Original Article

Anxiety and Depression Among Secondary School Students

Riyadh Mohammed Muhsin[1], Adil Ali Hussein[2], Haila Malik Sabty[2]

[1]Psychology and Media Department, Mazaya Private University, Nasiriya, Iraq, [2]College of Nursing, University of Basrah, Basrah, Iraq

Abstract

Background: Most prevalent psychiatric disorders, anxiety, and depression is characterized by a considerable degree of personal distress and disruption in people's lives. Understanding the condition during adolescence is crucial for determining its cause and course, establishing early detection and intervention, and because depression frequently manifests during this developmental period. **Objectives:** to investigate anxiety and depression among secondary school students. **Materials and Methods:** A cross-sectional study was conducted in secondary schools in Basra, Iraq, and includes 350 students was selected as a nonprobability (purposive) sample in order from October 30, 2022 until April 30, 2023. Statistical data analysis included percentage, frequency, standard deviation, ANOVA, Chi-Square, and t test were used to examine this study's data. **Results:** The study's findings show that 61.1% of adolescents are with age group of 17–19 years and 37.4% of them are with age group of 14–16 years. 58.3% of adolescents are females, highest percentage of them were a third-fourths born in family 38.9%. 52.3% of them are reported absence of 1–3 days per month from school and 52% of them have failed in the school. **Conclusion:** The present study concludes that the mild mood psychological disorders (major depressive disorder and separation anxiety disorder) and moderate (social phobia disorder, panic disorder, generalized anxiety disorder, and obsessive–compulsive disorder) among secondary school students.

Keywords: Adolescents, anxiety, depression, school health

Key Messages: At least 20% of teenagers are thought to have a mental illness each year, with despair and anxiety being the most prevalent. Teenage depression has serious consequences, including suicide, and has a severe impact on everyday activities at school, home, in the community, and interactions with family and peers.

Introduction

Children's and adolescents' mental health issues are a significant public health concern. Before the age of 14, the majority of young people's mental health issues begin. At least 20% of teenagers are thought to have a mental illness each year, with despair and anxiety being the most prevalent. Teenage depression has serious consequences, including suicide, and has a severe impact on everyday activities at school, home, in the community, and interactions with family and peers.[1,2] Up to 8.9% of adolescents are thought to suffer from depressive disorders. However, there are significant differences in the reported prevalence across other nations. The frequency of depression among female teenagers in Middle Eastern nations varied from 13.9% to 41.5% in Saudi Arabia. In comparison, just 7% of male adolescents in Egypt and 10.6% of those in Oman suffered depression.[3,4] However, 17.6% of children and teens in Lebanon were reported to have anxiety or depression. The incidence of depression was 14.4% among individuals aged 6–33 in Kuwait,[5] whereas the prevalence of depressive disorders was 17% among the same age group in Oman.[6]

Similar to how it is with adults, primary care is now practically integrated into the youth mental health system. The majority of young people contact their main care provider at least once a year; families seek the advice of medical experts with psychological issues; and primary care physicians are the ones who prescribe the majority of young people's psychotropic medications. Many families and primary care doctors are reluctant to contemplate the using antidepressant medication

Address for correspondence: Dr. Adil Ali Hussein, College of Nursing, University of Basrah, Basrah, Iraq.
E-mail: adil.hussein@uobasrah.edu.iq

Submission: 17-Jul-2023 **Accepted:** 17-Dec-2023 **Published:** 18-Aug-2026

This is an open access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 License (CC BY-NC-ND), where it is permissible to download and share the work provided it is properly cited. The work cannot be changed in any way or used commercially without permission from the journal.

For reprints contact: WKHLRPMedknow_reprints@wolterskluwer.com

How to cite this article: Muhsin RM, Hussein AA, Sabty HM. Anxiety and Depression among Secondary School Students. Med J Babylon 2026;23:1020-4.

