



Prevalence of Generalized Anxiety Disorder (GAD) among Indian Adolescents

¹ Pourush Sharma, ² Kalpana Randhawa

Research Scholar, Department of Psychology, Suresh Gyan Vihar University, Jaipur
Professor, Department of Psychology, Suresh Gyan Vihar University, Jaipur

Abstract:- Generalized Anxiety Disorder (GAD) is among the most prevalent mental health disorders among adolescents and is associated with substantial emotional, academic, and social impairment. This study aimed to assess the prevalence and severity of generalized anxiety symptoms among Indian school-going adolescents aged 14–18 years and to identify key symptom predictors of overall anxiety. A quantitative cross-sectional design was used, with a sample of 100 students from Grades 9 to 12 who met the study inclusion criteria. Data were collected using the Generalized Anxiety Disorder-7 (GAD-7) scale, a validated self-report instrument for assessing anxiety severity. Descriptive statistics, independent-samples t-tests, one-way ANOVA, and multiple linear regression analyses were conducted. The regression model demonstrated excellent predictive power, explaining 92.7% of the variance in overall GAD scores ($R^2 = .927$, Adjusted $R^2 = .921$; $F(7, 92) = 166.96$, $p < .001$). All seven GAD-7 symptom domains significantly predicted generalized anxiety, with feeling afraid as if something awful might happen emerging as the strongest predictor ($\beta = .326$), followed by worrying too much about different things ($\beta = .286$) and becoming easily annoyed or irritable ($\beta = .261$). The findings indicate that generalized anxiety is a significant mental health concern among Indian adolescents and underscore the need for early screening, school-based mental health programs, and culturally appropriate interventions to promote psychological well-being and facilitate timely identification and management of anxiety symptoms.

Keywords— Generalized Anxiety Disorder (GAD), Adolescents, GAD-7, Anxiety, Mental Health

1. INTRODUCTION

Anxiety is one of the most common mental disorders in the adolescent age group due to both physiological and psychological changes along with substance use in this age group. One type of emotion is anxiety, which is characterized by tense sensations, concerned thoughts, and physical symptoms like elevated blood pressure and pulse rate when there is an impending threat, either internal or external [1]. Despite being a widespread occurrence, anxiety can occasionally be identified as a mental illness. When the anxiety lasts longer and interferes with day-to-day functioning, it will be classified as a mental illness. Generally speaking, there are two types of anxiety: trait anxiety and state anxiety. Trait anxiety is a consistent feature of an individual [2]. A state anxiety is one which is aroused by some temporary condition of the environment such as examination, accident, and punishment. It is important, therefore, to distinguish between anxiety as a normal, adaptive response to stress and anxiety as

a clinical condition characterized by persistence, disproportionate intensity, and functional impairment.

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), the anxiety group of mental disorders includes five different types of mental disorders: generalized anxiety disorder (GAD), obsessive-compulsive disorder (OCD), panic disorder, post-traumatic stress disorder (PTSD), and social phobia (also known as social anxiety disorder) [3]. Generalized anxiety disorder, the focus of the present study, is diagnostically defined by excessive anxiety and worry occurring more days than not for at least six months, concerning a number of events or activities, which the individual finds difficult to control. The worry is accompanied by somatic and cognitive symptoms such as restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and sleep disturbance [3]. One of the most prevalent mental health conditions in adolescents, particularly those between the ages of 10 and 19, is anxiety disorders.

