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Social media and adolescent mental health: Why screen time is no longer the question?

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ABSTRACT

Children's and adolescents' exposure to social media has reached such a scale that the debate over whether they should be online has become moot. In Argentina, the average age at which children get their first personal phone with internet access is 9.6 years, and eight out of ten adolescents use social media every day. There remains genuine disagreement among researchers regarding the impact on mental health: while some authors argue that the widespread adoption of smartphones has reshaped childhood and accounts for the rise in anxiety, depression, and self-harm, others show that the effect on the general population is very small.

This update proposes a way to resolve the contradiction in practice: abandon duration of use as a risk criterion and structure clinical evaluation around patterns of use and individual vulnerability. Restricting access reduces exposure, but does not, on its own, improve mental health.

Keywords: *adolescents; social media; mental health; screen time; cyberbullying.*

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INTRODUCTION

For more than a decade, pediatric discussions about screen time have revolved around a single number: hours per day. Today, that no longer applies. Of a global population of 8250 million people, 6040 million use the internet, and 5660 million have at least one social media account.[1]

The relevant clinical question is no longer whether adolescents are online. It is how they are online—and at what cost. This narrative update is based on a non-systematic search of PubMed and institutional reports published between 2018 and 2026.

THE SCOPE OF THE PHENOMENON

The Kids Online Argentina 2025 Survey, which surveyed 5910 children and adolescents aged 9 to 17, provides the local figures.[2] The average age at which children get their first cell phone with internet access is 9.6 years. Eighty percent use social media every day. Forty-six percent reported experiencing some kind of problem related to internet, cell phone, or video game use in the past year, and 21% were insulted or bullied by a schoolmate online. One statistic that often goes unnoticed: 24% of adolescents aged 12 to 17 have gambled online at least once.

At the regional level, a study by the Ibero-American General Secretariat and the Ibero-American Youth Organization covering 22 countries found that Ibero-American youth spend an average of 3 hours and 32 minutes a day on social media—the highest figure in the world—and that one in five has a mental disorder linked to heavy use.[3] More than 60% report what the report terms "digital anxiety" or FOMO (fear of missing out). Against this backdrop, suicide is already the third leading cause of death among 15- to 19-year-olds in the region.

UNICEF and PAHO explicitly state that data on digital violence in Latin America remain limited.[4] It is important to distinguish between "limited" and "absent": the absence of data does not justify assuming a low prevalence, but it does make it necessary to ask about the issue during the consultation.

A REAL DISAGREEMENT

Regarding the harm social media causes, two opposing schools of thought exist, neither of which is marginal. On one side, Haidt and Twenge, American psychologists who study social media's impact on adolescent mental health, argue that between 2010 and 2015, childhood underwent a "major rewiring": smartphones and social media displaced free play, sleep, and face-to-face interaction.[5,6] Rates of anxiety, depression, self-harm, and adolescent suicide rose during this same period across several countries simultaneously, with a more pronounced effect on girls, which would be consistent with mechanisms of social comparison and relational aggression.[7,8] This has led to specific proposals: delaying the start of social media use, banning phones from schools, and regulating platforms. This stance has most influenced recent public policies in Australia and the United Kingdom.

On the other hand, Orben and Przybylski, British experimental psychologists, analyzed large databases using specification curve methods and concluded that digital technology accounts for at most about 0.4% of the variation in adolescent well-being.[9] Odgers, a developmental psychologist at the University of California, added a warning in *Nature* that is particularly relevant to us: attributing the youth mental health crisis to social media can divert resources and attention away from better-documented causes, such as poverty, violence, isolation, and lack of access to mental health services.[10]

THREE QUESTIONS THAT SHOULD BE ADDRESSED SEPARATELY

The two positions cease to contradict each other when we distinguish between three questions that public discourse tends to conflate: how long, how it is used, and who uses it—as described below.

