Research Article

Navigating Adolescence with Chronic Illness: A Review Study of Emotion Regulation and Psychological Adjustment

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Abstract

Adolescence is a critical developmental period marked by rapid biological, cognitive, and psychosocial changes. The presence of chronic physical illnesses such as Type 1 Diabetes Mellitus (T1DM), Inflammatory Bowel Disease (IBD), and Juvenile Idiopathic Arthritis (JIA) adds substantial emotional and self-management challenges, making emotion regulation a key determinant of psychological adjustment and long-term health outcomes. This review synthesizes current evidence on the role of emotion regulation in psychological adjustment among adolescents with chronic physical illnesses, highlighting underlying theoretical frameworks, disease-specific manifestations, interpersonal influences, and evidence-based interventions. A narrative review of contemporary literature was undertaken, integrating empirical studies and theoretical models examining emotion regulation, coping, illness identity, family and peer influences, and psychological interventions in adolescents with chronic health conditions. The literature consistently demonstrates that maladaptive emotion regulation strategies, including catastrophizing, rumination, experiential avoidance, and self-blame, are associated with increased anxiety, depression, poorer treatment adherence, impaired executive functioning, and reduced health-related quality of life. Conversely, adaptive strategies such as cognitive reappraisal, acceptance, and secondary control coping promote resilience, effective disease self-management, and positive psychological adjustment. Illness identity, family co-regulation, peer support, and disease-specific psychological interventions, including Cognitive Behavioral Therapy and Acceptance and Commitment Therapy, further influence emotional adaptation and long-term well-being. Emotion regulation represents a central biopsychosocial mechanism linking chronic illness with psychological and functional outcomes during adolescence. Integrating emotion regulation assessment and evidence-based psychological interventions into routine pediatric chronic illness care may improve emotional well-being, treatment adherence, and quality of life. Future research should employ longitudinal and ecologically valid methodologies to better understand developmental trajectories and optimize intervention strategies.

Keywords: Emotion regulation, Psychological Adjustment, Adolescents, Chronic illness, Illness identity, Coping strategies.

Introduction

Adolescence represents a critical developmental epoch characterized by rapid biological maturation, cognitive restructuring, identity consolidation, and evolving socioemotional dynamics. When a chronic physical health condition such as Type 1 Diabetes Mellitus (T1DM), Inflammatory Bowel Disease (IBD), or Juvenile Idiopathic Arthritis (JIA) is introduced into this developmental trajectory, the normative tasks of youth become exponentially more complex (Nagy et al., 2022; Oris et al., 2016). Managing a pediatric chronic illness requires sustained engagement in daily adherence behaviors, navigating unpredictable somatic symptoms, and coping with medical stress, all while attempting to achieve psychological autonomy and social integration.

Central to an adolescent's capacity to manage these dual developmental and medical demands is emotion regulation (ER) (Compas et al., 2017). Emotion regulation encompasses the intrinsic and extrinsic processes responsible for monitoring, evaluating, and modifying emotional reactions to achieve adaptive functioning and personal goals (Gross, 1998). Difficulties in modulating negative affective states not only elevate the risk for psychiatric comorbidities such as depression and anxiety but also directly compromise treatment adherence, exacerbate disease severity, and impair health-related quality of life.

This review provides a comprehensive synthesis of the empirical literature examining emotion regulation and psychological adjustment in adolescents living with chronic illness. It explores the neurodevelopmental and theoretical underpinnings of ER, delineates cognitive and behavioral regulatory mechanisms, examines the framework of illness identity integration, analyzes the interpersonal ecosystem of family and peers, and details evidence-based therapeutic interventions and methodological advances.