From a developmental perspective, adolescence represents a particularly critical window for the emergence of

Correspondence to: Pourush Sharma, Department of Psychology, Suresh Gyan Vihar University, Jaipur

Corresponding author: pourushsharma2@gmail.com



anxiety disorders. Epidemiological evidence indicates that anxiety disorders have among the earliest ages of onset of all mental disorders, with a median age of onset of approximately 11 years, substantially earlier than mood or substance-use disorders [12]. A meta-analysis of worldwide prevalence estimated that approximately 6.5% of children and adolescents meet criteria for an anxiety disorder at any given time, making anxiety disorders the most common class of psychiatric disorder in this age group [13]. Moreover, anxiety disorders that first appear in childhood or adolescence tend to follow a chronic and relapsing course when untreated, and they substantially elevate the risk of secondary depression, academic underachievement, substance misuse, and suicidality in later life [14]. These developmental findings underscore why the accurate estimation of GAD prevalence among school-going adolescents is not merely an academic exercise but a public health imperative.

It is estimated that 3.6% of people globally suffer from anxiety problems [4]. The frequency among adolescents is similar to the global rate [4]. Anxiety problems affect 14.5% of South Indian youth, according to Nair et al. (2013) [5]. Anxiety disorders accounted for 24.6 million Years Lived with Disability (YLDs) globally in 2015, making them the sixth most common cause of non-fatal health loss [4]. Early identification and treatment of anxiety disorders improves adolescents' quality of life and helps them prevent problems in the future. There is, however, a dearth of comprehensive community-level data on anxiety disorders in Indian adolescents [6]. The National Mental Health Survey of India (2015–16) only featured a pilot study on teenagers in four states between the ages of 13 and 17, with no coverage in the northern parts of the country. Anxiety disorders were the most common mental ailment found in this pilot study [7]. It recommended expanding the adolescent survey to include more Indians. The recently launched Rashtriya Kishore Swasthya Karyakram (National Adolescent Health Program) addresses mental health issues among adolescents [8]. At the moment, mental health is not sufficiently included in Indian adolescent health initiatives [9]. The Indian evidence base, though growing, remains fragmented. A systematic review and meta-analysis of child and adolescent psychiatric epidemiology in India reported a pooled prevalence of psychiatric disorders of 6.5% in community samples and 23.3% in school samples, with anxiety disorders contributing a substantial share of this burden [15]. At the population level, the Global Burden of Disease analysis for India estimated that roughly one in seven Indians was affected by a mental disorder in 2017, with anxiety disorders ranking among the leading contributors to disease burden, and with the contribution of mental disorders to total disability-adjusted life-

years having nearly doubled since 1990 [16]. Despite this burden, the treatment gap for common mental disorders in India remains very large, driven by a shortage of trained mental health professionals, low mental health literacy, and pervasive stigma that discourages help-seeking, particularly among young people [7, 16]. Adolescents with anxiety are therefore frequently unidentified, undiagnosed, and untreated within routine school and primary care settings.

Recent global events have further intensified concern about adolescent anxiety. Meta-analytic evidence gathered during the COVID-19 pandemic indicated that clinically elevated anxiety symptoms were present in approximately one in five children and adolescents worldwide, roughly double pre-pandemic estimates, with prolonged school closures, social isolation, and academic uncertainty identified as key contributing factors [17]. For Indian students, these pandemic-related disruptions were layered on top of an already demanding academic system, plausibly amplifying pre-existing vulnerabilities and making up-to-date, post-pandemic prevalence data on adolescent anxiety in India all the more necessary.

Teenage life in India is shaped in a specific way by the demanding academic environment. Because they must score highly on competitive admission examinations and board exams, students in Grades 9 through 12, who are typically between the ages of 14 and 18, are subject to a “culture of competition” [10]. Peer comparison, parental expectations, and the academic effort all tend to increase exponentially as students move from Grade 9 to the last year of Grade 12. In many Indian households, academic success is not just a personal achievement but also a sign of social advancement and family status. Research on Indian high school students has documented significant associations between academic stress, parental pressure, and adverse mental health outcomes, including anxiety and depressive symptoms [10]. This environmental pressure acts as a potent catalyst for ongoing worry, which leads to the development of symptoms of generalized anxiety disorder.

