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Prevalence and associated factors of anxiety disorders among secondary school-going adolescents in Mbarara City, Uganda: a cross-sectional study.

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ABSTRACT

Background:

Social anxiety disorder (SAD) is a common mental health condition that can interfere with adolescents' social functioning, academic participation, and overall well-being. However, evidence on the burden and factors associated with SAD among school-going adolescents in Uganda remains limited. This study assessed the prevalence and factors associated with SAD among secondary school-going adolescents in Mbarara City.

Methods:

A cross-sectional study was conducted among 380 secondary school-going adolescents in selected schools in Mbarara City. Data were collected using a structured questionnaire assessing socio-demographic characteristics, psychosocial factors, and symptoms of anxiety disorders. Data were analyzed using Stata version 19. Descriptive statistics were used to summarize participant characteristics and the prevalence of SAD, while cross-tabulations and tests of association were used to assess factors associated with SAD. Statistical significance was considered at a 5% level.

Results:

Among the 380 adolescents enrolled, 266 (70.0%) reported SAD. SAD was significantly associated with sex ($p<0.001$), school type ($p=0.003$), academic pressure ($p=0.006$), bullying ($p=0.024$), reported mental health conditions ($p=0.030$), neighborhood safety ($p<0.001$), and awareness of mental health programmes ($p=0.037$). SAD was more prevalent among adolescents reporting academic pressure, bullying, mental health conditions, and unsafe neighborhoods, as well as those attending public schools.

Conclusion:

SAD represents an important mental health concern among school-going adolescents in Mbarara City. School-based screening, counselling, bullying prevention, and supportive learning environments may facilitate early identification and support.

Recommendations:

Schools and health providers should strengthen age-appropriate mental health education and ensure that adolescents receive clear information on available mental health programmes and where to seek support. Awareness activities should be accompanied by accessible counselling, screening, and referral services delivered through confidential, adolescent-friendly channels to promote early help-seeking.

Keywords: *Social anxiety disorder; Adolescents; School-going adolescents; Mental health; Psychosocial wellbeing; Mbarara City; Uganda.*
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BACKGROUND

Social anxiety disorder (SAD) is a clinically important anxiety condition characterized by persistent fear of social situations involving possible scrutiny, negative evaluation, embarrassment, or rejection. A recent global systematic review and meta-analysis confirmed that social anxiety disorder is an important mental health concern among

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children, adolescents, and young people, although prevalence varies across populations and assessment approaches (Salari et al., 2024).

Recent evidence indicates that adolescent social anxiety is associated with interacting individual, interpersonal, family, and school-related factors. A systematic review and meta-analysis by Chiu et al. (2021) found prospective associations between social anxiety and peer functioning, particularly friendship quality, peer rejection, and peer victimization, suggesting that the relationship can be bidirectional rather than reflecting a single causal pathway.

According to Boulton (2023), bullying victimization was associated with social anxiety among early adolescents, while authentic self-esteem appeared to buffer some of the adverse effects. Family and school environments may further influence adolescents' vulnerability. Parenting practices and the quality of parent-adolescent relationships can shape self-esteem, emotional regulation, and confidence in social situations. School experiences may similarly affect social anxiety through academic demands, peer relationships, bullying, and perceived social support. Recent evidence has identified school-related experiences, bullying, self-esteem, resilience, and other individual characteristics as important correlates of social anxiety symptoms among adolescents (Feng et al., 2026).

Although internet-based communication can facilitate social connection, problematic internet use may coexist with social withdrawal and anxiety. In a systematic review and meta-analysis of 37 studies involving 36,013 adolescents and young adults, Ding et al. (2023) found a significant positive association between problematic internet use and social anxiety ($r = .333$, 95% CI [0.292, 0.373]). This relationship may be reciprocal; as socially anxious adolescents may prefer online interactions while problematic internet use may reduce opportunities for direct social engagement.

