

**PRIMARY TEACHERS' AWARENESS OF CHILDREN'S  
MENTAL HEALTH**

*Thesis Submitted to the Department of Education*

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**DOCTOR OF PHILOSOPHY (ARTS) IN EDUCATION**

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**KOLKATA**

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***This thesis is dedicated to my respected supervisor, Prof. Muktipada Sinha, my beloved parents, and my dearest husband***

## Certificate

Certified that the thesis entitled “**PRIMARY TEACHERS’ AWARENESS OF CHILDREN’S MENTAL HEALTH**” submitted by me for the award of the Degree of Doctor of Philosophy in Arts at Jadavpur University is based upon my work carried out under the supervision of Prof. Muktipada Sinha, Professor, Department of Education, Jadavpur University and that neither this thesis nor any part of it has been submitted before for any degree or diploma anywhere / elsewhere.

Countersigned by the

Supervisor

**(Prof. Muktipada Sinha)**

Pratiksha Goswami

Date:

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Dated:

Pratiksha Goswami

Place: Kolkata

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## Acronyms Index

<i>CP</i>	Conduct Problem
<i>DSM</i>	Diagnostic and Statistical Manual of Mental Disorders
<i>EP</i>	Emotional Problem
<i>HP</i>	Hyperactive Problem
<i>ICD</i>	International Classification of Diseases
<i>LSE</i>	Life Skills Education
<i>MGMH</i>	Movement for Global Mental Health
<i>MH</i>	Mental Health
<i>NCMH</i>	National Commission on Macroeconomics and Health
<i>SDG</i>	Sustainable Development Goals
<i>NMHP</i>	National Mental Health Programme
<i>MHF</i>	Mental Health Foundation
<i>PP</i>	Peer Problem
<i>PrS</i>	Pro-social Problem
<i>SDQ</i>	Strengths and Difficulties Questionnaire
<i>SOWC</i>	The State of World Children
<i>SPSS</i>	Statistical Package for Social Sciences
<i>TD</i>	Total Difficulty
<i>UNFPA</i>	United Nations Population Fund-India
<i>APA</i>	American Psychological Association
<i>UNICEF</i>	United Nations Children's Fund
<i>WBBSE</i>	West Bengal Board of Secondary Education
<i>NAMI</i>	National Alliance on Mental Illness
<i>PTPCMH</i>	Primary teachers' perception of children mental health
<i>WHO</i>	World Health Organization
<i>m</i>	Mean Value
<i>sd</i>	Standard Deviation Value
<i>F</i>	ANOVA Test Value
<i>p-Value</i>	Probability Value
<i>r-Value</i>	Correlation Value
<i>t-Value</i>	t-Test Value
<i>H<sub>0</sub></i>	Null Hypothesis
<i>ACEs</i>	Adverse Childhood Experiences
<i>S</i>	Significant
<i>NS</i>	Not Significant

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## **Abstract**

This study explores the awareness of primary school teachers in West Bengal regarding children's mental health. Recognizing teachers' crucial role in early identification and intervention of mental health issues, this research aimed to assess the current state of teachers' mental health literacy, identify socio-demographic factors influencing their awareness, and determine the need for targeted professional development. Utilizing a cross-sectional survey research design, data were collected from 550 primary teachers across ten districts of West Bengal. The study employed descriptive and inferential statistical analyses, including T-tests, ANOVA, and Pearson correlation, to evaluate the data. The key findings revealed that majority of teachers demonstrated low and moderate (36.73% & 37.82%) level of awareness on child mental health. Only 25.45% teachers showed high awareness on child mental health and significant differences found in mental health awareness based on gender, type of institution, mental health-related training, habitation, medium of instruction, highest educational qualification, and social category. Female teachers, private school educators, and those with mental health training demonstrated higher levels of awareness. Moreover, teachers from semi-urban areas and those with advanced educational qualifications were more attuned to children's mental health needs. Conversely, a negative correlation was found between teaching experience and mental health awareness, suggesting that more experienced teachers might rely on outdated knowledge. These findings underscore the necessity for ongoing professional development and mental health training for teachers to enhance their ability to support students' mental well-being. The study's implications are significant for policymakers, educators, and mental health professionals, highlighting the need for comprehensive strategies to improve mental health literacy among teachers, thereby fostering a supportive educational environment conducive to the well-being of all students. This research contributes valuable insights into the current state of mental health awareness among primary school teachers in West Bengal and offers a foundation for future studies and policy development.

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**CHAPTER - I**  
**THE CONTEXT OF THE STUDY**

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## CHAPTER I

### THE CONTEXT OF THE STUDY

#### 1.1 Introduction

Children's mental health is fundamental to their overall well-being and development. Teachers, who interact with children daily, are uniquely positioned to spot and address mental health concerns early on. Their awareness and understanding of child mental health are crucial for providing the right support and care to their students. In schools, teachers often act as the first responders to signs of mental health issues. These signs can show up in various ways, such as changes in behavior, drops in academic performance, or shifts in social interactions. When teachers are knowledgeable about mental health, they can recognize these early warning signs and take the necessary steps to help. However, not all teachers have the same level of awareness. Some might have had training in mental health, while others might not be as informed. This difference can lead to uneven support for students, with some children potentially not getting the help they need. It's vital to provide teachers with education and training in mental health. This training can come through professional development workshops, in-service training, and incorporating mental health topics into teacher education programs. With the right knowledge and tools, teachers can better understand and address mental health issues. Creating a supportive school environment goes beyond just training teachers. It also involves having mental health resources available, access to counselors, and fostering a school culture that values student well-being. By encouraging open discussions about mental health and providing strong support systems, schools can ensure all students receive the care they need. When teachers are more aware of child mental health, they can identify issues early, intervene promptly, and create a more nurturing learning environment. This approach not only benefits individual students but also enhances the overall well-being of the entire school community. "Mental health is largely determined by the social, economic and physical environments in which people live" (WHO, 2014). Conceptualized as "a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community" (WHO, 2004, p.11), The state of mental health is essentially good and comprehensive. Although the definition no longer limits mental health to the absence of

disease, it still includes mental health problems that may cause discomfort, suffering, and functional impairment. These illnesses can be acute or chronic, moderate to severe, and they can cause distress. The Sustainable Development Goals (SDGs), which aim to prevent non-communicable diseases, alcohol and drug abuse, and promote mental health and well-being, have recently given mental health more attention, despite its prior neglect as a key issue for global development (United Nations, 2015). SDG 3 specifically calls for a global commitment to promoting wellness for people of all ages.

## **1.2 Background of the study**

Children's mental health is a vital part of their overall development and well-being. Teachers, who spend considerable time with children, are uniquely positioned to spot early signs of mental health issues and provide essential support. Their awareness and understanding of children's mental health play a crucial role in effectively helping their students. Mental health is more than just the absence of mental illness. It includes emotional, psychological, and social well-being. According to the World Health Organization (2016), good mental health involves being self-aware, managing daily stresses, and contributing to the community. For children, good mental health is essential because it affects their learning, behavior, and ability to handle life's challenges. Teachers can support children's mental health by creating a positive and inclusive classroom environment, recognizing signs of distress, and fostering open communication. By being informed and proactive, teachers can make a significant difference in their students' lives, promoting a foundation for lifelong well-being.

Statistics showed increasing concerns about children's mental health worldwide. Approximately 10% to 20% of children and adolescents are estimated to have mental health problems, yet many go undiagnosed and untreated (UNICEF, 2021). In Canada, around 15-20% of children face mental health issues, meaning one in five students in a typical classroom is affected (Statistics Canada, 2017). In the United States, 17.4% of children aged 2-8 have a developmental, behavioral, or mental health diagnosis (CDC, 2022). Children's mental health problems can appear in various ways, including emotional, behavioral, and cognitive issues. Often, these behaviors are misunderstood as mere misbehavior rather than signs of underlying psychological stress. Teachers, being on the front lines, play a crucial role in identifying and addressing these issues early on.

However, research shows that many teachers feel unprepared to recognize and support students with mental health challenges. A survey by the Federation of Canadian teachers found that 70% of teachers felt unprepared to identify and support students with mental health issues (Carr & Byle, 2019). The gap in teachers' mental health literacy is significant. Mental health literacy involves understanding mental health, recognizing mental illnesses, seeking appropriate help, and reducing stigma (Wei, Stanley, & Kutcher, 2016). Improving teachers' mental health literacy can lead to better identification, prevention, and management of mental health issues in children. Understanding mental health involves looking at the complex interactions between biological, psychological, and social factors, as well as genetic influences. Germain (2012) emphasized that mental health, especially in early childhood, is as important as physical health. Children's mental health problems can include emotional, behavioral, and psychotic issues, often mistaken for misbehavior. These behaviors can be signs of underlying psychological stress that often goes unrecognized, potentially indicating past or potential abuse, neglect, or exploitation (Mental Health and Behaviour in Schools, 2018). There is a significant difference in mental health care needs between high-income and low-income countries, with the latter facing more challenges. Research by Crabb (2012) and Atiola (2015) shows that a lack of knowledge and resources leads to poor mental health management. Schools are increasingly seen as key places to address mental health issues through promotion, prevention, and care (McGorry et al., 2011). Teachers need to be informed and capable of providing the right support and interventions, with policies to promote student well-being (Fazel et al., 2015).

Teachers spend a lot of time with young people, and mental health issues often start before age 14, with rates rising globally (Kessler et al., 2005). A 2012 survey by the Federation of Canadian Teachers found that 70% of teachers felt unprepared to recognize and support students with mental health challenges (Carr & Byle, 2019). This gap highlights the need for better mental health literacy among teachers. Mental health literacy includes understanding mental health and illnesses, seeking help, and reducing stigma (Wei, Stanley, & Kutcher, 2016). Research by Yewande (2013) in South Western Nigeria found that despite teachers' limited knowledge and resources, schools are still crucial for supporting children with mental health challenges. Therefore, it's essential to educate teachers and raise awareness. A survey of 330 UK primary school teachers by the

Anna Freud National Centre for Children and Families found that many teachers lacked confidence in identifying mental health issues in students (Weale, 2017). Studies also show that school-related stress, social media use, and other factors contribute to mental health problems in young people (Cowburn & Blow, 2017; Royal Society for Public Health, 2017).

Schools play a crucial role in supporting children with mental health issues, despite the challenges they face. Studies highlight the importance of having comprehensive mental health education and resources available in schools. For instance, Yewande (2013) found that even with limited knowledge and resources, schools in South Western Nigeria are vital in helping children with mental health challenges. One key issue is the mental health literacy gap among primary school teachers. Addressing this gap is essential. By providing teachers with the necessary knowledge and skills, we can create a supportive and nurturing environment that promotes the mental well-being of all students. This will enable teachers to recognize signs of distress, offer appropriate support, and help children thrive both academically and emotionally.

### **1.3 Health and Mental Health**

Health and mental health are crucial to our overall well-being, shaping the quality of our lives. Traditionally, health has been seen as the absence of disease or infirmity. However, the World Health Organization (WHO) expands this definition to include complete physical, mental, and social well-being. This holistic view means that being healthy is not just about not being sick. It also involves having a strong body, a healthy mind, the ability to be productive, and fulfilling social relationships. It's about feeling good physically and mentally and being able to enjoy life and connect with others.

Mental health, specifically, is crucial as it influences how we think, feel, and behave daily. It's integral to coping with stress, relating to others, and making decisions. Just as physical health impacts our daily functioning, mental health significantly affects our ability to live a fulfilling life. Physical and mental health are closely connected; each affects the other. Poor physical health can lead to mental health issues like depression or anxiety. Conversely, untreated mental health conditions can harm physical health, causing stress-related illnesses or weakening the immune system. Therefore, promoting mental health is essential for overall well-being. Taking care of our minds helps keep our bodies healthy,

and maintaining physical health supports mental wellness. This involves fostering resilience, promoting supportive environments, and providing access to appropriate care and resources. Educating communities about mental health reduces stigma and encourages early intervention, enhancing individuals' ability to manage and recover from mental health challenges. Recognizing the interconnectedness of physical and mental health is pivotal for promoting a comprehensive approach to well-being. By prioritizing mental health alongside physical health, societies can better support individuals in leading healthier and more fulfilling lives.

Conferring to the World Health Organization (WHO, 2014), psychological well-being is a crucial part of overall well-being. WHO defines wellbeing as "a state of complete physical, mental, and social wellbeing, not merely the absence of disease or infirmity" (WHO, 1948). In 1986, WHO reiterated that health is a resource for life, emphasizing both individual and social strengths alongside physical abilities. Wellbeing goes beyond the absence of illness and includes -

- i. A healthy body
- ii. A healthy mind
- iii. Productive work skills
- iv. Healthy social relationships

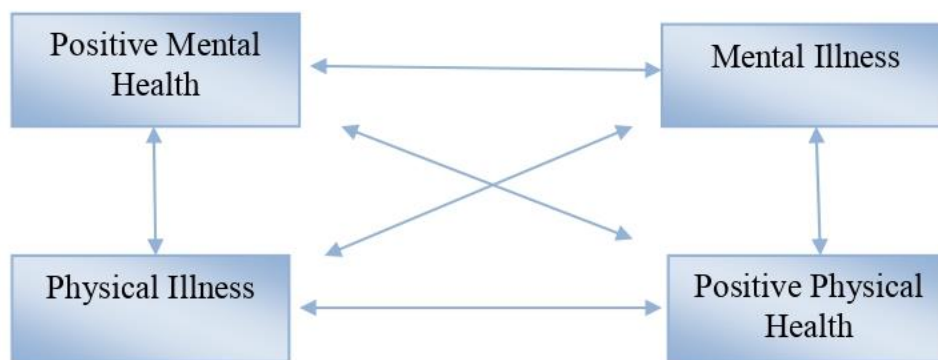
This definition highlights the importance of mental wellbeing as a crucial aspect of overall health. As Dr. Brock Chisholm, the first Director-General of WHO, emphasized, "without mental wellbeing, there can be no true physical health" (WHO, 2013). The link between mental and physical wellbeing is closely interconnected, underscoring a holistic approach to health. This understanding reinforces the age-old wisdom that a healthy mind contributes to a healthy body.

### **1.3.1 Holistic Approach to Health**

Conferring to the WHO (2001), mental wellbeing is about feeling capable, handling life's challenges effectively, being productive, and contributing to your community. It influences how we think, feel, and connect with others, impacting our ability to work and enjoy life. Maintaining mental wellbeing involves nurturing relationships, engaging in daily activities, and adapting to changes and stress. In simpler terms, mental wellbeing refers to how we think, feel, and act in various situations. It's about finding balance within

ourselves and with others, and living harmoniously with our surroundings (Sartorius, 1983). The Surgeon General's Report on Mental Health (1999), cited by Knopf et al. (2008), defines mental wellbeing as the effective functioning of mental processes, leading to productive activities, satisfying relationships, and resilience in facing challenges. WHO's World Health Report (2001) includes concepts like subjective wellbeing, perceived self-efficacy, independence, competence, and realizing one's emotional and mental potential in its definition of mental wellbeing. This balanced development of personality and emotional attitudes enables individuals to live harmoniously within their communities (Arumugam et al., 2013). Mental wellbeing is crucial for personal, social, and national prosperity. It's about achieving a healthy and fulfilling life by maintaining mental and emotional health, which is vital for overall well-being.

**Figure 1.1 Holistic Approach to Health**



*Source: Sinha, M.P. (2015), Mental Health of School Children (Beng. Ed.)*

### 1.3.2 Concept of Mental Health

Mental health is about how we think, feel, and act in our daily lives. It includes our emotional, psychological, and social well-being. Good mental health helps us handle stress, build positive relationships, and make good choices. It means being able to cope with life's challenges, maintain healthy relationships, and contribute to our community. Mental health is not just the absence of mental illness; it's about having a balanced and fulfilling life. Just like physical health, mental health is essential for overall well-being and happiness.

Mental well-being is a crucial part of overall health. According to Sartorius (2002), health can be seen in three ways: the absence of disease, the ability to perform necessary

functions, or a state of balance within oneself and with the external environment. Meeting basic health needs determines which definition applies. Maslow (1968) identified these needs as food, shelter, safety, social support, and freedom from pain, stress, and exploitation. Good mental health means being able to form and maintain positive relationships, fulfill social roles, manage change, express positive thoughts and behaviors, and control difficult emotions like sadness. A mentally healthy person has self-worth, control, and understands how their mind and body function. According to the Society for Health Education and Promotion Specialists (SHEPS, 1997), feeling good about oneself and others, being happy, and loving are also aspects of mental health. Mental wellness, like mental illness, is influenced by biological, social, psychological, and environmental factors. Our immediate social environment, including friends, family, coworkers, and employers, as well as broader society and culture, all play a role in our mental health. Building healthy communities and positive social interactions can promote mental health. The Health Education Authority (HEA, 1997) reported that mental health can deteriorate due to internal factors like low emotional resilience, self-esteem, and social status, as well as external factors like poor housing, poverty, unemployment, abuse, discrimination, cultural conflict, and stigma. T.Y. Lin once explained that teaching his child about mental health involved feeling comfortable in social situations and alone. A mentally healthy person feels confident, competent, and can build meaningful relationships while also enjoying their own company. Culture greatly influences self-concepts, and efforts to change these can create cultural tension and psychological discomfort. Core aspects of mental health include trust, challenge, competence, achievement, humor, and the ability to grow emotionally, intellectually, and spiritually. Being aware of and empathetic towards others, and using psychological distress as a learning process, are also important (HEA, 1997).

The Mental Health Foundation (2008) states that an individual's outlook on life and the challenges they face significantly impact their mental health. Mental health issues can lead to an inability to function, seize opportunities, and interact well with others. Physical and mental health are closely linked, influencing each other reciprocally. Therefore, mental health can be seen as a state of balance where a person is content with themselves, can interact productively with others, and meets both basic and higher functional needs. Positive functioning involves managing relationships, emotions, and change effectively.

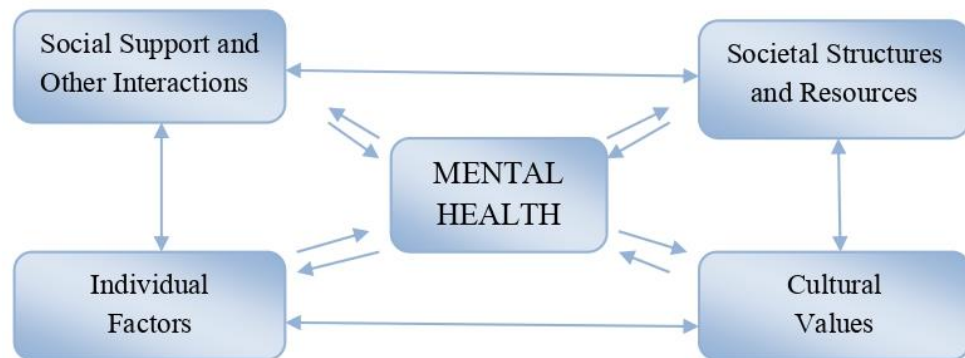
Psychiatry faces the challenge of integrating mental health preservation and promotion into public health initiatives and incorporating these concepts into practice, research, and teaching.

Conferring to estimates by Erskine et al. (2016), Kessler et al. (2007), and Vos et al. (2020), one in seven children and teenagers worldwide suffer from mental health disorders. Alarmingly, suicide is the fourth leading cause of death among teenagers globally, and depression is a major cause of disability among young people (WHO, 2021). Mental health issues often begin early in life, with 50% starting before age 14 and 75% by the mid-20s (WHO, 2021). The COVID-19 pandemic underscored the importance of mental health and the need for psychosocial support for everyone (Sharma et al., 2021). Despite increasing attention to mental health, there is still a lack of information about the factors affecting children's and adolescents' mental health, who is most at risk, and the most effective strategies for promoting mental health across different settings, cultures, and demographics. Many children live in low-resource settings where mental health care is scarce. Models and approaches to address mental health in children and adolescents are often developed and tested in underrepresented populations, giving us a skewed view of global child and adolescent mental health. For instance, Western, Educated, Industrialized, Rich, and Democratic (WEIRD) nations, which make up only 12% of the global population, account for 96% of the samples in significant mental health studies (Arnett, 2008). This creates a limited understanding of global child and adolescent mental health issues. Understanding the scope and nature of mental health issues affecting children and adolescents worldwide, and identifying the most effective interventions, is crucial for organizations like UNICEF. By broadening research and focusing on diverse populations, we can better address the mental health needs of children and adolescents globally, ensuring that all young people have the support they need to thrive.

Families and schools play crucial roles in supporting children's health and well-being. Schools have a primary responsibility to promote and maximize children's physical, social, and mental health. New challenges require schools to also focus on children's psychological needs and overall wellness. Identifying and preventing issues early can create safe environments. This book aims to align the roles and responsibilities of parents, schools, teachers, counselors, and special educators as primary caregivers at various developmental stages, fostering a constructive dialogue and proper sensitization.

Mental health and psychosocial well-being receive little attention in many countries. The National Mental Health Survey (2016) found that nearly 150 million people in our country need mental health support, but 70-90% did not receive timely, quality assistance. Globally, adolescents have high rates of self-harm (WHO). Early intervention can prevent many future mental health issues. Physical illness, lack of basic resources, inability to support oneself and family, and unmet life goals significantly affect mental health and well-being. Providing children with easy access to mental health services and support in schools is crucial for their physical and psychological safety. Mental health encompasses social, behavioral, and emotional well-being. Adaptability, the ability to handle daily demands effectively, is a key aspect of mental health. Creating a safe and secure school environment is essential. Balancing accessibility, well-being, and flexibility can establish a comprehensive support system in schools.

**Figure 1.2 Structural Model of Mental Health**



*Source: the intrinsic value of Mental Health, Ville Libtinen, Agustin Ozaniz  
Lyn Underwood, Mitchell Weiss, Chapter 4, WHO report*

#### **1.4 Mental Health Problems**

No one on the planet is in perfect health. Mental illness, in particular, is one of the most misunderstood conditions in today's society. Many people mistakenly believe that mental illness is a sign of weakness, but this couldn't be further from the truth. Mental illnesses are real conditions, and mental wellness is a deeply personal experience. According to the 1st Five-Year Plan, health is a positive state of well-being where it's crucial for a person's mental and physical faculties to develop harmoniously to achieve overall health.

A person's ability to live harmoniously with others depends on the balanced development of their personality and emotional attitude. When this balance is disrupted and a person starts to act unusually, we consider that person to be mentally ill.

#### **1.4.1 Historical Perspective of Mental Health Problem**

##### **➤ Old Indian Concept of Mental Well-being**

History can illuminate the present and inspire the future (Nizamine et al., 2010). While mental well-being is often considered a modern concept, in India, it has deep historical roots. Ancient Indian texts like the Vedas and other sacred writings discuss mental well-being, its development, and the treatment of mental disorders. In his presidential address at the 51st Annual Conference of the Indian Psychiatric Society in 1999, Dr. Shiv Gautam highlighted that aspects of mental well-being were recognized in ancient India well before the rise of Western civilization.

Dr. Shiv Gautam (1999), S.S. Chauhan (1999), and K. Rangaswami (2013) have explored the concept of mental well-being found in ancient Indian texts. According to them, the mind is seen as a functional component of the Atman (the soul or self), consisting of intellect, vitality, and matter. The Rig Veda and Yajur Veda mention that thoughts influence facial expressions and can be purified through mantras (rhymes), which in turn impact intuition. The Rig Veda, in its first chapter, talks about the speed of intellect, the pursuit of mental happiness, prayers for mental bliss, and methods to enhance intellect (medha).

The Yajur Veda conceptualizes the mind as the inner fire of knowledge (Gautam, 1999). The Atharva Veda delves into mental identity, discussing the power of the mind in healing. It describes three components of mental identity: Sattva (purity), Tamas (darkness), and Rajas (activity). Maintaining harmony among these three qualities determines mental well-being, while imbalances can lead to mental disorders. The Upanishads suggest that achieving mental well-being involves spiritual practices and meditation aimed at improving mental capabilities and integrating personality (Rangaswami, 2013).

The Atharva Veda also details willpower, emotions, motivation, and psychological states like depression, envy, joy, hostility, attachment, and lethargy (Gautam, 1999). Ancient Indian Ayurveda, including the works of physicians like Charaka and Susruta, adopted the

Atharva Vedic concept of mental well-being, viewing it as an essential part of overall health.

➤ **Ancient Western Concept of Mental Well-being**

Mental well-being issues have been recognized and recorded for a long time. According to Butcher et al. (2011), the earliest concepts of mental disorders, such as severe headaches and seizures, were treated by Stone Age cave dwellers through head operations using crude stone tools.

Early writings reveal that ancient civilizations such as the Chinese, Egyptians, Hebrews, and Greeks believed abnormal behavior was caused by possession by demons or gods. Later, Greek physician Hippocrates (460-377 B.C.) dismissed these supernatural beliefs and proposed that mental disorders were due to brain pathology and natural causes, a revolutionary idea for his time. He classified mental health issues into three categories: mania, depression, and phrenitis (brain fever).

Greek philosopher Plato (429-347 B.C.) viewed mental phenomena as responses of the whole organism, reflecting its internal state and biological needs. He emphasized individual differences in mental abilities and acknowledged socio-cultural influences on thought and behavior, although he still partly believed in divine causes of mental disorders. Later Greek and Roman philosophers and physicians, including Aristotle (384-322 B.C.) and Galen (A.D. 130-200), continued Hippocrates' work. During the Middle Ages, Islamic countries in the Middle East established the first mental hospitals, with one in Baghdad in A.D. 792.

In Europe, during the Middle Ages, abnormal behavior was often explained by superstition rather than scientific inquiry. Swiss physician Paracelsus (1490-1541) later rejected these superstitions and proposed the idea of psychic causes of mental illness.

## **1.5 Theoretical Framework for Promoting Positive Mental Health**

To thrive and enjoy life, young people need a variety of skills, including strong morals and character, a positive outlook, a healthy sense of identity, and cognitive, emotional, and social skills—how they think, feel, and relate to others. At the core of these areas is the concept of the "watching self" or self-awareness, which involves understanding one's own thoughts and emotions (Hayes et al., 2012; Zettle et al., 2018). This "witnessing self"

doesn't change but simply observes what is happening inside and around us without judging. The aim of acceptance and commitment therapy (Hayes et al., 2012), mindfulness techniques (Grossmann et al., 2004), and reflective practice (Krueger, 2005) is to cultivate this awareness of the witnessing self. The framework focuses on cognitive, emotional, and social domains because these areas are where positive values, identities, and attitudes are formed. These skills start to develop in infancy and continue to evolve through early adolescence. Throughout life, we continuously build on these competencies, with different skills becoming more important at different times.

These domains are interconnected; for example, appreciating diversity affects how we interact with others, and increasing social awareness can help us develop more prosocial attitudes.

**Figure 1.3 Showing interconnected domain**



Source: <https://positivementalhealth.eu/infographic-on-domains-of-social-and-emotional-competencies/>

### 1.5.1 Definitions of Mental health

- i. **American Psychological Association (APA)** defined Mental health as "a state of emotional and psychological well-being in which an individual is able to use his or her cognitive and emotional capabilities, function in society, and meet the ordinary demands of everyday life."
- ii. **World Health Organization (WHO)** defined Mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."
- iii. **National Alliance on Mental Illness (NAMI)** describes mental health as "a condition of well-being in which an individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."
- iv. **The Mayo Clinic** defines mental health as "a person's condition with regard to their psychological and emotional well-being."
- v. **American Psychiatric Association (APA)** describes mental health as "a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity."

### 1.6 Classification of Mental disorders

The **Diagnostic and Statistical Manual of Mental Disorders (DSM)**, published by the American Psychiatric Association (APA), is a widely used system for classifying mental disorders. The latest edition, DSM-5, organizes mental disorders into several broad categories -

- **Neurodevelopmental Disorders:** Includes conditions such as Autism Spectrum Disorder and Attention-Deficit/Hyperactivity Disorder (ADHD).
- **Schizophrenia Spectrum and Other Psychotic Disorders:** Encompasses disorders like Schizophrenia.
- **Bipolar and Related Disorders:** Covers Bipolar I Disorder and related conditions.

- **Depressive Disorders:** Includes Major Depressive Disorder and Persistent Depressive Disorder (Dysthymia).
- **Anxiety Disorders:** Covers disorders such as Generalized Anxiety Disorder and Panic Disorder.
- **Obsessive-Compulsive and Related Disorders:** Includes Obsessive-Compulsive Disorder (OCD) and Body Dysmorphic Disorder.
- **Trauma- and Stressor-Related Disorders:** Encompasses Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder.
- **Dissociative Disorders:** Includes Dissociative Identity Disorder and Dissociative Amnesia.
- **Somatic Symptom and Related Disorders:** Covers conditions like Somatic Symptom Disorder.
- **Feeding and Eating Disorders:** Includes Anorexia Nervosa and Bulimia Nervosa.
- **Sleep-Wake Disorders:** Covers Insomnia Disorder and Hypersomnolence Disorder.
- **Sexual Dysfunctions:** Includes Erectile Disorder and Female Orgasmic Disorder.
- **Gender Dysphoria:** Covers gender identity issues.
- **Disruptive, Impulse-Control, and Conduct Disorders:** Includes Oppositional Defiant Disorder and Conduct Disorder.
- **Substance-Related and Addictive Disorders:** Encompasses Alcohol Use Disorder and Gambling Disorder.
- **Neurocognitive Disorders:** Includes Alzheimer's Disease and other dementias.
- **Personality Disorders:** Covers conditions such as Borderline Personality Disorder and Antisocial Personality Disorder.
- **Paraphilic Disorders:** Includes Pedophilic Disorder and Exhibitionistic Disorder.

The **International Classification of Diseases (ICD)**, published by the World Health Organization (WHO), is a global standard for reporting diseases and health conditions, including mental disorders. The latest edition, ICD-11, organizes mental disorders into various categories -

- **Mental, Behavioural, or Neurodevelopmental Disorders:** Encompasses Schizophrenia, Bipolar Disorder, and ADHD.

- **Disorders Due to Substance Use or Addictive Behaviours:** Includes Alcohol Dependence and Gambling Disorder.
- **Schizophrenia Spectrum and Other Primary Psychotic Disorders:** Covers Schizophrenia and Schizoaffective Disorder.
- **Mood Disorders:** Encompasses Depression and Bipolar Disorder.
- **Anxiety and Fear-Related Disorders:** Includes Generalized Anxiety Disorder and Social Anxiety Disorder.
- **Obsessive-Compulsive or Related Disorders:** Covers Obsessive-Compulsive Disorder.
- **Disorders Specifically Associated with Stress:** Includes Post-Traumatic Stress Disorder (PTSD).
- **Dissociative Disorders:** Encompasses Dissociative Identity Disorder.
- **Feeding and Eating Disorders:** Includes Anorexia Nervosa and Bulimia Nervosa.
- **Elimination Disorders:** Covers conditions like Enuresis and Encopresis.
- **Sleep-Wake Disorders:** Includes Insomnia Disorder and Narcolepsy.
- **Sexual Dysfunctions:** Encompasses Erectile Dysfunction and Female Sexual Interest/Arousal Disorder.
- **Gender Incongruence:** Covers issues related to gender identity.
- **Impulse Control Disorders:** Includes conditions like Kleptomania.
- **Personality Disorders and Related Traits:** Encompasses Borderline Personality Disorder and Antisocial Personality Disorder.
- **Paraphilic Disorders:** Includes Pedophilic Disorder and Exhibitionistic Disorder.
- **Neurodevelopmental Disorders:** Covers Autism Spectrum Disorder and Intellectual Developmental Disorder.
- **Neurocognitive Disorders:** Includes Dementia and Mild Cognitive Impairment.

Both the DSM-5 and ICD-11 provide structured frameworks for diagnosing mental disorders, with the DSM-5 being predominantly used in the United States and the ICD-11 serving as the international standard. These classification systems aim to enhance

the understanding and treatment of mental health conditions by providing clear criteria and categories.

### **1.7 Characteristics of Mentally Healthy Person**

According to Park and Park, a person who is mentally healthy exhibits three key characteristics -

- **Confidence in Their Own Skin**

A mentally healthy person feels safe and competent in their abilities. They do not underestimate their own potential and have a healthy level of self-respect. This self-assurance allows them to face challenges with confidence and believe in their capacity to overcome obstacles.

- **Empathy and a Sense of Fairness**

A person in good mental health shows empathy and fairness towards others. They genuinely care about people and build lasting, fulfilling relationships. They have friends they trust and enjoy being around. This person values connections and demonstrates kindness and understanding in their interactions.