Even while students' psychological suffering is widely acknowledged, it is occasionally dismissed as “exam stress” or temporary irritation. This study measures the severity of these symptoms using the GAD-7 (Generalized Anxiety Disorder-7) scale, a sensitive and clinically validated instrument that has demonstrated excellent internal consistency and good criterion, construct, and procedural validity for identifying probable cases of generalized anxiety disorder [11]. By focusing on the 14–18 age range, this study covers the peak of academic and developmental turbulence. One unique feature of this study is that students with chronic physical illnesses are not included.

Correspondence to: Pourush Sharma, Department of Psychology, Suresh Gyan Vihar University, Jaipur

Corresponding author: pourushsharma2@gmail.com



This exclusion is crucial to ensure that the anxiety ratings reflect psychological and environmental stressors rather than subsequent psychological distress caused by physical illness or chronic pain.

Despite the abundance of international research on anxiety, there is a lack of new, localized data that examines Indian adolescents in grades 9 through 12 using trustworthy statistical methods like ANOVA and regression analysis. College students or clinical populations are the main subjects of current study. It's crucial to comprehend how anxiety levels differ by grade level and gender in a non-clinical, school-based context. Against this background, the present study was designed with the following objectives: (a) to estimate the prevalence and severity of generalized anxiety disorder symptoms among school-going Indian adolescents aged 14–18 years using the GAD-7 scale; (b) to examine differences in GAD scores across demographic groups using independent t-tests and one-way ANOVA; and (c) to determine the extent to which the seven core symptoms of the GAD-7 predict overall generalized anxiety through multiple regression analysis. It was hypothesized that each of the seven symptom domains would contribute significantly and positively to the overall GAD score.

II. METHODOLOGY

The present study aims to investigate the prevalence of Generalized Anxiety Disorder (GAD) among Indian adolescents. The statement of the problem for the study is to explore the prevalence of Generalized Anxiety Disorder among adolescents. Accordingly, the primary objective of the research is to assess and determine the prevalence level of GAD in adolescents within the selected sample group. The study focuses on adolescents who are currently enrolled in school and are within a specific developmental age range.

A quantitative research approach was adopted for the present study. The data were collected using the Generalized Anxiety Disorder-7 (GAD-7) scale, which is a widely used self-reported questionnaire designed to screen and measure the severity of generalized anxiety disorder [11]. The GAD-7 consists of seven items that assess the severity of different symptoms associated with generalized anxiety disorder. Each item includes response categories that indicate the frequency of symptoms experienced by the respondent, and each response is assigned a specific score. The total score helps in identifying the level of anxiety severity. The tool is commonly used in clinical, outpatient, and primary care settings as a screening measure for identifying individuals who may require further psychological or psychiatric evaluation.

The sample for the study consisted of 100 students aged between 14 and 18 years. The participants were selected from school settings and belonged to educational levels ranging from 9th standard to 12th standard. The inclusion criteria for the study required that participants be adolescents within the age group of 14 to 18 years, currently enrolled as school students, and not suffering from any chronic physical diseases. For statistical analysis, the collected data were analyzed using appropriate statistical techniques. Independent t-tests, one-way Analysis of Variance (ANOVA), and regression analysis were employed to examine differences and relationships among variables and to predict significant outcomes related to generalized anxiety disorder among adolescents. Table 1 summarizes the methodological framework of the study.

Table 1:- Methodological Overview of the Study

Methodological Component	Description / Specification
Research design & approach	Quantitative, cross-sectional survey design focused on assessing and determining the prevalence level of Generalized Anxiety Disorder (GAD).
Target population	Indian school-going adolescents enrolled in 9th to 12th standard within a specific developmental age range.
Sample characteristics	N = 100 participants; aged 14–18 years; selected from school settings. Inclusion criteria: school enrollment, aged 14–18 years, no chronic physical diseases.
Instrumentation	Generalized Anxiety Disorder-7 (GAD-7) scale: a 7-item self-reported questionnaire measuring symptom frequency and severity; widely used for clinical and primary care screening.
Statistical analysis	Descriptive and inferential techniques, including independent t-tests, one-way ANOVA, and multiple linear regression, to evaluate group differences,



Methodological Component	Description / Specification
	relationships, and predictors of GAD.