Screen time is the worst predictor we have. It explains very little, is difficult to measure—self-reported hours are notoriously inaccurate—and doesn't distinguish between a teenager who edits videos and one who scrolls through social media at 3 a.m. It serves as a conversation starter, not as a risk factor.

By contrast, the pattern of use is consistently associated with poorer well-being. We're talking about addiction-like symptoms, failed attempts to reduce use, and the displacement of sleep and other activities that were previously important to that young person. The WHO's HBSC study, which surveyed nearly 280 000 adolescents in 44 countries, estimates that 11% exhibit problematic social media use, compared to 7% in 2018.[11] This is the figure (and not the percentage of those who use social media) that should guide clinical practice.

The individual matters just as much as

the pattern. The risk is concentrated among adolescent girls, particularly between the ages of 11 and 13, those from low socioeconomic backgrounds, those with a history of psychopathology, and adolescents who are already socially isolated offline. A longitudinal study of 11 876 preteens from the ABCD cohort found that increases in usage above each child's average preceded more depressive symptoms, with no inverse relationship. In contrast, differences in usage between children were not associated with depressive symptoms.[12] Comparing how many hours one adolescent uses versus another does not predict anything; whether that same adolescent is using more than usual for them does.

WHERE DOES THE DAMAGE OCCUR, AND WHEN?

Once the subgroup has been identified, the next step is to determine

the pathway. There are at least six, with varying degrees of support and modifiability.

The first is sleep disruption, which is the best documented: a meta-analysis of access to and use of portable devices shows a consistent association with shorter sleep duration and poorer sleep quality.[13] Nighttime use reduces sleep duration and delays REM sleep, with known consequences for mood and performance.[14] It is also the only one for which there is a simple, free, and consistently supported recommendation: keep the device out of the bedroom.

The second is upward social comparison with idealized content, which has a stronger impact on women's body image and self-esteem. This mechanism explains the gender asymmetry noted above.

The third is digital violence: cyberbullying, sextortion, and the non-consensual sharing of images, which are highly prevalent but underreported. In Latin America, between 21% and 61% of adolescents reported experiencing some form of offensive online behavior.[4] Regarding sexting, a systematic review of 39 studies involving more than 110 000 participants provides the following figures: about 15% sent a sext, and 27% received one; more relevant to this discussion, 12% forwarded someone else's material without consent, and 8% had their own material shared without their consent.[15] The fourth is unsought algorithmic exposure to self-harm-promoting material, dietary restriction, or risk-related challenges.

The fifth is persuasive platform design, with infinite scrolling, approval metrics, and expiring content, which won't change through consultation but through regulatory channels.

The sixth category is online gambling, and it's the one we ask about the least. It doesn't come up as a separate activity, but rather in the same context as talking with friends, along with cryptocurrencies and in-app purchases.[16] An analysis of the Kids Online Survey shows that the prevalence rises from 23.7% to 31.3% when access to a cell phone before age 10 is combined with weak parental control.[17]

THE SAME SPACE ALSO PROVIDES PROTECTION

For some teenagers, online platforms offer a sense of community, belonging, and identity exploration. They also provide a real avenue for accessing health information and reducing stigma: many adolescents come to the doctor's office because of something they saw online. The so-called compensatory hypothesis suggests that the benefits are greatest precisely among those with fewer offline social resources.

The clinical implication is clear and runs counter to what many families expect to hear: disconnecting a teenager is not a neutral intervention. For some patients, removing social media eliminates a risk factor. For others, it eliminates their only support network. Before recommending a disconnect, we must ask what role that space plays in that boy's or girl's life.

WHAT TO EXPECT FROM BANS

Two natural experiments provide a benchmark for expectations. Australia banned children under 16 from accessing social media starting December 10, 2025. The official three-month evaluation, involving 803 children aged 10 to 15 and their families, found that use of restricted platforms dropped from 85.9% to 81.5% and the percentage of children with their own accounts fell from 52.4% to 42.1%.[18] One indicator did improve: the feeling of missing out fell from 43.3% to 36.3%. Interpret this finding with caution: the evaluation did not measure mental health, did not include a control group, and relied on self-reported data collected after three months.