- **Capability to Handle Everyday Challenges**

When problems arise, a mentally healthy person takes action promptly. They are capable of independent thought and decision-making, effectively managing their daily responsibilities. This individual is disciplined and remains untroubled by personal emotions such as love, guilt, anger, or fear. They maintain emotional stability and navigate life's ups and downs with resilience and grace.

Overall, mental health is characterized by a balanced self-view, meaningful relationships, and the ability to manage life's demands effectively. These traits enable individuals to live fulfilling and productive lives, contributing positively to their communities.

### **1.8 Risk Factors of Mental Health Conditions**

Each child is unique, shaped by a combination of social, environmental, and genetic influences. These factors can lead to emotional, behavioral, and interpersonal challenges

that may affect their ability to perform well in social situations. The bio-psycho-social model is a comprehensive framework for understanding the complexities of mental health.

### 1.8.1 Biological Factors

Mental well-being is closely tied to the function of nerve cells and neural pathways in the brain. Abnormalities or damage in specific brain regions can lead to a variety of mental health issues. According to "Mental Health and Wellbeing — A Perspective" by CBSE, several biological factors may contribute to the development of mental health disorders:

**Genetics:** Many mental health issues have a hereditary component, passed down from one generation to the next. These disorders often result from defective genes and their interactions with the environment. Factors like abuse, trauma, or stress can also play a significant role.

**Infections:** Certain infections can cause brain damage and lead to mental health disorders.

**Brain Defects or Injury:** Physical injuries to the brain can be associated with mental health issues.

**Prenatal Damage:** Trauma during birth or disruptions during early fetal development can cause mental health disorders like autism spectrum disorders.

**Other Factors:** Inadequate nutrition or exposure to harmful chemicals, such as lead, can significantly contribute to mental health problems.

### 1.8.2 Psychological Factors

Several psychological factors can influence mental health -

**Traumatic Childhood Experiences:** Any form of abuse during childhood can have long-lasting effects.

**Loss of a Parent or Caregiver:** Early loss can lead to significant emotional distress.

**Neglect by Caregivers:** Lack of attention and care can severely impact a child's psychological development.

**Insecure Attachment:** A child's fear of their caregiver during early development can result in insecure attachment, affecting mental health.

### 1.8.3 Environmental Factors

Certain stresses in a child's environment can lead to mental health disorders. These include –

**Loss of a Loved One:** Grief and loss can profoundly affect a child's mental state.

**Parental Divorce or Separation:** Changes in family structure can cause significant stress.

**Dysfunctional Family Dynamics:** Growing up in a troubled family environment can lead to mental health issues.

**Relocation:** Moving to a new place can be stressful and disruptive for a child.

**Social and Cultural Demands:** Expectations from society and media can create pressure.

**Substance Abuse:** Exposure to drugs and alcohol can have detrimental effects on mental health.

Understanding these factors is crucial for addressing and supporting the mental health of children. Each child's experience is different, and recognizing the diverse influences on their mental well-being is essential for providing effective care and support.

## 1.9 Conditions and Problems of The Mind that Prevalence in Preschool and Adolescence

### ❖ Attachment Concerns

The bond that forms between children and their parents or primary caregivers, known as attachment, significantly impacts a child's development and their ability to form lasting relationships later in life. Parents or caregivers might notice attachment issues as early as the child's first year. However, with patience and care, these difficulties can be addressed.

## Signals

A child might:

- Resist personal contact or affection
- Not smile in situations where it's expected
- Act inappropriately without showing regret, sorrow, or remorse
- Show no emotional response when left alone
- Struggle to show genuine empathy or concern
- Have tantrums or display passive-aggressive behaviour
- Show little interest in toys or games

## Probable Causes

- Children in institutional care, foster homes, or orphanages may be more susceptible to these issues.
- Extreme neglect by caregivers can increase the risk of bonding difficulties.
- Parents or caregivers struggling with mental health issues, substance abuse, or anger management problems can also contribute to these concerns.
- Divorce, separation, work relocation, or temporary care situations can affect attachment.
- Any form of verbal, physical, or sexual abuse can cause significant attachment concerns.
- Transitioning from an abusive family environment can leave a child vulnerable to similar challenges.

### ❖ Bowel and Bladder Control

In otherwise healthy children, losing control of bowel and bladder functions is considered mentally and socially debilitating. This can lead to severe emotional consequences, including extreme embarrassment, loneliness, depression, and a loss of confidence and self-worth.

## Signals

- Incontinence typically strikes a child after six years of age.

- Potential indicators or concerns about sexual abuse may increase the child's risk.
- Anxiety or performance pressure can cause similar worries.
- Continuous urine leakage may result from an incomplete bladder, which could be due to a physical or mental health issue.

### **Probable Causes**

- Medical or physical issues, such as infections or diabetes, might be the cause.
- Some children may not respond to or go to the bathroom when they feel the need, leading to fidgeting and clinging behaviours.

### **❖ Communication Issues**

Children may struggle to interact with others both at home and school. As they grow older, these challenges can become more pronounced, especially in academic settings where advanced writing and communication skills are required. Poor communication skills can lead to low self-esteem, poor academic and social performance, and a higher dropout rate.

### **Alarm Signals**

Children may:

- Avoid social interactions
- Struggle to understand information
- Have a limited vocabulary
- Find it difficult to express emotions and ideas
- Struggle to organize information and narrate stories
- Have trouble keeping up a conversation
- Find it hard to understand slang, humor, riddles, idioms, and sarcasm

### **Probable Causes**

- Physical disabilities, such as hearing loss or cleft lip and palate
- Brain or vocal cord injuries
- Autism spectrum disorders

- Limited cognitive abilities
- Emotional trauma
- Developmental delays in speech and language

### **Separation Anxiety**

Separation anxiety is common up to the age of three and is considered a normal developmental stage. However, if it persists beyond the ages of three or four, it can interfere with daily activities like attending school or socializing. It is characterized by intense anxiety or panic attacks that significantly impair a child's ability to function.

### **Alarm Signals**

The child may:

- Feel very distressed or uneasy when apart from parents or caregivers
- Have irrational fears about a parent's health or safety
- Refuse to travel due to separation anxiety
- Be reluctant to sleep away from home without a parent
- Experience physical symptoms like headaches and stomachaches when anticipating separation

### **Probable Causes**

- Traumatic events such as the illness or death of a loved one or pet
- Individual predispositions to anxiety
- Learned anxiety from role models
- Traumatic separation experiences during crises

### **❖ School Refusal**

Refusing to attend school is a significant issue for children of all ages, impacting their intellectual, psychological, and social development. School refusal can manifest as outbursts, yelling, or extreme force. It can also present physical symptoms such as headaches, stomachaches, fever, dizziness, and shortness of breath.

## Alarm Signals

Children may:

- Report frequent head or chest problems
- Regularly visit the school medical room without a clear reason
- Report feeling sick on evaluation days
- Frequently request to contact home
- Refuse to interact with classmates or participate in social events
- Show a lack of enthusiasm to complete their work

## Probable Causes

- Bullying, including coercion, teasing, cyberbullying, verbal abuse, and body shaming
- Parental conflict, such as divorce or frequent fights
- The untimely death of a family member
- Sibling rivalry, especially when one sibling is younger
- Overly concerned parents

### ❖ Inattention & Hyperactivity Difficulties

Children are naturally energetic and social, which can sometimes make it challenging for parents or teachers to keep them engaged. Some children are always on the go, switching between activities quickly. They are often attracted to sights and sounds and struggle to concentrate on details, leading to impulsivity, hyperactivity, and inattention.

## Probable Causes

- The exact cause of hyperactivity is unknown, but genetic or central nervous system issues are contributing factors.
- Hyperactivity may run in the family, affecting parents or siblings.
- Prenatal exposure to drugs, alcohol, or tobacco can also be a factor.

## ❖ Intellectual Functioning

“Intellectual disabilities are neurodevelopmental disorders that begin in childhood, characterized by intellectual difficulties and challenges in conceptual, social, and practical areas of living.” These include:

- IQ scores between 70-84 (approximately 14% of the population)
- Problems with adaptive functioning
- Onset during childhood

## Alarm Signals

Intellectual disabilities may present various signs and symptoms, particularly when the child starts school. Severe cases are easier to identify. Common signs include:

- Delayed physical milestones like walking and crawling
- Missing or failing to meet speech milestones
- Challenges with personal hygiene or self-sufficiency, such as eating
- Difficulty with complex tasks requiring logical thought or problem-solving
- Poor memory and inability to relate actions to consequences

## Probable Causes

Common causes of intellectual disability include:

- Genetic conditions inherited from parents
- Issues during pregnancy, such as drug or alcohol use, infections, or malnutrition
- Complications during childbirth, such as premature birth or lack of oxygen
- Childhood illnesses like measles, whooping cough, or meningitis
- Severe injuries, such as head trauma or near-drowning
- Environmental factors, such as malnutrition, exposure to toxic chemicals, and severe neglect or abuse.

## 1.10 Treatment Services for Mental illness

Conferring to Schacter et al. (2010), psychiatric hospitals, clinics, and various community mental health agencies offer conventional therapy and support for mental disorders. The primary methods of treatment include psychotherapy, medication, and other interventions such as electroconvulsive therapy and psychosurgery.

### ❖ Psychotherapy

There are several main types of psychotherapy. One popular type is cognitive behavioral therapy (CBT), which concentrations on altering the thought and behavior patterns related with specific conditions (Schacter et al., 2010). Another effective form of therapy is systemic therapy, also known as family therapy. This approach involves sessions with the individual and their significant others, such as family members. By including the person's support network, family therapy provides a broader support system and helps address issues within the context of their relationships. (Schacter et al., 2010).

### ❖ Psychiatric Medication

Psychiatric medications are classified into several main categories: mood stabilizers, stimulants, antipsychotics, anxiolytics, and antidepressants. Antidepressants are used to treat severe depression, anxiety, and various mental disorders. Sedatives and anxiolytics are used to manage anxiety disorders and related issues like insomnia. Mood stabilizers are mainly used for treating bipolar disorder. Antipsychotics are prescribed for psychotic disorders such as schizophrenia and are increasingly used for various other conditions. Stimulants are typically used to treat attention deficit hyperactivity disorder (ADHD) (Schacter et al., 2010).

### ❖ Electroconvulsive Therapy (ECT)

Electroconvulsive therapy (ECT) is sometimes used in severe cases when other treatments for resistant depression have not been successful. It involves a brief electrical stimulation of the brain while the patient is under anesthesia.

### ❖ **Psychosurgery**

Though considered experimental, psychosurgery is advocated by certain neurologists in rare cases (Mind Disorders Encyclopedia, 2014).

### ❖ **Counseling**

Counseling can be conducted by professionals or peers working together, providing support and guidance for mental health issues.

### ❖ **Psychoeducation and Creative Therapies**

Psychoeducation programs equip individuals with the knowledge needed to understand and manage their issues. Creative therapies, such as theater, painting, and music therapy, are also sometimes employed to help individuals express themselves and cope with their conditions.

### ❖ **Lifestyle Modifications and Supportive Actions**

Lifestyle changes and supportive measures are often used to enhance mental health. These include peer support, self-help groups, supported housing, and supported employment, such as social enterprises (Schacter et al., 2010).

## **1.11 Teacher's role in Promoting Primary School Students' Mental Health**

In recent years, there has been a noticeable increase in mental health issues among children. Research indicates that 10% to 20% of Greek children face challenges with psychosocial adjustment (Hatzihristou et al., 2006). Additionally, studies show that 10% of children with mental health issues meet the criteria for a diagnosed mental disorder. However, many educators feel unprepared to address these issues effectively in today's classrooms (Koller & Bertel, 2006). This rise in childhood mental health problems underscores the need for preventive measures. Schools can play a vital role in supporting students' mental health and enhancing their psychological resilience by equipping them with the tools to manage stress in challenging situations (Gross, 2008).

Mentally healthy children exhibit specific traits: they grow emotionally and cognitively, form and maintain relationships, engage in play and learning, develop a sense of right and

wrong, and overcome challenges and setbacks (Rothi, Leavey, & Best, 2008). Emotional and behavioral problems, which impede learning and are socially unacceptable, are often linked to mental health issues. Signs of emotional distress include social withdrawal and difficulty forming healthy relationships, such as hostility and isolation from peers. These mental health issues significantly hinder learning and academic achievement (Catalano, Haggerty, Oesterle, Fleming, & Hawkins, 2004). According to Fazel, Hoagwood, Stephan, & Ford (2014), these issues impact children's cognitive and social development.

Mental health problems in children can be categorized into two main groups: externalizing and internalizing disorders (Egger & Angold, 2006). Externalizing disorders involve aggressive and disruptive behavior, while internalizing disorders are associated with anxiety and depression. Externalizing behaviors are outwardly directed, whereas internalizing issues are focused inwardly (Achenbach & Edelbrock, 1981). It is common for children to experience both types of disorders simultaneously (Lilienfeld, 2003). Internalizing disorders arise from difficulties in managing negative emotions and manifest as low self-esteem, social withdrawal, shyness, and persistent worries (Graber, 2004). A child's temperament, especially inhibition characterized by fear and shyness during school age and irritability in infancy, increases the risk of developing anxiety disorders (Biederman et al., 1993). Inhibitory behavior in preschool and school age is a risk factor for anxiety and depression later in life (Bernstein, Borchardt, & Perwien, 1996).

Teachers and parents often overlook signs of depression and anxiety in children, mistaking these symptoms for good behavior because the children do not disrupt the classroom and follow instructions (Holmes, Slaughter, & Kasham, 2001). Adults tend to downplay the challenges children face and fail to recognize mental health issues in young people (Clauss-Ehlers & Levi, 2002). The connection between mental health, child development, and academic achievement has led to the development of mental health interventions. Schools are ideal settings for promoting children's mental health for several reasons: they provide access to the majority of the child population, and children spend most of their time there. Mental health promotion involves activities aimed at maximizing social and emotional well-being (Graham, Phelps, Maddison, & Fitzgerald, 2011). Schools play a crucial role in identifying mental health issues, providing services, and creating an environment that supports emotional well-being (Atkinson & Hornby, 2002).

### **1.12 Teachers as Leaders in Mental Health Disorders Prevention**

Schools play a crucial role in supporting children who need mental health care. Many students face mental health challenges, and long waiting lists for mental health services make it essential to offer these services within school settings. In the field of mental health, there are three levels of preventative interventions: universal, selected, and specified (Nastasi, Moore, & Varjas, 2004). Preclusion is closely tied to enhancing defensive factors. When protecting factors are present, they decrease the likelihood of negative impacts on a child's development. These protective factors include temperament traits, socio-cognitive and social skills, and cognitive abilities (Luthar & Zigler, 1992).

The second sort of protective factors involves the quality of interactions between children and their environments, including the school environment and the connection between family and school. Improving these protective factors and addressing risk factors are key to effective prevention. Factors related to the child's development include family, neighborhood, school, and their interactions (Severson et al., 2007). Psychological resilience, the ability of children to adapt to their environments despite adverse conditions, is closely linked to prevention (Luthar, Cicchetti, & Becker, 2000). Developing psychological resilience is a gradual process. By nurturing both internal factors, such as adaptive skills, and external factors, such as a supportive environment, especially in the early years, the effects of negative life experiences can be mitigated (Friedman & Chase-Lansdale, 2002).

Several protective factors contribute to psychological resilience in children, such as building emotionally secure and nurturing relationships with family and peers, fostering a sense of belonging, and developing effective communication and problem-solving skills. Social skills and the ability to self-regulate behavior and emotions are also crucial. Positive school environments that offer warmth, security, stability (consistent boundaries), and opportunities for participation in school, family, and community activities play a significant role in enhancing resilience. When designing early interventions to mitigate the negative impacts of mental health disorders, it's essential to consider factors that influence mental health. Teachers, in collaboration with mental health professionals, families, and students, can plan and implement targeted interventions for specific groups of children. Additionally, they can provide ongoing support to students and their families.

Teachers can identify children exposed to risk factors and work to strengthen protective factors for all students, promoting psychological well-being and resilience. Empowering children with skills related to psychological resilience can lower the risk of mental illness. Implementing socio-emotional learning interventions in schools is a crucial aspect of fostering children's resilience (Kay-Lambkin, Kemp, Stafford, & Hazell, 2007).

### **1.13 Role of Teachers in conducting interventions for Social and Emotional Learning**

Schools play an essential role in the holistic development of children, encompassing their cognitive, emotional, and psychomotor growth. By implementing social and emotional learning (SEL) programs, schools address the comprehensive development needs of children.

Socio-emotional learning involves acquiring skills to recognize and manage emotions, set and achieve positive goals, and make responsible decisions. It also includes understanding others' perspectives, building and maintaining relationships, and handling interpersonal situations constructively (Elias et al., 1997). SEL aims to develop five interconnected skills: self-awareness, self-management, social awareness, relationship-building, and responsible decision-making. These skills are associated with better adjustment and academic success, leading to fewer behavioral issues and less stress (Greenberg et al., 2003). SEL programs create an emotionally safe learning environment that supports children's socio-emotional development and improves classroom management (Hawkins et al., 2004). Teaching social and emotional skills helps facilitate relationships and provides students with a safe space to discuss challenging emotions and situations. These programs expand students' emotional vocabulary, positively impacting the school atmosphere and relationships within the classroom. Students gain confidence in managing their emotions and learn to recognize emotional cues (Greenberg et al., 1995). All these elements contribute to building strong, positive relationships between students and teachers.

In Greece, the program "Social and Emotional Education at School: A Program for the Promotion of Mental Health and Learning in School Community" (Hatzihristou, 2011a, b, c) has been implemented over the past decade. This program aims to enhance teachers' communication skills, equip them with tools to support students, and empower them in

their counseling roles. It also seeks to create a supportive classroom environment that promotes students' psychological well-being and mental health. The school environment and emotional connections within the school community strengthen students' psychological resilience (Hatzihristou et al., 2009). Strong emotional connections and communication between teachers and students increase students' willingness to participate in school activities and help them feel accepted and secure in the classroom. Fostering supportive relationships between teachers and students is a key component of teachers' counseling roles. This helps build a school community that values and supports its students (Hatzihristou, 2015; Battistich et al., 1997).

#### **1.14 Rationale of the Study**

Mental health problems among children and adolescents are increasingly concerning on a global scale, including in India. The increasing prevalence of these issues necessitates a comprehensive approach to their identification and management. Teachers, who spend a significant amount of time with children, are in a unique situation to witness and identify early symptoms of mental health problems. However, there is a notable gap in research, particularly in West Bengal, regarding primary teachers' awareness and understanding of child mental health. This study seeks to fill this gap by examining the awareness and perceptions of primary school teachers in West Bengal regarding child mental health issues.

In India, mental health remains a stigmatized and often neglected aspect of overall health, especially among children. The World Health Organization (WHO) estimates that 10-20% of children and adolescents experience mental disorders, yet these conditions are often undiagnosed and untreated. Early identification and intervention are crucial in mitigating the long-term impacts of mental health issues. Teachers play a pivotal role in this process, as they are often the first to notice changes in a child's behavior that may indicate underlying mental health problems. Despite the critical role of teachers, there is a significant lack of training and awareness among educators regarding child mental health. This issue is particularly acute in regions like West Bengal, where mental health resources are limited, and societal awareness is low. The lack of research in this area further exacerbates the problem, leaving teachers without the essential tools and information to provision their pupils effectively. This study is, therefore, crucial in highlighting the

current state of awareness among primary teachers in West Bengal and identifying areas where further training and resources are needed.

The rationale for this study is grounded in the pressing need to address the mental health needs of children in West Bengal through the education system. By understanding the level of awareness and the specific challenges faced by primary school teachers, this research aims to provide valuable insights that can inform policy and training programs. This, in turn, will contribute to a more supportive educational environment that promotes the mental well-being of children. The global burden of mental health disorders among children and adolescents is significant, with long-term consequences for individuals, families, and societies. Mental health problems can impact overall quality of life. In India, where educational and mental health systems are already under strain, the role of teachers becomes even more critical. Teachers who are aware of mental health issues and equipped with the appropriate skills can make a substantial difference in the early identification of these problems.

In West Bengal, the situation is further complicated by socio-economic factors that limit access to mental health care. The state has a diverse population with varying degrees of access to health and educational resources. In rural areas, in particular, there is often a severe shortage of mental health professionals and services. As a result, primary school teachers may be the only adults in a position to notice and address the early signs of mental health issues in children. However, without adequate training and awareness, they are ill-equipped to fulfill this role. This study is particularly timely and relevant given the recent emphasis on mental health in national and international policy. The Indian government has recognized the importance of mental health and has introduced several initiatives aimed at improving mental health services and awareness. However, there is a need for localized research to understand specific regional challenges and develop targeted interventions. In West Bengal, there is a clear gap in the literature regarding primary teachers' awareness of child mental health, making this study an essential contribution to the field.

This research aims to achieve several key objectives. First, it will assess the current level of awareness and understanding of child mental health among primary school teachers in West Bengal. Second, it seeks to identify the specific challenges and barriers teachers face

in recognizing and addressing mental health issues in their students. Third, the study will examine the training needs of teachers and offer recommendations for professional development programs to enhance their ability to support student mental health. The findings of this study will be significant for policymakers, educators, and mental health professionals. By identifying the gaps in awareness and training among primary teachers, the research will provide a foundation for developing targeted interventions to improve mental health outcomes for children in West Bengal. Additionally, the study will contribute to the broader discussion on child mental health in India, offering insights that can be applied to other regions facing similar challenges.

This research fills a significant void in the current literature regarding the awareness of child mental health among primary school educators in West Bengal. Given the significant role that teachers play in the early identification and support of mental health issues, it is essential to understand their current level of awareness and the challenges they face. This research will provide valuable insights that can inform policy and practice, ultimately contributing to the well-being of children in West Bengal and beyond.

### **1.15 Operational Definitions**

In research, an operational definition explains exactly how a concept or variable will be measured and understood. It turns abstract ideas into specific, measurable actions or criteria, ensuring everyone is on the same page when collecting and analyzing data. Researcher has given several operational definitions in this research as –

- i. **Primary teachers' perception of children mental health** - Primary teachers' perception of child mental health pertains to their awareness of their students' mental health issues. This awareness is assessed through seven dimensions of a questionnaire developed by Kerebih et al. in 2016. The dimensions were – emotional problems, peer- relationship problems, hyperactivity problems, conduct problems, pro-social deficit problems, learning problems and other problems. Where high scores indicated high awareness and low scores indicated low awareness.
- ii. **Semi-Urban** - Semi-urban areas are places that blend both urban and rural qualities. They usually have some urban features, like better infrastructure, access

to essential services, and some economic development. However, they don't fully meet all the criteria to be classified as urban.

- iii. **Primary Teachers** – In present study, Primary teachers of West Bengal are defined as the dedicated teachers who guide young children from class 1 to 4. Teachers who teach essential subjects like math, language, science, and social studies, helping to build the foundation for future learning. These teachers are vital in nurturing both the academic and social growth of their students.
- iv. **Children's Mental Health Problems** – In current research, children's mental health problems are described as issues related to their mental well-being, measured by dimensions identified by Kerebih et al. in 2016. These dimensions include emotional problems, peer- relationship problems, hyperactivity problems, conduct problems, pro-social deficit problems, learning problems and other problems. This research focuses on children aged 6 to 9 years old.
- v. **Mental health related training** – In the present research, teachers who had received direct mental health training or had participated in workshops, seminars, and conferences related to mental health were considered trained teachers.

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**CHAPTER - II**  
**PROBLEM OF THE STUDY**

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## **CHAPTER II**

### **PROBLEM OF THE STUDY**

#### **2.1 Emergence of the Problem**

Children and young people are vital to society. Their well-being shapes not only their personal growth but also the progress of a nation. Adolescence is a critical time filled with challenges, and it is during this period that many mental health issues can arise. According to the World Health Organization (WHO), half of all mental illnesses start by age 14, and three-quarters by the mid-20s. Research indicates that young people with mental health problems often struggle in adulthood. Mental health is now considered the most pressing health issue for young people worldwide, being the leading cause of disability among those aged 10-24 and contributing to 45% of the overall disease burden in this age group. However, young people have the lowest access to mental health care due to lack of awareness, barriers in the healthcare system, and societal neglect of the issue (McGorry et al., 2014).

Mental health is crucial for overall well-being, and evidence shows that countries must prioritize mental health care. The global mental health movement aims to improve services for people with mental health issues, especially in low- and middle-income countries where these services are often lacking. The movement is based on scientific evidence and human rights, emphasizing the importance of mental health for achieving the post-2015 development goals (Minas, 2014). Mental health significantly impacts various aspects of human development, including happiness and well-being, which are now key indicators of progress. The 2013 World Happiness Report identified mental health as the primary factor influencing happiness and life satisfaction, even more than physical health, age, gender, or income (Eaton et al., 2014).

The WHO (2001) estimated that 10-20% of children worldwide have one or more mental or behavioral disorders. The World Health Report 2001 revealed that mental and behavioral disorders account for 12.3% of the global disease burden, yet most countries allocate less than 1% of their health budgets to mental health. Over 40% of countries lack a mental health policy, and more than 30% have no mental health program. Additionally, over 90% of countries do not have a mental health policy for children and

adolescents. The rising prevalence of mental health issues among young people is a global concern. The WHO (2014) reported that half of all mental health disorders in adulthood begin by age 14, but most cases are undetected and untreated. Mental health and well-being are essential for our ability to think, feel, interact, work, and enjoy life. Therefore, protecting and promoting mental health should be a global priority. In May 2012, the Sixty-Fifth World Health Assembly adopted resolution WHA65.4, calling for a comprehensive, coordinated response to the global burden of mental disorders. In 2013, the Sixty-Sixth World Health Assembly adopted the WHO's comprehensive mental health action plan 2013-2020, which aims to strengthen leadership and governance for mental health, provide comprehensive and responsive services, implement strategies for mental health promotion and prevention, and enhance information systems, evidence, and research for mental health (WHO, 2013).

The Child Mental Health Atlas highlighted significant disparities in child and adolescent mental health policies and programs. Only 6.3% of African nations, compared to 66.7% of European nations, had a mental health program for young people. In low-income countries, including India, child and adolescent mental health policies are often nonexistent, whereas 78% of high-income countries have such policies (Sharan et al., 2007). Mental disorders impose a significant burden on individuals, families, and societies, making them a major public health concern. Despite effective management options, mental health issues are often under-recognized, under-treated, and under-prioritized globally. The Mental Health Atlas 2005 showed that global spending on mental health is grossly inadequate compared to the needs (Saxena et al., 2005).

Schools play a crucial role in children's overall development, including their physical, mental, and emotional well-being. They are key settings for implementing mental health promotion programs, such as inclusive policies, teacher training to recognize emotional distress, life skills education, personal development programs, systematic screening, and counseling services. These programs help remove barriers to learning and support students' mental health, ensuring their overall success and well-being (Fisher et al., 2011). Studies show that mental health issues not only affect children's health, emotions, and behavior but also significantly impact their academic performance. The National Commission on Macroeconomics and Health (NCMH, 2005) highlighted the need to address academic and learning-related problems alongside mental health issues.

Emotional and behavioral problems are strong predictors of poor school performance (Saleem et al., 2012; Akpan et al., 2010; Gupta et al., 2001). Comprehensive, integrated school-wide approaches are essential to address these issues and support students' academic and personal development (Taylor et al., 2000). Schools provide access to mental health services and offer opportunities for prevention and research activities (Adelman et al., 1999). Addressing mental health issues in school-going children will raise awareness among people and policymakers, leading to effective strategies to tackle these problems. By doing so, we can ensure that today's children grow into healthy, productive citizens of the future.

## **2.2 Literature Review**

A literature review is a synopsis of relevant academic works that lay the framework for the evidence needed to proceed with the current inquiry. To objectively examine the rising problem of the effects of religious practices on students' depression, anxiety and stress. It surveyed previous research on the subject, which helped justify the present investigation. To avoid redoing the analysis and finding the problem, you need to think about this part for a better understanding. It helped with both conceptualization and gaining an in-depth knowledge of the situation. In this regard we find the following related studies-

### **2.2.1 Studies conducted in India**

**Ma & Anto (2022)** in their work "Importance of mental health awareness among school teachers in bridging mental health treatment gap in India" aimed to understand how well school teachers in Kerala are aware of mental health issues and how they handle students showing signs of depression. We surveyed 74 high school and higher secondary teachers, using a questionnaire and a scenario describing a student with depression. While many teachers had good general knowledge about mental health, only 23% recognized the student's symptoms as a mental health issue, and just 18% identified it specifically as depression. Most teachers (54%) said they would talk to the student, but only 2% would refer them to a mental health professional. These findings highlight the need for better mental health training for teachers to help them support students more effectively.

**Tolan & Dodge (2005)** puts out an all-encompassing method for psychology that places emphasis on the importance of mental health to a child's overall well-being. This method aligns with the concepts of a care system and utilises the discoveries from epidemiology, risk-development, and intervention research to prioritise the following four areas: (1) Enhanced accessibility to top-notch, expert clinical services for children displaying disorders; (2) Broadened research on and application of effective prevention strategies for high-risk youth; (3) Heightened availability of concise, focused interventions in primary care settings; and (4) Amplified recognition and advocacy for the significance of mental health. The success of the plan depends greatly on the simultaneous execution of these factors and the inclusion of family-centered, culturally competent, evidence-based, and developmentally appropriate services.

**Prabhu (1987)** noted that Child and Adolescent Mental Health has not only been underfunded but has also faced several obstacles in India. Significant progress and advancement took place from the early 1950s until the mid-1960s. There was a period of inactivity until 1979, when the region started to exhibit signals of renewed activity. An estimated 66 children per 1,000 are expected to experience emotional issues. Research findings indicate that the general population does not perceive emotional disorders in children as significant medical conditions requiring the assistance of professionals. India and other developing nations encounter various obstacles in this domain, such as insufficient financial resources for conducting research on the personality development, socialisation process, stress tolerance, and coping mechanisms of underprivileged children; inadequate data on the demographics of individuals seeking clinical aid; and a dearth of strategies for cultivating the required human resources.

**Raman and Thomas (2023)** parents, teachers, society, governments, legislators, etc. all have a role to play in ensuring children and adolescents get the care and attention their developing minds and bodies require. Sufficient resources and collaboration are essential for the successful implementation of any intervention aimed at addressing difficulties. Extensive studies and widespread recognition in both poor and affluent countries have shown the beneficial impact of SMHPs on the comprehensive development of children. While it is crucial to provide training to teachers, it is also important to educate other professionals who possess the necessary skills to work with

children. In order to ensure the successful initiation, effective functioning, and favourable outcomes of SMHPs, mental health practitioners must go beyond mere classroom instruction. There is much justification for including mental health into the school system. Implementing integration strategies derived from evidence-based techniques described in scientific literature has the capacity to enhance the mental well-being of young individuals.

**Kulkarni et al (2019)** carried out their research in order to administer the standardized scale that assesses a person's attitude towards and level of knowledge about mental illness. The measure was distributed to primary school educators at three distinct sites in Karnataka, encompassing both urban and rural regions. The educational institutes located in metropolitan Bangalore, rural Ramanagar, and Udupi were taken into account. Two hundred primary school teachers, a significant number of whom were female, were provided with the scales. The research is being undertaken utilising a between-group design, which is a correlative study design. Prabhu (1983) devised an attitude scale of 30 items. Ms. Gnanaguruvammal, the researcher, revised the 20-item knowledge scale. G (2010) employed the purposive sampling method to select a sample of 200 persons. The participants were provided with detailed instructions, and their responses were then gathered and evaluated. The data analysis was done using SPSS version 20. Researchers used a t-test to compare the knowledge and attitudes of teachers in rural and urban areas. They conducted a correlation analysis to explore the link between their attitudes and knowledge about students with mental illnesses. The results showed that more knowledge reduces stigma ( $t = -19.99$ ). There is a strong positive correlation ( $r = 0.511$ ) between attitudes toward mental illness and the amount of information teachers have. Teachers in rural areas have different levels of knowledge compared to those in urban areas ( $t = 5.96$ ). There is also a significant difference in the opinions of teachers from urban and rural locations ( $t = 13.686$ ).