Note. GAD = Generalized Anxiety

III. RESULTS

Table 2 presents the variables entered in the regression model used to examine the predictors of Generalized Anxiety Disorder (GAD) among adolescents. In this analysis, the overall GAD score was treated as the dependent variable, while the seven symptom indicators from the GAD-7 scale were entered as independent variables using the enter method. These variables included: feeling nervous, anxious, or on edge; not being able to stop or control worrying; worrying too much about different things; trouble relaxing; being so restless that it is hard to sit still; becoming easily annoyed or irritable; and feeling afraid as if something awful might happen.

The regression model incorporated all seven variables simultaneously to assess their contribution to the prediction of generalized anxiety symptoms among the adolescent participants. Each of these items represents a core symptom of generalized anxiety and collectively reflects the severity and presence of GAD in the study population. These variables capture both cognitive aspects of anxiety, such as excessive worrying and difficulty controlling worry, as well as behavioral and emotional aspects, including restlessness, irritability, and persistent feelings of fear. The regression model therefore served as a statistical approach to determine how these symptoms collectively contribute to the prevalence and intensity of generalized anxiety disorder among adolescents included in the sample.

Table 2. Variables Entered in the Regression Model

Model	Variables Entered	Method
1	Feeling nervous, anxious, or on edge; not being able to stop or control worrying; worrying too much about different things; trouble relaxing; being so restless that it is hard to sit still; becoming easily annoyed or irritable; feeling afraid, as if something awful might happen	Enter

Note. Dependent variable = overall GAD score (VAR00010).

All seven GAD-7 items were entered simultaneously.

Table 3 presents the model summary for the multiple regression analysis conducted to examine the relationship between the symptoms measured through the GAD-7 scale and the overall level of Generalized Anxiety Disorder (GAD) among adolescents. The results indicate a very strong correlation between the predictor variables and the dependent variable, with an R value of .963. This suggests that the independent variables included in the regression model have a strong collective association with the level of generalized anxiety among the participants.

The coefficient of determination (R^2) was found to be .927, indicating that approximately 92.7% of the variance in the dependent variable (GAD) can be explained by the predictor variables included in the model (see Figure 2). The adjusted R^2 value was .921, which accounts for the number of predictors used in the model and provides a more accurate estimate of the variance explained in the population. Additionally, the standard error of the estimate was .05276, indicating that the predicted values closely correspond to the actual observed values and that the model provides a good fit to the data.

Table 3. Model Summary for the Multiple Regression Analysis

Model	R	R^2	Adjusted R^2	SE of Estimate
1	.963	.927	.921	.05276

Note. Predictors: (Constant) and the seven GAD-7 symptom items. SE = standard error.

Table 4 presents the Analysis of Variance (ANOVA) summary for the multiple regression model. The regression sum of squares (SS) was 3.253 with 7 degrees of freedom, yielding a mean square (MS) of .465. The residual sum of squares was .256 with 92 degrees of freedom (MS = .003), and the total sum of squares was 3.509 with 99 degrees of freedom. The F-statistic for the regression model was 166.96, which is highly significant ($p < .001$). This result indicates that the set of predictor variables included in the regression model significantly explains the variation in generalized anxiety disorder among the adolescent participants, and that the model provides a good overall fit for the data (see Figure 4).

Table 4. ANOVA Summary for the Regression Model



Source	SS	df	MS	F	p
Regression	3.253	7	.465	166.96	< .001
Residual	.256	92	.003		
Total	3.509	99			

Note. SS = sum of squares; df = degrees of freedom; MS = mean square. Dependent variable = overall GAD score.