In the United Kingdom, the SMART Schools study compared 1227 adolescents aged 12 to 15 in 30 schools, 20 of which had restrictive cell phone policies.[19] There was less use on school grounds—about 40 minutes less per day—but

no differences in total usage during the week or on weekends, and no differences in mental well-being, sleep, or academic performance. The study design is cross-sectional, and the low response rate limits firm causal conclusions.

Both studies point in the same direction but have different scopes. The Australian study shows that restricting access reduces exposure—though much less than expected—and did not measure mental health. The British study did measure mental health, along with sleep and performance, and found no differences. Restriction is a baseline measure, not a treatment.

WHAT TO DO AT THE DOCTOR'S OFFICE

The American Academy of Pediatrics has shifted its focus regarding screen use in its 2026 statement: it is no longer about "screen time," but rather the "digital ecosystem," which today includes at least five devices—phones, smartwatches, game consoles, computers, and tablets—and cannot be assessed by simply adding up minutes.[20]

In practice, six brief questions are enough to explore the pathways described (*Table 1*). In my experience, the second question works best: "Have you ever tried to use it less and been unable to?" It gets to the heart of problematic use and often helps the teenager open up. The fifth and sixth questions require some time alone with the teenager, without the parents present in the office.

An apparent contradiction remains worth pointing out. If time spent online is a poor predictor and restricting access does not in itself improve mental health, on what basis do we continue to recommend delaying the start of social media use? The argument is not about the amount of time spent, but about the timing: children typically begin using these platforms between the ages of 11 and 13 (the window during which the risk is concentrated), and postponing this start is not intended to reduce the total number of hours spent online, but rather to shift exposure outside of that period. The evidence supporting this is indirect, because it comes from vulnerability studies rather than trials on age of first use, and families should be told this clearly.

Some recommendations are worth following, while others should be abandoned (*Table 2*). Prescribing a few hours as if it were a dose gives us the illusion of action but changes nothing. Relying entirely on parental control software has the same problem, with the added drawback that it creates surveillance where conversation is needed. One principle underlies all the above:

Table 1. Six screening questions for pediatric visits

Question No.	What it screens for
1. Where do you charge your cell phone at night, and what time do you turn it off?	Sleep displacement
2. Have you ever tried to use it less but couldn't?	The core of the problematic use
3. What shows up in your feed that you didn't search for?	Algorithmic exposure, without sounding accusatory
4. What have you stopped doing lately because you've been online?	Functional displacement: sports, friends, school
5. Has anyone offended you, pressured you, or asked you for photos?	Digital violence, grooming, sextortion. Requires privacy
6. Did you bet money online or play a game for money?	Emerging exposure, high local prevalence, almost never asked

Table 2. Guidance: what to keep and what to let go of

To recommend	Stop recommending
Do not use electronic devices in the bedroom: the simplest measure with the most consistent evidence.	Prescribe a few hours as if it were a dose.
Delaying the debut on social media, which is not the same as a digital debut: the argument centers on the 11- to 13-year-old age range, not the total number of hours.	Set a total limit without evaluating the purpose of that time.
Agreed-upon family media plan, with rules that apply to adults as well.	Relying entirely on parental control software.
Teach them how to manage the algorithm: block, mute, click "Not interested."	Assuming that the absence of local data is equivalent to no risk.

adult supervision on social media should be a prerequisite for allowing children to participate. Supervision not as control, but as support.

CONCLUSION

Our job is not to decide whether social media is good or bad. The evidence does not support such a verdict—and probably never will—because the question is poorly framed. We do know two things the clinic can use today: restricting access isn't enough, and cutting off access without assessing the role that space plays can be harmful. Our job is to identify which adolescents are being harmed, through what means, and due to what pre-existing vulnerabilities. That isn't solved by setting a time limit or imposing a ban. It's solved by asking questions and asking them well. ■

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