In Uganda, evidence has demonstrated a substantial burden of mental health challenges among school-going adolescents, with factors within the school, family, and broader social environment contributing to adolescent psychological wellbeing (Batte et al., 2024). Another study in Uganda has also documented behavioral and emotional disorders among school-going adolescents, highlighting the need for greater attention to specific mental health conditions within school settings (Akol et al., 2025). However, evidence specifically examining social anxiety disorder and its associated factors among secondary school-going adolescents in Uganda remained limited.

Determining the factors associated with social anxiety disorder among adolescents in Uganda was important for early identification, appropriate assessment, prevention, and targeted psychological intervention. This study therefore aimed to determine the prevalence and factors associated with social anxiety disorder among secondary school-going adolescents in Mbarara City, Uganda.

METHODOLOGY

Study Design

A cross-sectional study design was employed to assess the prevalence and factors associated with social anxiety disorder among secondary school-going adolescents in Mbarara City, Uganda.

Study Site

The study was conducted in 5 selected secondary schools in Mbarara City, Uganda. These included Global High School, Gracious Secondary School, Mbarara Army Secondary School, Mbarara High School, and St. Mary's Secondary School. The schools were selected to provide representation of secondary school-going adolescents within Mbarara City. Data collection was conducted for 3 months from June,2026 to August,2026

Study Population

The study population comprised secondary school-going adolescents aged 11-19 years enrolled in the selected schools during the study period.

Eligibility criteria

Inclusion criteria: Adolescents aged 11-19 years who were enrolled in the selected secondary schools and available during the data collection period were eligible to participate. Participation was voluntary, and all selected adolescents provided the required consent or assent before completing the study questionnaire.

Exclusion criteria: Adolescents who were sitting examinations during the data collection period were not included in the sampling process because participation could interfere with their academic activities. No sampled participant was subsequently excluded because all adolescents selected for participation met the eligibility criteria and completed the study questionnaire.

Sampling and Sample Size

A total of 380 adolescents were randomly selected from the participating secondary schools. All adolescents selected met the study eligibility criteria and agreed to participate. Consequently, all 380 selected adolescents completed the study questionnaire, giving a final sample of 380

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participants and a 100% participation and completion rate. No participant was excluded or lost during data collection.

Study Variables

The primary outcome variable was social anxiety disorder. Independent variables included socio-demographic characteristics, school-related factors, psychosocial factors, peer-related factors, mental health-related factors, and environmental factors.

Data Collection Tools

Data were collected using a structured questionnaire incorporating the relevant sections for assessing socio-demographic characteristics, psychosocial and school-related factors, and anxiety disorder symptoms. The assessment of anxiety disorders was based on the Mini International Neuropsychiatric Interview (MINI) tool.

Data Collection Procedure

Permission was obtained from Bishop Stuart University and participating schools before data collection. Eligible adolescents were approached through their respective schools, and the study procedures were explained to them. After obtaining the required consent and assent, participants completed the study questionnaire in a private and appropriate setting. Completed questionnaires were checked for completeness before being collected.

Bias

Potential sources of bias were minimized through the use of clearly defined inclusion and exclusion criteria and consistent random sampling procedures across the five participating schools. Students who were sitting examinations during the data collection period were not included in the sampling process to avoid disruption of their academic activities. Participation was voluntary, and confidentiality was maintained throughout data collection. Information and response bias were minimized through the use of a structured questionnaire, standardized data collection procedures, and private settings for completing the questionnaire. Data collectors provided clarification where necessary while avoiding any influence on participants' responses.

Data Quality Control

Data quality was ensured through careful development and review of the data collection tools, appropriate training of data collectors, and adherence to standardized data collection procedures. Completed questionnaires were checked for completeness and consistency before data entry. Data were further cleaned and verified before analysis to minimize errors.

Data Analysis

Data were entered, cleaned, and analysed using Stata version 19. Descriptive statistics, including frequencies and percentages, were used to summarise participants' characteristics and the prevalence of social anxiety disorder. Cross-tabulations were performed to examine the distribution of SAD across independent variables, and appropriate tests of association were used to determine statistically significant relationships. Statistical significance was assessed at a 5% level.