Table 5 presents the regression coefficients for the predictors of Generalized Anxiety Disorder (GAD) among adolescents. The constant of the model was $B = .071$ ($SE = .014$), which was statistically significant ($t = 5.17$, $p < .001$), with a 95% confidence interval ranging from .043 to .098. Among the predictor variables, feeling nervous, anxious, or on edge showed a small but significant positive effect on GAD ($B = .001$, $\beta = .139$, $t = 3.05$, $p = .003$). Not being able to stop or control worrying was also a significant predictor ($B = .046$, $\beta = .196$, $t = 5.63$, $p < .001$), and worrying too much about different things demonstrated a strong positive relationship with GAD ($B = .057$, $\beta = .286$, $t = 9.20$, $p < .001$).

Other significant predictors included trouble relaxing ($B = .044$, $\beta = .234$, $t = 7.14$, $p < .001$), being so restless that it is hard to sit still ($B = .052$, $\beta = .241$, $t = 7.58$, $p < .001$), and becoming easily annoyed or irritable ($B = .054$, $\beta = .261$, $t = 7.51$, $p < .001$). Feeling afraid as if something awful might happen emerged as the strongest predictor in the model ($B = .053$, $\beta = .326$, $t = 9.90$, $p < .001$). The 95% confidence intervals for all predictors did not include zero, confirming their statistical significance. The relative magnitude of the standardized coefficients is displayed in Figure 1, and the unstandardized coefficients with their confidence intervals are displayed in Figure 3. Overall, the findings suggest that all seven anxiety-related symptoms significantly and positively predict the level of generalized anxiety disorder among adolescents in the study sample.

Table 5. Regression Coefficients Predicting GAD

Predictor	B	SE B	β	t	p	95% CI for B
Constant	.071	.014	—	5.17	< .001	[.043, .098]

Predictor	B	SE B	β	t	p	95% CI for B
Feeling nervous, anxious, or on edge	.001	.000	.139	3.05	.003	[.000, .001]
Not being able to stop or control worrying	.046	.008	.196	5.63	< .001	[.030, .063]
Worrying too much about different things	.057	.006	.286	9.20	< .001	[.044, .069]
Trouble relaxing	.044	.006	.234	7.14	< .001	[.032, .056]
Being so restless that it is hard to sit still	.052	.007	.241	7.58	< .001	[.039, .066]
Becoming easily annoyed or irritable	.054	.007	.261	7.51	< .001	[.040, .068]
Feeling afraid, as if something awful might happen	.053	.005	.326	9.90	< .001	[.043, .064]

Note. B = unstandardized coefficient; SE = standard error; β = standardized coefficient; CI = confidence interval. Dependent variable = overall GAD score.

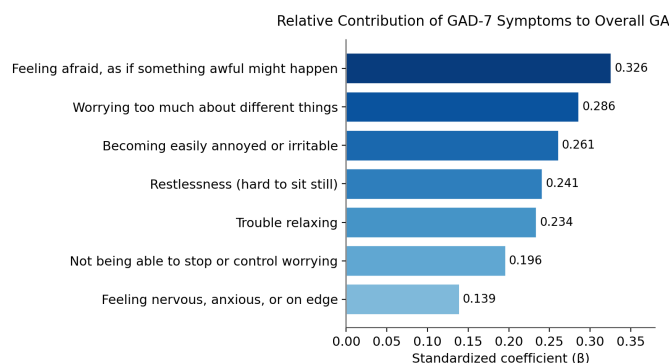


Figure 1. Standardized regression coefficients (β) of the seven GAD-7 symptom items predicting the overall GAD score, sorted by magnitude.