Access this article online

Quick Response Code:

Website: https://journals.lww.com/mjby

DOI: 10.4103/MJBL.MJBL_1029_23

and favoring psychosocial therapies, despite surveys of primary care suggesting that they see internalizing illnesses as part of their clinical obligations.[7] The justification for a primary care-based treatment paradigm is supported by the additional expenses that youths with mood and anxiety difficulties place on physical health systems. A result that cannot be explained by variations in physical health condition is that adolescents who internalize use health services substantially more than adolescents who do not feel anxiety or depression.[8] Additionally, physical symptoms such persistent headaches and abdominal discomfort that require medical attention are frequently co-occurring with pediatric anxiety and depression.[9] In adults, experiencing sadness is typically associated with worse health, including higher heart attack mortality rates and unhealthy health risk behaviors such unsafe sexual activity.[10,11]

Subjects and Methods

Study design

A cross-sectional study was performed to study anxiety and depression in secondary school students in Basra schools. It involved 350 students and was done from October 30, 2022, to April 30, 2023.

Study samples

There were 350 students chosen as a nonprobability (purposive) sample. The selection of the participants was based acceptance of the students.

Instrument

We adopted an assessment tool to assess anxiety and depression in schoolchildren. A questionnaire was designed to study the effect of anxiety and depression after reviewing several research studies. After completion, the questionnaire was distributed and presented to a panel of experts. Data was collected by interviewing school students.

There are two components that make up the instrument: The first section included the demographic characteristics of the participants in the study sample, and the second section involved the use of a Scale 11, which consists of 47 items to evaluate the impact that anxiety and depression have on school students.

Data collection

After giving each student their initial agreement to participate in the study and after explaining and clarifying the study's aims, the researchers were entirely responsible for interviewing the study sample. Each teen was given between 25 and 35 min to complete the interview and fill out the questionnaire.

Statistics

Statistical data analysis: Percentage, frequency, standard deviation, ANOVA, Chi-Square, and *t* test were used to examine this study's data.

Research ethics approval

Permissions were obtained for the project before data collection. University of Basrah\College of Nursing's research ethics committee gave its approval for this study to proceed. The written authorization was obtained by the Directorate of Education of the Basrah Governorate. In addition, the parents of all students who participated in the study submitted written informed consent.

Results

Table 1 shows that (61.1%) of adolescents are with age group of 17–19, and 58.3% of adolescents are females. Regarding birth order, the highest percentage indicates that adolescents are third-fourths born in family as reported among (38.9%) of them. 52.3% of them are reported absence of 1–3 days per month from school and 52% of them have failed in the school. Also the results reveals that (53.1%) of adolescents are resident in rural area and (45.1%) of them reported that their parents are relatives.

Table 1: Sociodemographic characteristics of the study samples

List	Characteristics		*f*	%
1	Age (years)	11–13	5	1.4
		14–16	131	37.4
		17–19	214	61.1
		Total	350	100
2	Gender	Male	146	41.7
		Female	204	58.3
		Total	350	100
3	Birth order	1st–2nd	121	34.6
		3rd–4th	136	38.9
		5th–6th	50	14.3
		7th–8th	43	12.3
		Total	350	100
4	Absence days per month	None	122	34.9
		1–3	183	52.3
		4–6	43	12.3
		7–9	2	0.6
		Total	350	100
5	Failed in school?	No	168	48
		Yes	182	52
		Total	350	100
6	Residency	Urban	164	46.9
		Rural	186	53.1
		Total	350	100
7	Relative degree among parents?	No	158	45.1
		Yes	192	54.9
		Total	350	100
8	Socioeconomic status	Low	56	16
		Moderate	224	64
		High	70	20
		Total	350	100

f: frequency, %: percentage

Table 2: Assessment of mood psychological disorders among adolescents

Mood psychological sisorders	Severity	*f*	%	*M*	SD	Assessment
Social phobia disorder	Normal	9	2.6	18.62	2.654	Moderate
	Mild	144	41.1			
	Moderate	166	47.4			
	Severe	31	8.9			
Panic disorder among	Normal	15	4.3	19.25	3.083	Moderate
	Mild	115	32.9			
	Moderate	176	50.3			
	Severe	44	12.6			
Major depression disorder	Normal	51	14.6	18.43	2.723	Mild
	Mild	222	63.4			
	Moderate	76	21.7			
	Severe	1	0.3			
Separation anxiety disorder	Normal	43	12.3	13.47	2.521	Mild
	Mild	188	53.7			
	Moderate	98	28			
	Severe	21	6			
Generalized anxiety disorder	Normal	28	8	12.39	2.099	Moderate
	Mild	137	39.1			
	Moderate	158	45.1			
	Severe	27	7.7			
Obsessive-compulsive disorder	Normal	11	3.1	13.21	1.871	Moderate
	Mild	99	28.3			
	Moderate	203	58			
	Severe	37	10.6			
Total		350	100			