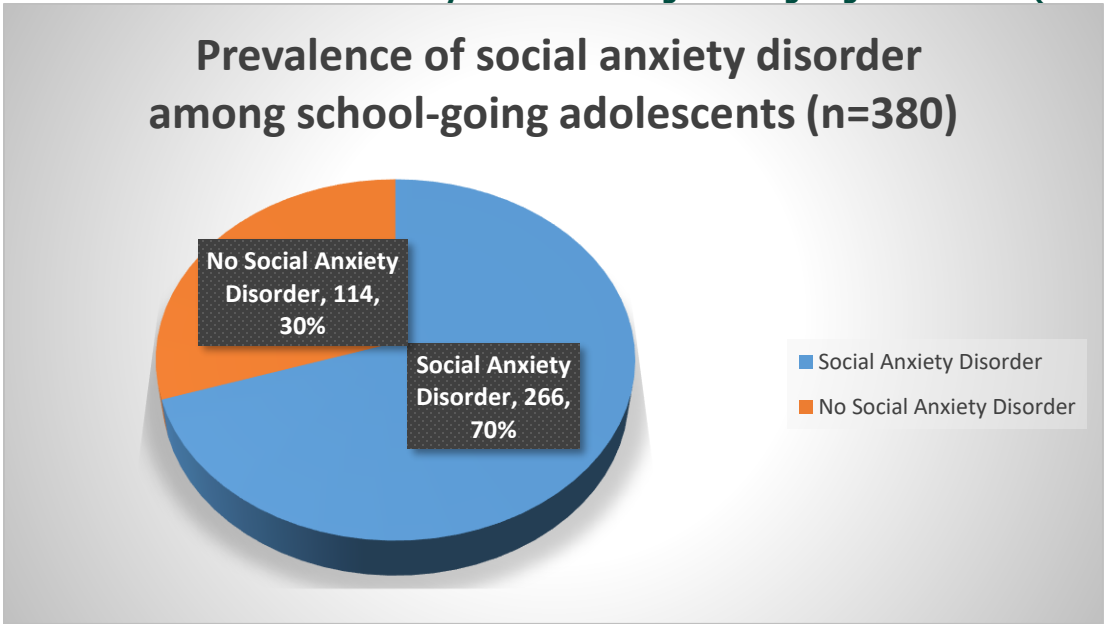
RESULTS

Prevalence of Social Anxiety Disorder among School-Going Adolescents

A total of 380 adolescents were randomly selected from the five participating secondary schools. All these adolescents were assessed for eligibility and met the eligibility criteria. All eligible adolescents participated in the study and completed the study questionnaire, resulting in a 100% participation and completion rate. There were no exclusions, refusals, withdrawals, or losses during data collection.

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Figure 1: Prevalence of social anxiety disorder among school-going adolescents (n=380)



Among the 380 school-going adolescents assessed, 266 (70.0%) reported social anxiety disorder, while 114 (30.0%) did not.

Distribution of Social Anxiety Disorder Symptoms using the Mini International Neuropsychiatric Interview (MINI) tool.

A total of 380 adolescents met the eligibility criteria, participated in the study, and completed the study questionnaire, resulting in a 100% participation and completion rate. All participants were assessed for social anxiety disorder using the Mini International Neuropsychiatric Interview (MINI), and no participants were excluded, refused participation, withdrew, or were lost during data collection.