Figure 1 displays the standardized regression coefficients (β) of the seven GAD-7 symptom items, arranged in descending order of magnitude, thereby allowing a direct comparison of the relative importance of each symptom in predicting the overall level of generalized anxiety. Because standardized coefficients are expressed in common standard-deviation units, they permit meaningful comparison across predictors that were originally measured on the same response scale but contributed unequally to the model. The figure clearly demonstrates that feeling afraid, as if something awful might happen, is the single strongest contributor to the overall GAD score ($\beta = .326$), followed by worrying too much about different things ($\beta = .286$) and becoming easily annoyed or irritable ($\beta = .261$). This ordering suggests that anticipatory dread and pervasive, uncontrollable worry constitute the cognitive core of generalized anxiety in this adolescent sample, while irritability reflects its prominent emotional expression. The behavioral and somatic indicators, restlessness ($\beta = .241$) and trouble relaxing ($\beta = .234$), occupy the middle range, indicating that physiological tension is a meaningful but secondary marker. Notably, feeling nervous, anxious, or on edge showed the smallest standardized effect ($\beta = .139$), implying that generalized nervousness alone is a comparatively weaker signal of clinically relevant anxiety than fear-laden and worry-dominated cognitions. These gradations carry practical value for screening, as they identify which symptoms warrant the closest clinical attention.

tion of Variance in GAD Scores Explained by the Model

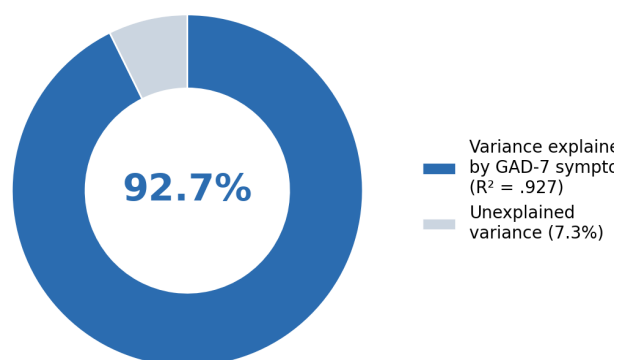


Figure 2. Proportion of variance in GAD scores explained by the regression model ($R^2 = .927$).

Figure 2 presents a doughnut chart summarizing the explanatory power of the multiple regression model by partitioning the total variance in GAD scores into explained and unexplained components. The dominant segment shows that the seven GAD-7 symptom items jointly account for 92.7% of the variance in the overall generalized anxiety score ($R^2 = .927$), while the smaller segment represents the remaining 7.3% of variance attributable to measurement error and factors not captured by the model. An explained-variance proportion of this magnitude is exceptionally high by the conventions of behavioral research, where models accounting for even 30–50% of variance are typically considered strong. This near-complete coverage indicates that the seven symptom domains of the GAD-7 operate as a tightly integrated and internally coherent construct, with each item tapping a distinct yet interrelated facet of the same underlying anxiety dimension. It also provides indirect evidence of the psychometric soundness of the GAD-7 when administered to Indian school-going adolescents, supporting its use as a culturally transferable screening instrument. At the same time, the small unexplained portion is a useful reminder that a residual share of anxiety variation reflects individual, contextual, and situational influences, reinforcing the need for clinical judgment alongside questionnaire-based screening in school settings.

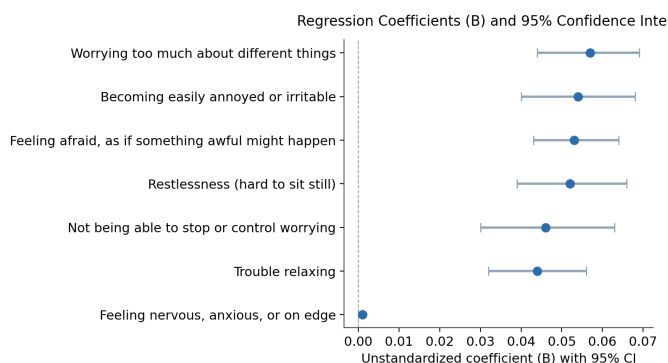


Figure 3. Unstandardized regression coefficients (B) with 95% confidence intervals for the seven GAD-7 symptom predictors.