Methodology

This narrative review synthesizes contemporary literature on emotion regulation and psychological adjustment among adolescents living with chronic physical illnesses, with a particular focus on Type 1 Diabetes Mellitus (T1DM), Inflammatory Bowel Disease (IBD), and Juvenile Idiopathic Arthritis (JIA). Relevant peer-reviewed articles were identified through electronic database searches of PubMed, Scopus, PsycINFO, and Web of Science. The review prioritized empirical studies, systematic reviews, meta-analyses, and theoretical papers published predominantly between 1995 and 2026 that examined emotion regulation, coping processes, illness identity, self-management, family and peer influences, and psychological interventions in pediatric chronic illness. The selected literature was critically synthesized to identify recurring themes, theoretical perspectives, disease-specific characteristics, and emerging clinical implications. Rather than providing a quantitative synthesis, this review offers an integrative narrative that highlights the biopsychosocial mechanisms linking emotion regulation with psychological adjustment and health outcomes in adolescents with chronic medical conditions.

Theoretical Foundations of Emotion Regulation and Coping in Pediatric Chronic Stress

Conceptualizing Emotion Regulation Versus Coping

Understanding psychological adjustment in chronic illness requires clear conceptual definitions distinguishing emotion regulation from coping, while acknowledging their theoretical overlap (Compas et al., 2012). Emotion regulation refers broadly to processes through which individuals influence which emotions they have, when they experience them, and how these emotions are expressed and experienced (Gross, 1998, 2001). These processes operate across conscious and unconscious levels and target both positive and negative emotional states to facilitate goal-directed behavior.

Conversely, coping is traditionally defined as conscious, volitional efforts to regulate cognitive, emotional, behavioral, physiological, and environmental responses to stressors. Contemporary pediatric research frequently adopts control-based models of coping, which organize regulatory efforts into three distinct domains (Compas et al., 2012):

- Primary Control Coping (Active Coping): Coping efforts aimed at directly altering the stressor or one's objective emotional response through problem-solving or direct emotional expression.
- Secondary Control Coping (Accommodative Coping): Coping efforts aimed at adapting to the source of stress and adjusting internal states through cognitive reappraisal, positive reframing, acceptance, or distraction.
- Disengagement Coping (Passive Coping): Coping efforts directed away from the stressor or emotional response via avoidance, denial, or wishful thinking.

Empirical evidence consistently demonstrates that secondary control coping is particularly adaptive for youth with chronic illness, given that many medical stressors such as disease flares, painful procedures, or genetic etiologies are inherently uncontrollable. Disengagement coping, in contrast, consistently predicts poorer psychological adjustment, elevated distress, and compromised medical self-management (Compas et al., 2012).

Allostatic Load and the Biological Cost of Chronic Stress

The psychological strain imposed by a long-term medical condition operates as a potent form of chronic stress. Unlike acute pediatric illnesses that resolve rapidly, chronic health conditions subject youth to prolonged physical and psychological demands. This continuous stress response triggers physiological processes associated with allostatic load the cumulative biological wear and tear on the neuroendocrine, metabolic, and immune systems caused by repeated or chronic activation of the stress response).

In adolescents with chronic conditions, elevated allostatic load can alter neurobiological development, particularly within frontolimbic circuits responsible for stress reactivity and top-down cognitive control (Suris, J. C et al., 2008). Chronic pediatric stress activates the hypothalamic-pituitary-adrenal axis and systemic inflammatory pathways, which subsequently feed back into the central nervous system to heighten emotional reactivity (Stapersma L et al., 2018). This biological wear and tear creates a bidirectional vulnerability: chronic medical stress impairs the neural substrates required for optimal emotion regulation, while emotional dysregulation sustains biological stress activation, potentially exacerbating underlying inflammatory and somatic processes (Fournier et al., 2020; Stapersma L et al., 2018).

Mechanistic Pathways: Emotion Regulation, Executive Function, and Self-Management

The Neurocognitive Paradox of Adolescent Self-Management

Adolescence is characterized by an evolutionary neurodevelopmental asynchronous maturation: subcortical limbic regions responsible for emotional reactivity develop earlier than prefrontal cortex networks governing executive functioning, impulse control, and long-term goal setting. This gap in neurodevelopment creates a fundamental paradox in pediatric chronic disease management (Suris, J. C et al., 2008).

