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Anxiety in Turkish Society

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Abstract

Anxiety in contemporary Turkish society is a multidimensional phenomenon shaped by psychological vulnerability, social change, cultural meaning, and structural uncertainty. This paper argues that anxiety should be understood not only as an individual psychopathological condition but also as a culturally mediated response to economic precarity, political instability, rapid urbanization, internal migration, changing family relations, and unequal access to social resources. Collective crises, including the 1999 Marmara earthquake, the COVID-19 pandemic, and the 2023 Kahramanmaraş earthquakes, intensified psychological distress while exposing existing social inequalities. The paper combines psychological theories of anxiety with sociological, anthropological, and public-health perspectives. It reviews evidence concerning university and graduate students, older adults, and children, showing that anxiety is unevenly distributed across social groups and is influenced by age, educational and employment status, family circumstances, parental health, gender, and region. Cultural interpretations and coping practices, including family, religious, communal, and traditional healing resources, shape how distress is understood and managed. Maslow's hierarchy of needs provides an additional framework for linking anxiety to threatened physiological security, safety, belonging, esteem, and opportunities for self-actualization. The analysis concludes that effective responses must combine accessible and culturally informed mental-health care with policies that strengthen economic security, educational and employment opportunities, social support, and disaster preparedness. Anxiety in Turkey is therefore both a public-health concern and an indicator of broader tensions produced by social transformation and persistent uncertainty.

Keywords: Anxiety, Turkish Society, Mental Health, Structural Vulnerability, Cultural Anthropology, Public Health

Definition of Anxiety

The American Psychological Association defines anxiety as an emotion marked by apprehension and bodily tension in anticipation of danger, catastrophe, or misfortune. The body may prepare for the perceived threat through muscular tension, faster breathing, and an increased heart rate. Anxiety differs from fear in its temporal and perceptual focus: anxiety is generally future-oriented, prolonged, and directed toward a diffuse threat, whereas fear is an immediate and short-lived response to an identifiable danger (APA) [1]. Stedman's Medical Dictionary similarly describes anxiety as apprehension or dread accompanied by symptoms such as restlessness, tension, tachycardia, and dyspnea in the absence of a clearly identifiable stimulus [2].

Introductions

Turkey is a historically and culturally plural society shaped by migration, imperial expansion, and state formation. Although ethnic Turks constitute the majority, the population includes Kurdish, Arab, Laz, Circassian, Georgian, Bosniak, Albanian, Pomak, Zaza, Armenian, Greek, Jewish, and Assyrian or Syriac communities. This diversity partly reflects the Ottoman legacy, including the millet system, which granted varying

degrees of communal autonomy primarily on the basis of religious affiliation [3-5]. Anthropological and sociological perspectives treat ethnic identities in Turkey as historically contingent and continually negotiated rather than fixed categories. Migration, intermarriage, state policies, education, urbanization, globalization, and economic development have reshaped ethnic boundaries and produced both greater integration and renewed assertions of cultural identity. Since the establishment of the Republic in 1923, policies promoting a unified national identity have coexisted with local languages, traditions, religious practices, and collective memories. Ethnicity therefore functions not only as a marker of ancestry but also as a social and political resource through which individuals and communities negotiate belonging, citizenship, and representation [6-9].

Anxiety in Turkish society has attracted psychological, sociological, anthropological, economic, and political analysis. Research associates elevated anxiety with urbanization, unemployment, inflation, political polarization, migration, natural disasters, and the weakening or reconfiguration of family and community support. Educational

pressures, precarious employment, financial insecurity, and changing social expectations place particular burdens on students, healthcare professionals, women, adolescents, and economically disadvantaged groups [10-12]. From a sociological and anthropological perspective, anxiety reflects broader processes of modernization and structural vulnerability. Neoliberal economic reforms, rural-to-urban migration, demographic change, changing gender relations, and socioeconomic inequality have altered social organization and collective identity. Cultural values, kinship relations, religious beliefs and rituals, and local coping practices mediate how distress is experienced, interpreted, and treated. Concerns about employment, housing, inflation, purchasing power, and the future demonstrate how political and economic conditions enter everyday emotional life. Anxiety is thus both a mental-health problem and a social indicator of rapid transformation [13].