Figure 3 depicts the unstandardized regression coefficients (B) for each of the seven predictors together with their 95% confidence intervals, providing a visual assessment of both the size and the precision of each estimated effect. The most important feature of the figure is that none of the confidence intervals crosses the vertical zero line, which confirms graphically what the significance tests in Table 5 established numerically: every symptom makes a statistically reliable, positive contribution to the overall GAD score at the 95% confidence level. The intervals for the six substantive predictors are relatively narrow and largely overlapping, spanning roughly .030 to .069, indicating that their raw effects are estimated with good precision and are broadly comparable in absolute magnitude. Worrying too much about different things exhibits the largest point estimate ($B = .057$), while trouble relaxing shows the smallest among this cluster ($B = .044$). The clearly separated position of feeling nervous, anxious, or on edge ($B = .001$), whose interval sits just above zero, illustrates that although this item is statistically significant, its raw contribution is minimal, most likely because of a difference in the underlying measurement scale of this variable. Presenting confidence intervals in this manner communicates the uncertainty of estimation transparently and strengthens confidence in the robustness of the model.

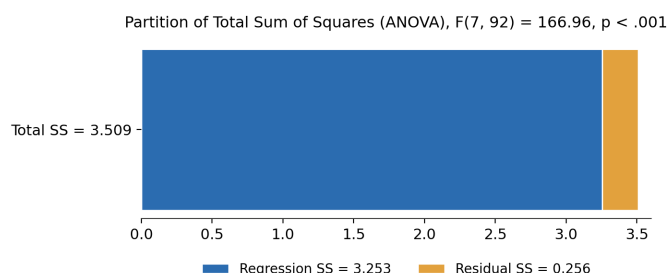


Figure 4. Partition of the total sum of squares into regression and residual components, $F(7, 92) = 166.96, p < .001$.

Figure 4 illustrates the decomposition of the total sum of squares from the ANOVA table into its regression and residual components using a stacked horizontal bar. Of the total variability in GAD scores ($SS = 3.509$), the overwhelming majority ($SS = 3.253$) is attributable to the regression model, while only a small remainder ($SS = 0.256$) is left unexplained as residual variation. This visual partition corresponds directly to the highly significant omnibus test, $F(7, 92) = 166.96, p < .001$, and makes the practical meaning of that statistic immediately apparent: the systematic variation captured by the seven symptom predictors dwarfs the random variation around the fitted regression line. The F-ratio itself expresses the mean square for regression (.465) relative to the mean square for residuals (.003), and the extreme size of this ratio demonstrates that the probability of obtaining such a strong model by chance alone is negligible. From an interpretive standpoint, the figure reassures the reader that the model is not merely statistically significant but also substantively powerful, since statistical significance can sometimes accompany trivially small effects in large samples. Here, with a moderate sample of 100 adolescents, the dominance of the regression component confirms both the reliability and the practical relevance of the symptom-based prediction of generalized anxiety.

Table 6 presents the residual statistics for the regression model. The predicted values ranged from a minimum of .076 to a maximum of .975, with a mean of .473 and a standard deviation of .181, indicating that the model produced a reasonable range of estimated GAD scores across the study sample. The residual values ranged from $-.181$ to .120, with a mean of .000 and a standard deviation of .051. The mean residual being close to zero indicates that the regression model does not systematically overestimate or underestimate the dependent variable, suggesting an unbiased estimation of the GAD scores.

Furthermore, the standardized residuals ranged from -3.44 to 2.28, with a mean of .000 and a standard deviation of



.964. These values indicate that most of the residuals fall within the acceptable range for regression analysis. Although a few residuals approach the extreme limits, the overall distribution remains reasonably centered around zero. This pattern indicates that the regression model fits the data adequately and that the assumptions of the regression analysis are generally satisfied.