f: frequency, %: percentage

M: mean for total score, SD: standard deviation for total score

Normal = 9–13.50, Mild = 13.51–18.00, Moderate = 18.01–22.50, Severe = 22.51–27

Table 3: Relationship among mood psychological disorders with sociodemographic variables of adolescents (*N* = 350)

Variables	Correlation Coefficient	Mood psychological disorders					
		SFD	PD	MDD	SAD	GAD	OCD
Age	Spearman	0.002	0.393**	0.117*	0.159**	−0.132*	0.107*
	Significant (2-tailed)	0.973	0.001	0.029	0.003	0.013	0.046
Gender	Point biserial	0.155**	0.124*	0.057	0.071	0.166**	0.058
	Significant (2-tailed)	0.004	0.020	0.288	0.184	0.002	0.280
Residency	Point biserial	0.036	0.347**	0.126*	0.167**	0.303**	0.091
	Significant (2-tailed)	0.501	0.001	0.019	0.002	0.001	0.088
SES	Spearman	0.041	0.246**	0.131*	0.066	0.132*	0.108*
	Significant (2-tailed)	0.447	0.001	0.014	0.215	0.013	0.044
Father's education	Spearman	0.004	0.075	0.017	0.025	0.121*	0.034
	Significant (2-tailed)	0.941	0.162	0.756	0.641	0.023	0.525
Mother's education	Spearman	0.001	−0.122*	0.046	0.017	0.160**	0.031
	Significant (2-tailed)	0.990	0.023	0.392	0.750	0.003	0.567

*Correlation is significant at the 0.05 level (2-tailed)

**Correlation is significant at the 0.01 level (2-tailed)

The socioeconomic status refers that 64% of adolescents are with moderate socioeconomic status.

Table 2 that the mild mood psychological disorders (major depressive disorder and separation anxiety disorder) with (mean ± SD = 18.43±2.723 and 13.47±2.521) and moderate (social phobia disorder, panic disorder, generalized anxiety disorder, and obsessive–compulsive disorder) with (mean ± SD = 18.62±2.654, 19.25±3.083, 12.39±2.099, and 13.21±1.871) among secondary school students.

Table 3 shows that there is significant relationship among adolescents' age with regard to panic disorder, major depressive disorder, separation anxiety disorder, generalized anxiety disorder, and obsessive-compulsive disorder at *P* value = 0.001, 0.029, 0.003, 0.013, and 0.046 respectively.

Also significant relationship among adolescents' gender with regard to school phobia disorder, panic disorder, and generalized anxiety disorder. at *P* value = 0.004, 0.020, and 0.002 respectively.

Significant relationship among adolescents' residency with regard to panic disorder, major depressive disorder, separation anxiety disorder, and generalized anxiety disorder at *P* value = 0.001, 0.019, 0.002, 0.001 respectively.

The socioeconomic status has reported significant relationships with regard to panic disorder, major depressive disorder, generalized anxiety disorder, and obsessive–compulsive disorder *P* value = 0.001, 0.014, 0.013, and 0.044 respectively.

The parents' education reported a significant relationship with generalized anxiety disorder at *P* value = 0.013 and 0.003.

Discussion

Although the prevalence of social phobia (social anxiety) is high in children and teenagers in particular, the majority of research on the disease has used adult samples. With a focus on the current state of empirically validated therapies, the nature of childhood and adolescent social phobia is described in the current review. An analysis of the research on childhood and teenage social phobia (social anxiety) is essential given the high incidence, seriousness, and early beginning of SAD. This study also found the 47.4% of adolescents associated with moderate social phobia disorder (mean ± SD = 18.62 ± 2.654).

The present study also supported by study about guide for child anxiety disorder,[12] According to epidemiological research, social phobia affects up to 13% of people at some point in their lifetime, making it the most widespread anxiety disorder and the third most common mental disease in the US. Contrary to the majority of other anxiety and mood disorders, there is compelling evidence that SAD develops early, with a mean age of onset of 15.5 years and pediatric diagnoses as early as age.