Table 1: Distribution of responses to social anxiety disorder assessment items among secondary school-going adolescents (n=380)

Social anxiety disorder assessment item	Yes n (%)	No n (%)
Fear or anxiety when being scrutinized by others in public speaking or social situations	170 (44.7)	210 (55.3)
Fear of humiliation, rejection, or embarrassment in social situations	184 (48.4)	196 (51.6)
Anxiety or fear triggered by social situations	197 (51.8)	183 (48.2)
Avoidance of social situations because of anxiety or distress	169 (44.5)	211 (55.5)
Anxiety that is excessive or disproportionate to the threat posed by social situations	165 (43.4)	215 (56.6)
Persistent fear, anxiety or avoidance lasting for at least six months	163 (42.9)	217 (57.1)
Significant distress or functional impairment resulting from fear, anxiety or avoidance	160 (42.1)	220 (57.9)

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The distribution of responses to the individual social anxiety disorder assessment items showed that anxiety or fear triggered by social situations was the most frequently reported feature, with 197 (51.8%) adolescents responding affirmatively. This was followed by fear of humiliation, rejection, or embarrassment in social situations, reported by 184 (48.4%) adolescents. Fear or anxiety when being scrutinized by others in public speaking or social situations was reported by 170 (44.7%), while 169 (44.5%) reported avoiding social situations because of anxiety or distress.
Further, 165 (43.4%) adolescents reported anxiety that was excessive or disproportionate to the perceived threat in social situations. Persistence of fear, anxiety, or avoidance for at least six months was reported by 163 (42.9%) respondents, while significant distress or functional impairment was the least frequently endorsed criterion, reported by 160 (42.1%) adolescents.

Factors Associated with Social Anxiety Disorder

The relationship between selected sociodemographic, school-related, psychosocial, and environmental factors and social anxiety disorder was examined using cross-tabulation. Pearson's chi-square test was used to assess associations.

Table 2: Factors associated with social anxiety disorder among school-going adolescents (n=380)

Factor	Category	No SAD n (%)	SAD n (%)	p-value
Sex	Female	85 (37.8)	140 (62.2)	**<0.001**
	Male	29 (18.7)	126 (81.3)	
School type	Private	82 (35.8)	147 (64.2)	**0.003**
	Public	32 (21.2)	119 (78.8)	
Academic pressure	No	59 (38.1)	96 (61.9)	**0.006**
	Yes	55 (24.4)	170 (75.6)	
Extracurricular activities	No	24 (22.4)	83 (77.6)	0.059
	Yes	90 (33.0)	183 (67.0)	
Bullying	No	99 (32.9)	202 (67.1)	**0.024**
	Yes	15 (19.0)	64 (81.0)	
Family conflict	No	74 (31.6)	160 (68.4)	0.448
	Yes	40 (27.4)	106 (72.6)	
Parental support	No	33 (25.4)	97 (74.6)	0.194
	Yes	81 (32.4)	169 (67.6)	
Mental Health condition	No	81 (34.2)	156 (65.8)	**0.030**
	Yes	33 (23.1)	110 (76.9)	
Chronic condition	No	73 (34.3)	140 (65.7)	0.105
	Yes	41 (24.2)	125 (73.5)	
Friend support	No	40 (26.5)	111 (73.5)	0.272
	Yes	74 (32.3)	155 (67.7)	
Neighborhood safety	No	37 (20.3)	145 (79.7)	**<0.001**
	Yes	77 (38.9)	121 (61.1)	
Traumatic event	No	67 (33.5)	133 (66.5)	0.145
	Yes	47 (26.1)	133 (73.9)	
Mental health services	No	56 (27.9)	145 (72.1)	0.394
	Yes	58 (32.4)	121 (67.6)	
Awareness of mental health programmes	No	65 (35.3)	119 (64.7)	**0.037**
	Yes	49 (25.0)	147 (75.0)	

The cross-tabulation showed that Social anxiety disorder was more common among male adolescents than female adolescents, with 81.3% of males meeting the criteria compared with 62.2% of females (p<0.001). Similarly, SAD

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was more common among adolescents attending public schools than those attending private schools (78.8% versus 64.2%, p=0.003).

Adolescents who reported academic pressure had a higher proportion of SAD (75.6%) compared with those who did not report academic pressure (61.9%, p=0.006). A higher proportion of adolescents who reported bullying met the criteria for SAD compared with those who did not report bullying (81.0% versus 67.1%, p=0.024). SAD was also more frequent among adolescents who reported a mental health condition than among those who did not (76.9% versus 65.8%, p=0.030).

