectionism, intolerance of uncertainty, negative self-assessment, need for control. In particular, the aim of this study is to investigate the presence and severity of anxiety symptoms in a sample population using the self-report SCARED (Screen for Child Anxiety Related Emotional Disorders) questionnaire. The study seeks to determine how many participants meet or exceed the established clinical cut-off scores for general and specific anxiety disorders, and to compare these findings with prevalence rates reported in the existing literature. Moreover, we would like to investigate whether age plays a role in each construct. Adolescence is a critical period for emotional regulation and identity formation (Cicchetti, 2002), and therefore, it is expected that differences may emerge when comparing younger and older adolescents.

In this study, a one-way Analysis of Variance (ANOVA) was selected as the primary statistical method to test for age-related differences across multiple psychological constructs. By using ANOVA, it is possible to statistically test whether these constructs vary systematically across different stages of adolescent development. This approach allows for the identification of age-sensitive patterns, supporting or refuting the notion that age influences the manifestation of anxiety-related traits.

### *Hypothesis*

The present study aims to explore anxiety levels and whether age influences various anxiety-related psychological constructs among adolescents.

The following hypotheses were formulated:

- **H1:** There are significant levels of anxiety symptoms in the sample, as measured by the self-report SCARED questionnaire. Based on existing literature, it is anticipated that approximately 1 in 4 individuals will meet or exceed this threshold by scoring above the clinical cut-off for an anxiety disorder.
- **H2:** There are significant differences in each construct across age groups. This hypothesis reflects the assumption that age, as a developmental factor, may impact the expression or intensity of certain cognitive and emotional traits associated with anxiety.

## *Methods*

The study involves the administration of six psychometric tests, five assessing specific cognitive constructs of anxiety and one evaluating anxiety symptoms.

## *Participants*

The participants include 260 students from the first to the fifth year from Istituto Artigianelli in Trento (TN), Italy. The age ranges from 14 to 21 years old. The sample includes students with Special Educational Needs (SEN), who are distributed across different classes. However, students with severe intellectual disabilities or mental retardation (referred to as PQS in this Institution, following a separate personalized educational plan) will not be included in the study.

## *Materials*

Six questionnaires were administered:

1. SCARED (Screen for Child Anxiety Related Emotional Disorders)
2. IUS-12 (Intolerance of Uncertainty Scale – Short Version)
3. CPQ (Clinical Perfectionism Questionnaire)
4. PSWQ-C (Penn State Worry Questionnaire – Children)
5. OCI-R (Obsessive-Compulsive Inventory – Revised)
6. RSES (Rosemberg Self-Esteem Scale)

## *Procedure*

In this study, six questionnaires were administered to high school students to assess various aspects of anxiety and related cognitive processes. The questionnaires were distributed anonymously using a Google Form, ensuring that responses could not be traced back to any individual. Students were invited to complete the questionnaires voluntarily, with clear information provided about the confidentiality of their responses. Only questions about age and year of study were included additionally.

All the questionnaires were distributed in their Italian version:

1. **SCARED (Screen for Child Anxiety Related Emotional Disorders)** – A tool for assessing anxiety symptoms in children and adolescents.
2. **IUS-12 (Intolerance of Uncertainty Scale – Short Version)** – A measure of intolerance of uncertainty.
3. **CPQ (Clinical Perfectionism Questionnaire)** – Designed to assess aspects of perfectionism.
4. **PSWQ-C (Penn State Worry Questionnaire – Children)** – A scale used to evaluate worry.
5. **OCI-R (Obsessive-Compulsive Inventory – Revised)** – A tool for assessing obsessive-compulsive symptoms.
6. **RSES (Rosenberg Self-Esteem Scale)** – A scale used to assess general self-esteem.

After a brief explanation of the task, the students completed the questionnaires during school hours on the computer, with a total time of 1 hour for the completion. Data were collected from 31<sup>st</sup> March 2025 to 7<sup>th</sup> April 2025. All responses were collected in a single Excel file for subsequent analysis.

## *Statistical Analysis*

To examine the potential influence of age on the psychological constructs under investigation, a series of one-way Analyses of Variance (ANOVA) were conducted, one for each questionnaire score (i.e., each psychological construct). The independent variable was age, treated as a categorical variable by grouping participants into age brackets, while the dependent variables were the total scores from each of the six questionnaires. The goal of this analysis was to determine whether there were statistically significant differences in anxiety-related cognitive traits and symptoms across different age groups within the adolescent sample.

## **Age Grouping**

To analyse the potential role of age, participants were grouped into five distinct age brackets, based on both school year and typical developmental stages during adolescence:

- Group 1: 14 years old (early to middle adolescence)
- Group 2: 15 years old (middle adolescence)
- Group 3: 16 years old (middle adolescence)
- Group 4: 17 years old (middle to late adolescence)
- Group 5: 18–21 years old (late adolescence)

Adolescence can generally be divided into three stages: early adolescence (approximately ages 11 to 13/14), middle adolescence (approximately ages 14 to 17), and late adolescence (approximately ages 17 to 19) (Barrett, 1996; K. Salmela-Aro, 2011). This categorization allows for a more precise comparison of psychological constructs across developmental phases, while maintaining a balanced number of participants per group where possible.

## ***Results***

### *SCARED – results*

The sample consisted of 260 participants who completed the SCARED (Screen for Child Anxiety Related Emotional Disorders) questionnaire. Among them, 180 participants (69.2%) scored 25 or above, indicating the presence of an anxiety disorder. Furthermore, 146 participants (56.2%) scored 30 or above, suggesting a more specific anxiety disorder according to SCARED criteria.