Previous studies have shown that panic disorder not only develops before maturity but also that its initial peak phase of emergence may be during adolescence. The median age of onset is midadolescence, and more girls than boys suffer from panic disorder. The base rate of panic disorder in adolescents is thought to be somewhat low.[13] Similar to the current study, which shows that 50.3% of teenagers had moderate panic disorder (mean ± SD = 19.25 ± 3.083).

The prevalence of depression increases from youth through adulthood. One in eight American adolescents (12–17) have experienced major depression, according to a recent survey. By the time they reach young adulthood, up to 8% of adolescents with major depressive episodes commit suicide, making it the second-leading cause of mortality for 12- to 17-year-olds.[14,15]

Because the signs and symptoms of depression in young people are different from those in adults, the condition is frequently misunderstood and left untreated. Up to 12% of young people may be affected. Negative impacts on social functioning, academic performance, and the incidence of suicidal thoughts and attempts are seen in patients whose depression goes untreated.[16] The previous mentioned studies supported present finding that shown 63.4% of adolescents associated with mild major depressive disorder (mean ± SD = 18.43 ± 2.723).

Our finding shown that 53.7% of adolescents associated with mild separation anxiety disorder (mean ± SD = 13.47 ± 2.521), this finding results supported by the study that concluded: Anxiety disorders, including separation anxiety disorder, generalized anxiety disorder, and social anxiety disorder, are common among children and adolescents. They manifest at a younger age than other internalizing psychiatric diseases, are markedly functionally impaired, and frequently last until adulthood. Generally speaking, a large portion of adult psychopathology can appear in childhood and adolescence, with childhood-onset disorders predicting teenage disorders as well as both child and adolescent difficulties and diagnoses predicting adult illnesses.[16]

More than 80% of adult instances of obsessive-compulsive disorder are thought to start before the age of 18, according to prevalence estimates. OCD is thought to start between childhood and mid-adolescence. According to reports, the typical age of onset is between 7.5 and 12.5 years, and among young people who have been referred by clinics, the lifetime prevalence rate is around 15%. OCD is thought to affect around twice as many women as men in adult samples, but this tendency tends to be inverted in children, with nearly twice as many boys as girls.[17] This finding support present study that found 58% of adolescents associated with moderate obsessive–compulsive disorder (mean ± SD = 13.21 ± 1.871).

Male adolescents were noticeably less likely than female to suffer from mental illnesses. The findings in Turkey and Oman[18,19] and this finding are in agreement. Teenage females, compared to males, are more prone to experience internalized disorders including anxiety and depression. The fact that female adolescents experience puberty more negatively than male may account for the increased frequency among females. This unfavorable effect during puberty may be the result of biological and hormonal changes, which affect girls more than males. In addition,

female adolescents have a worse body image and lower sense of self-worth than male, which may contribute to a higher incidence of depression and other diseases.[20]

Present the findings of a study demonstrating a significant correlation between age and mental disorders. Higher rates of mental illness were seen among older adolescents than among younger. This is consistent with findings made in the United States.[21] One possible explanation for this is increased anxiety, issues with concentration and social concerns affecting older adolescents, such as worries about their occupations, future, and responsibilities.[20]

Depression has been linked to low socioeconomic status and academic performance in female adolescents.[22] These research found a significant relationship between mental health problems and family income, as well as parents with lower levels of education, bad health, and poor academic achievement in the United States,[23] complement our findings.