Medical regimens require complex executive functioning tasks, including multi-step planning, working memory, cognitive flexibility, and future-oriented problem solving. Youth must perform daily medical adherence behaviors such as monitoring blood glucose levels, administering injections, managing dietary restrictions, or taking daily immunosuppressants frequently in contexts charged with competing socioemotional desires, peer pressure, or negative emotions (Simons, L. E et al., 2008). When emotional dysregulation occurs, prefrontal executive control is further diminished, leading adolescents to prioritize immediate emotional relief, such as skipping a painful or embarrassing procedure to fit in with peers, over long-term health outcomes.

Cognitive Emotion Regulation Strategies: Adaptive versus Maladaptive

Cognitive Emotion Regulation (CER) strategies reflect conscious, thinking-based processes used to manage emotionally charged information and stressful life events (Cserép, M et al., 2022). The specific selection of CER strategies significantly predicts psychiatric health, functional adaptation, and quality of life across pediatric populations.

Adaptive cognitive strategies serve to buffer the individual against disease-related stress. Positive reappraisal and reframing involve reinterpreting a stressful medical situation in terms of positive personal growth or manageable challenges (Compas et al., 2012). Positive reappraisal directly predicts higher psychological well-being, enhanced illness adaptation, and superior health-related quality of life in youth with T1DM, cancer, and IBD. Similarly, cognitive acceptance involves acknowledging the reality of the chronic condition without attempting to deny or minimize its existence, allowing cognitive resources to be directed toward adaptive life goals (Oris et al., 2018).

Conversely, maladaptive cognitive strategies exacerbate emotional distress and compromise physical health. Catastrophizing reflects an explicit overestimation of the likelihood and severity of negative disease outcomes, characterized by thoughts of magnification, helplessness, and persistent worry (Sullivan et al., 1995). Catastrophizing strongly predicts elevated depressive symptoms, anxiety, somatic symptom amplification, and reduced quality of life. Rumination involves obsessively focusing on the feelings and consequences associated with disease-related distress without engaging in problem-focused resolution (Compas et al., 2012). Rumination maintains emotional dysregulation and correlates with lower self-esteem and heightened depressive symptoms (Cserép, M et al., 2022). Finally, self-blame and other-blame involve attributing the etiology or burden of the illness inward toward the self or outward toward external agents, with self-blame functioning as a primary predictor of lower quality of life and heightened risk for affective disorders.

Disease-Specific Profiles and Manifestations

While emotion dysregulation acts as a transdiagnostic risk factor for psychopathology, its clinical presentation varies across disease topologies due to differing symptom profiles, treatment burdens, and social visibility.

Illness Category	Primary Somatic Stressors & Features	Common Dysregulated ER Profiles	Secondary Psychological & Functional Outcomes
Type 1 Diabetes Mellitus (T1DM)	Daily blood glucose monitoring, insulin administration, dietary management, hypoglycemic fears (Cserép, M et al., 2022; Oris et al., 2016).	Experiential avoidance, non-acceptance of emotional responses, public treatment anxiety (Cserép, M et al., 2022; Suris, J. C et al., 2008).	Treatment non-adherence, glycemic instability, diabetes distress, social isolation (Suris, J. C et al., 2008).

Inflammatory Bowel Disease (IBD)	Diarrhea, abdominal pain, rectal bleeding, fatigue, relapsing-remitting course (Stapersma L et al., 2018).	Illness-related shame, guilt, catastrophizing, alexithymia, externally oriented thinking (Fournier et al., 2020).	Subclinical/clinical anxiety (30–50%), depression (20–40%), school absenteeism, reduced flourishing (Stapersma L et al., 2018).
Juvenile Idiopathic Arthritis (JIA)	Chronic musculoskeletal pain, joint inflammation, morning stiffness, persistent fatigue (Sullivan et al., 1995).	Pain catastrophizing (rumination, magnification, helplessness), positive affect suppression (Sullivan et al., 1995).	Functional disability, altered pain sensitivity, reduced physical activity, low self-esteem (Sullivan et al., 1995).