Within the subgroup of 146 participants with scores  $\geq 30$ , the distribution of specific anxiety symptoms was as follows:

- School Avoidance: 118 participants (80.8%)
- Panic Disorder/Somatic Symptoms: 132 participants (90.4%)
- Generalized Anxiety Disorder: 142 participants (97.3%)
- Separation Anxiety: 85 participants (58.2%)
- Social Anxiety: 99 participants (67.8%)

These findings highlight a high prevalence of multiple overlapping anxiety symptoms among individuals who met the cutoff for a specific anxiety disorder.

**Table 2: SCARED results**

Category	Subcategory	Number of Participants	Percentage (%)
Participants	Total	260	100.0%
Score $\geq$ 25 (General Anxiety threshold)	Total	180	69.2%
Score $\geq$ 30 (Specific Anxiety threshold)	Total	146	56.2%
	School Avoidance	118	80.8%*
	Panic/Somatic Symptoms	132	90.4%*
	Generalized Anxiety	142	97.3%*
	Separation Anxiety	85	58.2%*
	Social Anxiety	99	67.8%*

\*Note: Percentages for specific anxiety types are calculated from the 146 participants with scores  $\geq$ 30.

### ANOVA – results

This section presents the findings from the one-way ANOVA analyses conducted to examine age-related differences in anxiety-related cognitive constructs among adolescents aged 14-21 years. In this analysis, adolescents older than 18 years old are grouped together under the age of 18.

**Table 3: ANOVA results**

Construct	Age 14 (M $\pm$ SD)	Age 15 (M $\pm$ SD)	Age 16 (M $\pm$ SD)	Age 17 (M $\pm$ SD)	Age 18+ (M $\pm$ SD)	ANOVA F (df)	p-value
<b>1. Anxiety Symptoms (SCARED)</b>	32.104 $\pm$ 12.057	30.511 $\pm$ 12.993	34.474 $\pm$ 16.607	35.370 $\pm$ 13.899	30.726 $\pm$ 11.947	1.332 (4, 255)	0.258
<b>2. Intolerance of Uncertainty (IUS-12)</b>	30.783 $\pm$ 10.690	29.021 $\pm$ 9.057	32.870 $\pm$ 10.220	33.234 $\pm$ 9.182	31.724 $\pm$ 9.961	1.739 (4, 249)	0.142
<b>3. Clinical Perfectionism (CPQ)</b>	26.404 $\pm$ 5.241	24.521 $\pm$ 4.192	26.464 $\pm$ 5.546	27.289 $\pm$ 5.194	25.800 $\pm$ 4.672	2.001 (4, 246)	0.095
<b>4. Worry (PSWQ-C)</b>	21.304 $\pm$ 7.553	20.479 $\pm$ 8.280	23.429 $\pm$ 9.694	23.000 $\pm$ 9.175	22.964 $\pm$ 9.696	0.988 (4, 244)	0.415
<b>5. Obsessive-Compulsive Symptoms (OCI-R)</b>	22.600 $\pm$ 11.624	19.458 $\pm$ 12.634	26.873 $\pm$ 15.788	25.682 $\pm$ 13.191	20.250 $\pm$ 10.684	3.247 (4, 243)	0.013*
<b>6. Self-Esteem (RSES)</b>	13.978 $\pm$ 6.148	16.833 $\pm$ 5.575	14.909 $\pm$ 6.311	15.024 $\pm$ 6.166	17.164 $\pm$ 5.315	2.623 (4, 239)	0.035*

### Anxiety Symptoms (SCARED)

No significant differences were found in general anxiety symptoms across age groups,  $F(4, 255) = 1.332$ ,  $p = 0.258$ . Descriptively, anxiety levels were highest during middle adolescence (age 16:  $M = 34.47$ ; age 17:  $M = 35.37$ ), with lower means at ages 15 and 18. However, these differences are not statistically significant.

### **Intolerance of Uncertainty (IUSC-12)**

Intolerance of uncertainty did not differ significantly by age,  $F(4, 249) = 1.739$ ,  $p = 0.142$ . Mean scores were numerically higher during middle adolescence (age 16:  $M = 32.87$ ; age 17:  $M = 33.23$ ) and lower at age 15 ( $M = 29.02$ ). However, the differences were not statistically meaningful.

### **Clinical Perfectionism (CPQ)**

Clinical perfectionism showed a marginal age effect,  $F(4, 246) = 2.001$ ,  $p = 0.095$ . Scores were lowest in middle adolescence (age 15:  $M = 24.52$ ) and highest in late adolescence (age 17:  $M = 27.29$ ). Although not statistically significant, the data suggest a possible U-shaped pattern, with some fluctuation across age groups.

### **Worry (PSWQ-C)**

No significant age differences in worry were observed,  $F(4, 244) = 0.988$ ,  $p = 0.415$ . Mean scores were relatively stable across groups, with a slight numerical increase during ages 16 to 18. However, given the lack of statistical significance, no developmental pattern can be reliably inferred.

### **Obsessive-Compulsive Symptoms (OCI-R)**

Age had a significant effect on obsessive-compulsive symptoms,  $F(4, 243) = 3.247$ ,  $p = 0.013$ . Symptom severity was highest during middle adolescence (age 16:  $M = 26.87$ ,  $SD = 15.79$ ; age 17:  $M = 25.68$ ,  $SD = 13.19$ ), and lower at age 15 and again in late adolescence (age 18). These findings indicate a curvilinear pattern, with mid-adolescence representing a period of increased vulnerability to obsessive-compulsive symptoms.