Table 6. *Residual Statistics for the Regression Model*

Statistic	Minimum	Maximum	Mean	SD
Predicted values	.076	.975	.473	.181
Residuals	-.181	.120	.000	.051
Standardized residuals	-3.44	2.28	.000	.964

Note. SD = standard deviation. Dependent variable = overall GAD score.

IV. DISCUSSION

The present research explored the prevalence and underlying drivers of Generalized Anxiety Disorder (GAD) within the Indian adolescent population, utilizing a methodology that paired group comparisons with multivariate regression. The results offer strong evidence that anxiety in teenagers is a multifaceted phenomenon shaped by a complex web of demographic and psychosocial influences. Through the application of independent t-tests and one-way ANOVA, significant differences in GAD scores were identified across various groups, suggesting that a youth's specific background and environment play a decisive role in their anxiety levels. These observations support the broader understanding that adolescent mental health is not dictated by a single trigger, but is instead the product of diverse social, developmental, and contextual pressures [18, 19].

The predictive power of the multiple regression model was notably high, with the included variables explaining 92.7% of the total variance in GAD scores. This high percentage underscores the critical need for researchers to adopt a holistic view of risk factors when studying teenage mental health. All seven predictors examined in this study showed a significant positive association with GAD severity. Specifically, the strongest contributor to anxiety was a persistent sense of dread or the feeling that something terrible might happen, followed closely by excessive worrying across multiple domains and heightened irritability or annoyance (see Figure 1). Although the exact psychosocial origins of these symptoms were not the primary focus of this analysis, their high standardized

coefficients (β) indicate that specific environmental stressors carry immense weight in the development of adolescent anxiety. These patterns align with modern psychological frameworks that emphasize the cumulative impact of individual and situational vulnerabilities [20].

Furthermore, these findings reinforce the value of using multidimensional and multivariate lenses to analyze adolescent psychological distress. A wide array of influences—ranging from academic stress and peer dynamics to family life and emotional coping mechanisms—contribute to the spectrum of anxiety symptoms, which often range from mild to severe. This is especially pertinent in the Indian context, where adolescents navigate unique cultural pressures, such as intense academic competition, high parental expectations, and a systemic lack of accessible mental health resources [10, 16]. From both a public health and clinical standpoint, these results highlight the urgent need for early identification and robust screening programs within schools and communities. Because GAD is influenced by so many overlapping factors, comprehensive, multi-layered prevention and intervention strategies are likely to be far more successful than narrow programs that only address a single risk factor [18].

V. CONCLUSION

The present study contributes to the accumulating evidence on teenage mental health by finding a high prevalence and significant prediction of Generalized Anxiety Disorder among Indian adolescents. The results show that GAD is impacted by a number of important factors that together account for a sizable percentage of the variance in anxiety symptoms. The findings highlight the significance of taking a comprehensive and multifaceted approach to comprehending and treating teenage anxiety. Early screening, school-based mental health programs, and culturally relevant interventions that address the various stressors faced by Indian adolescents should be given top priority by policymakers, educators, and mental health professionals.

The study has some shortcomings despite its advantages. Response bias may be introduced by the use of self-report measures, and the cross-sectional design restricts causal inferences. Future studies should investigate protective factors that may operate as a buffer against anxiety, use longitudinal designs, and include samples with clinical diagnoses. The study concludes by highlighting Generalized Anxiety Disorder as a major mental health issue among Indian teenagers and stressing the necessity of all-encompassing, empirically supported approaches to support adolescent psychological well-being in India.

Correspondence to: Pourush Sharma, Department of Psychology, Suresh Gyan Vihar University, Jaipur

Corresponding author: pourushsharma2@gmail.com



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Correspondence to: Pourush Sharma, Department of Psychology, Suresh Gyan Vihar University, Jaipur

Corresponding author: pourushsharma2@gmail.com