Inflammatory Bowel Disease and the Gut-Brain Axis

Adolescents with IBD demonstrate elevated risks for anxiety and depressive disorders compared to healthy peers and youth with other chronic conditions. The bidirectional communication of the gut-brain axis underlies this association, summarized by the inflammation-depression hypothesis (Stapersma L et al., 2018). Pro-inflammatory cytokines involved in intestinal inflammation alter central nervous system function, predisposing individuals to negative affectivity.

Concurrently, the embarrassing nature of IBD symptoms, such as flatulence, fecal urgency, and incontinence, engenders high levels of self-conscious emotions, specifically illness-related shame and guilt (Giri, S et al., 2025). When youth possess poor emotional clarity or high levels of alexithymia, marked by difficulty identifying and describing feelings, they struggle to differentiate somatic gastrointestinal sensations from emotional distress (Fournier et al., 2020). This ambiguity drives experiential avoidance and externalized thinking, maintaining a cycle where psychological distress amplifies intestinal inflammation and somatic symptom severity (Fournier et al., 2020; Trindade, I. A et al., 2020).

Juvenile Idiopathic Arthritis and Pain Catastrophizing

In pediatric chronic pain conditions such as JIA, pain catastrophizing serves as a key cognitive mechanism through which physical pain translates into disability and emotional distress (Sullivan et al., 1995). Pain catastrophizing is conceptualized across three distinct dimensions:

1. Rumination: Continuous, uncontrollable thoughts about pain ("I can't stop thinking about how much it hurts").
2. Magnification: Exaggerating the potential threat value of pain sensations ("I'm afraid something serious is going to happen").
3. Helplessness: Perceiving a total lack of personal control or agency over pain ("There's nothing I can do to reduce the pain").

Elevated pain catastrophizing in youth with JIA correlates with higher pain intensity, heightened pain sensitivity, greater functional disability, and reduced health-related quality of life, independent of objective disease activity.

Illness Identity Integration: The Oris and Luyckx Framework

A central component of psychological adjustment in chronically ill adolescents is the degree to which their medical condition becomes integrated into their overall self-concept (Oris et al., 2016). The Illness Identity Theory, developed by Oris, Luyckx, and colleagues, provides a validated framework for conceptualizing how youth navigate this integrative process (Rugg, T et al., 2026).

Identity State	Integration Adaptive Quality	Primary Behavioral Expression	Impact on Executive Function & Self-Management	Associated Psychological Outcomes
Rejection	Maladaptive (Oris et al., 2016)	Active avoidance of regimen, hiding illness from peers (Suris, J. C et al., 2008).	Severe treatment non-adherence, missed medication doses (Oris et al., 2016).	Depressive symptoms, identity confusion, high illness uncertainty.

Engulfment	Maladaptive (Gamwell et al., 2018; Oris et al., 2016)	Excessive focus on bodily symptoms, hyper-vigilance (Oris et al., 2016; Van Bulck et al., 2018).	Impaired executive functioning, over-reliance on healthcare systems (Van Bulck et al., 2018).	Elevated trait anxiety, low self-esteem, poor health-related QoL (Van Bulck et al., 2018).
Acceptance	Adaptive (Oris et al., 2018)	Routine execution of self-care, balanced self-concept (Oris et al., 2016).	Optimized self-management autonomy, strong problem-solving execution (Oris et al., 2016).	Emotional stability, low depressive symptoms, optimal QoL (Oris et al., 2018).
Enrichment	Adaptive (Oris et al., 2016, 2018)	Altruism, peer mentorship, positive health goal orientation (Oris et al., 2016).	Proactive disease management, high health self-efficacy (Lansing, A. H., & Berg, C. A.., 2014).	Psychological flourishing, high hope, robust resilience (Oris et al., 2016).