### **Self-Esteem (RSES)**

A significant age effect was found for self-esteem,  $F(4, 239) = 2.623$ ,  $p = 0.035$ . Self-esteem scores were lowest in early adolescence (age 14:  $M = 13.98$ ), increased throughout middle adolescence, and peaked at age 18 ( $M = 17.16$ ). These results support a developmental progression in self-esteem, marked by initial decline followed by gradual improvement into late adolescence.

## ANOVA ▼

ANOVA - OCI-R

Cases	Sum of Squares	df	Mean Square	F	p
Età	2173.641	4	543.410	3.247	0.013
Residuals	40666.871	243	167.353		

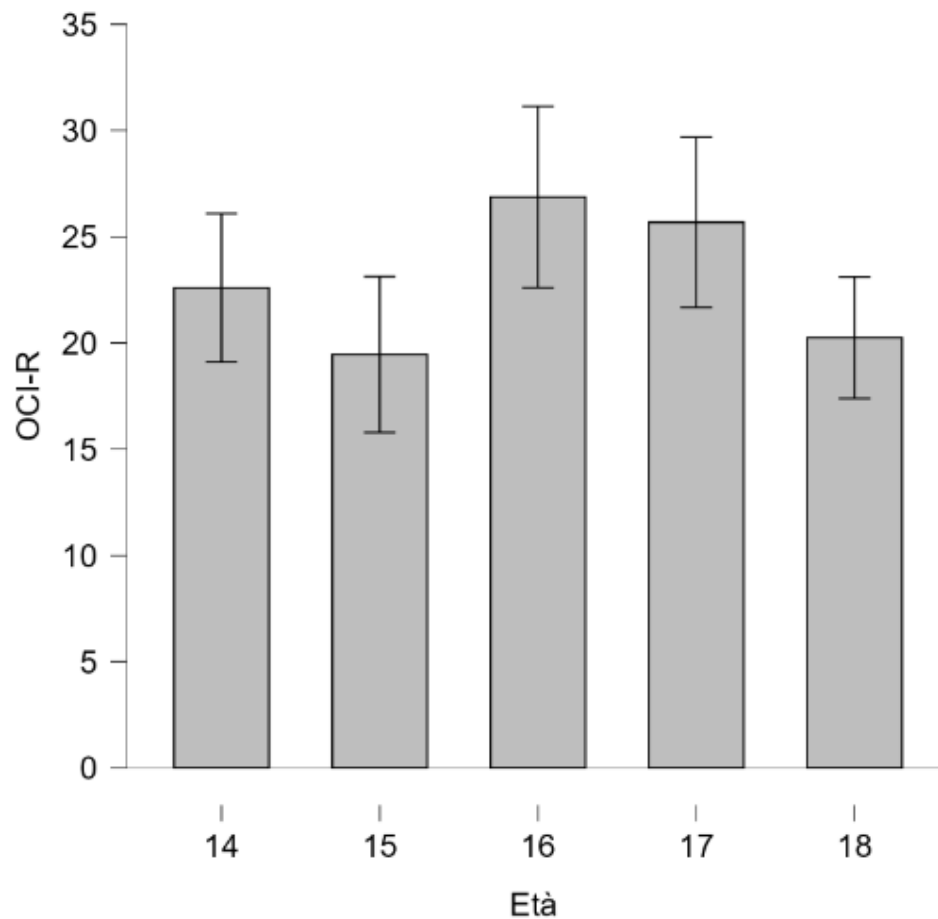
Note. Type III Sum of Squares

## Descriptives

Descriptives - OCI-R

Età	N	Mean	SD	SE	Coefficient of variation
14	45	22.600	11.624	1.733	0.514
15	48	19.458	12.634	1.824	0.649
16	55	26.873	15.788	2.129	0.588
17	44	25.682	13.191	1.989	0.514
18	56	20.250	10.684	1.428	0.528

## Bar plots



## ANOVA ▼

ANOVA - RSES

Cases	Sum of Squares	df	Mean Square	F	p
Età (numero)	365.287	4	91.322	2.623	0.035
Residuals	8320.693	239	34.815		