Neighborhood safety showed one of the biggest differences in the cross-tabulation. Among adolescents who reported that their neighborhood was not safe, 79.7% had SAD compared with 61.1% among those who considered their neighborhood safe (p<0.001). In addition, SAD was more common among adolescents who reported awareness of mental-health programmes (75.0%) than among those who were not aware of such programmes (64.7%, p=0.037).

No statistically significant association was observed between SAD and family conflict (p=0.448), friend support (p=0.272), access to mental-health services (p=0.394), or extracurricular activities (p=0.059). Parental support (p=0.194) and traumatic events (p=0.145) did not reach the conventional 5% level of statistical significance, although differences in the distribution of SAD were observed across their respective categories.

DISCUSSION

The study found a high burden of social anxiety disorder (SAD) among school-going adolescents, with 266 (70.0%) of the 380 adolescents reporting SAD, compared with 114 (30.0%) who did not. According to Akol et al. (2025), the prevalence of SAD among school-going adolescents in Uganda was substantially lower when DSM-5-based diagnostic criteria were applied. The higher prevalence observed in the present study may be attributed to differences in assessment tools, diagnostic thresholds, and operational definitions of SAD. This therefore highlights the importance of interpreting prevalence estimates within the context of the diagnostic approach used. Even so, the findings point to social anxiety as an important adolescent mental-health concern that warrants attention in school settings.

The study found that there was an association between academic pressure and SAD (p = 0.006), and this is consistent with a study by Steare et al. (2023), who reported that academic associated with poorer mental health among adolescents, particularly anxiety and depressive symptoms. Similarly, longitudinal evidence pressure is has linked increasing academic pressure with subsequent social anxiety among adolescents. Academic demands may increase concerns about performance, failure, and negative evaluation by teachers, parents, and peers, thereby creating circumstances that may intensify social anxiety. Bullying was also significantly associated with SAD (p = 0.024) in this study, which is similar to findings from a recent meta-analysis by Deng et al. (2024), which demonstrated a significant relationship between social anxiety and bullying victimization. This may be explained by the fact that bullying exposes adolescents to rejection, humiliation, and negative peer evaluation, experiences that are closely related to the fears underlying social anxiety. At the same time, the relationship may be bidirectional because socially anxious adolescents may also be more vulnerable to peer victimisation.

The association between reported mental-health conditions and SAD (p = 0.030) in this study further supports the interconnected nature of adolescent psychological difficulties. According to Akol et al. (2025), emotional and behavioral disorders occur among school-going adolescents, suggesting the need for integrated approaches to adolescent mental-health screening and support. Furthermore, the association between neighborhood safety and SAD (p=0.001**)** is consistent with evidence linking perceived neighborhood safety with adolescent internalizing symptoms (Yang et al., 2024). Adolescents who perceive their communities as unsafe may experience greater feelings of threat and fewer opportunities for safe social interaction, potentially increasing vulnerability to anxiety. Nevertheless, this relationship should be interpreted cautiously because the cross-sectional design does not establish whether perceived neighborhood insecurity contributes to social anxiety or whether anxiety influences perceptions of safety. Interestingly, awareness of mental-health programmes was also associated with SAD(p=0.037). Although this finding may appear unexpected, greater awareness does not necessarily indicate that mental-health programmes increase social anxiety. Rather, adolescents experiencing psychological difficulties may be more likely to encounter, recognise or seek information about mental-health programmes. Taken together, the findings suggest that SAD among school-going adolescents is embedded within individual, school, peer and environmental contexts. Therefore, strengthening school-based mental-health screening, addressing academic pressure, preventing bullying and improving access to psychosocial support may provide important opportunities for early identification and

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intervention. However, the observed relationships should be interpreted as associations rather than causal effects.