Theoretical and Cultural Perspectives

Early and Contemporary Theories

Abū Zayd al-Balkhī identified the fearful anticipation of an undesirable event as a common cause of anxiety. He observed that psychological disorders affect people differently according to temperament, disposition, gender, and age, and he emphasized the reciprocal relationship between physical and mental health: physical illness may harm the psyche, while psychological distress may contribute to physical illness [14]. Freud later defined anxiety as a signal produced by the ego in response to perceived internal or external danger. He distinguished realistic anxiety, which arises from actual threats; neurotic anxiety, which concerns the possible loss of control over unconscious impulses; and moral anxiety, which results from conflict between the ego and the superego and may be experienced as guilt or shame. The ego uses defenses such as repression, denial, and projection to manage anxiety, but unresolved conflict may sustain neurotic symptoms [15,16].

Contemporary theories view anxiety as the product of interacting biological, cognitive, emotional, and social processes. Cognitive models emphasize heightened attention to threat, catastrophic interpretations of uncertainty, and negative beliefs about one's capacity to cope [17]. Transdiagnostic models link anxiety to emotional sensitivity, low perceived control, and avoidance behaviors that maintain distress [18]. Neuroscientific accounts examine the amygdala, hippocampus, and prefrontal cortex, while genetic and epigenetic research explores the interaction between biological vulnerability and environmental stress. Biopsychosocial and socioecological approaches add the effects of social inequality, economic insecurity, political instability, technological change, and global crises [19,20].

Cultural Approaches to Anxiety and Healing

Arab-Muslim physicians recommended moderate exercise to strengthen the body, stimulate appetite, and facilitate the elimination of waste. Massage was used to promote recovery and relieve anxiety, stress, insomnia, depression, headaches, muscular pain, and other chronic pain. Its effects were understood

to vary by technique: vigorous massage strengthened the body, gentle massage promoted relaxation, and prolonged massage could reduce body fat [21]. Among Arab pastoral nomads of the Negev, Sinai, and Jordan, indigenous treatments for fear and anxiety combine material remedies, religious belief, and ritual practice. One remedy uses olive oil stored in a bag made from the skin of the desert monitor lizard (*Varanus griseus*); a tablespoon of the oil is taken each morning [22]. Sudden fright and unexplained anxiety may also be treated with the *tāsāt al-rajjah*, or fright cup. The vessel is inscribed with Qur'anic verses and sacred names, filled with water, milk, or yogurt, and left overnight while prayers are recited. Before dawn, the patient drinks the liquid. The ritual is usually conducted by women and is directed primarily toward women and children, although men may also receive it.

Comparative studies illustrate how culturally grounded healing can complement physiological, cognitive, and behavioral approaches. Native American practices may integrate prayer, singing, sacred plants, sweat-lodge ceremonies, and collaboration with traditional healers. Such practices provide communal and spiritual frameworks through which people express distress and seek harmony among mind, body, and spirit [23]. Research among Arab post-secondary students likewise shows that cultural context, education, self-esteem, stigma, and trust in mental-health professionals affect help-seeking attitudes [24-26]. These comparisons clarify why culturally informed care matters in Turkey's plural society.

Collective Crises and the COVID-19 Pandemic

Collective crises intensify anxiety by threatening health, income, housing, and social stability. The 1999 Marmara earthquake, the COVID-19 pandemic, and the 2023 Kahramanmaraş earthquakes produced widespread distress and trauma-related symptoms while exposing inequalities in resources and protection. Globally, anxiety disorders increased by approximately 26 percent during the first year of the COVID-19 pandemic, largely because of isolation, uncertainty, economic disruption, and fear of illness [27]. Persistent economic hardship during the pandemic was also strongly associated with anxiety and psychological distress [28]. During the early pandemic, many health systems struggled to control infection, while illness, mortality, unemployment, and economic disruption generated substantial distress. Medicinal plants, fruits, and vegetables attracted attention as complementary measures for prevention and symptom relief. In Turkey, medicinal plants and herbal products were used to support immunity, prevent infection, alleviate symptoms, and reduce anxiety [29]. These practices should be understood as complementary responses embedded in local health beliefs rather than substitutes for evidence-based medical care.