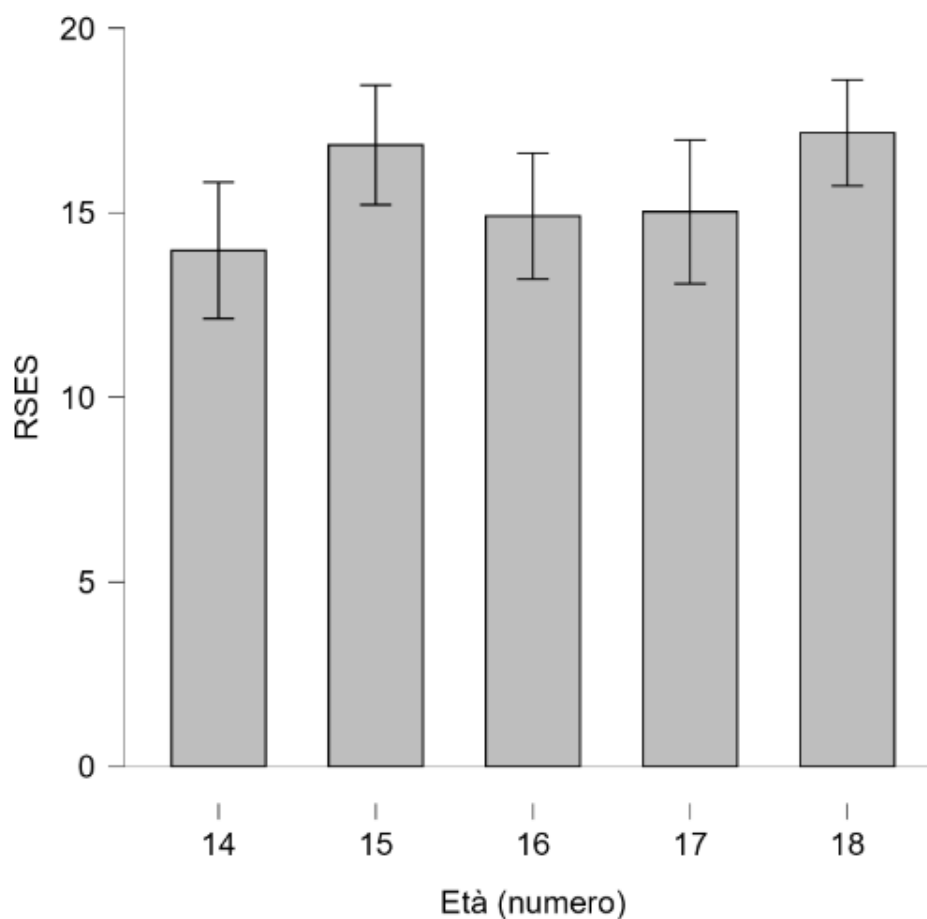
Note. Type III Sum of Squares

## Descriptives

Descriptives - RSES

Età (numero)	N	Mean	SD	SE	Coefficient of variation
14	45	13.978	6.148	0.916	0.440
15	48	16.833	5.575	0.805	0.331
16	55	14.909	6.311	0.851	0.423
17	41	15.024	6.166	0.963	0.410
18	55	17.164	5.315	0.717	0.310

## Bar plots



## ANOVA ▼

ANOVA - CPQ

Cases	Sum of Squares	df	Mean Square	F	p
Età	199.972	4	49.993	2.001	0.095
Residuals	6147.271	246	24.989		

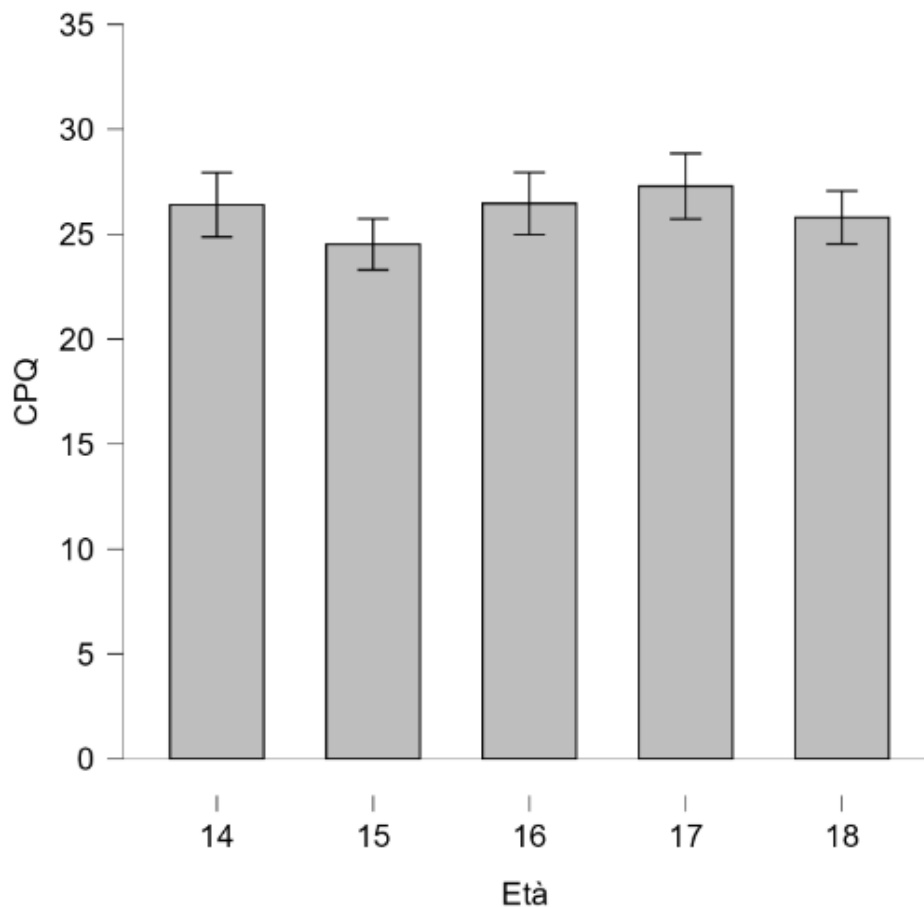
Note. Type III Sum of Squares

## Descriptives

Descriptives - CPQ

Età	N	Mean	SD	SE	Coefficient of variation
14	47	26.404	5.241	0.764	0.198
15	48	24.521	4.192	0.605	0.171
16	56	26.464	5.546	0.741	0.210
17	45	27.289	5.194	0.774	0.190
18	55	25.800	4.672	0.630	0.181

## Bar plots



*Table 4: Summary of results*

<b>Construct</b>	<b>Significant Age Effect (p&lt;0.05)</b>	<b>Peak Age(s)</b>	<b>Notable Pattern</b>
<b>Anxiety Symptoms (SCARED)</b>	No	16–17 (n.s.*)	Mid-adolescent peak (non-significant)
<b>Intolerance of Uncertainty (IUSC-12)</b>	No	16–17 (n.s.*)	Mild, non-significant increase
<b>Clinical Perfectionism (CPQ)</b>	Marginal	17 (trend)	U-shaped, peak at 17
<b>Worry (PSWQ-C)</b>	No	16–18 (n.s.*)	Slight, non-significant increase
<b>Obsessive-Compulsive (OCI-R)</b>	Yes	16–17	Curvilinear, mid-adolescent peak
<b>Self-Esteem (RSES)</b>	Yes	18	Lowest at 14, increases to 18