Generalizability

The findings contribute context-specific evidence on social anxiety disorder among secondary school-going adolescents in Mbarara City and highlight the relevance of school and psychosocial experiences, including academic pressure, bullying, and mental-health concerns. These findings may be informative for comparable urban school settings in Uganda. However, their applicability to rural communities, adolescents who are out of school, or settings outside Uganda may be limited because differences in social environments, educational experiences, cultural contexts, and access to mental-health services may influence both the prevalence of SAD and its associated factors.

Conclusion

This study demonstrates that social anxiety disorder is an important mental health concern among school-going adolescents in Mbarara City. The findings indicate that social anxiety is associated with interconnected individual, school, peer, psychological, and environmental factors, highlighting that adolescent mental health is shaped by the broader contexts in which young people live and learn. The observed associations with sex, school type, academic pressure, bullying, reported mental health conditions, neighborhood safety, and awareness of mental health programmes underscore the multifaceted nature of social anxiety during adolescence. These findings emphasize the importance of strengthening mental health identification and psychosocial support within schools, while creating supportive and safe learning environments that address academic pressures, bullying, and other factors that may affect adolescents' psychological wellbeing. The study provides evidence for integrating social anxiety into adolescent mental health initiatives and for promoting early identification and appropriate support within school and community settings.

Study limitations

The school-based setting of the study may have influenced participants' responses to questions concerning their personal and psychosocial experiences. Although privacy and confidentiality were maintained throughout data collection, some adolescents may have been less willing to disclose sensitive information, which could have affected the completeness and accuracy of the information reported.

Recommendation

Schools and health providers should strengthen age-appropriate mental health education and ensure that adolescents receive clear information on available mental health programmes and where to seek support. Given the observed association between awareness of mental health programmes and social anxiety disorder, awareness activities should be accompanied by accessible counselling, screening, and referral services so that adolescents who recognize symptoms can obtain appropriate support. Schools should also use confidential and adolescent-friendly channels to encourage early help-seeking without creating stigma around mental health concerns.

List of abbreviations

BSU: Bishop Stuart University
MINI**:** Mini International Neuropsychiatric Interview
SAD**:** Social Anxiety Disorder
WHO**:** World Health Organization

Ethical considerations

Ethical approval was obtained from Bishop Stuart University Research Ethics Committee (BSU-REC-2025-581), with permission obtained from participating schools and education authorities. Written informed consent from parents/guardians and assent from adolescents were obtained before participation, and participation was voluntary, with confidentiality, privacy, and the right to withdraw maintained throughout the study. Data were securely stored, accessed only by principle investigator, and reported in aggregate form to protect participants' identities.

Source of funding

This study received no external funding.

Conflict of interest

The authors declare that they have no conflict of interest in this study.

Data availability

The data supporting the findings of this study are available from the corresponding author upon reasonable request, subject to appropriate ethical and confidentiality considerations.

Author contributions

The principal investigator contributed to the conceptualization and design of the study, data collection,

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data analysis, interpretation of findings, and preparation of the manuscript. The study supervisor provided guidance throughout the study, contributed to the study design and interpretation of findings, and critically reviewed and revised the manuscript. Both authors reviewed and approved the final manuscript.

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Author biography

Charity Ikiriza is a Principal Investigator in this study and a student of Counseling Psychology at Bishop Stuart University, Uganda. Her research interests include adolescent mental health, psychological well-being, and anxiety disorders, with particular interest in psychosocial factors affecting adolescents in school settings. She has an interest in generating evidence to inform mental health promotion and appropriate psychological support for adolescents.

Dr. Anne Tweheyo Otwine is a Senior Lecturer in the Department of Public Health and Biomedical Sciences and Dean of the Faculty of Health Sciences at Bishop Stuart University, Uganda. She is a Counseling Psychology scholar with interests in mental health, counseling, adolescent well-being, research supervision, mentorship, and academic leadership. She has experience in teaching, research supervision, and supporting research activities within the health sciences.

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