The Four Dimensions of Illness Identity

The framework identifies four distinct illness identity states measured via the Illness Identity Questionnaire (IIQ):

- Rejection: The degree to which the illness is viewed as an unacceptable threat to the self and is actively denied or rejected. Adolescents scoring high in rejection attempt to separate their diagnosis from their personal identity, often avoiding self-management behaviors to maintain a self-image of being "normal" (Oris et al., 2016; Suris, J. C et al., 2008).
- Engulfment: The degree to which the chronic illness completely dominates the individual's identity and daily existence (Van Bulck et al., 2018). Youth experiencing engulfment define themselves primarily through their disease, feeling overwhelmed by their patient role.
- Acceptance: The adaptive integration of the chronic condition into the self-concept alongside other normative social roles, without allowing the illness to dominate life (Oris et al., 2018).
- Enrichment: The perception that living with a chronic illness has fostered positive life changes, personal growth, resilience, and a deeper sense of meaning (Oris et al., 2018).

Second-Order Implications of Illness Identity on Healthcare Utilization

Illness identity states exert influence over healthcare behavior and long-term functional outcomes. Research demonstrates that engulfment significantly predicts increased non-essential healthcare visits and emergency department utilization. Because individuals experiencing engulfment perceive their entire identity through the matrix of their somatic disease, minor bodily fluctuations trigger threat appraisals, overwhelming prefrontal regulatory capacity and prompting immediate medical contacts (Van Bulck et al., 2018).

Conversely, rejection leads to the opposite clinical problem: under-utilization of care, medical disengagement, and severe non-adherence. Adolescents who reject their illness frequently present during acute, severe medical crises due to neglected daily disease management). Fostering acceptance and enrichment serves as an effective protective factor, promoting self-care behavior while insulating youth against emotional distress and psychiatric comorbidity (Oris et al., 2018).

Interpersonal and Socioecological Dynamics: The Family and Peer Ecosystem

Emotion regulation during adolescence does not occur in isolated neural circuits; rather, it operates as an interpersonal phenomenon coordinated within family and social environments. The dynamic coordination model posits that individual neurocognitive self-regulation, underlying stress regulatory systems, and social interactions move in synchronized patterns over time (Serbin, L. A et al., 2014).

Parental Factors and Dyadic Co-Regulation

The family environment serves as the primary system for emotional socialization and co-regulation (Lansing, A. H., & Berg, C. A.., 2014). However, parenting a child with a severe chronic illness introduces substantial parenting stress, grief, and emotional burden. Parental cognitive emotion regulation strategies directly influence adolescent adjustment. Specifically, parental self-blame acts as an independent predictor of poorer quality of life in adolescents with chronic illness, even after accounting for the adolescent's own cognitive regulation strategies (Cserép, M et al., 2022). When parents struggle to adaptively regulate their distress regarding the child's disease, their dysregulation manifests in altered parenting practices, such as excessive control or anxious hyper-vigilance.

In pediatric pain and chronic disease conditions, parental responses to adolescent somatic distress shape adolescent pain behavior and emotion regulation through operant and emotional pathways. Protective responses characterized by excessive attention, sympathy, or special privileges provided in response to symptom expression frequently backfire (Simons et al., 2008). While driven by empathy, daily diary studies demonstrate that high levels of protective responses inadvertently reinforce pain behavior, heighten pain intensity, increase functional disability, and elevate child negative affect over time. Conversely, minimizing or invalidating responses, which involve dismissing or punishing emotional distress, disrupt the adolescent's emotional clarity and heighten pain catastrophizing (Simons et al., 2008). Validating responses, defined by empathic recognition and acceptance of the adolescent's state, promote effective emotion regulation, decrease internalizing symptoms, and strengthen parent-child attachment security (Lansing, A. H., & Berg, C. A.., 2014).