\*Note: n.s. = non-significant

## ***Discussion***

The review of current literature suggests that the cognitive dimension plays a central role in both the onset and maintenance of anxiety in adolescence. The findings highlight that anxiety in young people is not limited to emotional or physiological symptoms but is also deeply rooted in persistent and maladaptive thought patterns. This understanding is crucial, as it shifts the focus from merely addressing symptoms to intervening on the underlying cognitive mechanisms that sustain anxiety. From these considerations, it emerges that early identification and intervention are essential to prevent the negative consequences of untreated anxiety, such as impaired social and academic functioning, and long-term psychological distress.

Regarding the empirical research, the results from the SCARED questionnaire indicate that a substantial proportion of the sample exhibited significant symptoms of anxiety, with over half meeting the threshold for a specific anxiety disorder according to the SCARED questionnaire. The high percentage of participants (69.2%) scoring  $\geq 25$  suggests a widespread presence of anxiety symptoms within the population studied. These results surpass the figures reported in current literature, which indicate that approximately 1 in 4 adolescents experience anxiety. Such a substantial discrepancy highlights a potentially alarming mental health burden in this population and underscores the urgent need for early identification, targeted intervention, and further investigation. Among those with more severe symptomatology (scores  $\geq 30$ ), generalized anxiety disorder emerged as the most commonly reported condition (97.3%), followed closely by panic/somatic symptoms (90.4%) and school avoidance (80.8%). These findings suggest that generalized and somatic/panic symptoms may be particularly prominent manifestations of anxiety within this group. Additionally, a notable portion

of participants reported symptoms related to social anxiety (67.8%) and separation anxiety (58.2%), indicating the multifaceted nature of anxiety disorders in this population. The overlap of symptoms across different domains reflects the comorbid and complex presentation often seen in anxiety disorders. Overall, these results underscore the importance of early screening and comprehensive assessment for anxiety in order to address the broad range of symptoms that may affect individuals.

Complementing these results, the analysed data from the ANOVA reveal a diverse range of outcomes. Obsessive-compulsive symptoms (OCI-R) and self-esteem (RSES) were the only constructs showing statistically significant age effects, with OC symptoms peaking mid-adolescence (age 16 and 17) and self-esteem lowest at early and middle adolescence (age 14, 16 and 17) and increasing toward late adolescence (age 18). Other constructs – such as worry, intolerance of uncertainty and general anxiety symptoms – exhibited non-significant results. Only clinical perfectionism exhibited a marginal trend ( $p = 0.095$ ) of elevated scores during mid-adolescence, suggesting this developmental period as a critical window for anxiety vulnerability. Nonetheless, further research is needed to statistically prove this hypothesis. The only construct which shows an inversed pattern is self-esteem. However, this is consistent with the current literature, as anxiety is related to low self-esteem (or, high negative self-evaluation). Lastly, the curvilinear patterns observed, particularly in obsessive-compulsive symptoms, suggest non-linear developmental trajectories rather than steady increases or decreases. The inverse pattern in self-esteem supports the role of negative self-evaluations in anxiety during adolescence. The mid-adolescent peak in some constructs could represent an important aspect in studying youth anxiety and further research is required to gain a deeper understanding of the phenomena, such as underlying causes, consequences and risk factors. As a matter of fact, the peak in anxiety and cognitive constructs observed between the ages of 16 and 17 may be hypothetically linked to the vocational qualification exams (“*esami di qualifica triennale*” in Italian) typically held at the end of the third year in graphic design vocational schools. While this remains a speculative explanation, it would be interesting to explore this potential association further in future research.

In conclusion, the findings highlight mid-adolescence as a pivotal developmental stage marked by increased vulnerability to some anxiety-related cognitive constructs. The interplay between declining self-esteem and rising obsessive-compulsive traits suggests the need for early, multidimensional approaches to screening and intervention. Addressing these issues during this critical window could hypothetically reduce the risk of chronic anxiety disorders in later adolescence and adulthood. Moreover, it would be worth investigating the role of external factors, such as the school environment and the stress load experienced by students.

## *Limitations and implications*

The present study offers important insights into anxiety-related cognitive constructs. However, several limitations must be acknowledged. First, the sample was drawn from a single institution, which may limit the generalizability of the findings to the broader adolescent population. The reliance on self-report questionnaires introduces the possibility of response biases, such as social desirability or inaccurate self-assessment, potentially affecting the reliability of the data. Furthermore, the cross-sectional design limits causal inference and developmental trajectory analysis. Future longitudinal research is needed to confirm these patterns within individuals over time. Additionally, the study was conducted within a specific academic and cultural context, and external factors such as the school environment, family support, or societal stressors may have influenced the results and should be considered when interpreting the findings. Furthermore, variables such as gender, socioeconomic status, and life events should also be examined as potential moderating factors.