**Venkataraman et al. (2019)** said that the prevalence of mental illnesses is a developing public health issue. According to reports from the World Health Organisation (WHO), 20% of young people suffer a debilitating mental disorder. Most mental health illnesses typically originate throughout adolescence. The initial steps in managing mental illnesses involve identifying the specific needs of the adolescent and providing appropriate therapy and support. Most children and adolescents typically enrol in

educational institutions, where they dedicate around half of their active hours under the supervision of their educators. Teachers regularly engage with children and possess the ability to identify behavioural problems in them prior to their manifestation as serious symptoms. Therefore, educators can be a significant asset in providing fundamental mental health interventions. An often neglected yet vital aspect of education is the teacher's ability to identify the initial signs of mental illness in teenagers. There has been limited attention given to the mental health knowledge and understanding of educators, who play a vital role as role models and influential figures in promoting mental health literacy. This is because most studies in this area have been conducted within the community or with teenage students. The scarcity of research undertaken among teachers in India is a disheartening circumstance.

**Vasuki and Kanakaraj (2012)** carried out research on "Prospective Teachers' Mental Health and Emotional Intelligence." This study examined the emotional intelligence and mental well-being of individuals desiring to become teachers. The study included 320 future teachers from four B.Ed. colleges near Thoothukudi. The findings showed no clear link between their emotional intelligence and mental health.

**Basu (2011)** examined "Primary School Teachers' Mental Health and Teaching Effectiveness." This study aims to determine how teaching effectiveness affects the mental health of primary school teachers. A total of 225 teachers from the Rohilkhand area were selected. Data was collected using the Mental Health Inventory and the Teaching Efficiency Scale. The analysis used mean, standard deviation, and t-test. Results showed that effective teachers had significantly better mental health than ineffective ones. Even after considering factors like gender, years of teaching experience, and region, effective teachers still had better health than their less effective counterparts.

**Sood and Anand (2011)** studied on "The Relationship Between Individuals' Mental Health and Emotional Competence". This study aimed to understand how emotional competence affects the mental health of senior secondary school students. Researchers believed there might be a link between the emotional skills of 41 students and their mental health. They collected data from 300 students in Mandi and Hamirpur districts of Himachal Pradesh using the Mental Health Inventory and the Emotional Competence

Scale. A two-way ANOVA with a 3x2 factorial design and some descriptive statistics were used for analysis. The results showed a positive and significant correlation between students' mental health and their emotional competence. There were no significant differences in mental health based on gender or region. However, the study found that gender, region, and emotional competence together significantly influenced the mental health of senior secondary school students.

**Somasundaram & Gowri. A. (2011)** carried out research on the mental health of teenage pupils. This research was carried out to find out how teenage kids in Madurantakam, Kanchipuram District, Tamilnadu, were doing in terms of their mental health. Based on the findings, most of the sample exhibited normal mental health. Girls' schools, government-aided schools, and children whose parents are employed by private enterprises had superior mental well-being compared to the whole population. The study titled "Resilience and Mental Health: A Study on Adolescents in Varanasi" was carried out in 2011 by Amrita Deb and Meenakshi Arora. This study aimed to explore the mental well-being and stress coping abilities of adolescents preparing for engineering and medical entrance exams in Varanasi, India. The study included 566 teens, with 200 (average age 18.36) selected for facing significant academic challenges. These students scored above the third quartile on the Academic Adversity Scale developed for this research. Their resilience was measured using the Resilience Scale (Mampane, 2005), and they were divided into high resilience (HR) and low resilience (LR) groups based on a median split of their resilience scores. Mental health was assessed using Goldberg's Indian adaptation (1972) and the General Health Questionnaire by Singh (2000). The findings showed that males had significantly higher resilience than females, with a 42-point difference in resilience scores. Additionally, HR students were better at managing their mental health compared to LR students.

**Pathajay & Mulchopadhyay (2010)** researched "A Comparison of Mental Health: Depression in Risk, Vulnerable, and Normal Adolescents." The objective of the study was to examine the mental well-being of adolescents who now do not exhibit symptoms of depression, as well as those who are susceptible to developing depression in the future. The study's sample consisted of three hundred kids, aged fourteen to eighteen, who attended secondary schools in Varanasi. The Beck Depression Inventory and the Depression Symptom Checklist were utilised as assessment tools in this study. The

group of individuals sensitive to depression (n=21) had screening that included additional information on the loss of impulse control, specifically focusing on those who scored lower on the criteria for depression. The group of individuals "at risk" for depression (n=21) was identified based on predetermined scores that served as a cutoff point. Additionally, the investigation included a control group consisting of an equal number of individuals. The Mental Health Inventory was given to three groups. ANOVA analysis showed significant differences among the groups in autonomy, environmental mastery, group-oriented attitude, positive self-evaluation, and personality integration.

**Thamodharan V., (2009)** performed, an investigation higher secondary students' mental health; ii) determine whether there are any significant differences between higher secondary students' mental health and the variables of (a) gender; (b) language of instruction; (c) location; (d) religion; (e) family income; and iii) determine higher secondary students' academic achievement in English. iv) To determine the relationship between students' academic achievement in English and their mental health in higher secondary education. A sample of 250 pupils enrolled in the XI standard is used. The "Mental Health Inventory," created by Jegadeesh Srivasta, and the "Achievement Test in English," standardized by the investigator, served as the study's instruments. The techniques utilized to analyze the data were the "t" test, the "F" test, "correlation, and percentage analysis. Major Findings: i) There is no significant difference between students' mental health and academic achievement in the Higher Secondary class with reference to 43 variables, including gender, family income, and the institution's location; ii) Students of different religions have significantly different mental health; and iii) There is a significant relationship between students' academic achievement in English and their mental health".

**Kaur (2018)** sought to determine the degree of awareness of ADHD among primary school teachers in a subset of Mohali district schools in order to create an educational pamphlet. A decision was made to employ a quantitative strategy with a descriptive design. A purposive sampling strategy was used to select one hundred primary school teachers from a subset of schools in the Mohali district. Data were collected from primary school teachers in selected schools in the Mohali district using the modified Knowledge of Attention Deficit Disorders Scale (KADDS). The study's findings indicate that the majority of the samples, specifically 42% of them, were females between the

ages of 35 and 44. Additionally, 60% of the samples had successfully obtained a Bachelor of Education degree, while 71% had completed a Master of Education degree. Furthermore, 50% of the samples had accumulated more than five years of work experience, and 83% of them were affiliated with government organisations. It is worth noting that 56% of the samples had no prior knowledge of ADHD, and only 15% had acquired information about the disorder from television. Lastly, a significant majority of 87% had not encountered a child with an ADHD diagnosis. A total of 56% of elementary school instructors indicated that they possessed insufficient information. There was a significant association between the participants' level of pre-existing knowledge of ADHD and their exposure to diagnosed children with the disease.

**Perumal (2008)**, attempted to investigate the mental health condition of Kerala's VIII Standard students as well as the link between the students' locus of control and mental health. The current research utilised the English Standard, Normative Survey Method, employing the disproportionate stratified sample approach. The study used the Mental Health Status Scale by Abraham and Prasanna (1981) and Rotter's Internal-External Locus of Control Scale (1966) to measure students' mental health. Data was analysed using the 't' test and correlation. The main findings are: 1) There are no significant gender differences in the mental health of eighth-grade students in Kerala. 2) A significant number of eighth-grade students in Kerala have poor mental well-being. 3) There is no clear link between students' performance in English, their internal locus of control, and their mental health.

**Khan & Srivastava (2008)** performed, his research to ascertain if mental health affects college and school teachers' degrees of burnout. The sample consisted of 640 instructors from 4 regions in the eastern United Provinces' schools and universities. The drawing was conducted through the utilisation of a technique referred to as random sampling. The study employed the Mithila Mental Health Status Inventory and the Dr. Tripte Hatwal burnout scale as its assessment tools. The primary findings indicate that mental health exhibits significant variability depending on factors such as intelligence quotient (IQ), personality traits, job satisfaction, stressful life events, and stress related to one's role. ii) The likelihood of experiencing burnout is strongly associated with a condition known as mental health.

**Srividhya. V (2007)** An investigation of the mental health and adjustment issues of pupils attending state and Navodaya Central schools was conducted. A group of 233 adolescents was selected. Due to insufficient information provided, six respondents were excluded from the sample, resulting in a final sample size of 227 teenagers. Data was collected using the General Information Schedule, the Problem Check List by Joshi and Pandey (2005), and the Mental Health Inventory by Jagadish and Srivastava (1983). Only 6.6% of students had excellent mental health, with none rated as very good. Over 40% had poor mental health, and 45.4% had average mental health. There were no significant differences in mental health aspects like positive self-evaluation, perception of reality, personality integration, autonomy, group-oriented attitude, and environmental mastery across different educational systems. Boys and girls at Central School had similar mental health levels, although girls generally had better mental health. Religion did not affect the mental well-being of scheduled caste/tribe students, but they had worse mental health compared to other groups. Students' mental health declined as their problems increased.

**Ravindranadan (2006)** conducted a study on the "quality of life, emotional intelligence, and mental health status of parents of children with special needs". The study aimed to examine the psychological well-being, life satisfaction, and emotional intelligence of parents who have children with special needs. Regarding the research variable of mental health status, there exists a significant disparity between parents of children with special needs and parents of typically developing children. The sample consisted of 400 parents of children with exceptional needs. The research conducted in 1998 utilised emotional intelligence as a tool, with Jayaraj, B. and Dr. Sam Sananda Raj being the individuals responsible for its implementation. The research shows significant differences in the mental health of populations in Kerala and Dubai based on their education levels. These differences affect self-actualization, self-esteem, perception of reality, adaptability, and overall psychological well-being, influenced by both national and local factors. Additionally, parents of children with special needs have much different mental health statuses compared to parents of typical children.

**Shanker & Jabaraj (2006)** research "Tsunami's effects on Adolescent Orphan Children's Mental Health". The research aimed to explore the mental well-being of teenage orphans affected by the tsunami and how their mental health might affect their

academic performance. The sample consisted of eighty teenage orphans. There are a total of 52 boys and 28 girls between the ages of 9 and 15. Srivastava, A.K. (2003) developed a mental health assessment tool. The outcomes of the present study demonstrate a robust association between the academic achievement and emotional well-being of adolescent orphans affected by the tsunami. The orphans affected by the tsunami were found to have a significantly deteriorated mental health status.

**Jeba A. (2005)** carried out research titled "Student teachers' mental health and teaching competency in a District Institute of Education and Training (DIET)." The research aimed to assess the differences in teaching proficiency and mental well-being among genders and groups of student teachers in DIET. (ii) To determine the correlation between the mental well-being of students and the teaching effectiveness of DIET instructors. The sample consisted of 150 male and 150 female DIET student instructors. The study utilised Abraham M. and K. C. B. Prasanna's Mental Health Status Scale 46 as the assessment tool. (ii) The researcher's development of the Teaching Competency Assessment scale. The data were examined using correlation and the "t" test. The study discovered a correlation between the level of teaching proficiency and mental well-being.

**Srivastava (2004)** did research named "Personality adjustment and mental health among the community of optimistic and pessimistic students." The study aimed to compare the mental health and personality adjustment of optimistic and pessimistic students. A total of 150 students took part in the research, with 75 of them being male and the other 75 being female. The research utilised Anand Kumar's Mental Health Status Inventory, C.P. Sharma's Personality Adjustment Inventory, and S. Parasha and Mithila's Optimistic, Pessimist Attitude Scale as the assessment tools. The primary findings indicated significant differences in personality adjustment between optimistic and pessimistic students.

**Sarita et al. (2015)** "carried out comparative research on the mental health of senior secondary school pupils attending private and public schools. The objective of the study was to examine the psychological well-being of high school students in their last year, who are enrolled in both private and public educational institutions. This study was carried out in the city of Rohtak in the state of Haryana. The research utilised the Mental

Health Inventory, which was developed by Dr. Arun Kumar Singh and Alpana Sen Gupta in 1987. The study's primary findings indicate a large disparity in the mental well-being of males attending private versus state senior secondary schools. 2) The mental well-being of female students at private senior secondary schools significantly varies from that of students in government institutions. 3) There is not a significant difference in the mental health of males and girls attending government senior secondary schools. 4) There is no substantial difference in the mental health of boys and girls who attend private senior secondary schools.

**Farahbakhsh S. (2004)** carried out research named "Secondary school principals' mental health in relation to occupational variables". The research had two main goals: (i) "To compare the mental health of secondary school principals in relation to their administrative experience and total service in teaching; and (ii) To compare the mental health of secondary school principals in relation to the number of teachers, students, and educational quality level of their schools. The six measures of mental health were overall personal well-being, anxiety factor disability systems, capacity to establish constructive relationships, and capacity to cope with the ordinary demands and others of life. A sample of sixty principals of government secondary schools participated in the research. The study's main conclusions were (ii) The Mental Health Scores showed that principals' scores did not significantly change based on the number of teachers in their respective schools".

**Ojiha (2002)** titled "Social anxiety and mental health of normal and physically challenged adolescents" researched and published the findings. The objective of the study was to investigate the psychological well-being and social apprehension of adolescents with physical disabilities in comparison to those without such disabilities. The sample had 60 participants, of which 47 were randomly selected from different places in Varanasi. Among these, there were 15 females with orthopaedic problems and a matched control group of normal teenagers. The Jadadish and Srivastava (1983) Mental Health Inventory was employed to assess mental health. There was no noticeable disparity in the mental well-being between the group with orthopaedic challenges and the group without any physical limitations.

***Dharanendrappa and Ningamma (2002)*** "Importance of Mental Health and Emotional Intelligence in the Learning Process" was researched. Secondary school has a crucial role in shaping children for the future society. Adolescents with high emotional intelligence and sound mental well-being are likely to have improved peer connections and have acceptable social adaptability. Moreover, it provides comprehensive assistance to individuals in actualizing their personal capabilities. This article explores the significance of mental health and emotional intelligence in the learning process of secondary school students. The strategies aim to enhance children's emotional intelligence and mental well-being, both of which are crucial for better adaptation and academic achievement in secondary school.

***Kumari & Kumar (2022)*** indicated that there are a number of difficulties and challenges relating to mental health in India, including misunderstandings about mental health, a lack of resources and knowledge, and concerns with technology, society, personal finances, the environment, and the eco-system. Additionally, it was found that there is a lack of therapeutic facilities and resources, which contributes to the treatment gap. Prevention and therapy are the primary factors for maintaining optimal mental health. Secondary school students would tremendously benefit from comprehensive orientation and education on mental health concerns and challenges. This will aid individuals in effectively managing challenging situations and in adapting harmoniously within their families and communities. The findings of this study will be invaluable to educators, parents, guidance counsellors, and administrators in fostering a conducive environment both at home and in school, so promoting the mental well-being of secondary school students.

***Swapnajaidupally (2015)*** explains how schools can help children grow emotionally in a healthy way. Counsellors and other professionals working in schools have the potential to serve as family advisers, community partners, and student advocates, which can contribute to enhancing children's wellness. Families and schools are the predominant institutions in a child's life throughout various geographical regions. The decline of familial and cultural institutions, which were once crucial for children's support, can be attributed to factors such as rapid urbanisation, single-parent families, geographic mobility, and the easy accessibility to potentially dangerous drugs and activities. In contemporary times, educational institutions hold a pivotal position in

fostering the growth and progress of young individuals. Consequently, schools have the main obligation for the mental well-being of children. As the nation progresses towards achieving universal education, schools must assume a more significant role in providing mental and physical health care.

**Singh (2020)** discusses the integration of mental health and education in academic settings, the role that schools play in promoting and adopting programmes that include life skills, psychoeducation, and mental health, and the development of a framework that encourages school-age adolescents to lead healthier lifestyles. This study utilises a comparative analysis to scrutinise the present education system in India, and it also conducts literature research to explore the mental health policies of different states. Proposing a novel framework to tackle existing problems and advance education systems towards incorporating health policies that are comprehensive and inclusive. This approach aims to not only achieve multiple intermediate goals but also eliminate the social stigma surrounding mental health.

**Rani et al. (2012)** carried out research on mental health depending on the kind of school and gender. The objective of the research is to ascertain the correlation between mental health and different demographic parameters. A sample of one hundred instructors was assessed using Singh and Sengupta's Mental Health Battery to collect data. The study's findings indicated that the mental well-being of primary school teachers was considered to be average. There was no significant difference in the overall level of mental health between male and female instructors. There is no disparity in the mental well-being of teachers working at public and private educational institutions.

**Sharma et al. (2014)** investigated the mental health of the teenagers and made an effort to determine how mental health and the educational setting related to each other. The data was gathered through the utilisation of a survey. A total of 210 tenth graders from the Hoshiarpur District were included in the study by random selection. The research findings indicate that the school environment has a notable impact on the positive mental health of adolescent students. There is a significant disparity in the mental health of adolescent males and females. Segregated and coeducational schools were discovered to possess distinct cultures.

**Bartwal (2014)** investigated senior secondary students' mental health with the goal of comparing their social intelligence and mental health. By employing a simple and direct random selection method, a total of 400 students were chosen from Government senior secondary schools located in the Saharanpur district of Uttar Pradesh and the Chamoli district of Uttarakhand. The information was collected using a descriptive survey methodology. The statistical significance of the means and the strength of the relationship between dependent and independent variables were assessed using the "t" test and correlation, respectively. Based on the research findings, there were no notable differences in the mental well-being of students residing in rural and urban areas. The study also examined the potential beneficial correlation between social intelligence and mental health.

*In a review study **Bhola and Kapur (2003)** we believe that the growing emphasis on child mental health in developing nations like India highlights the significance of epidemiological data in creating paradigms for research, training, and services. The study had two main objectives: to identify and analyse significant conceptual and methodological patterns, and to consolidate and evaluate the existing research on the prevalence of mental disorders among children and adolescents in India. A total of 55 epidemiological investigations were conducted in community and school settings from 1964 to 2002. The reviewers opined that despite notable progress, certain methodological deficiencies continue to limit the utility of epidemiological surveys. These encompass issues related to tools, methods for defining cases, sampling, gathering data from several sources, and analysing the data. In their investigation, they found a wide range of prevalence rates for mental health concerns. The range of percentages in community-based research varied from 0.48% to 29.40%, while in school-based research it ranged from 3.23% to 36.50%. The research discovered that the majority of Indian studies demonstrate a lower incidence of mental illness compared to larger studies conducted in other countries, specifically when examining the mental health of children and adolescents. Studies conducted in France, Germany, New Zealand, Puerto Rico, the United States, Canada, and the Netherlands indicate that the average prevalence rate is 29%. Currently, the prevalence statistics from other countries have consistently been greater than those from India. Switzerland has a prevalence rate of 22.5% among individuals aged 7 to 16, as reported by Steinhausen et*

al. in 1998. The USA has a prevalence rate of 21.0% among those aged 9 to 17, as reported by Shaffer et al. in 1996. Ethiopia has a prevalence rate of 17.7% among those aged 5 to 15, as reported by Tadesse et al. in 1999. The review provided recommendations for future research directions to inform the development of interventions targeting the mental health needs of at-risk children and adolescents.

**Sharan et al. (2007)** Suicide accounted for 25% of fatalities in boys and between 50% and 75% of deaths in girls between the ages of 10 and 19 years old, according to an editorial published in "Mental Health Policy for Children and Adolescents in Developing Countries." A significant lack of child and adolescent mental health care systems has been observed in most countries outside of Europe and the Americas. In impoverished nations, the availability of beds in traditional hospital facilities for children and adolescents with mental health problems is extremely limited. School-based mental health consulting services are underutilised in both developing and wealthy countries. Moreover, the absence of additional training in child mental health hinders the utilisation of professionals with specialised knowledge in social work, psychology, education, and other fields in developing countries for the purpose of addressing the mental well-being of children and adolescents. Expanding mental health care in developing countries is crucial, as these nations are home to 80% of children and adolescents globally, which accounts for almost a third of India's population. The editorial highlighted the inadequate efforts in formulating policies to address the mental health needs of children and adolescents, despite the recognition of these needs. Services pertaining to the mental well-being of children and teenagers have demonstrated a higher vulnerability to alterations in the system and are a prominent contender for reductions in financing.

**Arumugam & Neelima (2019)** intended to look at the mental health of primary school teachers with regard to their gender, place of residence, and experience as instructors." The study recruited 200 primary school teachers, aged 35 to 50, from two regions in Telangana, namely Hyderabad and Rangareddy. Dr. Jagadish developed and established the Mental Health Inventory, which was utilised in this study by Dr. A. K. Srivastava. The inventory contains a total of 56 goods, with 32 of them being positive claims and the remaining 24 being negative ones. The test designers established that the test-retest reliability coefficient was 0.77. The study's findings indicated that 17% of elementary

school teachers exhibited suboptimal mental well-being. Approximately 65 percent of teachers exhibited intermediate mental health, while the remaining 18 percent had excellent mental health. Primary school instructors exhibit variations in their mental health.

### 2.2.2 Studies Conducted abroad

**Kamel et al. (2020)** conducted a study “Beliefs about students’ mental health issues among teachers at elementary and high schools, Hail Governorate, Saudi Arabia.” This study aimed to understand how aware and perceptive elementary and secondary school teachers in Hail Governorate, Saudi Arabia, are about students' mental health issues. A survey was undertaken, with the participation of 2398 instructors, resulting in a response rate of 60%. Our research revealed that the majority of instructors displayed a favourable disposition towards children with mental health concerns, achieving an average score of 74.7% on our attitude scale. However, their level of awareness regarding these difficulties was comparatively lower, with an average score of 55.1%. The survey revealed that a significant percentage of teachers (73.7%) acknowledged the importance of receiving mental health training for themselves, as well as for other school personnel (76.2%). Furthermore, a majority of teachers (81.1%) recognised the value of having psychologists present in schools. Additionally, there was a strong consensus among teachers regarding the necessity of access to instructional resources (78.1%), a support hotline (78.5%), and increased mental health awareness in the media (84.4%). This study emphasises the imperative of providing mental health training and resources to facilitate the optimal growth and well-being of children.

**Mahmoud et al. (2018)** in their study “Impact of awareness program on knowledge of primary school teachers regarding mental disorders among school children” aimed to see how much primary school teachers knew about children's mental disorders and to find out if an awareness program could improve their knowledge. Between September and November 2017, 200 teachers from four public primary schools in Beni-Suef City participated in a study. An interview questionnaire was used to assess their understanding of the causes, types, signs, and treatments of mental illness. Initially, only 49.5% of the teachers had a good understanding of these topics. After the awareness program, there were significant improvements: knowledge of causes rose from 15.5%

to 50%, types from 62.5% to 90%, signs from 62.5% to 76%, and treatments from 21% to 42%. The program clearly helped, highlighting the need for more studies on how teachers can help identify mental health issues in children.

**Kerebih et al. (2018)** conducted a study “Perception of primary school teachers to school children’s mental health problems in Southwest Ethiopia.” This study aimed to understand how primary school teachers in Jimma town, Ethiopia, perceive child mental health problems and their attitudes towards school-based mental health programs. Conducted in October 2013, 568 teachers participated by completing a structured questionnaire. We found that only 40% of teachers recognized the listed child mental health issues, though 54.4% rated these problems as severe, especially externalizing behaviors. Teachers with more experience and those in public schools were more likely to see these issues as severe. Despite this, 95% of teachers agreed that school-based mental health programs are important, but noted these programs are rare. These findings highlight the need for increased mental health awareness among teachers and the creation of mental health services in schools to better support children.

**Shateri et al. (2019)** in their study “The relationship between mental health and spiritual intelligence among primary school teachers” tried to investigate how spiritual intelligence relates to mental health among primary school teachers. We focused on 203 randomly selected teachers from Darreshahr in Ilam province during the 2016-2017 school year. Using surveys, we measured their spiritual intelligence and mental health. Our analysis revealed a strong connection: teachers with higher spiritual intelligence tended to have better mental health. In particular, aspects like transcendental awareness and finding personal meaning were key predictors of mental well-being. The results suggest that boosting spiritual intelligence could help improve teachers' mental health. Therefore, it's recommended that educational programs focus on enhancing spiritual intelligence to support teachers' mental health.

**Maclean & Law (2022)** studied on “Supporting primary school students' mental health needs: Teachers' perceptions of roles, barriers, and abilities.” This study looked into the challenges faced by Scottish primary school teachers in supporting children's mental health. Researchers surveyed 179 teachers from 30 council areas about their observations, knowledge, and training. Teachers recognized their important role in

children's mental health but felt they lacked the necessary skills and knowledge. The biggest barrier was inadequate training. These results highlight the urgent need for better professional development and preservice training to help teachers effectively support children's mental health.

**Bella et al. (2011)** had done a work "Towards School Mental Health in Nigeria: Baseline Knowledge and Attitudes of Elementary School Teachers." This study aimed to understand how Nigerian elementary school teachers perceive child and adolescent mental health (CAMH) to create a better training program. Teachers filled out confidential questionnaires, which showed that they had no prior training in CAMH. The results revealed a significant gap in their knowledge and often intolerant attitudes towards children with mental health issues. These findings highlight the need to include CAMH care in teacher education programs. By doing so, teachers can become valuable partners in school mental health initiatives, helping to address the critical shortage of CAMH professionals and ensuring early identification and support for children in need.

**Gorsy et al. (2015)** studied on "Mental health among government school teachers." This study looked at the mental health of public-school teachers, especially those teaching at secondary and higher secondary levels. We surveyed 100 teachers using the Mental Health Index (MHI). The results showed that male teachers generally had better mental health than their female colleagues. Also, teachers working in urban schools had higher mental health levels compared to those in rural schools. These findings highlight how changing socio-economic conditions and job demands can impact teachers' well-being. Addressing these issues is crucial for supporting teachers' mental health and helping them thrive both personally and professionally.

**Shelemy et al. (2019)** In their work "Supporting students' mental health in schools: what do teachers want and need?" tried to investigate what kind of mental health training secondary school teachers in the UK need to better support their students. We held nine focus groups with four to eight teachers each, discussing their training needs and preferences. Teachers reviewed three online training resources and shared their thoughts. They expressed a strong desire for training that helps them identify and support students with mental health issues early on, without feeling like they have to become therapists. They emphasized the need for practical, hands-on training led by

experts, with resources they can adapt to their specific school settings. These findings emphasize the need for specialized mental health training to help teachers better support their students.

**Bryer & Signorini (2011)** conducted a study “Primary pre-service teachers' understanding of students' internalising problems of mental health and wellbeing.” This study explored how well fourth-year preservice primary teachers in Australia are prepared to recognize and support students with internalizing mental health issues. Through a survey, we found that their exposure to these issues during training was inconsistent, and their university courses offered limited preparation. These future teachers applied general teaching methods to help students and were keen to learn from their colleagues. A smaller group shared more detailed insights after their practicum and coursework. The findings suggest that new teachers need better training to effectively support students with internalizing problems in their classrooms.

**Mbwayo et al. (2020)** studied on “Mental health in Kenyan schools: teachers' perspectives.” This study explored how teachers in public primary and secondary schools in Kiambu County, Kenya, perceive mental health issues among their students. Through focus group discussions with teachers from rural, suburban, and urban areas, we aimed to understand their experiences and how they handle these problems. Teachers recognized various mental health issues, such as learning difficulties, behavioral problems, and substance abuse. They admitted facing challenges due to a lack of skills and time. The findings show the need for in-service training to help teachers identify and refer students with mental health issues. They also emphasize the importance of hiring school psychologists to provide needed support.

**Glazzard & Rose (2020)** conducted a study “The impact of teacher well-being and mental health on pupil progress in primary schools.” This study examined factors affecting teacher well-being and mental health, their impact on student progress, and strategies effective teachers use to cope with poor mental health. Conducted in ten primary schools in England, the research involved interviews with 35 teachers and head teachers, as well as discussions with 64 Year 3 pupils. Teachers identified stress triggers like busy assessment periods, extracurricular pressures, unexpected events, and changes in school leadership. Interestingly, children could sense their teachers' stress,

even when teachers tried to hide it. These findings emphasize the importance of supporting teacher well-being to help both teachers and students thrive.

**Ni Chorcora & Swords (2022)** had done a work “Mental health literacy and help-giving responses of Irish primary school teachers.” This study looked at how well primary school teachers understand and respond to children's mental health issues. We surveyed 356 teachers using three scenarios: one non-clinical and two clinical, describing children with anxiety and depression. We wanted to see if teachers could recognize these issues and how they would respond. Most teachers did well, with 84% identifying anxiety and 71% identifying depression correctly. Female teachers and those with more experience with mental illness showed greater concern for these children. Teachers who were more confident and concerned were more likely to offer help, though those with more years of teaching experience were less likely to do similar. The results suggested that mental health literacy training could help teachers better support students with mental health difficulties.

**Nash & Lopez (2024)** conducted a study “Mental health issues in children: exploring primary school teachers’ experiences, knowledge and training needs.” This study looked at how well Irish primary school teachers understand and handle their students' mental health issues. We surveyed teachers online through two teaching unions. The most common problems teachers saw were anxiety, ADHD, autism, and oppositional defiant disorder. Teachers had different levels of knowledge about these issues and children's mental healthcare. Most hadn't received any formal training but were keen to learn more. They generally had positive attitudes towards helping students with mental health problems. The results show a great opportunity for mental health nurses to step in and provide the needed training and support for these teachers, helping them to better identify and manage mental health issues in their students.

**Granada-Lopez et al. (2023)** studied on “Mental health knowledge and classroom experiences of school teachers in Aragon, Spain.” This study examined the experiences of school teachers in Aragón, Spain, regarding students' mental health issues and their training needs. We surveyed 685 teachers from urban and rural areas in Infant-Primary and Secondary Education-Baccalaureate schools. More than half of the teachers reported dealing with mental health issues such as ADHD, anxiety, conduct disorders,

and autism in their classrooms. Most teachers felt they needed more training to recognize these symptoms and understand the available care resources, with 80% saying they had never received any such training. They preferred training formats that were face-to-face or a mix of online and in-person. Teachers also felt that managing their own mental health was important and should be part of any training. The findings suggest that early identification protocols and teacher self-care could create healthier school environments and reduce stigma.

**Osagiede et al. (2018)** in their work “Teachers’ perceptions of student mental health: The role of school-based mental health services delivery model explored how teachers view student mental health in two different school-based mental health service models: one with on-site therapists and one with community-based therapists. We surveyed 468 teachers from a large school district in the Southeast United States. The study compared how these models affected teachers’ awareness, knowledge, comfort with student mental health, training received, and satisfaction. Teachers with on-site therapists felt more aware and knowledgeable about student mental health but were only comfortable accessing services, not discussing mental health directly with students. The results suggest that having an on-site therapist helps, but teachers also need specific training to better manage and talk about mental health issues with their students.

**Koller et al. (2004)** in their work “Differences between novice and expert teachers’ undergraduate preparation and ratings of importance in the area of children’s mental health” tried to investigate public school teachers are increasingly encountering students with mental health issues, emphasizing the need for evidence-based mental health prevention in schools. This study explored teachers’ awareness of mental health issues and the training they received during their university programs. We surveyed experienced mentor teachers and new teachers. Both groups acknowledged the importance of addressing mental health for teaching success but reported receiving very little formal training in mental health prevention during their studies. These findings highlight the need for better mental health training in teacher education programs to help teachers effectively support their students.

**Ibeziako et al. (2009)** conducted a study on “Teachers’ perspectives of mental health needs in Nigerian schools.” This study looked at educators’ views on children’s mental health needs and the creation of school mental health programs in the South-West

region of Nigeria. Focus group discussions were held with teachers from randomly selected urban and rural primary schools in Ibadan, Nigeria, and the data were analyzed using interpretative phenomenological analysis. Teachers noted significant mental health issues in school-aged children and identified various contributing factors, including lack of support, poverty, spiritual influences, physical illnesses, and genetic factors. Despite teachers lacking knowledge, skills, and resources, schools were seen as ideal places to address children's mental health issues. The study proposed a comprehensive school mental health program that includes teacher training, awareness campaigns, and the provision of necessary resources. The findings provide insight into current efforts to address children's mental health in a low-resource setting and highlight areas for future program development.

The study "Child mental health and service needs in Iraq: beliefs and attitudes of primary school teachers" was conducted in **(2013) by Nelson et al.** to conduct a survey on the attitudes and views of Iraqi primary school teachers about children's behavioural issues and mental health. A closed-ended questionnaire was administered to 148 educators from 10 primary schools in Baghdad to gather their perspectives and insights on the requirements, resources, instructional limitations, and behavioural and mental health concerns of their students. Disruptive activities were identified as the primary worry by most instructors. Seventy percent of teachers emphasized the need for in-service training to identify students with social, emotional, or behavioral problems and to implement effective behavior management strategies. Most teachers had not received any mental health training during their careers. Additionally, there was a lack of awareness about the available school-based mental health services.