A key developmental task of adolescence is separation-individuation gradually establishing autonomy from caregivers (Stapersma L et al., 2018). Chronic illness directly disrupts this process. Because parents often manage complex treatments throughout childhood, transitioning responsibility to the adolescent frequently generates conflict (Compas et al., 2012). Unrequested parental monitoring and intrusive involvement represent common sources of family conflict. When adolescents lack the cognitive and emotional regulation skills to respond constructively to parental over-involvement, they may resort to emotional suppression, secretiveness, or risky non-adherence as misdirected assertions of autonomy (Lansing, A. H., & Berg, C. A.., 2014).

Peer Context, Stigma, and School Functioning

As adolescents transition away from primary reliance on the nuclear family, peer acceptance becomes a crucial determinant of self-esteem and emotional well-being (Serbin, L. A et al., 2014). Living with a visible or socially disruptive chronic condition poses distinct social risks (Stapersma L et al., 2018). Youth with conditions that carry embarrassing physical manifestations, such as IBD or visible medical hardware like insulin pumps, often experience heightened social anxiety and illness-related stigma.

To avoid peer rejection, cyberbullying, or being perceived as abnormal, adolescents frequently choose secrecy over disclosure (Serbin, L. A et al., 2014; Suris, J. C et al., 2008). Concealment often forces youth to skip necessary medical tasks during school hours such as measuring blood glucose, self-administering injections, or visiting the school nurse thereby directly compromising disease control to preserve peer status. Conversely, high-quality peer support acts as a primary buffer against psychological distress. Supportive friend networks foster positive emotion regulation by providing emotional validation, reducing feelings of isolation, and reinforcing self-worth (Serbin, L. A et al., 2014). Participation in chronic illness support groups or disease-specific camps allows youth to normalize their experiences, share coping strategies, and decrease illness-related stigma (Suris, J. C et al., 2008).

Therapeutic Implications, Interventions, and Methodological Advances

Evidence-Based Psychological Interventions

To address emotional dysregulation and promote adaptation in chronically ill youth, clinical psychology has developed specialized, disease-adapted interventions.

Intervention Approach	Primary Therapeutic Targets	Core Mechanisms of Action	Documented Clinical Outcomes
Cognitive Behavioral Therapy (CBT)	Maladaptive cognitions (catastrophizing, rumination), treatment anxiety (Suris, J. C et al., 2008).	Cognitive restructuring, systematic exposure hierarchies, problem-solving skills training (Compas et al., 2012).	Reductions in anxiety/depression, improved school attendance, enhanced

			disease coping (Stapersma L et al., 2018).
Acceptance and Commitment Therapy (ACT)	Experiential avoidance, illness engulfment, cognitive fusion (Trindade, I. A et al., 2020).	Psychological flexibility, mindfulness, value-guided behavior, cognitive defusion (Trindade, I. A et al., 2020).	Reduced pain interference, decreased illness stigma, enhanced quality of life (Trindade, I. A et al., 2020).
Transition Readiness Protocols	Cognitive-emotional readiness, self-management autonomy, healthcare transfer (Stapersma L et al., 2018).	Emotion coaching, autonomous self-advocacy, medical self-management training (Serbin, L. A et al., 2014).	Successful transfer to adult care, optimized medication adherence, sustained QoL (Cserép, M et al., 2022).

Targeted CBT protocols seek to modify maladaptive cognitive regulation strategies specifically catastrophizing, rumination, and self-blame while promoting adaptive cognitive reframing and problem-solving skills (Compas et al., 2012). Disease-specific protocols, such as the HAPPY-IBD protocol, target subclinical depressive and anxiety symptoms in adolescents, aiming to interrupt the vicious cycle between psychological distress and somatic inflammation (Stapersma L et al., 2018). CBT also utilizes fear hierarchies and exposure exercises (Suris, J. C et al., 2008). For instance, adolescents experiencing social anxiety surrounding medical management in public settings undergo exposure homework to systematically reduce avoidance and build self-efficacy (Suris, J. C et al., 2008).