The implications of these findings are significant for both practice and research. The results of this research underscore the importance of early identification and intervention, especially in school settings. Targeted programs – either universal, selective or indicated – should be implemented and may help reduce the burden of anxiety among adolescents. For educational and clinical practice, it is essential that parents, teachers, school psychologists, and clinicians are trained to recognize the cognitive and behavioural signs of anxiety. Integrating mental health education into the school curriculum could foster greater awareness and reduce stigma, encouraging students to seek help when needed. The results also point to several paths for future research, including longitudinal studies to track changes over time and exploration of additional factors – such as personal and environmental factors – that may influence adolescent anxiety. Findings underscore the importance of targeting mid-adolescence (16–17 years) for preventive and intervention efforts addressing anxiety symptoms and cognitions. The statistically significant increase in obsessive-compulsive symptoms and non-statistically relevant but consistent patterns in clinical perfectionism suggest this period is critical for early identification and support. The drop in self-esteem during middle adolescence suggests the importance of interventions enhancing self-esteem and self-efficacy, which could be beneficial in reducing anxiety vulnerability. Lastly, it would be valuable to further investigate the interplay between the studied cognitive constructs and anxiety, particularly the role of obsessive-compulsive symptoms and self-esteem in sustaining anxious states. A correlational study could provide deeper insight into these associations.

## Conclusion

This thesis has explored the intricate relationship between anxiety and core cognitive constructs (repetitive negative thinking, drive for control, intolerance of uncertainty, concern over mistakes, and negative self-evaluation) among adolescents. Anxiety, like anger and happiness, is a deep-rooted emotion and a part of the humankind. Nonetheless, an early onset of anxiety disorders has various consequences, especially in adolescence. Primarily, it may hinder social and academic functioning. Moreover, anxiety in youth could potentially trigger additional problems in adulthood.

Unfortunately, results show that there is high level of anxiety in adolescents, confirming that anxiety is a significant and widespread issue in this age group. The analysis of the data collected through the questionnaires revealed several key findings. More than two-thirds of the students scored above the clinical cut-off for anxiety disorders. Among these, generalized anxiety, panic/somatic symptoms, and school avoidance emerged as the most prevalent symptom domains. Age plays an important role in obsessive-compulsive symptoms and self-esteem, creating a vulnerability window at the end of mid-adolescence (age 16-17). Similarly, clinical perfectionism reached a marginal effect. Other constructs – such as worry, intolerance of uncertainty, and general anxiety symptoms – did not reach significance.

This study has several limitations: a non-representative sample drawn from a single vocational school, reliance on self-report measures, and a cross-sectional design, which prevents conclusions about causality or developmental trajectories. Future longitudinal research is needed to explore how cognitive constructs and anxiety evolve over time and to examine the influence of moderating factors such as gender, socioeconomic background, and school-related stress. Moreover, a correlational study could further investigate the relationship between anxiety and the studied cognitive constructs. While acknowledging the study's limitations, the results have important implications for both research and practice. Understanding the cognitive foundations of anxiety in adolescence is crucial for developing effective prevention and early intervention strategies. By identifying the thought patterns that sustain and exacerbate anxiety, parents, educators, and clinicians can better support young people in managing their emotions and navigating the challenges of adolescence. Ultimately, fostering a supportive environment that prioritizes mental health can help adolescents not only cope with anxiety but also thrive academically, socially, and emotionally.

On a personal note, conducting this study has deepened my understanding of the complexity of anxiety in adolescence. I was struck by how deeply maladaptive cognitive patterns can be rooted in a young person's life experience. I believe that raising awareness, not only among professionals but also among educators, parents, and adolescents themselves, is essential to reducing stigma and encouraging early intervention.

In conclusion, anxiety in adolescence is a pressing issue, but one that can be addressed with the right tools, timely actions, and a multidisciplinary approach. My hope is that this study contributes, even in a small way, to a broader understanding of the phenomenon and inspires further research and innovation in both clinical practice and prevention.

## Bibliography

- APA. (2018a). *Anxiety*. APA Dictionary of Psychology.
- APA. (2018b). *Worry*. APA Dictionary of Psychology.
- Barrett, D. E. (1996). The Three Stages of Adolescence. *University of North Carolina Press*, 79(4), 333–339. <https://www.jstor.org/stable/40364502>
- Burns, H., Hurst, A., Garay, P., Murray, N. E., Stewart, S. H., Mejia, J., Bagnell, A., Klein, R. M., & Meier, S. (2025). Attentional biases for dynamic stimuli in emerging adults with anxiety: A preliminary eye-tracking study. *Journal of Psychiatric Research*, 184, 262–271. <https://doi.org/10.1016/j.jpsychires.2025.02.046>
- Chiu, A., Falk, A., & Walkup, J. T. (2016). Anxiety Disorders Among Children and Adolescents. *Focus*, 14(1), 26–33. <https://doi.org/10.1176/appi.focus.20150029>
- Cicchetti, D. , & R. F. A. (2002). A developmental psychopathology perspective on adolescence. *Journal of Consulting and Clinical Psychology*, 70(1), 6–20.
- Colombo G. (2001). Disturbi dell'affettività e dei sentimenti. In *Manuale di Psicopatologia Generale*. Cleup.
- de Lijster, J. M., Dieleman, G. C., Utens, E. M. W. J., Dierckx, B., Wierenga, M., Verhulst, F. C., & Legerstee, J. S. (2018). Social and academic functioning in adolescents with anxiety disorders: A systematic review. In *Journal of Affective Disorders* (Vol. 230, pp. 108–117). Elsevier B.V. <https://doi.org/10.1016/j.jad.2018.01.008>
- Donovan, C. L. , & S. S. H. (2000). Prevention of childhood anxiety disorders. *Clinical Psychology Review*, 20(4), 509–531.
- D'Souza, F., Egan, S. J., & Rees, C. S. (2011). The relationship between perfectionism, stress and burnout in clinical psychologists. *Behaviour Change*, 28(1), 17–28. <https://doi.org/10.1375/bech.28.1.17>
- Dugas, M. J., Freeston, M. H., & Ladouceur, R. (1997). Intolerance of Uncertainty and Problem Orientation in Worry 1. In *Cognitive Therapy and Research* (Vol. 21, Issue 6).
- Egan, S. J., Wade, T. D., & Shafran, R. (2011). Perfectionism as a transdiagnostic process: A clinical review. In *Clinical Psychology Review* (Vol. 31, Issue 2, pp. 203–212). <https://doi.org/10.1016/j.cpr.2010.04.009>
- Essau CA. (2005). Frequency and patterns of mental health services utilization among adolescents with anxiety and depressive disorders. *Depress Anxiety*, 22, 130–137.