A study on "The Development of a School-Based Measure of Child Mental Health" was conducted in **by Deighton et al. (2013)** The implementation of preventative and intervention techniques for child mental health issues in schools depends on the early recognition of such issues. In order to develop a practical mental health and well-being assessment for this scenario, it must be feasible both in terms of logistics and scientific methodology. This study introduces the initial verification of a concise self-assessment instrument for assessing the mental health of children, which is suitable for use with 8-year-old individuals. The two subscales that emerged from component analysis and research of measurement invariance are emotional problems and behavioural concerns.

These two subscales exhibited robust correlations with achievement, deprivation, and educational prerequisites, as well as with pertinent dimensions of the Strengths and Difficulties Questionnaire (SDQ). The relationships observed were similar to those found between these demographic factors and the SDQ. The results suggest that this self-report tool used in schools is reliable and valid. It can be used for mental health surveys, evaluating interventions, and identifying mental health issues in educational settings.

Research by *Houri et al. (2012)* titled "The Mental Health of Adolescent School Children: a Comparison among Japan, Korea, and China" examined the emotional well-being of high school students in these three countries. This study examined the emotional well-being of adolescents in China, South Korea, Japan, and other nations in northeast Asia. The study involved 1,399 third-year middle school students: 632 from Yonago and Tottori in Japan, 377 from Wonju in Korea, and 390 from Changchun in China. Their mental health was assessed using the Ochanomizu University Health Examination. The study encompasses various physical symptoms, eating disorders, melancholy, interpersonal connections, emotions of helplessness, and impulsivity. Additionally, it examines measures of resilience, relationships with loved ones, prior depression, present happiness, and therapeutic assistance. The study revealed that Japanese students encountered greater challenges in establishing interpersonal connections and experienced a heightened sense of helplessness in comparison to their Korean and Chinese counterparts. Chinese students exhibited higher prevalence of depression compared to Korean and Japanese students, while Korean students had more susceptibility to somatic symptoms and impulsivity. Furthermore, a greater percentage of female students compared to male students were part of the demographic experiencing poor mental health. Furthermore, while considering the Resilience Index ratings, female Japanese students ranked the lowest compared to all other categories. Furthermore, students sought direction from their instructors (including club, health, or classroom teachers) for study-related matters and turned to their friends for advice regarding interpersonal interactions with classmates and family.

*Gracious et al. (2007)* made an effort to investigate college students in the Tuticorin region who were aware of mental health issues. In this study, the researcher has opted to collect data through the use of surveys. 250 samples were randomly selected based

on the research conducted by Jagdish and A.K. Srivastava in 1997. The main findings are: i) Male and female college students have significantly different average scores in positive self-evaluation, group-oriented attitudes, and environment mastery. ii) Female and coeducational college students have significantly different average scores in autonomy within the mental health awareness dimension.

A research titled "Illusion and well-being: A social psychological perspective on mental health" was carried out by *Taylor et al. in (2012)*. According to some renowned philosophers, having precise perceptions of oneself, the external environment, and the future is essential for maintaining good mental health. Nevertheless, a substantial amount of research suggests that false optimism, inflated sensations of control or mastery, and excessively high self-evaluations are all inherent aspects of typical human cognition. Moreover, it appears that these delusions contribute to other facets of mental well-being, such as empathy, enjoyment, and the ability to engage in creative and productive activities. These approaches are likely to be effective primarily because negative information is often delivered in a non-threatening manner, while positive information is distorted by filters imposed by the social context and cognitive-processing machinery. When an individual receives unfavourable feedback or experiences any form of threat, these positive illusions can be highly beneficial and flexible.

*Beyer et al. (2012)* undertook four-year longitudinal research to learn more about the course and long-term effects of mental health issues in young children from prekindergarten through elementary school. Longitudinal research spanning four years was conducted to examine the behavioural and emotional challenges experienced by 814 persons from kindergarten to primary school. The Child Behaviour Checklist (CBCL) was employed to evaluate psychological issues. The study found that internalising symptoms were consistent across the four-year course of the CBCL broadband study, but externalising symptoms at the beginning transformed into a mix of internalising and externalising symptoms at the follow-up. At follow-up, the incidence of mental health concerns was found to be associated with gender, especially in boys, as well as previous mental health challenges at baseline and parent separation or divorce. However, mother's age, educational attainment, and single-family status did not show any significant correlation. The increasing occurrence of children exhibiting both

internalising and externalising symptoms during the transition from preschool to school age reflects the intricate nature of children's mental health issues.

*Research by Reinke et al. (2011)* titled "Supporting Children's Mental Health in Schools: Teacher Perceptions of Needs, Roles, and Barriers" examined the perspectives of teachers on these issues. Extensive study has been conducted on the treatment and practices gap in mental health within educational settings. Understanding educators' perspectives can help bridge the gap between research and implementation of school-based mental health interventions. This study aimed to explore educators' views on mental health issues in schools, their current knowledge, skills, training experiences, and needs, as well as the obstacles they face in addressing students' mental health needs in the classroom. A total of 292 instructors from 5 districts participated. According to 89 teachers, school psychologists play a crucial role in most mental health activities at schools, including screening students, conducting behavioral assessments, monitoring progress, and connecting students to resources. Teachers noted that school psychologists were mainly responsible for implementing classroom-based behavioral treatments, even though their role in teaching social and emotional skills was seen as more important.

The study "Mental health status of Japanese-Brazilian children at Brazilian schools in Japan" was conducted by *Kondo et al. in (2010)*. The study sampled 241 children, aged 4 to 10, from five Brazilian schools in Japan. Educators and caretakers used the Strengths and Difficulties Questionnaire to identify potential mental health issues. Demographic information of the children's guardians was also collected to study risk factors for behavioral disorders. Emotional disorders were found in 0.8% of children, conduct disorders in 9.1%, hyperactivity disorders in 2.1%, and any mental disorder in 10.0%. Risk factors for conduct disorders included being male, aged 8 to 10, fatherless, and having infrequent communication with teachers. Behavioral problems were most prevalent in children without a father, both at home and at school.

*The purpose of Yuniarni's (2019)* research was to ascertain how educators felt about the mental health and general wellness of their pupils. This research is qualitative and takes the form of a case study. Interviews and focus groups with seven kindergarten teachers from four different classrooms were used to collect the data. According to the

study's findings, the majority of kindergarten instructors agree that it's important to maintain kids' mental health because happy, excited kids who are ready to participate in school activities, overcome challenges, and exude confidence are all signs of mental health. Every teacher agrees to prioritise the children's well-being since happy, content youngsters enjoy social interactions, are at ease, don't seem uptight, are receptive to new experiences, and can express their emotions in a healthy way. All educators should also be able to provide an example of how to maintain the mental health and wellness of the students in their care. These methods include always being aware of the individual needs of each student, focusing extra attention on those who need it, and assigning enjoyable assignments that encourage students to actively participate in class activities.

*Tyson et al.'s research from (2009)* asked, "Can Implementation of a Resilience Programme for Primary School Children Enhance the Mental Health of Teachers?" This study examined how a plan to improve students' mental health and prevent internalizing problems affected teachers' emotional well-being. Teachers' levels of job-related anxiety and depression were assessed before implementing the Aussie Optimism program, and again at 12 and 24 months. Schools and teachers were randomly assigned to one of three groups: Usual Care (using the standard Western Australian Health Education Curriculum), Aussie Optimism (with teacher training), or Aussie Optimism (with training and coaching for teachers). All groups received social and emotional competence instruction for third and fourth graders. Teachers in the control group received Aussie Optimism training after the first year. Data was collected from 405 elementary school teachers in 63 public schools. Multiple hierarchical regression analyses partially supported the hypotheses. Teachers in the Training and Coaching group reported significantly lower levels of depression at both the 12-month and 24-month assessments, and lower job-related anxiety at 12 months. There was no difference between the Training alone group and the control group after the intervention.

Research by *Furniss et al. (2009)* titled "Impact of life events on child mental health before school entry at age six" The study evaluated how a child's living circumstances influence their mental health before they start formal education. Both the additive and multiplicative impacts of several stressful life events on children's mental health were investigated. In one city in northern Germany, the whole preschool class of one year was

included in the primary school admission exam. The parents of 1,887 children filled out standardized questionnaires to record significant life events and mental health symptoms. From birth through the first day of kindergarten, everything was documented. Almost eighty percent of youngsters had at least one significant incident documented in their lives. There was no correlation between age group or education level and the average number of life events (2.2). There was a strong correlation between the number of life events a kid had and the incidence of mental health problems. Six family-change variables were identified using factor analysis, with the most consistent factors highlighted. The clinical consequences and epidemiology of adverse childhood experiences and psychopathology are significantly aided by the data presented here. It has been proven that a child's mental health is far more affected by the sum of their life events than by any one incident.

Studying the social and mental health correlates of peer victimization in elementary school-aged children, estimating the prevalence of peer victimization, and evaluating the utilization of health care services were the goals of a 2009 study titled "Self Reported Peer Victimization and Child Mental Health: Results of a Cross-Sectional Survey Among French Primary School Children" by *Shojaei et al.* In a large region of France, 91 schools were selected at random, each having 25 kids between the ages of 6 and 11. Parents and children filled out standardised self-report questionnaires (Strengths and Difficulties Questionnaire and Dominic Interactive, respectively) to provide information. There were 91 fundamental questions in the Dominic interactive, and three images showing victimisation situations were included. Three mutually exclusive types of victimisation were considered: fearful of being attacked, fearful of being assaulted, and fearful of being bullied. The results showed that full information was available for 1,274 children (54.4%). More above the usual number of children (21.0%) reported being bullied; 19.6% reported being attacked without fear; and 21.0% reported being worried but not assaulted. Because of their young age (often between 6 and 8 years old) and chronic health problems, bullied children were particularly at risk. The most significant associations were seen between parent-reported issues in peer interactions and self-reported symptoms of anxiety and major depressive disorder. There was no correlation between having easier access to mental health services and becoming a victim (odds ratio = 1.0; 95% confidence range = 0.5-2.1). The majority of

students, excluding those with chronic diseases, experienced victimisation at the hands of their peers throughout their time in school. Students who experienced bullying had a lower likelihood of having access to medical care (odds ratio = 0.3; 95% confidence range = 0.2-0.7). Findings emphasized the importance of public health programs in schools and the role of physicians in identifying at-risk children.

**Chen and others (2009)** Researchers in Taiwan looked at how primary school students' food insecurity affected their physical and emotional health. The study analyzed 18 types of pediatric illnesses, including infections, asthma, nutrition, endocrine and metabolic diseases, mental health, accidents, and poisonings, and their link to food insecurity among children in Taiwan. Using limited NHI data, researchers created three proxies for food insecurity: low birth weight, economic status (poverty vs. non-poor), and time of year (summer vacation vs. school term). They followed 764,526 primary school students in Taiwan to compare ambulatory care visits for these illnesses between children born with low birth weight and those who were not, as well as between impoverished and non-impoverished children. The difference-in-differences approach was used to investigate if a publicly funded lunch program could reduce the negative health impacts of food insecurity on low-income children. Findings showed that children living in poverty had a much higher likelihood of ambulatory visits for mental illnesses, diabetes, iron deficiency anemia, hereditary metabolic diseases, and nutrition-related symptoms. Additionally, children born with low birth weight were at higher risk for endocrine disorders and nutritional deficiencies. The study found that the school lunch program did not significantly reduce the negative health effects of food insecurity. This suggests that a more intensive food program or alternative approaches might be needed to help these children.

The study "Enhancing schools' capacity to support children in poverty: An ecological model of school-based mental health services" was conducted by **Cappella et al. in 2008**. Children living in poverty may benefit from school-based mental health treatments that use schools' innate ability to foster growth and create connections between the home and community ecologies. To focus school-based services in underprivileged areas on promoting learning, They suggest an ecological model influenced by organizational theory and public health. They outline how integrating mental health resources with educational objectives involves prioritising universal

programming, using local school and community resources, and bolstering essential instructional technology. To advance science and raise healthy children, They propose an integrated research-practice method to programme adaption and implementation.

**In 2008, Stormark et al.** conducted study with the title, "Predicting nonresponsive bias from teacher ratings of mental health problems in primary school children." Researchers used a prospective teacher screen to examine the impact of nonresponse on estimates of mental health issues in a community survey of 9,155 children aged 7-9. Of these children, 6,611 had their parents' approval to participate (responders), while 2,544 did not (nonresponders). The teacher screening assessed various functional impairments and mental health symptoms. When calculating nonresponse bias using effect sizes and nonresponse percentages, we found minimal bias for both mean scores and correlations. However, binary logistic regressions showed that students identified by teachers with mental health disorders were less likely to participate, especially those with moderate symptoms. This also included children with severe symptoms of depression, anxiety, irritability, and mania. These findings suggested that metrics based on effect sizes may underestimate nonresponse bias. A logistic regression approach would be more suitable for studies aiming to determine the prevalence of mental health problems in children.

A study by **Liu et al. in 2005** examined the mental health of only children in China, focusing on both urban and rural high school students. This study is particularly relevant in China due to the "one-child policy." The sample included 299 students from a rural high school in Qing a Man and 333 students from an urban high school in Harbin, both in Heilongjiang Sheng Province, with an average age of 17.2 years. The findings showed that urban only children had higher levels of trait anxiety, perceived stress, neurotic and social melancholy, and interpersonal dependence, along with lower levels of familial affection, compared to urban non-only children. There were no significant differences in mental health between rural only children and non-only children. The study also found that low levels of affection from peers and parents were linked to higher rates of negative mental health issues in the children. This lack of affection increased perceived stress, and the analysis showed that this stress contributed to poor mental health.

Study results were published in the journal *Child Psychiatry* by **Kashala et al. (2005)** under the title "Mental health ratings by teachers among schoolchildren in Kinshasa, Democratic Republic of the Congo." In Kinshasa, researchers piloted the Strengths and Difficulties Questionnaire (SDQ) to find links between mental health problems and factors such as education level, age, and eating habits. They randomly selected 1,187 schoolchildren, ages seven to nine, for the study. Teachers used the SDQ, a behavioral screening tool, to assess mental health concerns. The reliability of the SDQ's structure was examined using principal component factor analysis, and the internal consistency of the scales was measured. The analysis revealed five subscales consistent with previous SDQ findings, and the SDQ showed good internal consistency overall. The 90th percentile cutoff scores were slightly higher than the standard values for this younger group. The study found that poor nutrition, low socioeconomic status, and illness were linked to a higher risk of mental health problems and lower academic performance.

A research titled "Different measures, different informants, same outcomes?" was carried out by **Katherine et al. in 2005**. This study examines the mental health of elementary school students using data from the KidsMatter mental health initiative in 100 primary schools across Australia. About 4,900 parents/caregivers and teachers filled out the Strengths and Difficulties Questionnaire (SDQ) to evaluate children's mental health. Additionally, the Flinders Student Competencies Scale (SCS) was used to measure students' social awareness, relationship skills, responsible decision-making, optimism, and problem-solving abilities. Teachers and school leaders identified students "at risk" of social, emotional, or behavioral issues through a non-clinical evaluation. The findings show significant correlations between the three measures of student mental health.

**A 2003 study by Witt et al. (2003)** examined "The role of socio-demographics, functional limitations, family burdens, and care coordination in the use of mental health services among school-aged children with disabilities." This study investigated the use of mental health services and related factors among disabled children aged 6 to 17. The data came from the National Health Interview Survey Disability Supplements (NHIS-D) from 1994 and 1995, covering 4,939 disabled children, representing eight million disabled children in the country. The analysis showed that poor psychosocial adjustment, communication and social interaction impairments, learning disabilities,

public health insurance, and family financial constraints were linked to higher service usage. Children with disabilities were more likely to access outpatient mental health services when both a family member and a health professional collaborated on their care, compared to when a health professional worked alone. Race and family burden did not affect the likelihood of receiving mental health counseling in special education settings, unlike inpatient and outpatient treatment. Only two out of five disabled children with poor psychosocial adjustment received mental health care. The study highlights the importance of involving families and medical professionals in coordinating care to improve access to mental health services for disabled children.

The study "Mental health, locus of control, and self-esteem of young children in two contrasted schools" was conducted by *Alles-Jardel et al. in 2002*. Researchers presented the findings of two comparative studies. In the first study, a Preparatory Class (average age of 6) from a school in a Priority Education Zone (ZEP) in the Provence-Alpes-Côte d'Azur region is compared to two other groups of students. The 24 subjects were selected based on how well each one adjusted to school and how well they learned overall, especially how to read. In second research, conducted in Corsica, we compared two groups of twenty kids based on whether or not they attended a school located in a ZEP. We considered the child's individual factors in both studies: self-esteem, locus of control, and mental health, all of which we believe are strongly linked to social and educational integration. The "Dominique" questionnaire, developed by Dr. Valla in Quebec, is used to evaluate mental health on paper (Valla al., 1994; 1997).

*Stein et al. 2002*, entitled "Theoretical basis and programme design of a school-based mental health intervention for traumatized immigrant children: A collaborative research partnership," examined this issue. This report proposes a collaborative research model for school-based mental health treatment for recently immigrated children with violence-related mental health symptoms. It outlines the creation, testing, and implementation of the Mental Health for Immigrants Programme (MHIP). The model emphasizes a partnership between academia and the community. The report discusses challenges faced and provides examples of how a participatory research partnership can work together through all stages, from design to implementation and assessment, to meet community needs and generate useful information for others. It also addresses the challenges and limitations of collaborative research and the role of

participatory research in developing and evaluating school-based mental health services.

For their 2002 study "Classroom Climate and the Mental Health of Primary School Children," *Dellas et al.* This study aimed to determine if second-grade students with emotional and behavioral difficulties were more affected by a negative classroom environment four years later. Teachers completed questionnaires for 861 students in the second grade (aged 8) and again in the sixth grade (aged 12). The Rutter Teacher Questionnaire (RB2) was used in the second grade, and the Teacher Report Form (TRF) was used in the sixth grade to measure internalizing, externalizing, and overall problem scores. At Time 2, a composite variable measured the classroom atmosphere. The findings show that a negative school environment in the sixth grade is linked to increased emotional and behavioral issues in both boys and girls. Sixth-grade girls, especially those with externalizing issues in the second grade, were particularly vulnerable to a hostile learning environment.

*Somersalo et al. (2002)* studied on "Classroom climate and the mental health of primary school children." This research examined the link between primary school students' mental health and the classroom environment. It also investigated whether second-grade students with emotional and behavioral issues were more affected by a negative classroom environment four years later. Teachers completed questionnaires for 861 students in the second grade (aged 8) and again in the sixth grade (aged 12). The Rutter Teacher Questionnaire (RB2) was used in the second grade, and the Teacher Report Form (TRF) was used in the sixth grade to measure internalizing, externalizing, and overall problem scores. At Time 2, a composite variable measured the classroom atmosphere. The findings showed that a negative school environment in the sixth grade is linked to increased behavioral and emotional issues in both boys and girls. Sixth-grade girls, especially those with externalizing issues in the second grade, were particularly vulnerable to a hostile classroom environment.

*Spomer and Cowen* compared the characteristics of young English- and Spanish-speaking children referred to mental health services at their respective schools in 2001. This study compared the school adjustment of students referred to school mental health services, focusing on those who were English as a Second Language (ESL) learners and

those who were not. Both groups were predominantly Hispanic. The Teacher-Child Rating Scale (T-CRS) and the Child Rating Scale (CRS) were used to assess total, factor, and item scores related to school adjustment. Teachers perceived ESL students as less impulsive, more shy/anxious, and having learning difficulties compared to non-ESL students. ESL students were also seen as less competent in general, particularly in assertive social skills and peer social skills, but they were found to be more tolerant of frustration. Factor analyses of the T-CRS for both ESL and non-ESL students validated the component structure previously found in non-referred, English-speaking children. However, for ESL students, a factor analysis of the CRS revealed an extended anxiety component, which included three additional peer-sociality items.

**Christina M. Cruz et al. (2021)** In their study "Perceptions, Attitudes, and Knowledge of Teachers Serving as Mental Health Lay Counsellors in a Low- and Middle-Income Country: A Mixed Methods Pragmatic Pilot Study," used semi-structured interviews along with study-specific assessments to measure teachers' perceptions of serving as lay counsellors and their attitudes towards mental health. Paired t-tests were used to compare average scores before, during, and after the training. Post-intervention interviews coded teachers' attitudes towards mental health, their experience level, and their views on being lay counsellors. Teachers interviewed showed a greater inclination towards inclusivity in their mental health attitudes and were willing to serve as lay counsellors, retaining relevant mental health information for teaching. Survey results showed a significant shift towards inclusivity before and after training, but attitudes reverted to initial levels after the intervention. There was no change in teachers' understanding of mental health counselling on the quantitative measure, both before and after training or intervention.

In 2018 and 2019, **Spichak et al. (2020)** conducted research in Moscow involving 250 children from 12 kindergartens and 200 students from 3 primary schools. The children were divided into two groups based on their daily online time: a control group with a maximum of fifteen minutes and an experimental group with unrestricted online activity. The study included four groups in total. The research examined the dynamics of aggression and performance indicators, specifically the average score. Parents completed a questionnaire, and during the second academic year, both parents and children attended lectures from instructors and psychologists. The findings showed a

correlation between parents' deceptive behavior and children's excessive internet use, leading to increased aggression in children. The study confirmed that combined efforts from psychologists, parents, and children reduced aggression and improved mental well-being. Children in the control groups showed a faster decrease in aggression, with an average rate 1.4 to 1.6 times higher than the experimental groups (1.2 times,  $p < 0.05$ ). Lack of parental monitoring was linked to increased hostility and excessive internet use in children. The experimental group had 1.5 to 1.7 times more children displaying angry behavior compared to the control group ( $p < 0.01$ ). This trend was also observed in the parent survey. The experimental group showed a higher level of significance (0.5 to 0.7 times,  $p < 0.05$ ) for both collaboration in aggression and aggressive responses to communication with instructors.

### 2.2.3 Matrix of Literature Review

**Table 2.1 Showing matrix of literature review**

<b>Authors Name</b>	<b>Year</b>	<b>Objectives</b>	<b>Findings</b>
Ma & Anto	2022	To understand teachers' awareness of mental health in Kerala.	23% recognized mental health symptoms; 18% identified depression; 54% would talk to students; 2% would refer to professionals.
Tolan & Dodge	2005	Emphasize the importance of mental health for children's well-being.	Four areas of focus: access to services, prevention, targeted interventions, and promotion of mental health.
Prabhu	1987	Highlight obstacles in child and adolescent mental health in India.	Noted underfunding, obstacles, and a 66 per 1,000 prevalence rate of emotional difficulties.
Raman & Thomas	2023	Explore roles in ensuring mental health care for children and adolescents.	Highlighted the importance of resources and cooperation among various stakeholders.

Kulkarni et al.	2019	Assess attitudes and knowledge of primary school teachers about mental illness.	Greater knowledge reduces stigma; significant differences in knowledge and attitudes between urban and rural teachers.
Venkataraman et al.	2019	Discuss prevalence and management of mental illnesses among adolescents.	Emphasized teachers' role in recognizing early indicators of mental illness in students.
Vasuki & Kanakaraj	2012	Examine emotional intelligence and mental health of aspiring teachers.	Found no discernible relationship between emotional intelligence and mental health.
Basu	2011	Find out how teaching effectiveness impacts the mental health of primary school teachers.	Effective teachers had significantly better mental health than less effective counterparts.
Sood & Anand	2011	Investigate how emotional competency affects students' mental health.	Found a positive and substantial relationship between health and emotional competence.
Somasundaram & Gowri	2011	Assess mental health of teenage students in Tamilnadu.	Majority had average mental health; some groups had better mental health than the general population.
Deb & Arora	2011	Examine mental health and resilience among students preparing for exams.	Found higher resilience in males and better mental health in high resilience students.
Pathajay & Mulchopadhyay	2010	Compare mental health among normal, at-risk, and vulnerable adolescents.	Significant differences in mental health domains among groups.

Thamodharan	2009	Investigate mental health and academic achievement among higher secondary students.	No significant difference in mental health based on gender, income, or location.
Kaur	2018	Determine ADHD awareness among primary school teachers.	Found inadequate knowledge about ADHD among teachers.
Perumal	2008	Investigate mental health of VIII Standard students and its link to locus of control.	Majority of students did not have good mental health; no discernible relationship with locus of control.
Khan & Srivastava	2008	Ascertain the effect of mental health on burnout among teachers.	High variation in mental health based on various factors; burnout linked to mental health.
Srividhya	2007	Investigate mental health and adjustment issues among state and central school students.	Majority had ordinary mental health; significant differences among various groups.
Ravindrana dan	2006	Study mental health, quality of life, and emotional intelligence of parents of special needs children.	Significant differences in mental health between parents of special needs and typical children.
Shanker & Jabaraj	2006	Investigate mental health of tsunami-affected teenage orphans.	Poor mental health among affected orphans; strong correlation with academic success.
Jeba	2005	Determine disparities in teaching ability and mental health among	Found a link between teaching competence and mental health.

		student teachers.	
Srivastava	2004	Compare the mental health and personality adjustment of optimistic students to those of pessimistic students.	Significant differences in personality adjustment between optimistic and pessimistic students.
Sarita et al.	2015	Investigate mental health among private and public senior secondary school students.	Significant differences in mental health between genders and types of schools.
Farahbakhs h	2004	Compare mental health of secondary school principals based on occupational variables.	No significant change in mental health scores based on number of teachers.
Ojiha	2002	Examine mental health and social anxiety of normal and physically challenged adolescents.	No discernible difference in mental health between groups.
Dharanendr appa & Ningamma	2002	Discuss importance of mental health and emotional intelligence in learning process.	Importance of mental health and emotional intelligence for better adjustment and academic success.
Kumari & Kumar	2022	Discuss challenges related to mental health in India and the need for awareness.	Highlighted various challenges and the importance of prevention and treatment.
Swapnajaid upally	2015	Explain how schools can help in children's emotional growth.	Emphasized the role of schools in children's mental health development.
Singh	2020	Discuss integration of mental health and education in schools.	Advocated for integrated health policies in education systems.

Rani et al.	2012	Determine mental health status of teachers based on school type and gender.	Found ordinary mental health among teachers; no significant differences between genders or school types.
Sharma et al.	2014	Investigate the relationship between mental health and educational setting among teenagers.	Found significant impact of school environment on students' mental health.
Bartwal	2014	Compare mental health and social intelligence among senior secondary students.	No significant disparities in mental health between rural and urban students.
Bhola & Kapur	2003	Highlight the importance of epidemiological data in child mental health.	Found significant methodological flaws in epidemiological surveys.
Sharan et al.	2007	Discuss mental health policy for children and adolescents in developing countries.	Highlighted the need for comprehensive mental health services and policies.
Arumugam & Neelima	2019	Investigate mental health of primary school teachers based on gender and location.	Found differences in mental health based on various factors.
Kamel et al.	2020	Understand beliefs about student mental health among teachers in Saudi Arabia.	Found positive attitudes but low awareness; highlighted the need for training and resources.
Mahmoud et al.	2018	Assess impact of awareness program on teachers' knowledge of mental disorders.	Significant improvements in knowledge after awareness program.

Kerebih et al.	2018	Understand teachers' perception of child mental health problems in Ethiopia.	Found low recognition of mental health issues; highlighted the need for school-based programs.
Shateri et al.	2019	Examine the relationship between mental health and spiritual intelligence among teachers.	Found a strong connection; suggested boosting spiritual intelligence for better mental health.
Maclean & Law	2022	Explore challenges Scottish teachers face in supporting children's mental health.	Highlighted need for better professional development and training.
Bella et al.	2011	Understand perceptions of child mental health among Nigerian teachers.	Found significant gaps in knowledge and attitudes; suggested including CAMH in teacher education.
Gorsy et al.	2015	Examine mental health among government school teachers.	Found better mental health in male and urban teachers; highlighted impact of socio-economic conditions.
Shelemy et al.	2019	Investigate mental health training needs of UK secondary school teachers.	Emphasized need for practical, hands-on training and resources.
Bryer & Signorini	2011	Investigate pre-service teachers' understanding of students' internalizing problems.	Found inconsistent exposure and limited preparation during training.
Mbwayo et al.	2020	Explore teachers' perspectives on mental health in Kenyan schools.	Found various challenges and highlighted need for in-service training and school psychologists.

Glazzard & Rose	2020	Examine impact of teacher well-being on student progress.	Found stress triggers and emphasized importance of supporting teacher well-being.
Ni Chorcora & Swords	2022	Assess mental health literacy of Irish primary school teachers.	Found good recognition of issues; suggested need for mental health literacy training.
Nash & Lopez	2024	Explore experiences and training needs of Irish primary school teachers.	Found common issues; highlighted opportunity for mental health nurse involvement.
Granada-Lopez et al.	2023	Examine the mental health knowledge and experiences of teachers in Spain.	Found high need for training; suggested early identification protocols and self-care.
Osagiede et al.	2018	Explore teachers' perceptions of student mental health in different service models.	Found better awareness with on-site therapists; suggested need for specific training.
Koller et al.	2004	Investigate differences in mental health training between novice and expert teachers.	Found need for better mental health training in teacher education programs.
Ibeziako et al.	2009	Examine mental health needs and program establishment in Nigerian schools.	Found notable issues and proposed comprehensive school mental health program.
Nelson et al.	2013	Survey attitudes of Iraqi teachers about child mental health.	Found disruptive actions as top concern; highlighted need for in-service training.
Deighton et al.	2013	Develop a school-based measure of child mental health.	Validated a short self-report tool for child mental health.

Houri et al.	2012	Compare mental health of adolescents in Japan, Korea, and China.	Found different challenges in each country; emphasized need for counselling support.
Gracious et al.	2007	Investigate mental health awareness among college students.	Found significant differences in various areas of mental health awareness.
Taylor et al.	2012	Explore social psychological perspective on mental health.	Found that positive illusions support mental wellness.
Beyer et al.	2012	Study the course and effects of mental health issues in young children.	Found stability of symptoms and factors linked with mental health concerns.
Reinke et al.	2011	Examine teachers' perceptions of mental health needs and the barriers they face.	Found need for better training and resources to meet mental health care needs.
Kondo et al.	2010	Evaluate the mental health of Japanese-Brazilian children living in Japan.	Found various mental health issues and identified risk factors.
Yuniarni	2019	Ascertain educators' views on children's mental health and well-being.	Found consensus on importance and provided examples of maintaining mental health.
Tyson et al.	2009	Examine impact of resilience program on teachers' mental health.	Found significant reduction in depression and anxiety in intervention group.
Furniss et al.	2009	Assess the impact of life events on children's mental health before they start school.	Found strong correlation between life events and mental health problems.

Shojaei et al.	2009	Study peer victimization and child mental health in French schools.	Found high prevalence of victimization and significant mental health impacts.
Chen et al.	2009	Investigate impact of food insecurity on health of Taiwanese children.	Found significant health issues linked to poverty and low birth weight.
Cappella et al.	2008	Propose an ecological model for school-based mental health services.	Suggested integrating mental health resources with educational objectives.
Stormark et al.	2008	Examine impact of non-response bias in teacher ratings of child mental health.	Found bias underestimated; logistic regression more appropriate for frequency estimation.
Liu et al.	2005	Compare mental health of only children in urban and rural China.	Found higher levels of anxiety and perceived stress in urban only-children.
Kashala et al.	2005	Pilot SDQ and link mental health issues to factors in Kinshasa.	Found high prevalence of mental health issues linked to poor nutrition and low SES.
Katherine et al.	2005	Examine mental health of elementary school students using different measures.	Found substantial correlations between student mental health variables.
Witt et al.	2003	Investigate mental health service use among disabled children.	Found higher access to services with family and professional involvement.
Alles-Jardel et al.	2002	Compare mental health of children in different educational settings.	Found strong link between mental health, self-esteem, and locus of control.
Stein et al.	2002	Propose a model for school-based mental	Emphasized participatory research in program

		health intervention for immigrant children.	development and evaluation.
Dellas et al.	2002	Study impact of classroom climate on mental health of children.	Found significant impact of negative classroom environment on emotional and behavioral issues.
Somersalo et al.	2002	Examine relationship between classroom climate and mental health.	Found negative classroom environment linked to increased behavioral and emotional issues.
Spomer & Cowen	2001	Compare characteristics of ESL and non-ESL students referred to mental health services.	Found significant differences in school adjustment and social skills.
Cruz et al.	2021	Assess teachers' perceptions of serving as mental health lay counsellors.	Found increased inclusive attitudes and readiness to act as lay counsellors.
Spichak et al.	2020	Study impact of internet use on aggression and mental health in children.	Found parental supervision and collaboration reduced aggression and improved mental health.