Anxiety Across the Life Course

University and Graduate Students

Köksal and Topkaya studied 1,372 university students, including 974 women and 398 men aged 18-35 [30]. The most frequently reported problems were test anxiety, sleep disturbance, depression, loneliness, and difficulty with self-

understanding. Sexual problems, excessive alcohol use, and substance use were least frequently reported. Several problem domains significantly predicted depression, anxiety, and stress, demonstrating the close relationship between students' psychosocial difficulties and mental health. The authors recommended preventive programs, timely psychological support, campaigns that encourage help-seeking, and expanded online counseling for students unable to attend in person. Kılıç and Karahan examined depression, anxiety, and academic distress among 459 graduate students in Turkey [31]. Scores did not differ significantly by gender or place of residence, but they varied by age, educational level, faculty, employment status, relationship status, and previous psychological help. Younger participants, master's students, unmarried students, and those with a history of seeking psychological support reported greater distress. These findings support early identification and targeted intervention through university counseling services.

Older Adults

Kırmızıoğlu et al. examined anxiety disorders among older adults in Sivas Province [32]. The current prevalence of any anxiety disorder was 17.1 percent and lifetime prevalence was 18.6 percent. Current rates included panic disorder at 0.4 percent, obsessive-compulsive disorder at 3.2 percent, post-traumatic stress disorder at 1.9 percent, social phobia at 2.8 percent, specific phobia at 11.5 percent, and generalized anxiety disorder at 6.9 percent. The authors concluded that anxiety among older adults was more common than previously recognized and recommended standardized epidemiological research and age-appropriate treatment. Social isolation, reduced autonomy, health problems, and economic hardship may increase vulnerability, while multigenerational households and family support may offer protection.

Children and Adolescents

Mutluer et al. (2023: 919–929) conducted a nationally representative study of 5,842 school-aged children in urban Turkey. The prevalence of any anxiety disorder was 16.7 percent when functional impairment was not required and 5.2 percent when impairment was included. Specific phobia was the most common subtype, accounting for 8 percent, and both specific phobia and separation anxiety tended to begin before age 12. The prevalence of any anxiety disorder, specific phobia, and post-traumatic stress disorder without impairment was significantly higher among girls than boys. These results were slightly higher than the 2016 national estimates of 13.9 percent without impairment and 2.6 percent with impairment [33]. Differences across studies may reflect age, instruments, informants, diagnostic systems, and impairment criteria [34]. The study also linked childhood anxiety to parental and social conditions. Maternal physical and psychiatric illness, paternal physical illness, and lower parental education were associated with anxiety. Lower educational attainment may indicate broader socioeconomic disadvantage, including fewer occupational, social, and economic resources [35–38]. The demographic model explained only 5.1 percent of the variance, however, showing that demographic factors alone have limited predictive power.

Children with anxiety disorders had significantly higher rates of attention-deficit/hyperactivity disorder, disruptive behavior disorders, mood disorders, tic disorders, obsessive-compulsive disorder, encopresis, and intellectual disability. ADHD was the most frequent comorbid condition; children with anxiety were approximately three times more likely to have comorbid ADHD [39–41]. Symptom overlap can complicate diagnosis and contribute to the underrecognition of co-occurring disorders. Regional variation further demonstrates the importance of context. The highest prevalence was reported in the Black Sea region, while parental physical illness and residence in the Marmara, Mediterranean, and Black Sea regions predicted anxiety disorders with impairment. Cultural understandings influence how parents and professionals recognize emotional and behavioral symptoms, and parenting practices may contribute to risk [42]. Advanced paternal age was also associated with increased risk, although evidence concerning this relationship remains limited [43].

Maslow's Hierarchy of Needs and Anxiety

Maslow's hierarchy of needs offers a framework for relating anxiety to disrupted physiological, safety, belonging, esteem, and self-actualization needs [44–46]. In Turkey, inflation, unemployment, rising housing costs, political uncertainty, natural disasters, and the COVID-19 pandemic have threatened material security and perceptions of physical safety. Chronic uncertainty at these basic levels can generate anxiety across diverse social groups. Family ties, kinship networks, neighborhood solidarity, and religious communities have traditionally supported belonging and protected against distress. Rapid urbanization, internal migration, changing gender roles, and greater individualization have weakened some of these networks, increasing loneliness and vulnerability, especially among young adults and university students. Esteem needs are also affected by competitive examinations, youth unemployment, financial pressures, family expectations, and the high social value placed on education and occupational success. When individuals cannot attain socially valued goals, they may experience inadequacy, frustration, and anxiety.