- Frost, R. O., Turcotte, T. A., Heimberg, R. G., Mattia, J. I., Holt, C. S., & Hope, D. A. (1995). Reactions to Mistakes Among Subjects High and Low in Perfectionistic Concern over Mistakes. In *Cognitive Therapy and Research* (Vol. 19, Issue 2).
- Georgeta, S., & Nicoleta\*, R.-M. (2019). *Anxiety And Coping Mechanisms*. 2067–2074. <https://doi.org/10.15405/epsbs.2019.08.03.256>
- Ghandour RM, S. L. V. C. et al. (2019). Prevalence and treatment of depression, anxiety, and conduct problems in US children. *J Pediatr*, 256–267.
- Gladstone, T. R. G. , & B. W. R. (2009). The prevention of depression in children and adolescents: a review. *Canadian Journal of Psychiatry-Revue Canadienne De Psychiatrie*, 54(4), 212–221.
- Hewitt, P. L. , & F. G. L. (1991). Perfectionism in the self and social contexts: conceptualization, assessment, and association with psychopathology. . *Journal of Personality and Social Psychology*, 60(3), 456.
- Hijne, K., Penninx, B. W., van Hemert, A. M., & Spinhoven, P. (2020). The association of changes in repetitive negative thinking with changes in depression and anxiety. *Journal of Affective Disorders*, 275, 157–164. <https://doi.org/10.1016/j.jad.2020.07.002>
- Hoehn-Saric, R., & Mcleod, D. R. (2000). Anxiety and arousal: physiological changes and their perception. In *Journal of Affective Disorders* (Vol. 61). [www.elsevier.com/locate/jad](http://www.elsevier.com/locate/jad)
- Iizuka, C. A., Barrett, P., & Morris, K. (2012). Anxiety Prevention in School Children and Adolescents: The FRIENDS Program. In *The Wiley-Blackwell Handbook of The Treatment of Childhood and Adolescent Anxiety* (pp. 519–543). John Wiley and Sons. <https://doi.org/10.1002/9781118315088.ch22>
- Jones, A. C., Kassam-Adams, N., Ciesla, J. A., Barakat, L. P., & Marsac, M. L. (2019). A Prospective Examination of Child Avoidance Coping and Parental Coping Assistance after Pediatric Injury: A Mixed-Methods Approach. *Journal of Pediatric Psychology*, 44(8), 914–927. <https://doi.org/10.1093/jpepsy/jsz016>
- K. Salmela-Aro. (2011). *Stages of Adolescence* (B. Bradford Brown & Mitchell J. Prinstein, Eds.). Encyclopedia of Adolescence, Academic Press.
- Kajastus, K., Haravuori, H., Kiviruusu, O., Marttunen, M., & Ranta, K. (2024). Associations of generalized anxiety and social anxiety with perceived difficulties in school in the adolescent general population. *Journal of Adolescence*, 96(2), 291–304. <https://doi.org/10.1002/jad.12275>
- Luana Marques, P. (2020, October 27). *Do I have anxiety or worry: What's the difference?* Harvard Health Publishing.
- Lunn, J., Greene, D., Callaghan, T., & Egan, S. J. (2023). Associations between perfectionism and symptoms of anxiety, obsessive-compulsive disorder and depression in young people: a meta-

- analysis. In *Cognitive Behaviour Therapy* (Vol. 52, Issue 5, pp. 460–487). Routledge. <https://doi.org/10.1080/16506073.2023.2211736>
- Mattison, R. E. (1992). Anxiety disorders. In S. R. Hooper, G. W. Hynd, & R. E. Mattison (Eds.), *Child Psychopathology: Diagnostic Criteria and Clinical Assessment* (pp. 179–202).
- Neil, A. L. , & C. H. (2009). Efficacy and effectiveness of school-based prevention and early intervention programs for anxiety. *Clinical Psychology Review*, 29(3), 208–215.
- Perrotta, G. (2019). Anxiety Disorders: Definitions, Contexts, Neural Correlates And Strategic Therapy. *Jacobs Journal of Neurology and Neuroscience*, 042.
- Polanczyk GV, S. G. S. L. et al. (2015). Annual research review: a meta-analysis of the worldwide prevalence of mental disorders in children and adolescents. *J Child Psychol Psychiatry*, 345–365.
- Rachman. (2004). *L'ansia*. Latenza Editori.
- Rapee, R. M. , K. S. , I. M. , E. S. , & S. L. (2005). Prevention and early intervention of anxiety disorders in inhibited preschool children. *Journal of Consulting and Clinical Psychology*, 73(3), 488–497.
- Sassaroli, S., & Ruggiero, G. M. (2002). Teoria I costrutti dell'ansia: obbligo di controllo, perfezionismo patologico, pensiero catastrofico, autovalutazione negativa e intolleranza dell'incertezza. In *Psicoterapia Cognitiva e Comportamentale-2002* (Vol. 8, Issue 1).
- Sassaroli, S., & Ruggiero, G. M. (2003). La psicopatologia cognitiva del rimuginio (worry). In *Psicoterapia Cognitiva e Comportamentale-2003* (Vol. 9, Issue 1).
- Spinhoven, P., van Hemert, A. M., & Penninx, B. W. (2018). Repetitive negative thinking as a predictor of depression and anxiety: A longitudinal cohort study. *Journal of Affective Disorders*, 241, 216–225. <https://doi.org/10.1016/j.jad.2018.08.037>
- Taylor, M. M., & Snyder, H. R. (2021). Repetitive Negative Thinking Shared Across Rumination and Worry Predicts Symptoms of Depression and Anxiety. *Journal of Psychopathology and Behavioral Assessment*, 43(4), 904–915. <https://doi.org/10.1007/s10862-021-09898-9>
- Warnock-Parkes, E., Wild, J., Thew, G., Kerr, A., Grey, N., & Clark, D. M. (2022). “I’m unlikeable, boring, weird, foolish, inferior, inadequate”: how to address the persistent negative self-evaluations that are central to social anxiety disorder with cognitive therapy. *Cognitive Behaviour Therapist*, 15. <https://doi.org/10.1017/S1754470X22000496>
- WHO. (2004). *Prevention of Mental Disorders: Effective Interventions and Policy Options*. World Health Organization.
- WHO. (2022). *World mental health report: transforming mental health for all*.