### 2.3 Statement of the Problem

The researcher examined a limited number of scholarly publications on the origins, presence, and remedies for mental health issues among various demographic groups. Additionally, the researcher reviewed studies on teachers' perspectives regarding the mental health of children. This exploration prompted the researcher to delve further into the assessment of teachers' awareness of child mental health using diverse criteria. The researcher was unable to find a study that provided substantial evidence about instructors' perception of child mental health based on empirical data. While there have been many theoretical explanations proposing the presence of mental health issues in

emerging nations, especially in the undeveloped areas of these nations, there is still a dearth of actual evidence to support these claims. Prior scholars have undertaken thorough investigations on both teachers and staff at higher education institutions, such as colleges and universities. However, the field of school education remained completely unexplored. Given the current demand for teachers' responsibilities and the necessity for a modern school education system, this endeavor is of utmost importance. Consequently, the researcher proceeded to perform a study on the topic of teachers' perception of child mental health. The researcher has discovered a significant disparity in the understanding and application of child mental health awareness among primary school teachers in West Bengal. Through the researcher's examination and evaluation of the current literature, the following research questions on the present study were identified as –

- 1) Do the primary teachers of West Bengal have adequate awareness on child mental health?
- 2) How do different socio-demographic factors result in variation on primary teacher's awareness of child mental health at West Bengal?

In search of the suitable answers of above-mentioned research questions, the researcher framed and stated the problem of the study as - ***“PRIMARY TEACHERS' AWARENESS OF CHILDREN'S MENTAL HEALTH”***.

#### **2.4 Delimitations of the study**

Current study was delimited to followings:

- i. The present study was delimited to only ten districts of West Bengal i.e., Purba Bardhaman, Paschim Bardhaman, Hooghly, Kolkata, Bankura, Paschim Medinipur, North 24 PGS., South 24 PGS., Nadia and Birbhum.
- ii. The study was restricted to 550 primary school teachers only.
- iii. Demographic characteristics were delimited to gender, type of institution, mental health related training, habitation, medium of instruction, highest educational qualification, social category and teaching experience only.

## 2.5 Objectives of the study

The study generated objectives based on the research questions and study delimitations. The objectives are as follows:

- i. To determine the level of awareness regarding child mental health among primary teachers in West Bengal.
- ii. To understand the present state of awareness possessed by the primary teachers of West Bengal on child mental health.
- iii. To explore the difference in various dimension of primary teachers' awareness of children mental health based on various independent indicators i.e, gender, type of institution, mental health related training, habitation, medium of instruction, highest educational qualification, social category.
- iv. To investigate the variation of various independent indicators viz; gender, type of institution, mental health related training, habitation, medium of instruction, highest educational qualification, social category of primary teachers on their perception of child mental health.
- v. To examine the correlation between teacher's teaching experience and their perception of child mental health.

## 2.6 Hypotheses of the study

Based on objectives, the researcher formulated the null hypotheses as -

**H<sub>01</sub>:** There is no significance difference in perception of teachers on child mental health with respect to their gender.

**H<sub>02</sub>:** There is no significance difference in perception of teachers on child mental health with respect to types of institutions.

**H<sub>03</sub>:** There is no significance difference in perception of teachers on child mental health with respect to mental health related training.

**H<sub>04</sub>:** There is no significance difference in perception of teachers on child mental health with respect to their habitation.

**H<sub>05</sub>:** There is no significance difference in perception of teachers on child mental health with respect to their medium of instruction.

**H<sub>06</sub>:** There is no significance difference in perception of teachers on child mental health with respect to their highest educational qualification.

**H<sub>07</sub>:** There is no significance difference in perception of teachers on child mental health with respect to their social categories.

**H<sub>08</sub>:** There is no significance correlation between perception of teachers on child mental health and their teaching experience.

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**CHAPTER - III**  
**METHOD AND PROCEDURE**  
**OF STUDY**

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## CHAPTER III

### METHOD AND PROCEDURE OF STUDY

The efficacy of every research endeavor hinges on the meticulousness of its method. Due to the distinct nature of each problem, it is essential to choose an appropriate methodology that aligns with the specific characteristics of the problem. In this chapter, the researcher provides an outline of the research design, which is divided into two parts. One section of this chapter included the study's design, sample, demographic, variables, and data collection instrument. The second section outlines the general technique for collecting data.

#### 3.1 Method

Research methods refer to the systematic techniques employed to collect, analyze, and evaluate data within a study. An explicitly stated research methodology is essential for upholding rigor and credibility. It offers a well-organized framework that assists researchers in the methodical gathering of data and improves the ability to replicate the study. Mixed techniques, which involve the integration of qualitative and quantitative approaches, are frequently utilized to achieve a more thorough comprehension of the research issue. The choice of a research methodology is closely linked to the philosophical foundations of the study, determining whether the research tends towards objectivity, subjectivity, or critical reflection. In essence, a meticulously selected and implemented research methodology enhances the internal and external validity of the study, therefore influencing the entire research process and furthering our understanding of the world.

The current study was an attempt to understand the perception of West Bengal's primary school teachers on children's mental health. In order to achieve the purpose, the research has conducted a concentrated survey upon primary school teachers at West Bengal.

##### 3.1.1 Study Design

Study design is the systematic framework or outline that delineates the methodologies and protocols for carrying out research. It refers to the comprehensive approach used to tackle research topics or hypotheses. The design of a study plays a crucial role in determining the methods used to collect, analyze, and interpret data, ultimately impacting the reliability and validity of the study. The selection of study design is

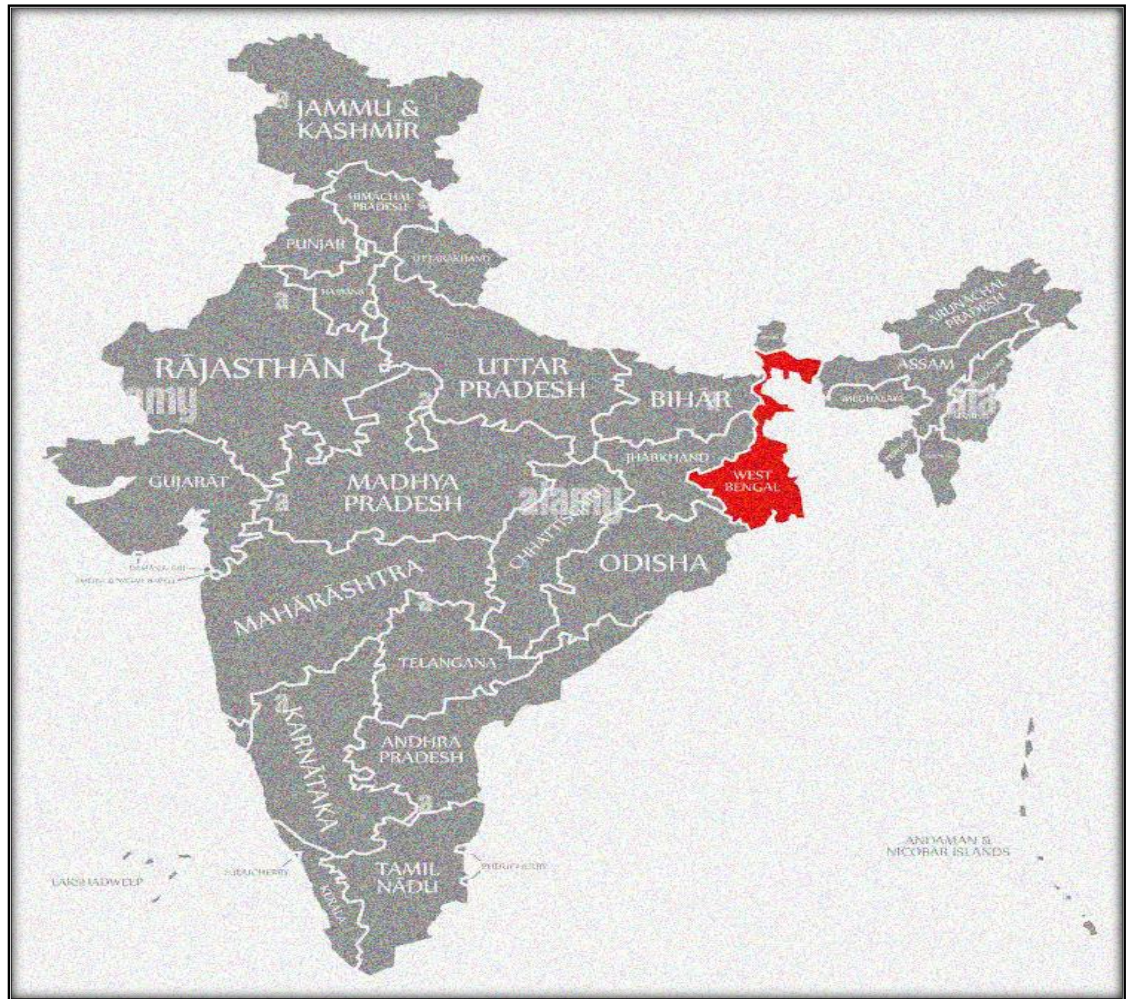
contingent upon the nature of the research question and the intended results, guaranteeing a methodical and meticulous approach to the production of information.

The researcher utilized a cross-sectional survey methodology to gather quantitative data through the administration of a questionnaire. A cross-sectional survey is a research methodology that gathers data from participants at a certain moment in time. It offers a concise representation of a population, analyzing certain variables of relevance at a given moment. This survey methodology is valuable for examining the prevalence, patterns, and relationships among a population. The researcher employed statistical analysis to evaluate the hypothesis and characterize the characteristics of the population.

### **3.1.2 Population**

In the context of study, the phrase "population" encompasses the whole group of people; objects, or events that the researcher intends to investigate. It encompasses the broader population that the study's results will be applied to. The researcher has considered all the primary school teachers of West Bengal as the population for this study. According to the records of the government, approx. 300,000 teachers are currently employed at primary schools in West Bengal. Through the following map, the location of the population area is presented, given in figure 3.1 –

**Figure 3.1** Showing population area of study as West Bengal



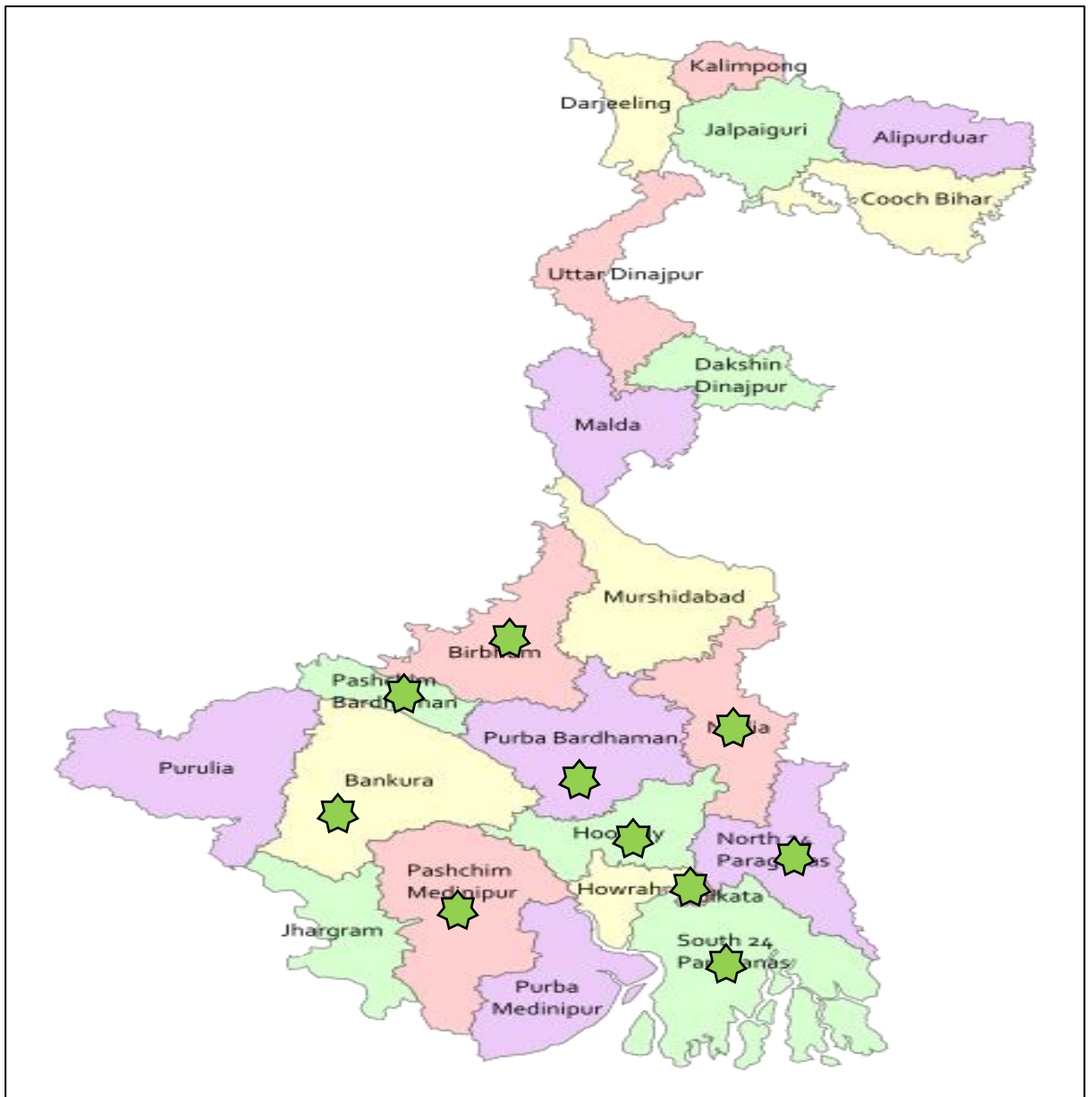
Retrieve from <https://www.alamy.com/west-bengal-red-highlighted-in-map-of-india>.

### ● Showing population area of study as West Bengal

#### 3.1.3 Sample

A sample refers to a smaller group of individuals, items, or elements that are chosen from a larger population in order to accurately represent it in research. Owing to limitations such as resource availability and ease of access, the researcher often examines a subset of the population instead than the full population. A total number of 550 teachers, who were employed in primary schools in the West Bengal, were taken as the sample of the study.

Figure 3.2 Showing sampling area of study



★ Showing sampling area of study

**Table 3.1 Representing district wise sample distribution**

District	Frequency (N)	Percentage (%)
Purba Bardhaman	61	11.09%
Paschim Bardhaman	46	8.36%
Hooghly	56	10.18%
Kolkata	53	9.63%
Bankura	46	8.36%
Paschim Medinipur	69	10.73%
North 24 PGS.	58	10.55%
South 24 PGS.	52	9.45%
Nadia	58	10.55%
Birbhum	51	9.27%
Total	550	100%

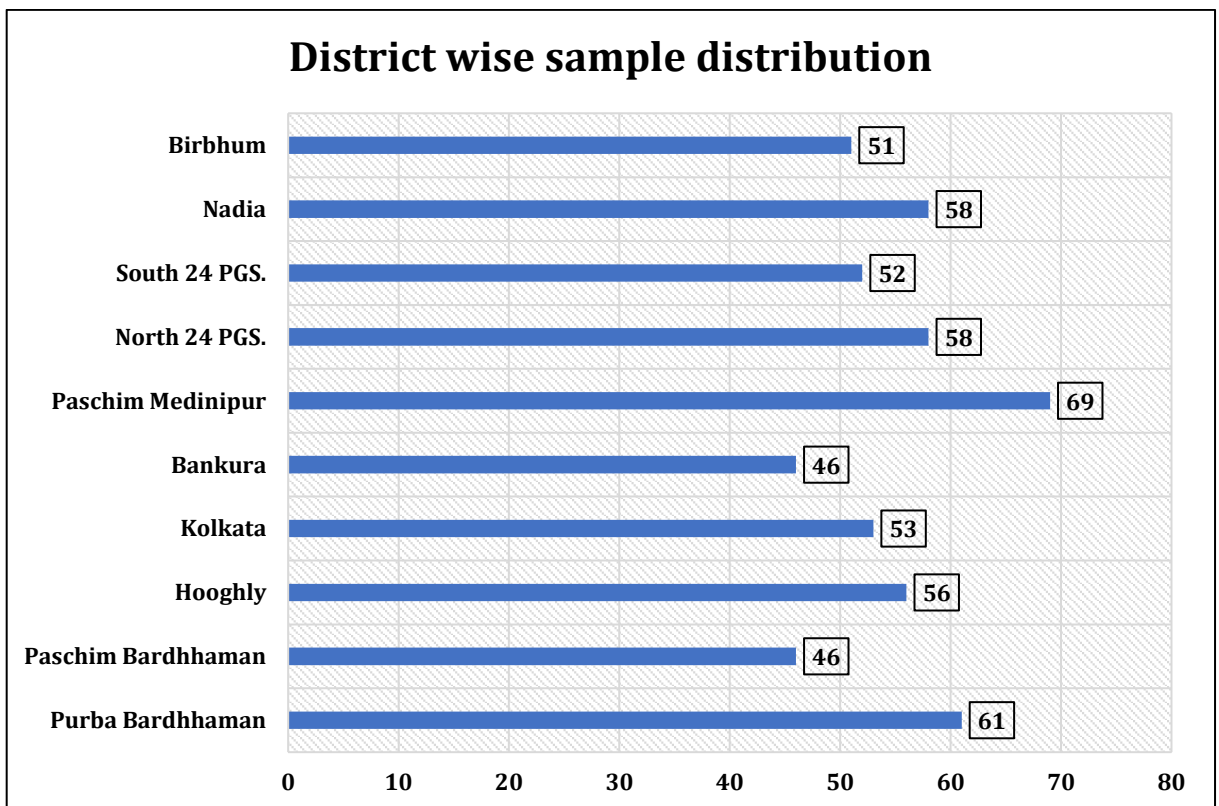
**Figure 3.3 Showing district wise sample distribution**

Figure 3.3 presented district wise sample distribution. Out of 550 samples 61 samples were drawn from Purba Bardhaman district, which was approx. 11.09 percentage of total percentage. 46 samples were drawn from Paschim Bardhaman district, which was approx. 8.36 percentage of total percentage. 56 samples were drawn from Hooghly district, which was approx. 10.18 percentage of total percentage. 53 samples were drawn from Kolkata district, which was approx. 9.63 percentage of total percentage. 56 samples were drawn from Hooghly district, which was approx. 10.18 percentage of total percentage. 46 samples were drawn from Bankura district, which was approx. 8.36 percentage of total percentage. 69 samples were drawn from Paschim Medinipur district, which was approx. 10.73 percentage of total percentage. 58 samples were drawn from North 24 PGS. district, which was approx. 10.55 percentage of total percentage. 52 samples were drawn from South 24 PGS. district, which was approx. 9.45 percentage of total percentage. 58 samples were drawn from Nadia district, which was approx. 10.55 percentage of total percentage. 51 samples were drawn from Birbhum district, which was approx. 9.27 percentage of total percentage.

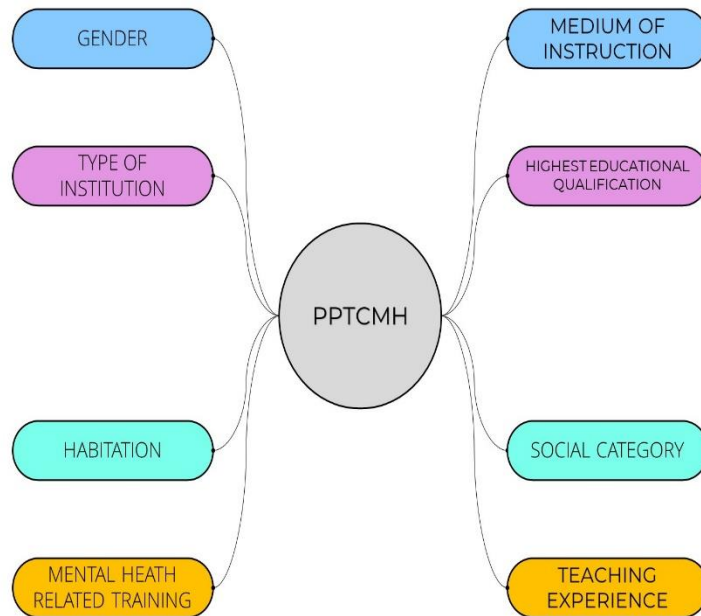
#### 3.1.4 Variables

Variables in a study refer to the factors or characteristics that are measured, manipulated, or controlled. Variables are entities that researchers can observe, measure, or manipulate in their studies. In the resent study the following variables were identified and used:

- A. Independent Variables:** These factors are intentionally manipulated or controlled by researchers to observe their impact on other variables. They are alternatively referred to as predictor variables or explanatory variables. In this study, the independent factors have been identified based on previous research. The following items are provided:
- i. **Gender:** Gender was categorized in two categories as Male and Female.
  - ii. **Type of institution:** Type of institution was categorized in two categories as Government and Private.
  - iii. **Habitation:** Habitation was categorized in three categories as Rural, Urban and Semi-Urban.
  - iv. **Mental health related training:** Mental health related training was categorized in two categories as trained and non-trained.

- v. **Medium of instruction:** Medium of instruction was categorized in three categories as Bengali, English and Both.
- vi. **Highest Educational qualification:** Highest educational qualification was categorized in five categories as Higher Secondary, Bachelor Degree, Master degree, Master of Philosophy and Doctor of Philosophy.
- vii. **Social Category:** Social category was categorized in four categories as General, Scheduled Caste, Scheduled tribe and Other Backward Classes.
- viii. **Teaching experience:** Teaching experience has taken as the continuous variable in the study.

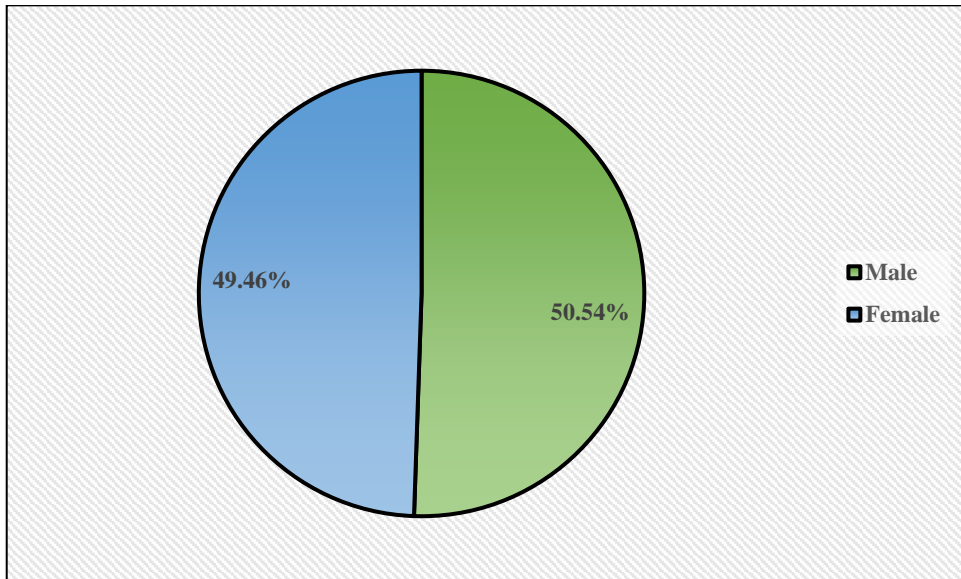
**B. Dependent Variable:** These variables are measured or observed to ascertain the outcome or impact of the independent variables. They are alternatively referred to as end variables or response variables. In the present study **perception of Primary school teachers on children's mental health** was considered as dependent variable.

**Figure 3.4** Showing the variable interaction**Table 3.2** Showing variable wise the sample distribution

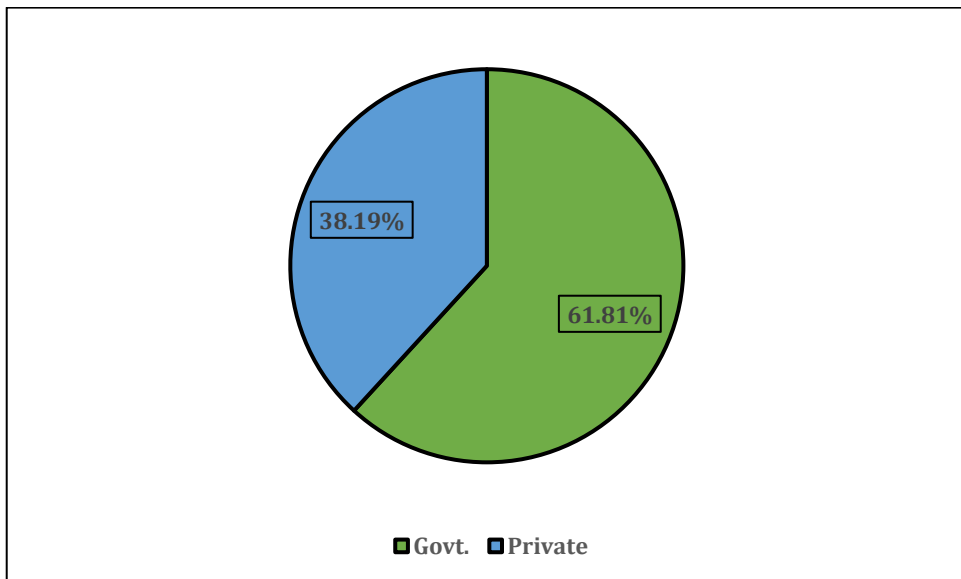
Variable	Category	Frequency (N)	Percentage (%)
<b>Gender</b>	Male	278	50.54%
	Female	272	49.46%
	Total	550	100%
<b>Type of institution</b>	Govt.	340	61.81%
	Private	210	38.19%
	Total	550	100%
<b>Habitation</b>	Rural	188	34.18%
	Urban	136	25.09%
	Semi-Urban	226	41.09%
	Total	550	100%
<b>Mental health related training</b>	Trained	224	40.73%
	Non-trained	326	59.27%

	Total	550	100%
<b>Medium of Instruction</b>	Bengali	336	61.09%
	English	98	17.82%
	Both	116	21.09%
	Total	550	100%
<b>Highest educational qualification</b>	Higher Secondary	71	12.91%
	Bachelor Degree	206	37.45%
	Master Degree	246	44.73%
	Master of Philosophy	24	4.36%
	Doctor of Philosophy	3	0.55%
	Total	550	100%
<b>Social category</b>	General	349	63.45%
	Scheduled Caste	134	24.36%
	Scheduled Tribe	24	4.36%
	Other Backward Classes	43	7.82%
	Total	550	100%
<b>Teaching experience</b>	Total	550	100%

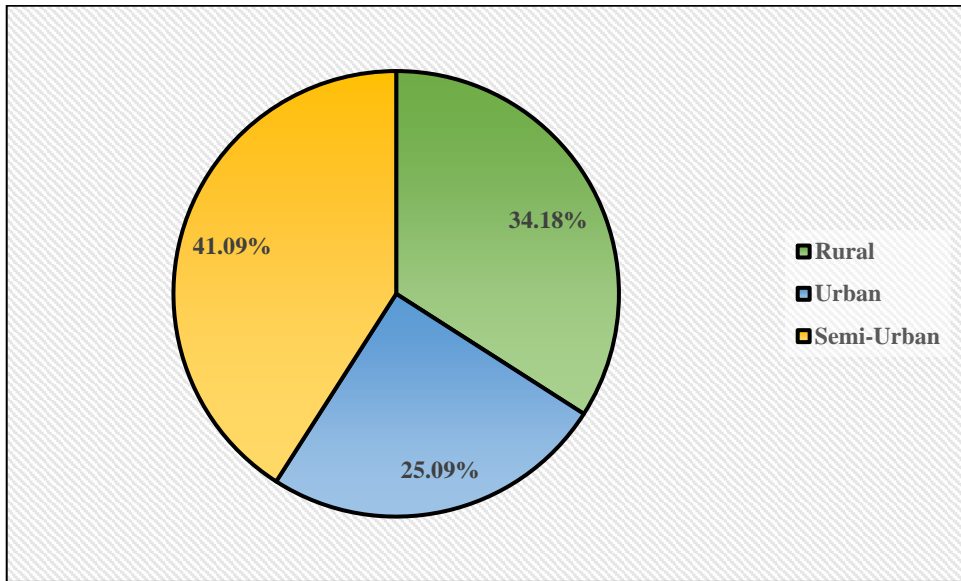
**Figure 3.5** Showing gender wise sample distribution



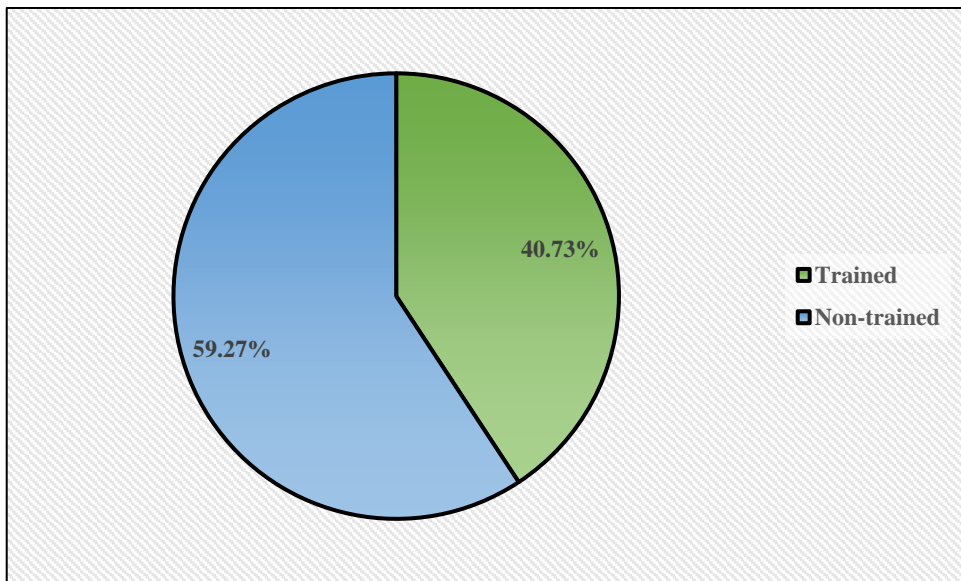
**Figure 3.6** Showing Type of institution wise sample distribution



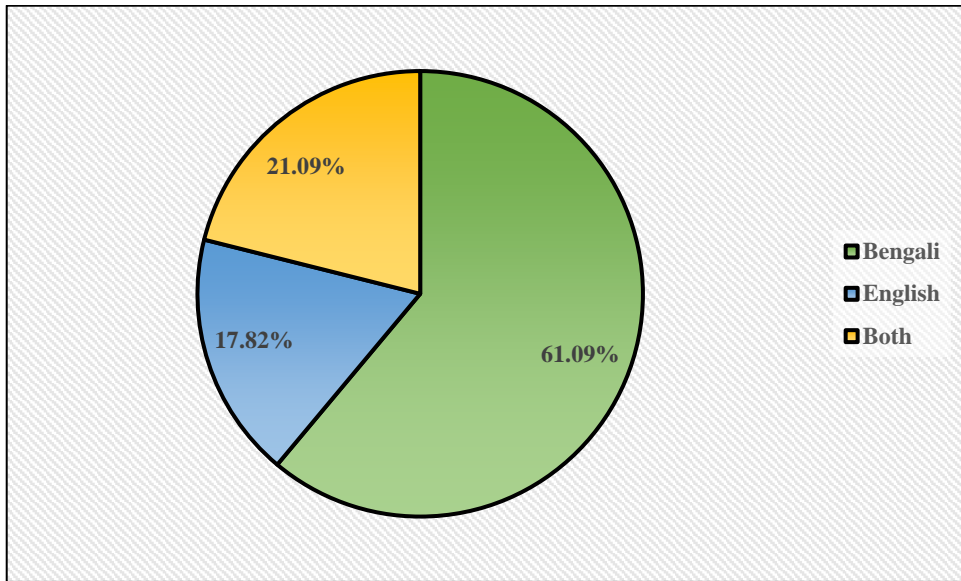
**Figure 3.7 Showing habitation wise sample distribution**



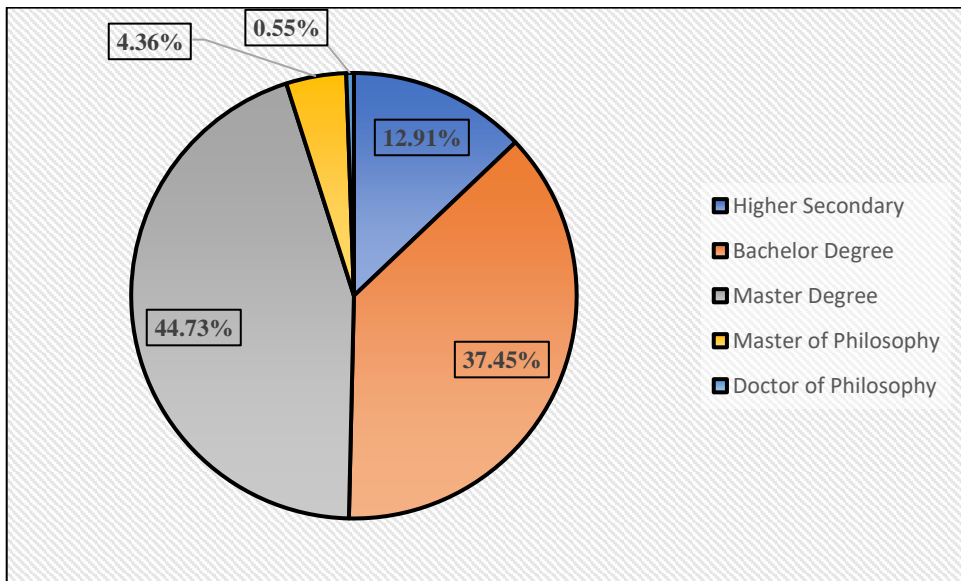
**Figure 3.8 Showing mental health related training wise sample distribution**

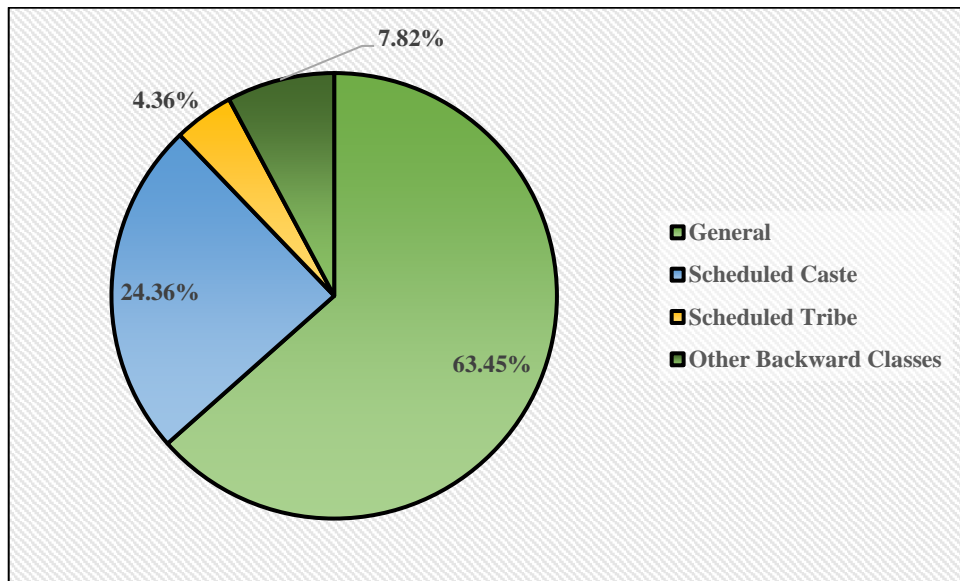


**Figure 3.9 Showing medium of instruction wise sample distribution**



**Figure 3.10 Showing highest educational qualification wise sample distribution**



**Figure 3.11 Showing social category wise sample distribution**

### 3.1.5 Tools for data collection

Two different tools were employed in this research to collect information and data in accordance with the study design. These methods were employed to assess both quantitative and qualitative measurements of the variables being investigated.