Economic hardship and structural inequality may also constrain self-actualization by forcing people to devote their resources to basic survival. Opportunities for creativity, professional fulfillment, and personal development may consequently be delayed or restricted. In Turkey's predominantly collectivist context, personal well-being is closely connected to family obligations, community expectations, and shared identities. Anxiety therefore extends beyond individual concerns to the welfare, education, employment, reputation, and future security of the household.

Maslow argued that behavior is usually multi-motivated: a single action may express several needs at once. Major events such as divorce or job loss can disrupt several levels of the hierarchy simultaneously and increase vulnerability to anxiety. The model is therefore most useful when interpreted flexibly and culturally, as a way of connecting personal distress to social relationships and structural conditions rather than as a rigid universal sequence.

Conclusion

Anxiety in contemporary Turkish society is a multidimensional phenomenon that cannot be adequately explained solely as an individual psychopathological condition. The evidence examined in this paper demonstrates that psychological vulnerability interacts with economic precarity, political uncertainty, rapid urbanization, internal migration, changing family relations, natural disasters, and unequal access to social resources. Anxiety is therefore both a personal experience and a social indicator: it reveals how broad structural transformations enter everyday emotional life and affect people's sense of safety, belonging, dignity, and hope for the future. The findings also show that anxiety is unevenly distributed across the life course. University and graduate students face examination pressures, uncertain employment prospects, loneliness, financial strain, and demanding social expectations. Children's anxiety is associated not only with individual vulnerability but also with parental health, socioeconomic disadvantage, comorbid disorders, gender, and regional context. Among older adults, chronic illness, reduced autonomy, economic hardship, bereavement, and social isolation may increase risk, while family relationships and multigenerational households may provide meaningful protection. These differences demonstrate that prevention and treatment must be adapted to the circumstances of particular age groups and communities rather than based on a single universal model.

A comprehensive understanding of anxiety in Turkey must therefore integrate psychological, sociological, anthropological, and public-health perspectives. Psychological theories clarify cognitive, emotional, behavioral, and biological processes, whereas sociological and anthropological approaches reveal how inequality, collective crises, cultural values, religious beliefs, kinship relations, and local healing traditions shape the interpretation and management of distress. Maslow's hierarchy of needs further illustrates how threats to material security, physical safety, belonging, esteem, and self-actualization may operate simultaneously. Interpreted flexibly and within Turkey's cultural context, this framework connects individual suffering with household welfare, community relations, and structural opportunity. Effective responses must consequently extend beyond clinical treatment. Universities require accessible counseling, preventive education, early identification, and online services for students who cannot seek help in person. Children and their families need timely assessment, support for parental difficulties, and coordinated treatment of comorbid conditions. Older adults require age-appropriate services that address physical illness, reduced independence, and isolation while recognizing the protective potential of family and community networks. At the population level, reducing anxiety also requires policies that strengthen economic security, affordable housing, educational and employment opportunities, social solidarity, disaster preparedness, and equitable access to culturally informed mental-health care. Traditional, religious, and communal practices may contribute to coping and social support when they complement, rather than replace, appropriate evidence-based care.

Future research should examine anxiety across Turkey's diverse ethnic, religious, socioeconomic, and regional populations through longitudinal and mixed-method studies. Greater attention should be given to rural and urban differences, gender relations, migration, digital life, stigma, changing family structures, and the long-term psychological consequences of the COVID-19 pandemic and major earthquakes. Research should also investigate how formal mental-health services can cooperate ethically with trusted family, community, religious, and traditional resources. Such work would support interventions that are both scientifically grounded and culturally meaningful. Ultimately, improving psychological well-being in Turkey requires not only treating anxiety after it develops but also creating social conditions in which individuals and communities can feel secure, maintain supportive relationships, receive fair recognition, and imagine a viable future.

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