Zhang, Q. (2024). Coping styles and the developmental trajectories of anxiety symptoms in children during transition into early adolescence. *British Journal of Psychology*, 115(3), 475–496. <https://doi.org/10.1111/bjop.12699>

### **Web sources**

Luana Marques, P. (2020, October 27). *Do I have anxiety or worry: What's the difference?*

Retrieved March 2025 from Harvard Health Publishing.

Watkins, E. (2022, December 32). *Worry and Rumination*. Retrieved March 2025 from Oxford Research Encyclopedia of Psychology.

NHS. (2023, January 9). *Anxiety in Children*. Retrieved March 2025 from NHS.uk:

<https://www.nhs.uk/mental-health/children-and-young-adults/advice-for-parents/anxiety-in-children/>

# Appendix

## S.C.A.R.E.D.

(Screen for Child Anxiety Related Emotional Disorders SCARED, Birmaher et al., 1997)

Nome \_\_\_\_\_ Et  \_\_\_\_\_ Classe \_\_\_\_\_ Data \_\_\_\_\_

### **Istruzioni:**

Di seguito   riportato un elenco di frasi che descrivono come le persone si sentono. Leggi ciascuna frase e decidi se per te   "Non vero o quasi mai vero" o "Un po' vero o talvolta vero" o "Molto vero o spesso vero". Dopo, per ciascuna frase, riempi il cerchio che corrisponde alla risposta che sembra descrivere te stesso negli ultimi 3 mesi.

	<b>0 Non vero o quasi mai vero</b>	<b>1 Un po' vero o talvolta vero</b>	<b>2 Molto vero o spesso vero</b>
1. Quando sono spaventato, mi � difficile respirare.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Ho mal di testa quando sono a scuola.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Non mi piace stare con persone che non conosco.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Ho paura a dormire fuori casa.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Sono preoccupato per le persone che mi vogliono bene.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Quando sono spaventato, mi sento come svenire.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Sono nervoso.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Seguo i miei genitori dovunque vadano.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Gli altri mi dicono che sono nervoso.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Mi sento a disagio con le persone che non conosco bene.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Ho mal di stomaco a scuola.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Quando sono spaventato, mi sembra di perdere la testa.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Mi preoccupa il fatto di dormire da solo.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Mi preoccupa il pensiero di non essere bravo come gli altri.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Quando sono spaventato, ho la sensazione che le cose non siano reali.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Faccio dei brutti sogni che riguardano i miei genitori.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Mi preoccupa il fatto di andare a scuola.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. Quando sono spaventato, il mio cuore batte veloce.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. Quando sono spaventato, mi sento tremare.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. Faccio dei sogni in cui mi succedono delle brutte cose.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. Mi preoccupa per le cose che vanno male.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. Quando sono spaventato, sudo molto.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. Sono una persona che si preoccupa.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	<b>0 Non vero o quasi mai vero</b>	<b>1 Un po' vero o talvolta vero</b>	<b>2 Molto vero o spesso vero</b>
24. Mi spavento per cose da nulla.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. Ho paura a stare da solo in casa.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. Mi è difficile parlare con persone che non conosco.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. Quando sono spaventato, mi sento come soffocare.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. Gli altri mi dicono che mi preoccupo troppo.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. Non mi piace stare lontano dalla mia famiglia.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. Temo di avere degli attacchi di ansia (di panico).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31. Sono preoccupato che succeda qualcosa di brutto ai miei genitori.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32. Sono timido con le persone che non conosco bene.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33. Il futuro mi preoccupa.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
34. Quando sono spaventato, mi viene da vomitare.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
35. Mi preoccupo di far bene le cose.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36. Ho paura ad andare a scuola.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
37. Mi preoccupo di cose che sono ormai accadute.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
38. Quando sono spaventato, mi gira la testa (ho le vertigini).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
39. Sono nervoso quando sono con altri bambini o adulti e io devo fare qualcosa mentre loro mi guardano (per esempio: leggere ad alta voce, parlare, giocare ad un gioco, giocare ad uno sport).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
40. Sono nervoso quando devo andare alle feste, balli, o in qualche posto dove ci saranno persone che non conosco bene.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
41. Sono timido.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>