In order to testing the hypotheses, researchers must collect pertinent data. To gather information and data for the purpose of describing and evaluating the study design, the researcher has created a set of questions provided as statements. In order to successfully accomplish the goals of the study, the researcher employed a specific technique and a basic information strategy to collect relevant data from the teacher participants. This section provides a succinct summary of both tools as follows:

- I. **Basic Information Schedule** – A blank demographic information sheet was used to collect relevant data from respondents and also it was deployed to gather socio-economic and demographic information from teachers.
- II. **Perception of primary school teachers on children’s Mental Health Questionnaire** – Kerebih et al. (2016) developed this self-administered questionnaire, where most of the items were taken from SDQ. The implemented measuring instrument was utilized to evaluate the teachers' perception regarding whether the relevant elements constituted a mental health issue or not. Present

investigator has adopted and modified this questionnaire according to her research purpose. The questionnaire comprised of 36 items and teachers should assess the severity of each issue using a Likert scale ranging from 0 (not a problem) to 5 (a very serious problem).

### Description of Tool

**Table 3.3** Showing description of tool

<b>DIMENSIONS</b>	<b>ITEM NO.</b>
<b>1.Emotional problems</b>	<b>8,11,17,18,21</b>
<b>2.Peer-relationship problems</b>	<b>14,15,19,22,24</b>
<b>3.Hyperactivity problems</b>	<b>1,2,5,7,9</b>
<b>4.Conduct problems</b>	<b>3,4,13,16,31</b>
<b>5.Pro-social deficit problems</b>	<b>6,10,20,23,26</b>
<b>6.Learning problems</b>	<b>12,28,29,30,33</b>
<b>7.Other problems</b>	<b>25,27,32,34,35,36</b>
<b>TOTAL</b>	<b>36 ITEMS</b>

### Scoring Procedure

**Table 3.4** Showing the scoring procedure

<b>Responses</b>	<b>Interpretation</b>
<b>0</b>	<b>NOT A PROBLEM</b>
<b>1</b>	<b>-</b>
<b>2</b>	<b>-</b>
<b>3</b>	<b>-</b>
<b>4</b>	<b>-</b>
<b>5</b>	<b>VERY SERIOUS PROBLEM</b>

## Levels of Awareness

**Table 3.5** Showing the levels of awareness

Sl No.	Levels of Awareness	PTPCMH
1.	High	25-36
2.	Moderate	13-24
3.	Low	0-12

## Reliability and Validity

The first English version of the questionnaire was translated into Bengali and subsequently retranslated into English to maintain its coherence. The data was acquired using the bilingual version of the questionnaire. Content and face validity of particular questionnaire was determined by two experts. The researcher conducted a pilot study on 200 sample units after determining tool's validity. The calculated Cronbach alpha reliability coefficient was determined to be 0.904. Subsequently, a survey was administered to a cohort of 550 teachers. Once again, the internal consistency value was determined to be 0.925.

### 3.2 Procedure

This section provides a comprehensive explanation of the process of administering the instruments used to collect data, followed by the subsequent steps of filtering and tabulating.

#### 3.2.1 Collection of Data

During the school visit, the researcher approached the headmasters or headmistresses of each school to provide a clear explanation of the study's purpose and methodology. The researcher offered a lucid elucidation of the confidentiality provisions pertaining to the furnished information and data. In addition, they presented an authorization letter, issued by the supervisor on behalf of the Department of Education at Jadavpur University, in order to obtain the required data. After receiving authorization from the school administration, the researcher initiated the process of collecting authentic data. The researcher surveyed a total of 50 schools spanning all ten districts, with 44 schools successfully obtaining agreement from their teachers for data collection. After receiving

the required authorization, two instruments were given to the teachers who were taking part. No explicit time constraint was imposed on the participants for completing the surveys. Approximately 95% of the teachers completed the questionnaires within a timeframe of approximately 30 minutes. Data collection was conducted solely on weekdays between June 15th, 2023 and September 16th, 2023.

### **3.2.2 Data Quality**

In aggregate, 572 teachers provided responses to the questionnaire. However, 22 of them were excluded from the dataset because they either did not complete the questionnaires or provided an excessive amount of incomplete information. As a result, the data obtained from the remaining 550 participating teachers were incorporated and utilized as sample units in the present study.

### **3.2.3 Tabulation of the data**

The entire dataset was methodically collected and organized in a sequential manner to facilitate subsequent analysis and draw conclusions in line with the aims of the current study. The researcher meticulously tabulated the raw data of 550 teachers individually in an Excel file. Moreover, it was encoded using several identities and prepared for subsequent analysis.

### **3.2.4 Data Analysis**

The researcher used Microsoft Excel for data tabulation and IBM SPSS version 20 for data analysis. Descriptive statistics, such as the mean and standard deviation, were used to analyze the sample's features. Teachers' perceptions of mental health based on various criteria were illustrated with bar diagrams and pie charts for clear understanding. Inferential statistical techniques included the independent sample T-test, one-way ANOVA, and Pearson correlation. These methods helped draw conclusions about the population based on the sample data.

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**CHAPTER - IV**  
**ANALYSIS AND INTERPRETATION**  
**OF DATA**

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## CHAPTER IV

### ANALYSIS AND INTERPRETATION OF DATA

Data analysis and interpretation are essential stages in the research process. Data analysis refers to the systematic arrangement and condensation of data with the purpose of addressing research inquiries. Data interpretation encompasses the process of elucidating the importance of the data and deducing conclusions from it. Various techniques can be employed to analyze data, such as statistical analysis and qualitative analysis. Statistical analysis is employed to scrutinize quantitative data, such as survey findings and experimental data. Qualitative analysis is employed to scrutinize non-numeric data, such as transcripts of interviews and notes taken in the field. Data interpretation encompasses the process of elucidating the importance of the data and drawing logical inferences from it. This can be achieved by doing a comparative analysis of the data with past research, formulating hypotheses, or constructing theories. Data interpretation should be conducted in a straightforward, succinct, and unbiased manner. Data analysis and interpretation are essential components of the research process. They facilitate researchers in addressing research inquiries, formulating ideas, and generating novel knowledge. The researcher has separated this chapter into two main sections: descriptive statistics and inferential statistics, which includes hypotheses testing. The descriptive section provided a precise depiction of the nature and attributes of the data, while inferential statistics were employed to analyze the significance of the conclusions derived from the data.

#### 4.1 Descriptive Statistics

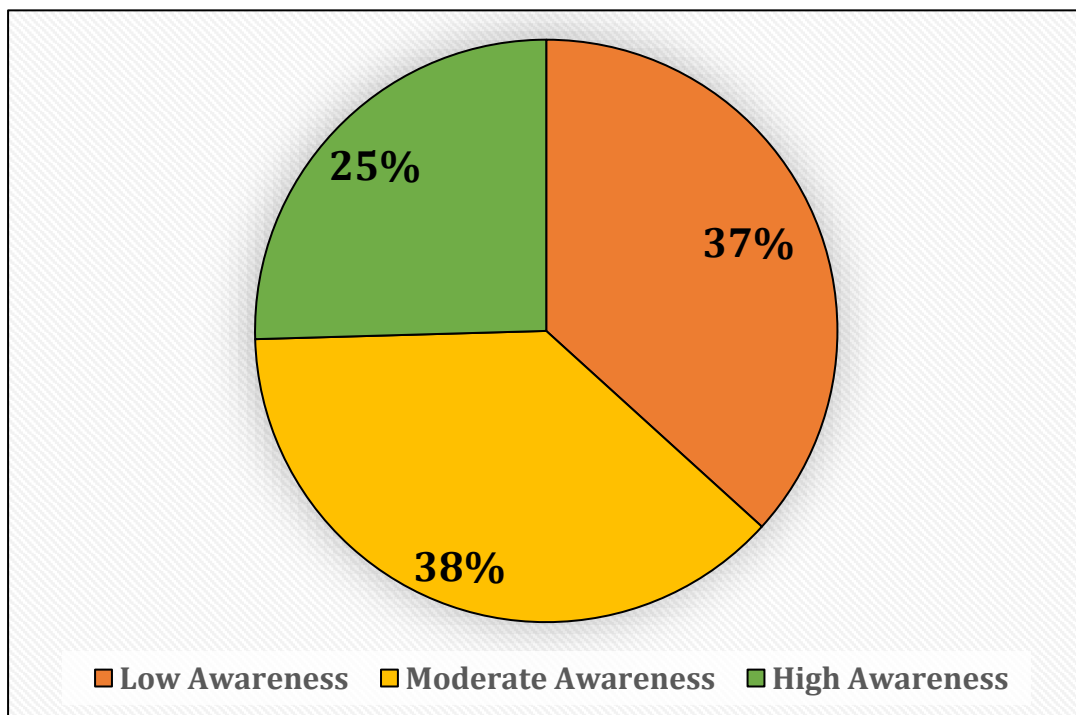
Descriptive statistics constitutes a sector within the field of statistics dedicated to gathering, scrutinizing, interpreting, displaying, and structuring data. Its fundamental objective is to encapsulate and elucidate the key characteristics of a dataset, offering a succinct and insightful synopsis. By doing so, descriptive statistics plays a crucial role in condensing extensive data sets into a more manageable and comprehensible format. In the current investigation, the descriptive statistics portion revealed the distribution of mean scores and standard deviation for diverse explanatory and independent variables, contingent upon the teacher's awareness of child mental health.

#### 4.1.1 Level of teacher's awareness of child mental health.

**Table 4.1** Showing level of teacher's awareness of child mental health.

	Frequency	Percentage
Low Awareness	202	36.73%
Moderate Awareness	208	37.82%
High Awareness	140	25.45%
Total	550	100%

**Figure 4.1** Presenting level of teacher's awareness of child mental health.



Among 550 primary teachers, 202 teachers (36.73%) demonstrated low level of awareness of child mental health; 208 teachers (37.82%) demonstrated moderate level of awareness of child mental health and 140 teachers (25.45%) demonstrated high level of awareness of child mental health.

#### 4.1.2 Overall descriptive scores of teacher's awareness of child mental health based on various demographic variables.

**Table 4.2** Showing mean score distribution of teacher's awareness of child mental health based on gender of primary teachers.

DEPENDENT VARIABLE	CATEGORY OF GENDER	N	MEAN	STD. DEVIATION
PRIMARY TEACHER'S AWARENESS OF CHILD MENTAL HEALTH	MALE	278	31.09	20.467
	FEMALE	272	38.36	26.480

**Figure 4.2** Presenting mean score distribution of teacher's awareness of child mental health based on gender of primary teachers.

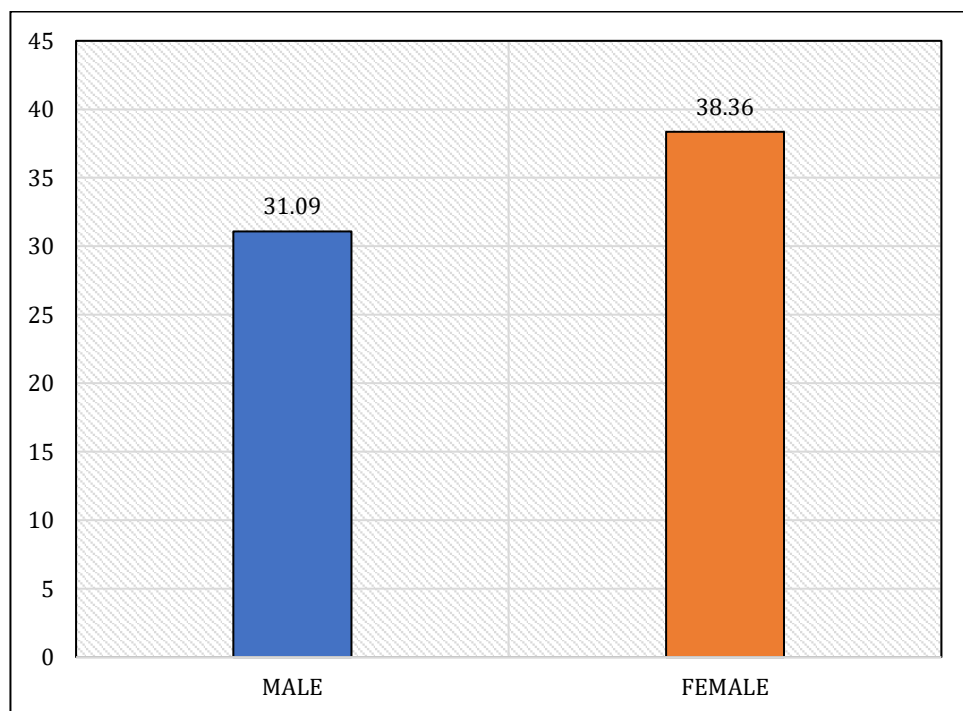


Figure 4.2 showed mean score distribution of Primary teacher's awareness of child mental health based on gender. Gender wise male and female teachers showed awareness

as 31.09 & 38.36 and standard deviation found to be 20.467 & 26.480 respectively. So, Female teachers showed greater awareness than male teachers.

**Table 4.3** Showing mean score distribution of teacher's awareness of child mental health based on type of institution.

DEPENDENT VARIABLE	CATEGORY OF TYPE OF INSTITUTION	N	MEAN	STD. DEVIATION
PRIMARY TEACHER'S AWARENESS OF CHILD MENTAL HEALTH	GOVT.	340	34.49	23.917
	PRIVATE	210	35.01	23.900

**Figure 4.3** Presenting mean score distribution of teacher's awareness of child mental health based on type of institution.

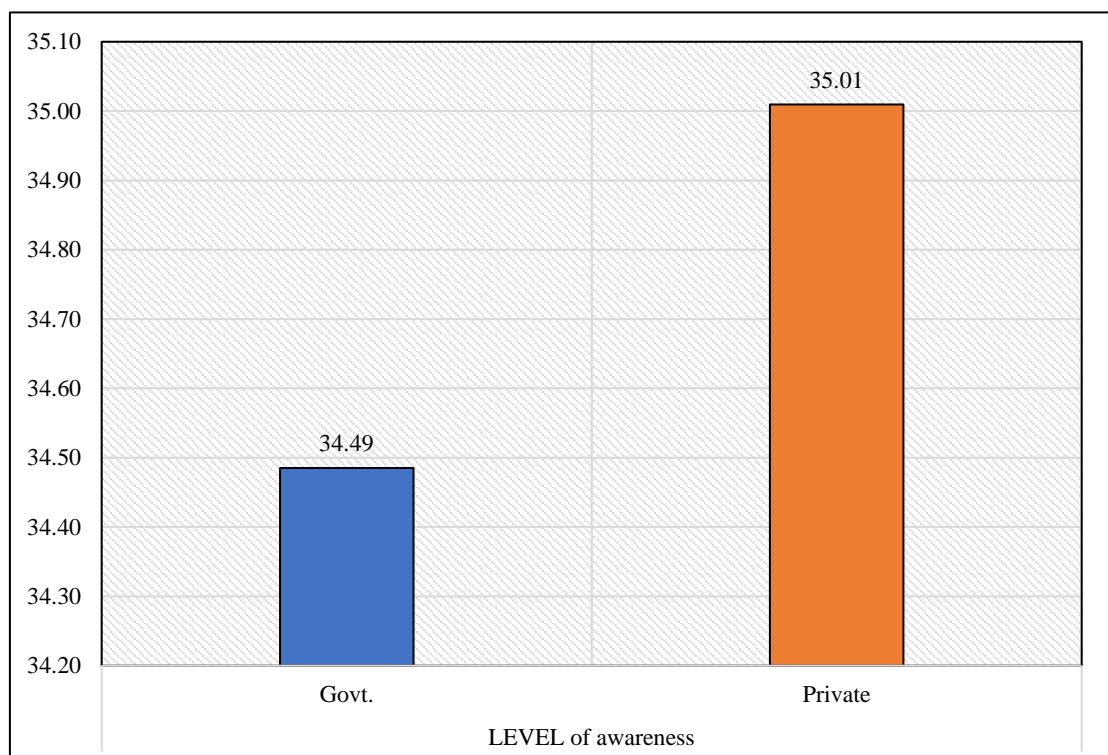


Figure 4.3 showed mean score distribution of Primary teacher's awareness of child mental health based on type of institution. Govt. and Private teachers showed awareness as 34.49 & 35.01 and standard deviation found to be 23.917 & 23.900 respectively. So, type of institution wise private teachers showed greater awareness than govt. teachers.

**Table 4.4 Showing mean score distribution of teacher's awareness of child mental health based on habitation.**

DEPENDENT VARIABLE	CATEGORY OF HABITATION	N	MEAN	STD. DEVIATION
PRIMARY TEACHER'S AWARENESS OF CHILD MENTAL HEALTH	RURAL	188	35.09	23.421
	URBAN	136	28.57	17.582
	SEMI-URBAN	226	38.03	26.781

**Figure 4.4 Presenting mean score distribution of teacher's awareness of child mental health based on habitation.**

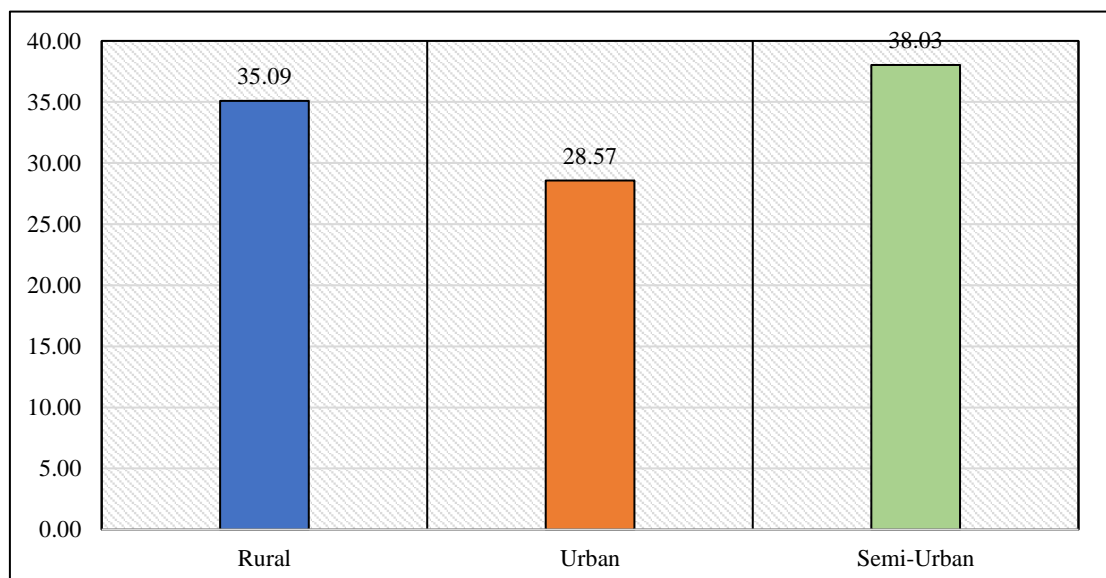


Figure 4.4 showed mean score distribution of Primary teacher's awareness of child mental health based on habitation. Rural, urban and semi-urban teachers showed awareness as 35.09, 28.57 & 38.03 and standard deviation found to be 23.421, 17.582 & 26.781 respectively. So, habitation wise semi-urban teachers showed greater awareness than its other counterparts.

**Table 4.5 Showing mean score distribution of teacher's awareness of child mental health based on mental health related training.**

DEPENDENT VARIABLE	CATEGORY OF MENTAL HEALTH RELATED TRAINING	N	MEAN	STD. DEVIATION
PRIMARY TEACHER'S AWARENESS OF CHILD MENTAL HEALTH	NON-TRAINED	326	32.50	17.719
	TRAINED	224	37.86	30.503

**Figure 4.5 Presenting mean score distribution of teacher's awareness of child mental health based on mental health related training.**

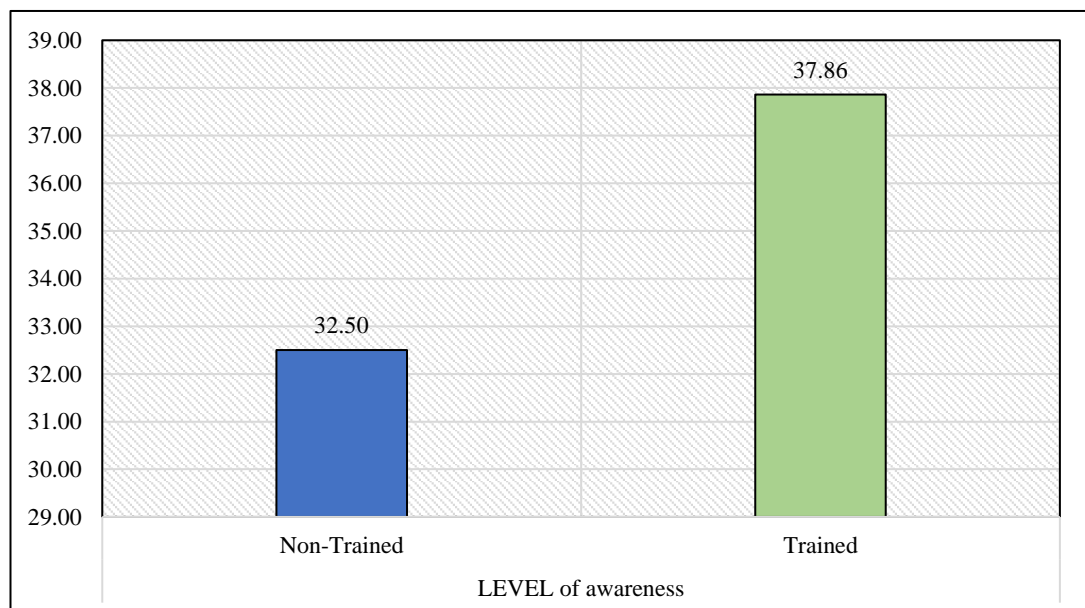


Figure 4.5 showed mean score distribution of Primary teacher's awareness of child mental health based on mental health related training. Trained and non-trained teachers showed awareness as 37.86 & 32.50 and standard deviation found to be 30.503 & 17.719 respectively. So, mental health related training wise trained teachers showed greater awareness than non-trained teachers.

**Table 4.6 Showing mean score distribution of teacher's awareness of child mental health based on highest educational qualification.**

<b>DEPENDENT VARIABLE</b>	<b>CATEGORY OF HIGHEST EDUCATIONAL QUALIFICATION</b>	<b>N</b>	<b>MEAN</b>	<b>STD. DEVIATION</b>
<b>PRIMARY TEACHER'S AWARENESS OF CHILD MENTAL HEALTH</b>	HIGHER SECONDARY	71	32.00	21.949
	GRADUATION	206	32.96	20.371
	POST-GRADUATION	246	37.87	26.997
	M.PHIL.	24	23.38	17.077
	PH.D.	03	45.67	33.292

**Figure 4.6 Presenting mean score distribution of teacher's awareness of child mental health based on highest educational qualification.**

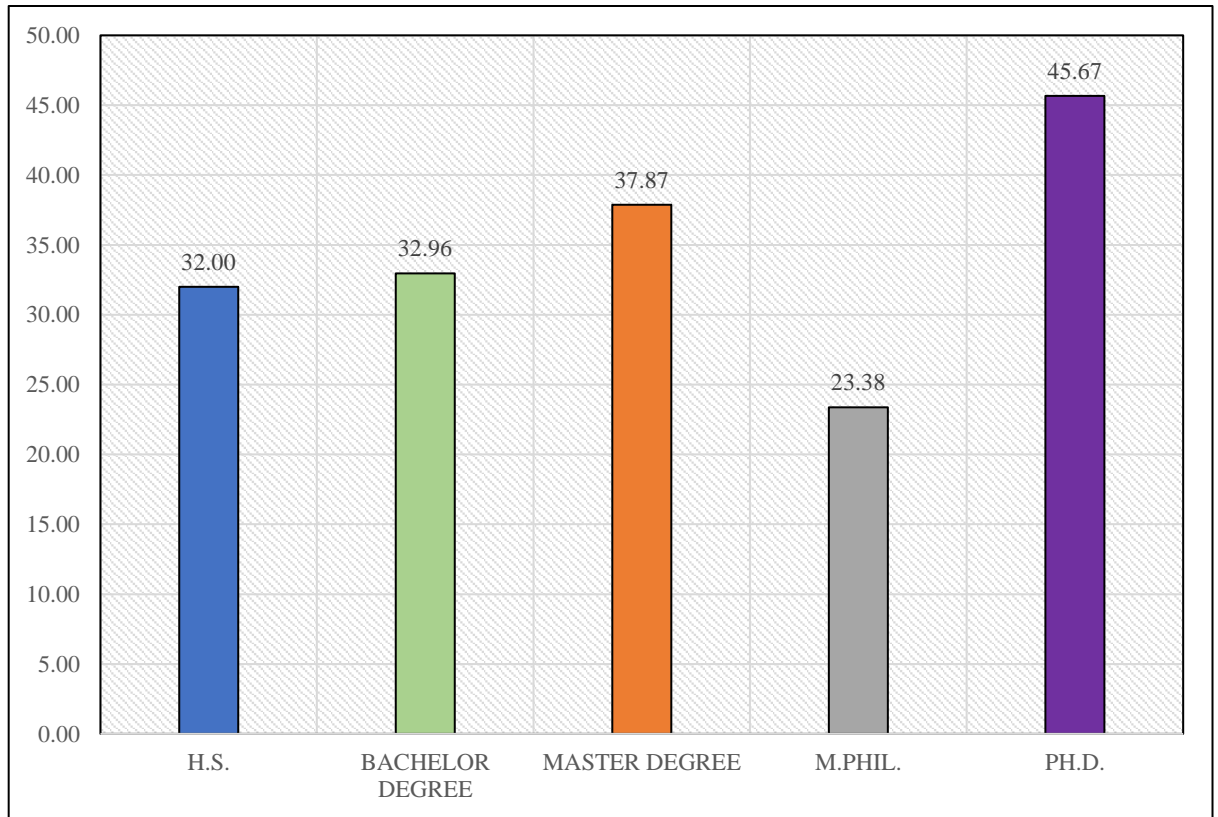


Figure 4.6 showed mean score distribution of Primary teacher's awareness of child mental health based on highest educational qualification. H.S., graduate, post-graduate, M.Phil., & Ph.D. degree holder teachers showed awareness as 32.00, 32.96, 37.87, 23.38 & 45.67 and standard deviation found to be 21.949, 20.371, 26.997, 17.077 & 33.292 respectively. So, highest educational qualification wise Ph.D. degree holder teachers showed greater awareness than its other counterparts.

**Table 4.7** Showing mean score distribution of teacher's awareness of child mental health based on medium of instruction.

DEPENDENT VARIABLE	CATEGORY OF MEDIUM OF INSTRUCTION	N	MEAN	STD. DEVIATION
PRIMARY TEACHER'S AWARENESS OF CHILD MENTAL HEALTH	BENGALI	336	34.24	23.117
	BOTH	116	40.43	25.414
	ENGLISH	98	29.43	23.468

**Figure 4.7** Presenting mean score distribution of teacher's awareness of child mental health based on medium of instruction.

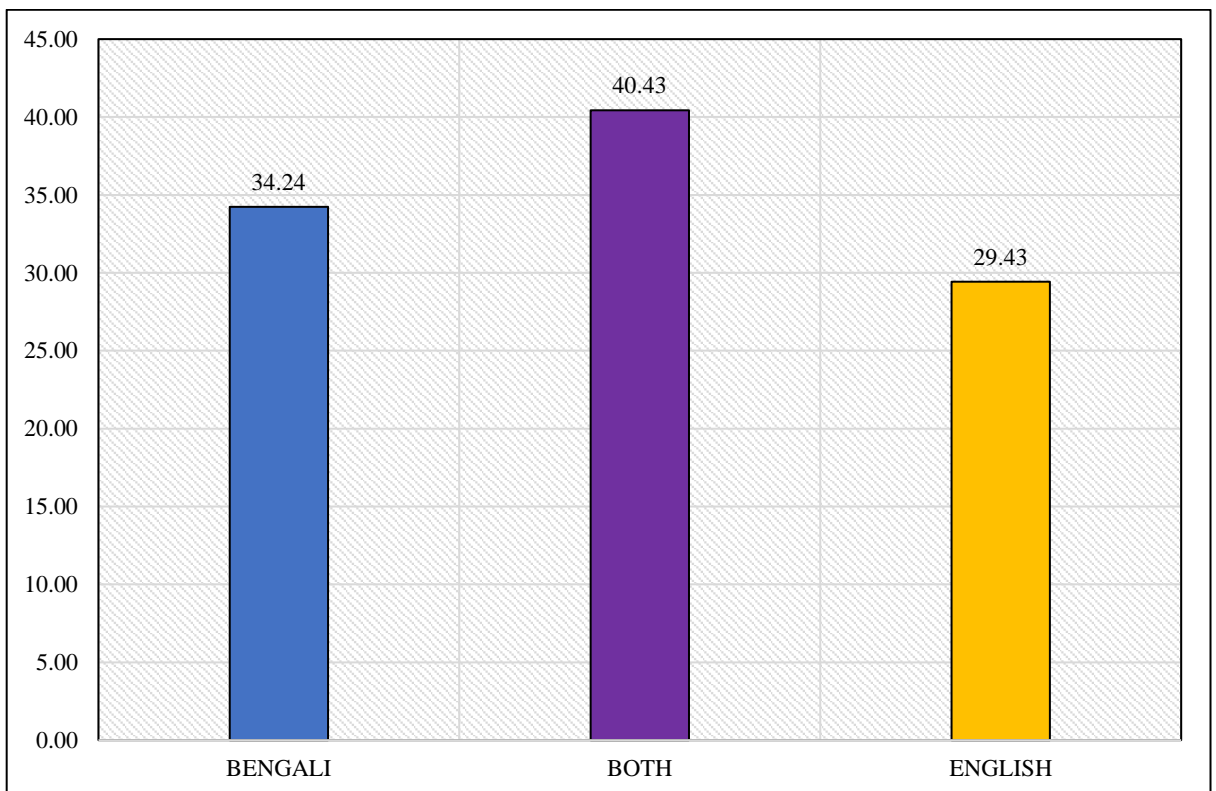


Figure 4.7 showed mean score distribution of Primary teacher's awareness of child mental health based on medium of instruction. Teachers who used Bengali, English and both as instruction medium showed awareness as 34.24, 29.43 & 40.43 and standard deviation found to be 23.117, 23.468 & 25,414 respectively. So, medium of instruction wise teachers who used both mediums showed greater awareness than its other counterparts.