Grounded in contextual behavioral science, ACT focuses on enhancing psychological flexibility rather than directly altering thought content. ACT targets experiential avoidance the unwillingness to remain in contact with painful internal experiences such as bodily pain, fatigue, or illness anxiety (Trindade, I. A et al., 2020). By cultivating mindfulness, emotional acceptance, and values-guided behavior, ACT assists adolescents in integrating their medical realities without allowing the disease to define their identity, directly reducing engulfment. Furthermore, as adolescents prepare to transition to adult healthcare systems, interventions must cultivate both functional self-management skills and cognitive emotional readiness (Cserép, M et al., 2022; Stapersma L et al., 2018). Research confirms that adaptive cognitive emotion regulation mediates the relationship between transition readiness and overall quality of life.

Methodological Advances in Adolescent Emotion Regulation Research

Historically, pediatric psychology literature relied heavily on static, retrospective cross-sectional self-report questionnaires to capture emotion regulation (Serbin, L. A et al., 2014; Simons et al., 2008). Modern research paradigms have undergone significant methodological shifts to capture the dynamic, real-time nature of emotional processing (Cserép, M et al., 2022).

Trait measures of emotion regulation fail to account for day-to-day fluctuations in emotional capacity driven by somatic symptoms, daily stressors, and fatigue. The integration of intensive electronic diary methods and Ecological Momentary Assessment (EMA) allows researchers to capture real-time, ecologically valid state fluctuations in emotion, pain, and disease management (Lansing, A. H., & Berg, C. A.., 2014). EMA methodologies illuminate the critical distinction between an adolescent's baseline regulatory capacity (trait) and their actualized daily regulatory execution (state).

Contemporary research paradigms also combine behavioral self-reports with biological measures of stress reactivity, including autonomic nervous system indices such as heart rate variability and neuroendocrine markers such as cortisol secretion patterns (Lansing, A. H., & Berg, C. A.., 2014). Furthermore, utilizing multi-informant designs collecting concurrent data from both adolescents and parents enables complex analyses of parent-child reporting discrepancies. Identifying dynamic discrepancies in symptom reporting reveals key dyadic patterns: parental over-

reporting often highlights anxiety-driven parental overprotection, whereas parental under-reporting may signal adolescent internalizing distress or secretiveness (Simons et al., 2008).

Conclusion

Navigating adolescence with a chronic medical condition requires continuous balance between developmental drives for independence, social belonging, and identity formation, and the medical demands of long-term disease management. Emotion regulation serves as a core psychological foundation underlying both individual self-management capabilities and interpersonal relationships across family and peer systems.

The empirical literature establishes that maladaptive cognitive emotion regulation strategies such as catastrophizing, rumination, self-blame, and experiential avoidance exacerbate psychiatric distress, impair treatment adherence, disrupt prefrontal executive functioning, and lower health-related quality of life. Conversely, adaptive strategies centered on secondary control, such as positive reappraisal, acceptance, and positive reframing, buffer youth against medical stressors and foster psychological resilience. Furthermore, the framework of illness identity illustrates that helping youth transition away from identity rejection or engulfment toward acceptance and enrichment is crucial for optimizing healthcare utilization and long-term adaptation.

Because adolescent emotion regulation is an interpersonal process, family dynamics, parental cognitive regulation, and dyadic validation play important roles in shaping adjustment. Clinical care models must move beyond purely somatic management to integrate holistic biopsychosocial care. Implementing evidence-based psychological interventions including Cognitive Behavioral Therapy, Acceptance and Commitment Therapy, and transition readiness training alongside multimethod ecological research designs, provides a comprehensive pathway to support chronically ill youth as they transition into healthy, autonomous, and flourishing adults.

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