Acknowledgment

The researchers greatly value the contribution of each and every student who participated in the study and would like to express their gratitude.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

References

1. World Health Organization. Mental health: A state of well-being; 2014. Available from: https://www.who.int/news-room/facts-in-pictures/detail/mental-health. [Last accessed on 20 Jun 2022].
2. Mehler-Wex C, Kolch M. Depression in children and adolescents. Dtsch Arztebl Int 2008;105:149-55.
3. Afifi M. Depression in adolescents: Gender differences in Oman and Egypt. East Mediterr Health J 2006;12:61-71.
4. Gelban KS, Al-Amri HS, Mostafa OA. Prevalence of depression, anxiety and stress as measured by the Depression, Anxiety, and Stress Scale (DASS-42) among secondary school girls in Abha, Saudi Arabia. Sultan Qaboos Univ Med J 2009;9: 140-7.
5. Al-Turkait FA, Ohaeri JU. Psychopathological status, behavior problems, and family adjustment of Kuwaiti children whose fathers were involved in the first gulf war. Child Adolesc Psychiatry Ment Health 2008;2:12.
6. Afifi M, Riyami AA, Morsi M, Kharusil HA. Depressive symptoms among high school adolescents in Oman. East Mediterr Health J 2006;12:S126-37.
7. Olson AL, Kelleher KJ, Kemper KJ, Zuckerman BS, Hammond CS, Dietrich AJ. Primary care pediatricians' roles and perceived responsibilities in the identification and management of depression in children and adolescents. Ambul Pediatr 2001;1:91-8.
8. Weersing VR, Rozenman MS, Maher-Bridge M, Campo JV. Anxiety, depression, and somatic distress: Developing a transdiagnostic internalizing toolbox for pediatric practice. Cogn Behav Pract 2012;19:68-82.
9. Powers SW, Gilman DK, Hershey AD. Headache and psychological functioning in children and adolescents. Headache 2006;46:1404-15.
10. Mathyssek CM, Olino TM, Hartman CA, Ormel J, Verhulst FC, Van Oort FV. Does the revised child anxiety and depression scale (RCADS) measure anxiety symptoms consistently across adolescence? The TRAILS study. Int J Methods Psychiatr Res 2013;22:27-35.
11. Baron I, Hurn R, Adlington R, Maguire E, Shapiro L. Revised children's anxiety and depression scale (RCADS): Psychometric properties in a clinical sample in the United Kingdom. Clin Pediatr 2021;6:1000186.
12. Beidel DC, Alfano CA. Child Anxiety Disorders: A Guide to Research and Treatment. New York, USA: Routledge; 2011.
13. Pincus DB, May JE, Whitton SW, Mattis SG, Barlow DH. Cognitive-behavioral treatment of panic disorder in adolescence. J Clinical Child Adolescent Psychol 2010;39:638-49.
14. Bitsko RH, Claussen AH, Lichstein J, Black LI, Jones SE, Danielson ML, *et al*. Mental health surveillance among children—United States, 2013–2019. MMWR Suppl 2022;71:1.
15. O'Connor BC, Lewandowski RE, Rodriguez S, Tinoco A, Gardner W, Hoagwood K, *et al*. Usual care for adolescent depression from symptom identification through treatment initiation. JAMA Pediatr 2016;170:373-80.
16. Mullen S. Major depressive disorder in children and adolescents. Mental Health Clin 2018;8:275-83.
17. Comer JS, Kendall PC, Franklin ME, Hudson JL, Pimentel SS. Obsessing/worrying about the overlap between obsessive–compulsive disorder and generalized anxiety disorder in youth. Clin Psychol Rev 2004;24:663-83.
18. Odaci H. Are adolescent girls more depressive than adolescent boys in Turkey? Int J Soc Behav Educ Econ Bus Ind Eng 2011;5:1183-86.
19. Afifi M, Riyami AA, Morsi M, Kharusil HA. Depressive symptoms among high school adolescents in Oman. East Mediterr Health J 2006;12:S126-37.
20. Oldehinkel AJ, Verhulst FC, Ormel J. Mental health problems during puberty: Tanner stage-related differences in specific symptoms—The trails study. J Adolesc 2010;34:73-85.
21. Roberts RE, Roberts CR, Chan W. One-year incidence of psychiatric disorders and associated risk factors among adolescents in the community. J Child Psychol Psychiatry 2009;50:405-15.
22. Al Gelban KS. Prevalence of psychological symptoms in Saudi secondary school girls in Abha, Saudi Arabia. Ann Saudi Med 2009;29:275-9.
23. Van Voorhees BW, Paunesku D, Kuwabara SA, Basu A, Gollan J, Hankin BL, *et al*. Protective and vulnerability factors predicting new-onset depressive episode in a representative of US adolescents. J Adolesc Health 2008;42:605-16.