**Table 4.8 Showing mean score distribution of teacher's awareness of child mental health based on social category.**

<b>DEPENDENT VARIABLE</b>	<b>CATEGORY OF MEDIUM OF INSTRUCTION</b>	<b>N</b>	<b>MEAN</b>	<b>STD. DEVIATION</b>
<b>PRIMARY TEACHER'S AWARENESS OF CHILD MENTAL HEALTH</b>	GENERAL	349	34.34	23.688
	SCHEDULED CASTE	134	34.07	20.876
	SCHEDULED TRIBE	24	23.38	16.489
	OTHER BACKWARD CLASSES	43	44.98	33.147

**Figure 4.8 Presenting mean score distribution of teacher's awareness of child mental health based on social category.**

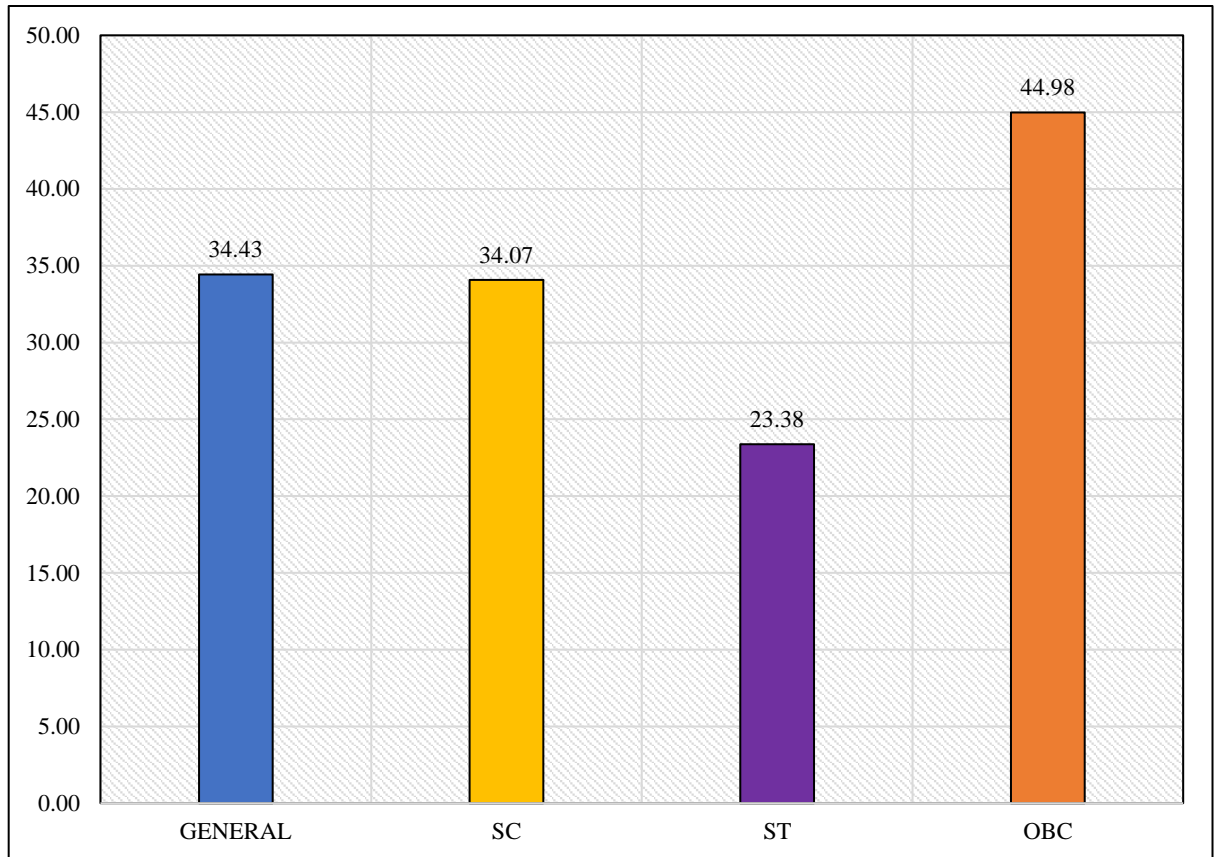


Figure 4.8 showed mean score distribution of Primary teacher's awareness of child mental health based on social category. Teachers belongs to general, scheduled caste, scheduled tribe and other backward class category showed awareness as 34.43, 34.07, 23.38 & 44.98 and standard deviation found to be 23.688, 20.876, 16.489 & 33.147 respectively. So, social category wise teachers who belonged to other backward class showed greater awareness than its other counterparts.

**Table 4.9** Showing mean score distribution of dimensions wise teacher's awareness of child mental health based on gender.

Emotional Problems		Peer-relationship problems		Hyperactivity Problems		Conduct Problems		Pro-social Deficit problems		Learning Problems		Other Problems	
Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
3.96	4.94	3.55	4.38	5.99	7.48	5.01	6.22	3.36	3.98	5.37	6.7	3.83	4.66

**Figure 4.9** Presenting mean score distribution of dimensions wise teacher's awareness of child mental health based on gender.

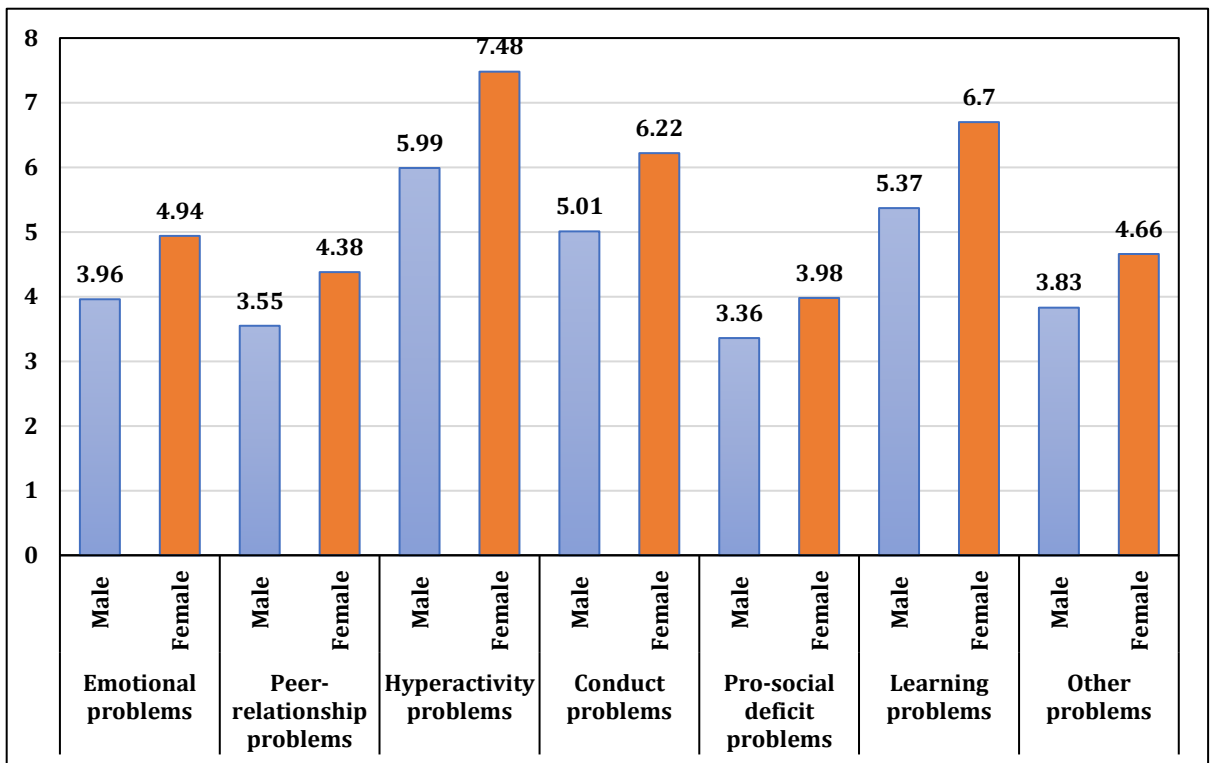


Figure 4.9 showed that in emotional problem dimension, male and female teachers appeared with mean score of 3.96 and 4.94 respectively. In peer-relationship problem dimension, male and female teachers appeared with mean score of 3.55 and 4.38 respectively. In hyperactivity problem dimension, male and female teachers appeared with mean score of 5.99 and 7.48 respectively. In conduct problem dimension, male and female teachers appeared with mean score of 5.01 and 6.22 respectively. In pro-social deficit problem dimension, male and female teachers appeared with mean score of 3.36

and 3.98 respectively. In learning problem dimension, male and female teachers appeared with mean score of 5.37 and 6.7 respectively. In other problem dimension, male and female teachers appeared with mean score of 3.83 and 4.66 respectively. So, it can be said from above figure that female teachers showed greater awareness in all the dimensions than male teachers.

**Table 4.10 Showing mean score distribution of dimensions wise teacher's awareness of child mental health based on type of institution.**

<b>DEPENDENT VARIABLE</b>	<b>DIMENSIONS</b>	<b>TYPE OF INSTITUTION CATEGORY</b>	<b>MEAN</b>
<b>PRIMARY TEACHER'S AWARENESS OF CHILD MENTAL HEALTH</b>	<b>Emotional Problems</b>	Govt.	<b>4.39</b>
		Private	<b>4.52</b>
	<b>Peer-relationship problems</b>	Govt.	<b>3.94</b>
		Private	<b>4.00</b>
	<b>Hyperactivity Problems</b>	Govt.	<b>6.53</b>
		Private	<b>7.06</b>
	<b>Conduct Problems</b>	Govt.	<b>5.59</b>
		Private	<b>5.64</b>
	<b>Pro-social Deficit problems</b>	Govt.	<b>3.86</b>
		Private	<b>3.36</b>
	<b>Learning Problems</b>	Govt.	<b>5.98</b>
		Private	<b>6.11</b>
	<b>Other Problems</b>	Govt.	<b>4.20</b>
		Private	<b>4.31</b>

**Figure 4.10 Presenting mean score distribution of dimensions wise teacher's awareness of child mental health based on type of institution.**

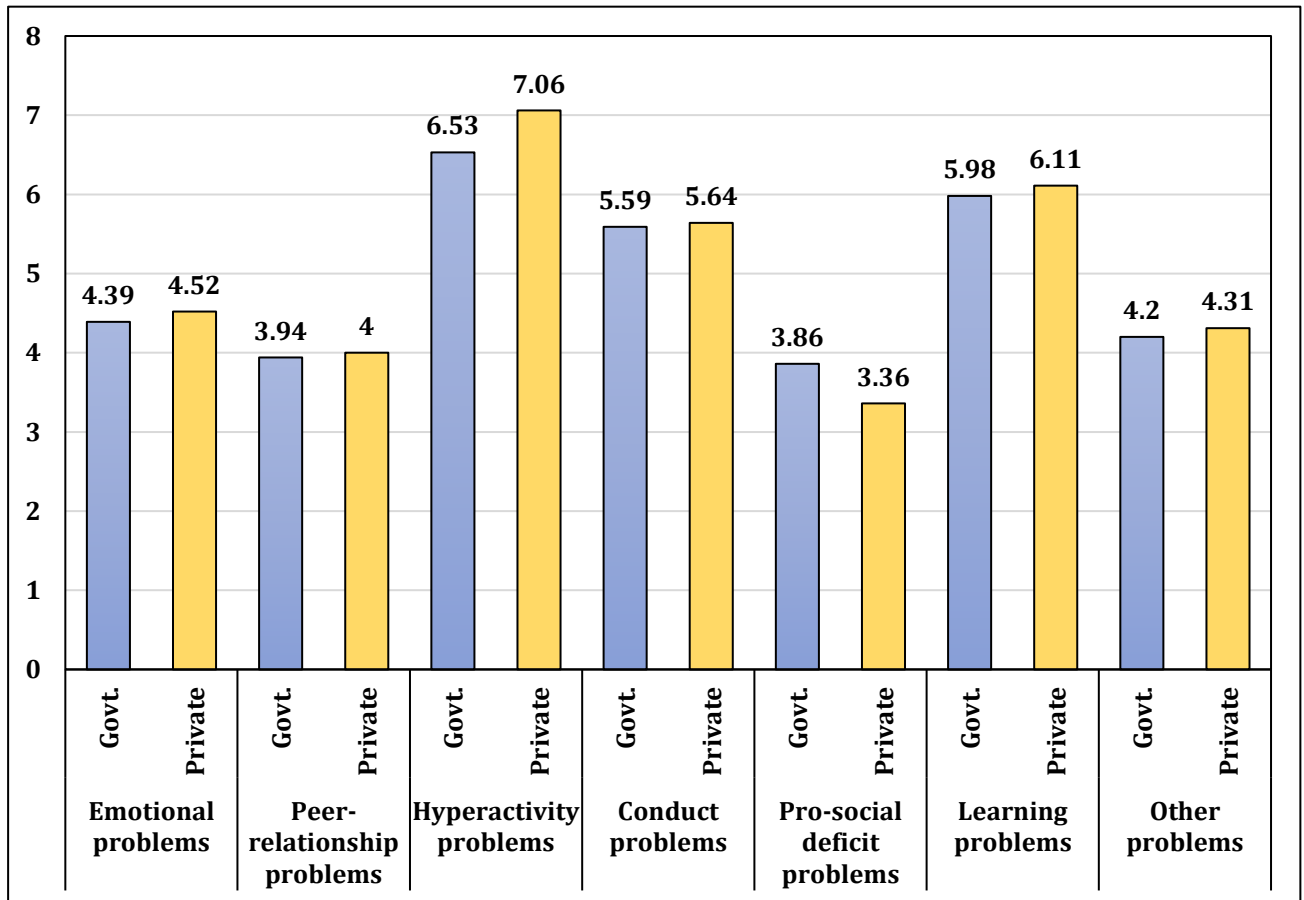


Figure 4.10 showed that in emotional problem dimension, govt. and private teachers appeared with mean score of 4.39 and 4.52 respectively. In peer-relationship problem dimension, govt. and private teachers appeared with mean score of 3.94 and 4.00 respectively. In hyperactivity problem dimension, govt. and private teachers appeared with mean score of 6.53 and 7.06 respectively. In conduct problem dimension, govt. and private teachers appeared with mean score of 5.59 and 5.64 respectively. In pro-social deficit problem dimension, govt. and private teachers appeared with mean score of 3.86 and 3.36 respectively. In learning problem dimension, govt. and private teachers appeared with mean score of 5.98 and 6.11 respectively. In other problem dimension, govt. and private teachers appeared with mean score of 4.2 and 4.31 respectively. So, it can be said from above figure that private teachers showed greater awareness in all the dimensions than govt. teachers expect pro-social deficit problems dimension.

**Table 4.11 Showing mean score distribution of dimensions wise teacher's awareness of child mental health based on mental health related training.**

<b>DEPENDENT VARIABLE</b>	<b>DIMENSIONS</b>	<b>MENTAL HEALTH RELATED TRAINING CATEGORY</b>	<b>MEAN</b>
<b>PRIMARY TEACHER'S AWARENESS OF CHILD MENTAL HEALTH</b>	<b>Emotional Problems</b>	Non-trained	<b>4.25</b>
		trained	<b>4.73</b>
	<b>Peer-relationship problems</b>	Non-trained	<b>3.61</b>
		trained	<b>4.48</b>
	<b>Hyperactivity Problems</b>	Non-trained	<b>6.64</b>
		trained	<b>6.86</b>
	<b>Conduct Problems</b>	Non-trained	<b>4.88</b>
		trained	<b>6.68</b>
	<b>Pro-social Deficit problems</b>	Non-trained	<b>3.52</b>
		trained	<b>3.88</b>
	<b>Learning Problems</b>	Non-trained	<b>5.93</b>
		trained	<b>6.18</b>
	<b>Other Problems</b>	Non-trained	<b>3.69</b>
		trained	<b>5.05</b>

**Figure 4.11 Presenting mean score distribution of dimensions wise teacher's awareness of child mental health based on mental health related training.**

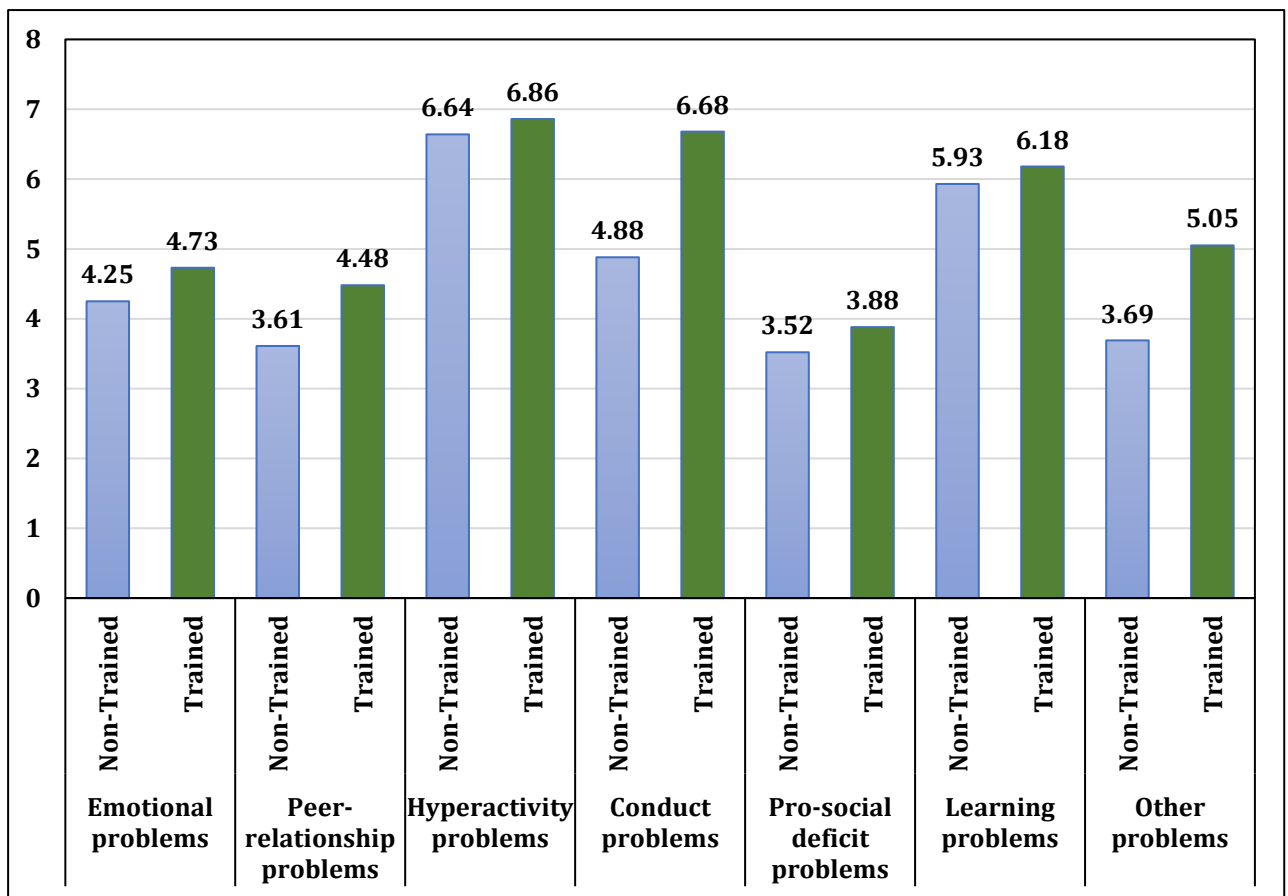


Figure 4.11 showed that in emotional problem dimension, non-trained and trained teachers appeared with mean score of 4.25 and 4.73 respectively. In peer-relationship problem dimension, non-trained and trained teachers appeared with mean score of 3.61 and 4.48 respectively. In hyperactivity problem dimension, non-trained and trained teachers appeared with mean score of 6.64 and 6.86 respectively. In conduct problem dimension, non-trained and trained teachers appeared with mean score of 4.88 and 6.68 respectively. In pro-social deficit problem dimension, non-trained and trained teachers appeared with mean score of 3.52 and 3.88 respectively. In learning problem dimension, non-trained and trained teachers appeared with mean score of 5.93 and 6.18 respectively. In other problem dimension, non-trained and trained teachers appeared with mean score of 3.69 and 5.05 respectively. So, it can be said from above figure that trained teachers showed greater awareness in all the dimensions than non-trained teachers.

**Table 4.12 Showing mean score distribution of dimensions wise teacher's awareness of child mental health based on habitation.**

<b>DEPENDENT VARIABLE</b>	<b>DIMENSIONS</b>	<b>HABITATION CATEGORY</b>	<b>MEAN</b>
<b>PRIMARY TEACHER'S AWARENESS OF CHILD MENTAL HEALTH</b>	<b>Emotional Problems</b>	Rural	<b>4.49</b>
		Urban	<b>3.84</b>
		Semi-Urban	<b>4.76</b>
	<b>Peer-relationship problems</b>	Rural	<b>4.08</b>
		Urban	<b>3.56</b>
		Semi-Urban	<b>4.11</b>
	<b>Hyperactivity Problems</b>	Rural	<b>6.66</b>
		Urban	<b>5.65</b>
		Semi-Urban	<b>7.43</b>
	<b>Conduct Problems</b>	Rural	<b>5.53</b>
		Urban	<b>4.9</b>
		Semi-Urban	<b>6.12</b>
	<b>Pro-social Deficit problems</b>	Rural	<b>3.95</b>
		Urban	<b>3.12</b>
		Semi-Urban	<b>3.76</b>
	<b>Learning Problems</b>	Rural	<b>6.02</b>
		Urban	<b>4.42</b>
		Semi-Urban	<b>7.01</b>
	<b>Other Problems</b>	Rural	<b>4.35</b>
		Urban	<b>3.09</b>
		Semi-Urban	<b>4.85</b>

**Figure 4.12 Presenting mean score distribution of dimensions wise teacher's awareness of child mental health based on habitation.**

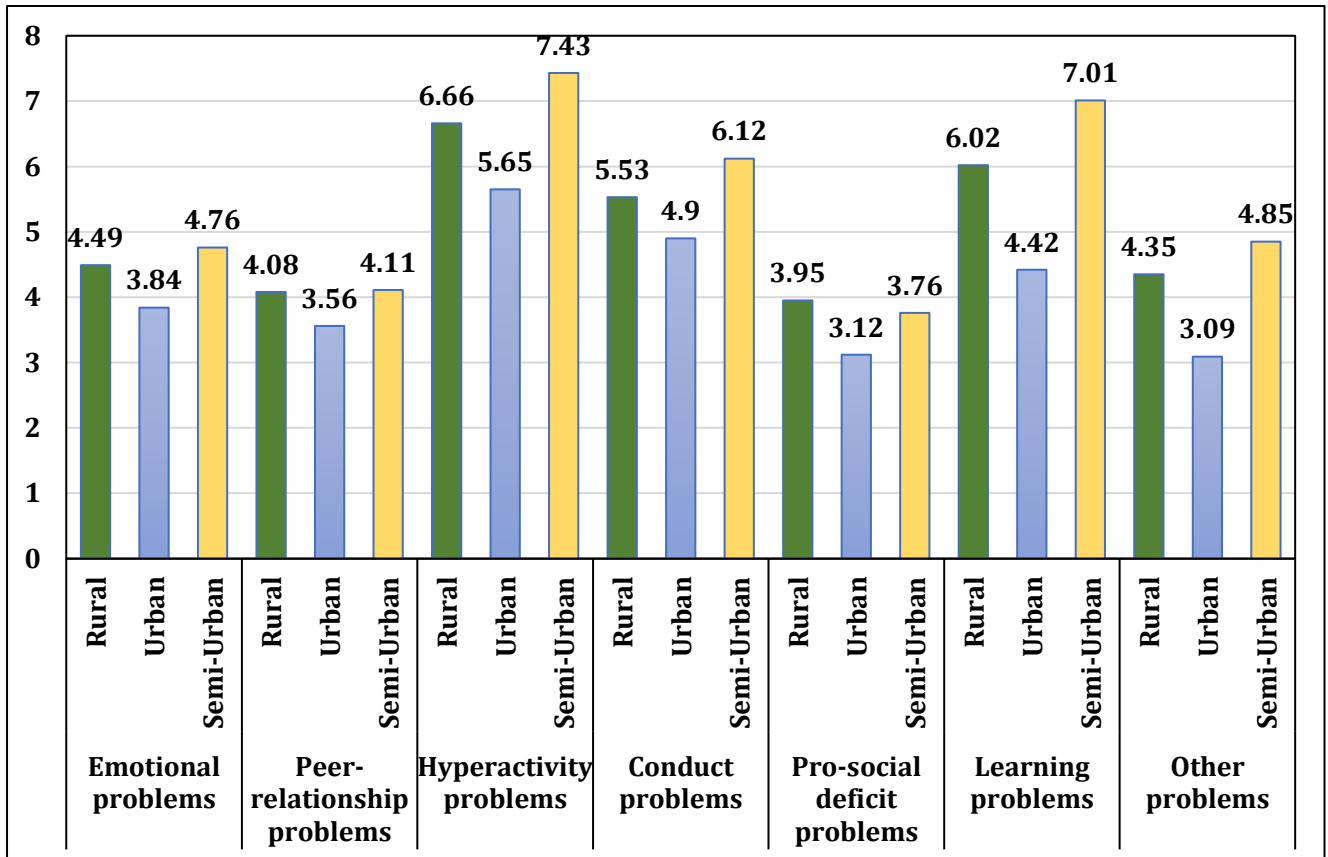


Figure 4.12 showed that in emotional problem dimension, teachers from rural, urban and semi-urban habitation appeared with mean score of 4.49, 3.84 and 4.76 respectively. In peer-relationship problem dimension, teachers from rural, urban and semi-urban habitation appeared with mean score of 4.08, 3.56 and 4.11 respectively. In hyperactivity problem dimension teachers from rural, urban and semi-urban habitation appeared with mean score of 6.66, 5.65 and 7.43 respectively. In conduct problem dimension, teachers from rural, urban and semi-urban habitation appeared with mean score of 5.53, 4.9 and 6.12 respectively. In pro-social deficit problem dimension, teachers from rural, urban and semi-urban habitation appeared with mean score of 3.95, 3.12 and 3.76 respectively. In learning problem dimension teachers from rural, urban and semi-urban habitation appeared with mean score of 6.02, 4.42 and 7.01 respectively. In other problem dimension teachers from rural, urban and semi-urban habitation appeared with mean score of 4.35, 3.09 and 4.85 respectively. So, it can be said from above figure that teachers from semi-

urban habitation showed greater awareness in all the dimensions than its other counterparts expect pro-social deficit problems dimension.

**Table 4.13 Showing mean score distribution of dimensions wise teacher's awareness of child mental health based on highest educational qualification.**

<b>DEPENDENT VARIABLE</b>	<b>DIMENSIONS</b>	<b>HIGHEST EDUCATIONAL QUALIFICATION CATEGORY</b>	<b>MEAN</b>
<b>PRIMARY TEACHER'S AWARENESS OF CHILD MENTAL HEALTH</b>	<b>Emotional Problems</b>	Higher secondary	<b>4.24</b>
		Graduation	<b>4.14</b>
		Post-graduation	<b>4.89</b>
		M.Phil.	<b>2.92</b>
		Ph.D.	<b>5.67</b>
	<b>Peer-relationship problems</b>	Higher secondary	<b>4.38</b>
		Graduation	<b>3.39</b>
		Post-graduation	<b>4.38</b>
		M.Phil.	<b>3.08</b>
		Ph.D.	<b>6.33</b>
	<b>Hyperactivity Problems</b>	Higher secondary	<b>6.03</b>
		Graduation	<b>6.68</b>
		Post-graduation	<b>7.19</b>
		M.Phil.	<b>4.5</b>
		Ph.D.	<b>6.67</b>
	<b>Conduct Problems</b>	Higher secondary	<b>5.59</b>
		Graduation	<b>5.42</b>
		Post-graduation	<b>5.86</b>
		M.Phil.	<b>4.42</b>
		Ph.D.	<b>8.33</b>
<b>Pro-social Deficit problems</b>	Higher secondary	<b>3.48</b>	
	Graduation	<b>3.53</b>	
	Post-graduation	<b>4</b>	
	M.Phil.	<b>1.92</b>	

	Learning Problems	Ph.D.	4
		Higher secondary	5.17
		Graduation	5.93
		Post-graduation	6.56
		M.Phil.	3.88
	Other Problems	Ph.D.	7.33
		Higher secondary	3.11
		Graduation	3.87
		Post-graduation	4.99
		M.Phil.	2.67
	Ph.D.	7.33	

**Figure 4.13 Presenting mean score distribution of dimensions wise teacher's awareness of child mental health based on highest educational qualification.**

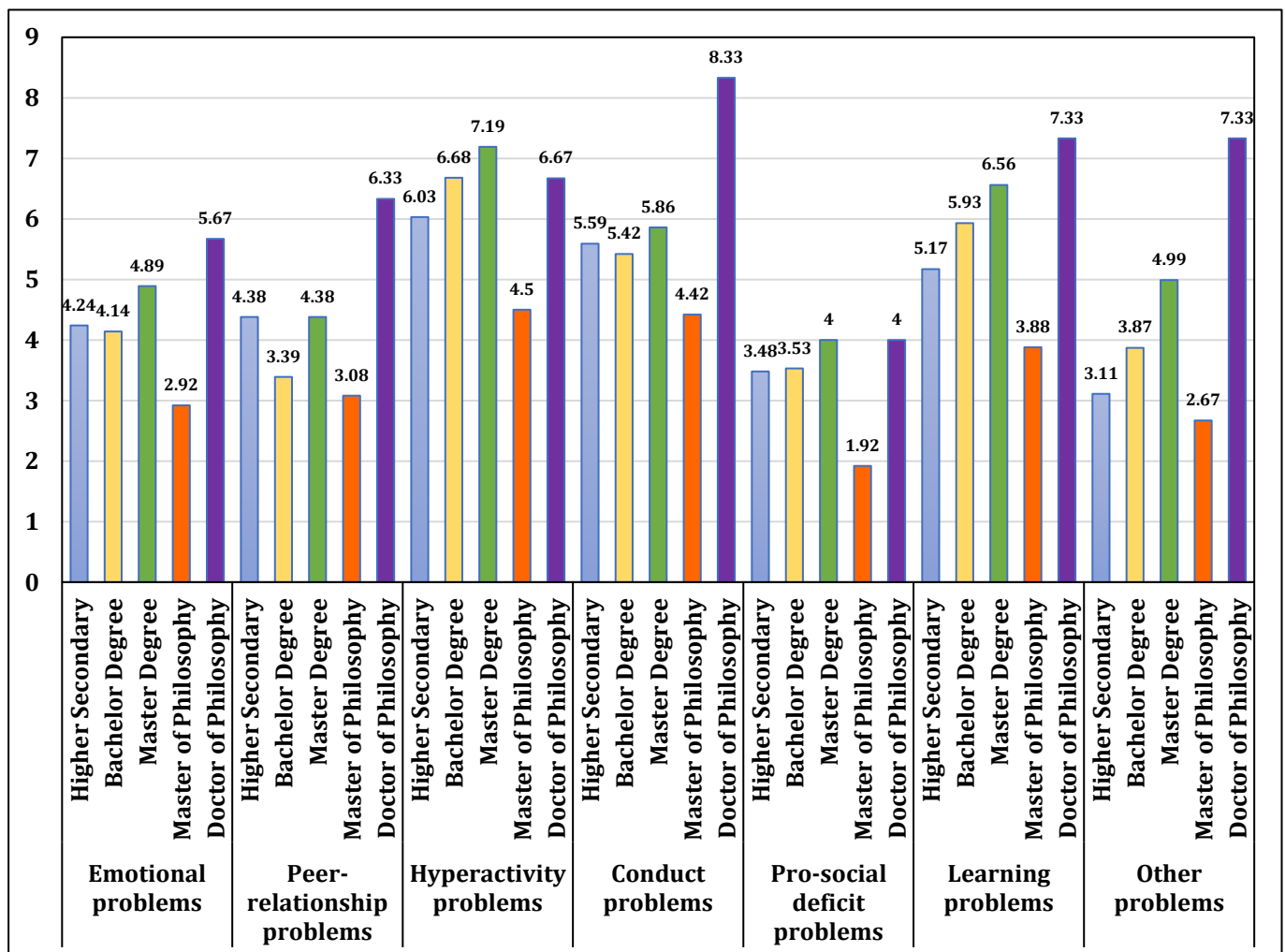


Figure 4.13 showed that in emotional problem dimension, teachers hold H.S., Bachelor, Master, M.Phil., and Ph.D. degree appeared with mean score of 4.24, 4.14, 4.89, 2.92 and 5.67 respectively. In peer-relationship problem dimension, teachers hold H.S., Bachelor, Master, M.Phil., and Ph.D. degree appeared with mean score of 4.38, 3.39, 4.38, 3.08 and 6.33 respectively. In hyperactivity problem dimension teachers hold H.S., Bachelor, Master, M.Phil., and Ph.D. degree appeared with mean score of 6.03, 6.68, 7.19, 4.5 and 6.67 respectively. In conduct problem dimension, teachers hold H.S., Bachelor, Master, M.Phil., and Ph.D. degree appeared with mean score of 5.59, 5.42, 5.86, 4.42 and 8.33 respectively. In pro-social deficit problem dimension, teachers hold H.S., Bachelor, Master, M.Phil., and Ph.D. degree appeared with mean score of 3.48, 5.53, 4, 1.92 and 4 respectively. In learning problem dimension teachers hold H.S., Bachelor, Master, M.Phil., and Ph.D. degree appeared with mean score of 5.17, 5.93, 6.56, 3.88 and 7.33 respectively. In other problem dimension teachers hold H.S., Bachelor, Master, M.Phil., and Ph.D. degree appeared with mean score of 3.11, 3.87, 4.99, 2.67 and 7.33 respectively. So, it can be said from above figure that teachers hold Ph.D. degree showed greater awareness in all the dimensions than its other counterparts expect hyperactivity problems dimension.

**Table 4.14 Showing mean score distribution of dimensions wise teacher's awareness of child mental health based on medium of instruction.**

<b>DEPENDENT VARIABLE</b>	<b>DIMENSIONS</b>	<b>MEDIUM OF INSTRUCTION CATEGORY</b>	<b>MEAN</b>
<b>PRIMARY TEACHER'S AWARENESS OF</b>	<b>Emotional Problems</b>	Bengali	<b>4.37</b>
		Both	<b>5.35</b>
		English	<b>3.62</b>
	<b>Peer-relationship problems</b>	Bengali	<b>3.93</b>
		Both	<b>3.99</b>
		English	<b>4.06</b>
	<b>Hyperactivity Problems</b>	Bengali	<b>6.47</b>
		Both	<b>8.72</b>
		English	<b>5.27</b>
	<b>Conduct Problems</b>	Bengali	<b>5.57</b>
		Both	<b>6.2</b>

<b>CHILD MENTAL HEALTH</b>	<b>Pro-social Deficit problems</b>	English	<b>5.06</b>
		Bengali	<b>3.79</b>
		Both	<b>3.89</b>
	<b>Learning Problems</b>	English	<b>2.97</b>
		Bengali	<b>5.94</b>
		Both	<b>7.41</b>
	<b>Other Problems</b>	English	<b>4.69</b>
		Bengali	<b>4.17</b>
		Both	<b>4.86</b>
		English	<b>3.76</b>

Figure 4.14 Presenting mean score distribution of dimensions wise teacher's awareness of child mental health based on medium of instruction.

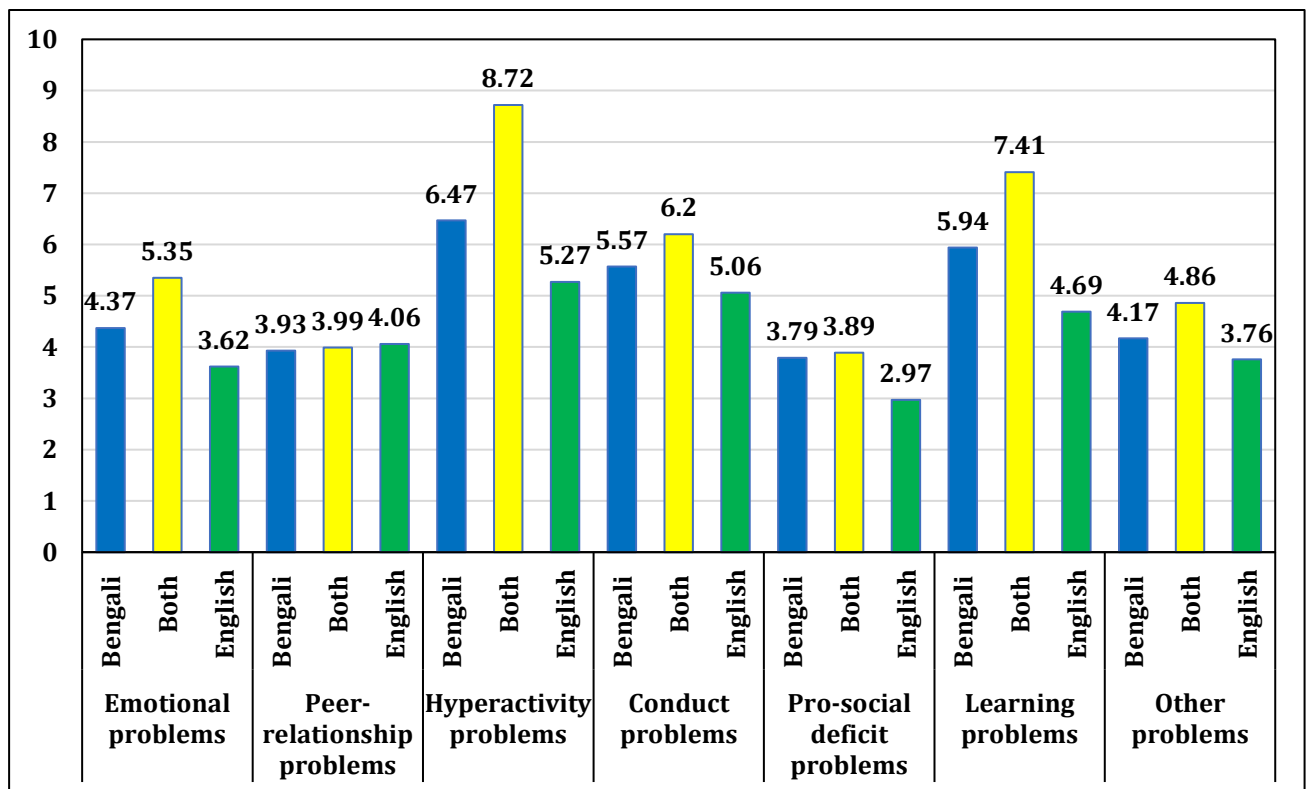


Figure 4.14 showed that in emotional problem dimension, teachers who used Bengali, both and English medium for instruction appeared with mean score of 4.37, 5.35 and 3.62 respectively. In peer-relationship problem dimension, teachers who used Bengali, both and English medium for instruction appeared with mean score of 3.93, 3.99 and 4.06

respectively. In hyperactivity problem dimension teachers who used Bengali, both and English medium for instruction appeared with mean score of 6.47, 8.72 and 5.27 respectively. In conduct problem dimension, teachers who used Bengali, both and English medium for instruction appeared with mean score of 5.57, 6.2 and 5.06 respectively. In pro-social deficit problem dimension, teachers who used Bengali, both and English medium for instruction appeared with mean score of 3.79, 3.89 and 2.97 respectively. In learning problem dimension teachers who used Bengali, both and English medium for instruction with mean score of 5.94, 7.41 and 4.69 respectively. In other problem dimension teachers who used Bengali, both and English medium for instruction appeared with mean score of 4.17, 4.86 and 3.76 respectively. So, it can be said from above figure that who used both (Bengali & English) medium for instruction showed greater awareness in all the dimensions than its other counterparts expect peer-relationship problems dimension.

**Table 4.15 Showing mean score distribution of dimensions wise teacher's awareness of child mental health based on social category.**

<b>DEPENDENT VARIABLE</b>	<b>DIMENSIONS</b>	<b>SOCIAL STATUS CATEGORY</b>	<b>MEAN</b>
<b>PRIMARY TEACHER'S AWARENESS OF</b>	<b>Emotional Problems</b>	General	<b>4.54</b>
		Scheduled caste	<b>4.01</b>
		Scheduled tribe	<b>2.75</b>
		Other backward class	<b>5.93</b>
	<b>Peer-relationship problems</b>	General	<b>3.77</b>
		Scheduled caste	<b>4.25</b>
		Scheduled tribe	<b>2.21</b>
		Other backward class	<b>5.67</b>
	<b>Hyperactivity Problems</b>	General	<b>6.74</b>
		Scheduled caste	<b>6.51</b>
		Scheduled tribe	<b>6</b>
		Other backward class	<b>7.74</b>
	<b>Conduct Problems</b>	General	<b>5.36</b>
		Scheduled caste	<b>5.98</b>

<b>CHILD MENTAL HEALTH</b>		Scheduled tribe	<b>4.04</b>
		Other backward class	<b>7.37</b>
	<b>Pro-social Deficit problems</b>	General	<b>3.56</b>
		Scheduled caste	<b>3.8</b>
		Scheduled tribe	<b>2.21</b>
		Other backward class	<b>4.93</b>
	<b>Learning Problems</b>	General	<b>6.14</b>
		Scheduled caste	<b>5.72</b>
		Scheduled tribe	<b>4.46</b>
		Other backward class	<b>6.98</b>
	<b>Other Problems</b>	General	<b>4.32</b>
		Scheduled caste	<b>3.82</b>
		Scheduled tribe	<b>1.71</b>
		Other backward class	<b>6.35</b>

**Figure 4.15 Presenting mean score distribution of dimensions wise teacher's awareness of child mental health based on social category.**

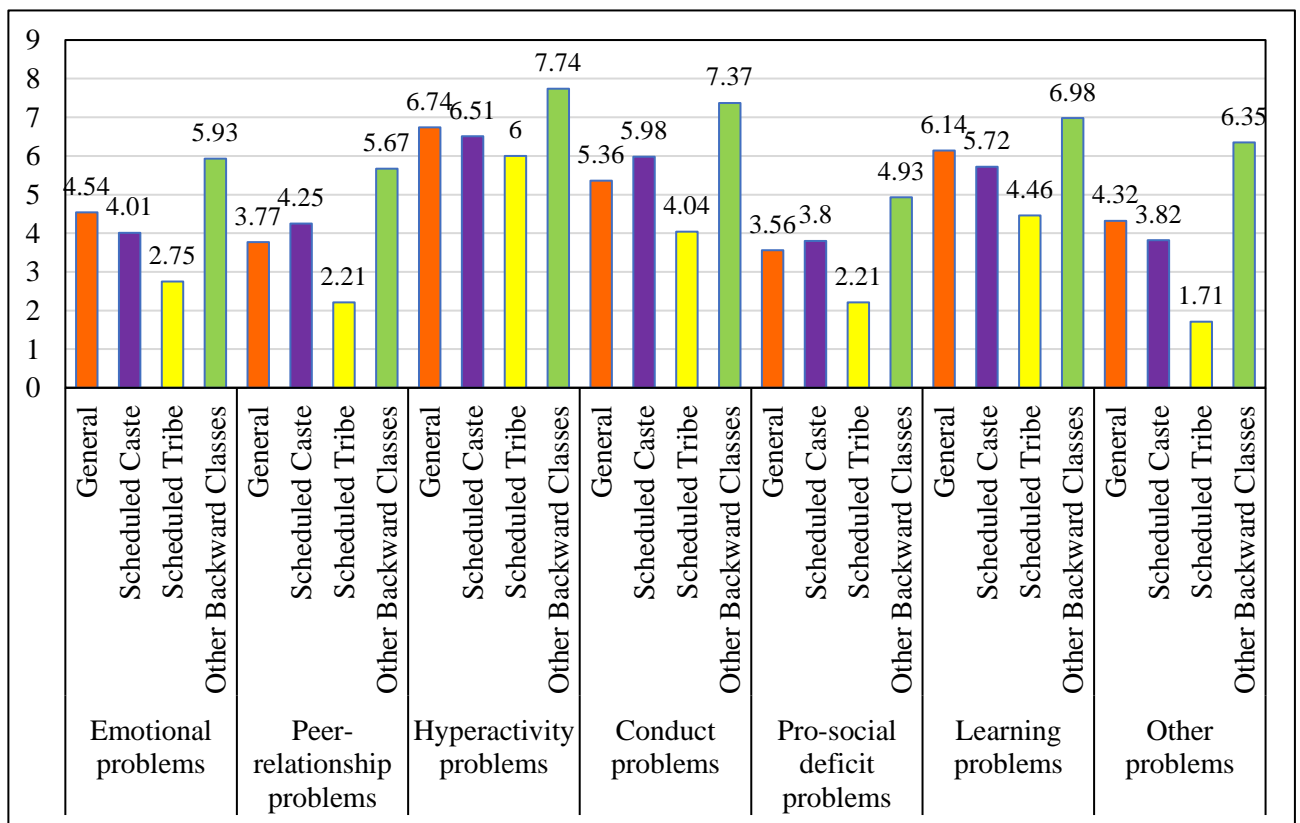


Figure 4.15 showed that in emotional problem dimension, teachers who belonged to general, scheduled caste, scheduled tribe and other backward class category appeared with mean score of 5.54, 4.01, 2.75 and 5.93 respectively. In peer-relationship problem dimension, teachers who belonged to general, scheduled caste, scheduled tribe and other backward class category appeared with mean score of 3.77, 4.25, 2.21 and 5.67 respectively. In hyperactivity problem dimension teachers who belonged to general, scheduled caste, scheduled tribe and other backward class category appeared with mean score of 6.74, 6.51, 6 and 7.74 respectively. In conduct problem dimension, teachers who belonged to general, scheduled caste, scheduled tribe and other backward class category appeared with mean score of 5.36, 5.98, 4.04 and 7.37 respectively. In pro-social deficit problem dimension, teachers who belonged to general, scheduled caste, scheduled tribe and other backward class category appeared with mean score of 3.56, 3.8, 2.21 and 4.93 respectively. In learning problem dimension teachers who belonged to general, scheduled caste, scheduled tribe and other backward class category with mean score of 6.14, 5.72, 4.46 and 6.98 respectively. In other problem dimension teachers who belonged to general, scheduled caste, scheduled tribe and other backward class category appeared with mean score of 4.32, 3.82, 1.71 and 6.35 respectively. So, it can be said from above figure that who belonged to other backward class category showed greater awareness in all the dimensions than its other counterparts.

## 4.2 Inferential Statistics

### 4.2.1 Hypotheses Testing

**H<sub>0</sub>1: There is no significance difference in perception of teachers on child mental health with respect to their gender.**

**Table 4.16 Showing Independent sample T-test based on H<sub>0</sub>1.**

Variable	Category	Mean	t	df	Std. error Diff.	p-value	Remarks
Gender	Male	31.09	-3.597	509.	2.021	0.000	*S P<0.05
	Female	38.36		947			

(\*S-Significant, NS-Not Significant)

It can be concluded from the above table that female teachers possessed higher awareness than male teachers and t-value found to be -3.597 ( $p=0.000$ ). The found difference was statistically significant ( $p<0.05$ ).

Hence,  $H_01$ : There is no significance difference in perception of teachers on child mental health with respect to their gender – *is rejected*.

**$H_02$ : There is no significance difference in perception of teachers on child mental health with respect to types of institutions.**

**Table 4.17 Showing Independent sample T-test based on  $H_02$ .**

Variable	Category	Mean	t	df	Std. error Diff.	p-value	Remarks
Type of institution	Govt.	34.49	-0.250	548	2.099	0.803	NS $P>0.05$
	Private	35.01					

(\*S-Significant, NS-Not Significant)

It can be concluded from the above table that private teachers possessed higher awareness than Govt. teachers and t-value found to be -0.250 ( $p=0.803$ ). The found difference was not statistically significant ( $p>0.05$ ).

Hence,  $H_02$ : There is no significance difference in perception of teachers on child mental health with respect to types of institutions - *is failed to reject*.

**$H_03$ : There is no significance difference in perception of teachers on child mental health with respect to mental health related training.**

**Table 4.18 Showing Independent sample T-test based on  $H_03$ .**

Variable	Category	Mean	t	df	Std. error Diff.	p-value	Remarks
Mental health related training	Non-trained	32.50	-2.369	326.	2.262	0.018	*S $P<0.05$
	Trained	37.86		355			

(\*S-Significant, NS-Not Significant)

It can be concluded from the above table that trained teachers possessed higher awareness than non-trained teachers and t-value found to be -2.369 ( $p=0.018$ ). The found difference was statistically significant ( $p<0.05$ ).

Hence,  $H_03$ : There is no significance difference in perception of teachers on child mental health with respect to mental health related training- *is rejected*.

**$H_04$ : There is no significance difference in perception of teachers on child mental health with respect to their habitation.**

**Table 4.19 Showing One-way ANOVA based on  $H_04$ .**

One-way ANOVA						
	Sum of Squares	df	Mean Square	F	Sig.	Remarks
Between Groups	7639.897	2	3819.949	6.835	0.001	*S P<0.05
Within Groups	305690.686	547	558.850			
Total	313330.584	549				

**(\*S-Significant, NS-Not Significant)**

Table 4.19 showed that the computed value of one-way ANOVA comparing the mean scores of habitations with respect to teachers' perception of child mental health was found to be statistically significant [ $F(2, 547) = 6.835, p<0.05$ ]. Therefore, the null hypothesis is rejected at 0.05 level and it cannot be said that the found difference in the mean scores was due to a random chance factor.

Hence,  $H_04$ : There is no significance difference in perception of teachers on child mental health with respect to their habitation – *is rejected*.

**H<sub>05</sub>: There is no significance difference in perception of teachers on child mental health with respect to their medium of instruction.**

**Table 4.20 Showing One-way ANOVA based on H<sub>05</sub>.**

One-way ANOVA						
	Sum of Squares	df	Mean Square	F	Sig.	Remarks
Between Groups	6605.710	2	3302.855	5.890	0.003	*S P<0.05
Within Groups	306724.874	547	560.740			
Total	313330.584	549				

(\*S-Significant, NS-Not Significant)

Table 4.20 showed that the computed value of one-way ANOVA comparing the mean scores of mediums of instructions with respect to teachers' perception of child mental health was found to be statistically significant [F (2, 547) = 5.890, p<0.05]. Therefore, the null hypothesis is rejected at 0.05 level and it cannot be said that the found difference in the mean scores was due to a random chance factor.

Hence, H<sub>05</sub>: There is no significance difference in perception of teachers on child mental health with respect to their medium of instruction- *is rejected*.

**H<sub>06</sub>: There is no significance difference in perception of teachers on child mental health with respect to their highest educational qualification.**

**Table 4.21 Showing One-way ANOVA based on H<sub>06</sub>.**

One-way ANOVA						
	Sum of Squares	df	Mean Square	F	Sig.	Remarks
Between Groups	7057.509	4	1764.377	3.140	0.014	*S P<0.05
Within Groups	306273.074	545	561.969			
Total	313330.584	549				

**(\*S-Significant, NS-Not Significant)**

Table 4.21 showed that the computed value of one-way ANOVA comparing the mean scores of highest educational qualifications with respect to teachers' perception of child mental health was found to be statistically significant [ $F(4, 545) = 3.140, p < 0.05$ ]. Therefore, the null hypothesis is rejected at 0.05 level and it cannot be said that the found difference in the mean scores was due to a random chance factor.

Hence,  $H_06$ : There is no significance difference in perception of teachers on child mental health with respect to their highest educational qualification– *is rejected*.

**$H_07$ : There is no significance difference in perception of teachers on child mental health with respect to their social categories.**

**Table 4.22 Showing One-way ANOVA based on  $H_07$ .**

One-way ANOVA						
	Sum of Squares	df	Mean Square	F	Sig.	Remarks
Between Groups	7697.198	3	2565.733	4.584	0.004	*S P<0.05
Within Groups	305633.386	546	559.768			
Total	313330.584	549				

**(\*S-Significant, NS-Not Significant)**

Table 4.22 showed that the computed value of one-way ANOVA comparing the mean scores of social categories with respect to teachers' perception of child mental health was found to be statistically significant [ $F(3, 546) = 4.584, p < 0.05$ ]. Therefore, the null hypothesis is rejected at 0.05 level and it cannot be said that the found difference in the mean scores was due to a random chance factor.

Hence,  $H_07$ : There is no significance difference in perception of teachers on child mental health with respect to their social categories– *is rejected*.

**H<sub>08</sub>: There is no significance correlation between perception of teachers on child mental health and their teaching experience.**

**Table 4.23 Showing Pearson correlation based on H<sub>08</sub>.**

PEARSON'S CORRELATION			
		TEACHERS' AWARENESS	TEACHING EXPERIENCE
TEACHERS' AWARENESS	Pearson Correlation	1	-0.027
	Sig. (2-tailed)		0.523
	N	550	550
TEACHING EXPERIENCE	Pearson Correlation	-0.027	1
	Sig. (2-tailed)	0.523	
	N	550	550

It can be observed from Table 4.23 that the value of Pearson correlation between teachers' awareness and teaching experience was negatively correlated ( $r = -0.027$ ). results also revealed that there is no statistically significant correlation at the 0.05 level ( $p = 0.523$ ). Therefore, it is evident that increase in teaching experience led to lower awareness of child mental health and vice-versa.

Hence, H<sub>08</sub>: There is no significance correlation between perception of teachers on child mental health and their teaching experience – *is failed to reject*.

#### 4.2.2 Hypotheses Testing matrix

**Table 4.24 Showing hypotheses testing matrix.**

HYPOTHESES	REMARKS
<b>H<sub>01</sub></b> : THERE IS NO SIGNIFICANCE DIFFERENCE IN PERCEPTION OF TEACHERS ON CHILD MENTAL HEALTH WITH RESPECT TO THEIR GENDER.	<b>REJECTED</b>
<b>H<sub>02</sub></b> : THERE IS NO SIGNIFICANCE DIFFERENCE IN PERCEPTION OF TEACHERS ON CHILD MENTAL HEALTH WITH RESPECT TO TYPES OF INSTITUTIONS.	<b>FAILED TO REJECT</b>
<b>H<sub>03</sub></b> : THERE IS NO SIGNIFICANCE DIFFERENCE IN PERCEPTION OF TEACHERS ON CHILD MENTAL HEALTH WITH RESPECT TO MENTAL HEALTH RELATED TRAINING.	<b>REJECTED</b>
<b>H<sub>04</sub></b> : THERE IS NO SIGNIFICANCE DIFFERENCE IN PERCEPTION OF TEACHERS ON CHILD MENTAL HEALTH WITH RESPECT TO THEIR HABITATION.	<b>REJECTED</b>
<b>H<sub>05</sub></b> : THERE IS NO SIGNIFICANCE DIFFERENCE IN PERCEPTION OF TEACHERS ON CHILD MENTAL HEALTH WITH RESPECT TO THEIR MEDIUM OF INSTRUCTION.	<b>REJECTED</b>
<b>H<sub>06</sub></b> : THERE IS NO SIGNIFICANCE DIFFERENCE IN PERCEPTION OF TEACHERS ON CHILD MENTAL HEALTH WITH RESPECT TO THEIR HIGHEST EDUCATIONAL QUALIFICATION.	<b>REJECTED</b>
<b>H<sub>07</sub></b> : THERE IS NO SIGNIFICANCE DIFFERENCE IN PERCEPTION OF TEACHERS ON CHILD MENTAL HEALTH WITH RESPECT TO THEIR SOCIAL CATEGORIES.	<b>REJECTED</b>
<b>H<sub>08</sub></b> : THERE IS NO SIGNIFICANCE CORRELATION BETWEEN PERCEPTION OF TEACHERS ON CHILD MENTAL HEALTH AND THEIR TEACHING EXPERIENCE.	<b>FAILED TO REJECT</b>

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**CHAPTER - V**  
**CONCLUSION**

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## CHAPTER V

### CONCLUSION

The current study utilized a cross-sectional survey approach to collect quantitative data via a questionnaire along with a basic information schedule. Major research findings are crucial because they expand existing knowledge, validate or challenge hypotheses, and have practical implications in current research domain. These findings are the foundation of scientific advancement and inform decision-making across various fields. Peer review ensured the accuracy and reproducibility of results, fostering confidence in quantitative work. Furthermore, these findings drive further research, prompting theoretical revisions and raising ethical considerations. Their significance extends beyond academia, impacting policy, practice, and society by aiding decision-making, advancing knowledge, and addressing real-world problems.

#### 5.1 Summary of findings

- **Level of teacher's awareness of child mental health**
  - i. Majority of teachers demonstrated low and moderate (36.73% & 37.82%) level of awareness on child mental health. Only 25.45% teachers showed high awareness on child mental health.
- **Primary teachers' awareness of child mental health and gender**
  - i. Female teachers showed higher awareness in identifying emotional problems among children than male teachers.
  - ii. Female teachers showed higher awareness in identifying peer relationship problems among children than male teachers.
  - iii. Female teachers showed higher awareness in identifying hyperactivity problems among children than male teachers.
  - iv. Female teachers showed higher awareness in identifying conduct problems among children than male teachers.
  - v. Female teachers showed higher awareness in identifying pro-social deficit problems among children than male teachers.
  - vi. Female teachers showed higher awareness in identifying learning problems among children than male teachers.

- vii. Female teachers showed higher awareness in identifying others' problems among children than male teachers.
  - viii. Finally, Female teachers appeared with high awareness of mental health of children than male teachers and the found difference was statistically significant.
- **Primary teachers' awareness of child mental health and type of institutions**
    - i. Private school teachers showed higher awareness in identifying emotional problems among children than govt. school teachers.
    - ii. Private school teachers showed higher awareness in identifying peer relationship problems among children than govt. school teachers.
    - iii. Private school teachers showed higher awareness in identifying hyperactivity problems among children than govt. school teachers.
    - iv. Private school teachers showed higher awareness in identifying conduct problems among children than govt. school teachers.
    - v. Govt. school teachers showed higher awareness in identifying pro-social deficit problems among children than private school teachers.
    - vi. Private school teachers showed higher awareness in identifying learning problems among children than govt. school teachers.
    - vii. Private school teachers showed higher awareness in identifying others' problems among children than govt. school teachers.
    - viii. Finally, Private school teachers possessed high awareness of mental health of children than Govt. school teachers but the found difference was statistically not significant.
  - **Primary teachers' awareness of child mental health and mental health related training**
    - i. Trained teachers showed higher awareness in identifying emotional problems among children than non-trained teachers.
    - ii. Trained teachers showed higher awareness in identifying peer relationship problems among children than non-trained teachers.
    - iii. Trained teachers showed higher awareness in identifying hyperactivity problems among children than non-trained teachers.

- iv. Trained teachers showed higher awareness in identifying conduct problems among children than non-trained teachers.
  - v. Trained teachers showed higher awareness in identifying pro-social deficit problems among children than non-trained teachers.
  - vi. Trained teachers showed higher awareness in identifying learning problems among children than non-trained teachers.
  - vii. Trained teachers showed higher awareness in identifying others' problems among children than non-trained teachers.
  - viii. Finally, Teachers who have any kind of mental health related training showed high awareness of mental health of children than that of who were non-trained and the found difference was statistically significant.
- **Primary teachers' awareness of child mental health and habitation**
    - i. Teachers belonged to semi-urban habitation showed higher awareness in identifying emotional problems among children than teachers belonged to rural and urban habitation.
    - ii. Teachers belonged to semi-urban habitation showed higher awareness in identifying peer relationship problems among children than teachers belonged to rural and urban habitation.
    - iii. Teachers belonged to semi-urban habitation showed higher awareness in identifying hyperactivity problems among children than teachers belonged to rural and urban habitation.
    - iv. Teachers belonged to semi-urban habitation showed higher awareness in identifying conduct problems among children than teachers belonged to rural and urban habitation.
    - v. Teachers belonged to rural habitation showed higher awareness in identifying pro-social deficit problems among children than teachers belonged to semi-urban and urban habitation.
    - vi. Teachers belonged to semi-urban habitation showed higher awareness in identifying learning problems among children than teachers belonged to rural and urban habitation.

- vii. Teachers belonged to semi-urban habitation showed higher awareness in identifying others' problems among children than teachers belonged to rural and urban habitation.
  - viii. Finally, Teachers from semi-urban habitation showed high awareness of mental health of children than teachers from rural and urban habitation and the found difference was statistically significant.
- **Primary teachers' awareness of child mental health and medium of instruction**
    - i. Teachers who used bengali and english both mediums together as medium of instruction appeared with high awareness in identifying emotional problems among children compared to only bengali and english medium separately.
    - ii. Teachers who used bengali and english both mediums together as medium of instruction appeared with high awareness in identifying peer-relationship problems among children compared to only bengali and english medium separately.
    - iii. Teachers who used bengali and english both mediums together as medium of instruction appeared with high awareness in identifying hyperactivity problems among children compared to only bengali and english medium separately.
    - iv. Teachers who used bengali and english both mediums together as medium of instruction appeared with high awareness in identifying conduct problems among children compared to only bengali and english medium separately.
    - v. Teachers who used bengali and english both mediums together as medium of instruction appeared with high awareness in identifying pro-social deficit problems among children compared to only bengali and english medium separately.
    - vi. Teachers who used bengali and english both mediums together as medium of instruction appeared with high awareness in identifying learning problems among children compared to only bengali and english medium separately.
    - vii. Teachers who used bengali and english both mediums together as medium of instruction appeared with high awareness in identifying others' problems among children compared to only bengali and english medium separately.

- viii. Finally, Teachers who usually taught students using both English and Bengali medium, they showed high awareness of mental health of children than teachers who taught in either Bengali or English medium and the found difference was statistically significant.
- **Primary teachers' awareness of child mental health and highest educational qualification**
    - i. Teachers with a Doctor of Philosophy (PhD) degree demonstrated higher awareness in identifying emotional problems among children compared to its other counterparts.
    - ii. Teachers with a Doctor of Philosophy (PhD) degree demonstrated higher awareness in identifying peer relationship problems among children compared to its other counterparts.
    - iii. Teachers with a Master degree demonstrated higher awareness in identifying hyperactivity problems among children compared to its other counterparts.
    - iv. Teachers with a Doctor of Philosophy (PhD) degree demonstrated higher awareness in identifying conduct problems among children compared to its other counterparts.
    - v. Teachers with a both Master and Doctor of Philosophy (PhD) degree demonstrated higher awareness in identifying pro-social deficit problems among children compared to its other counterparts.
    - vi. Teachers with a Doctor of Philosophy (PhD) degree demonstrated higher awareness in identifying learning problems among children compared to its other counterparts.
    - vii. Teachers with a Doctor of Philosophy (PhD) degree demonstrated higher awareness in identifying others' problems among children compared to its other counterparts.
    - viii. Teachers with a Doctor of Philosophy (PhD) degree demonstrated higher mental health awareness of children compared to its other counterparts and found difference statistically significant.

- **Primary teachers' awareness of child mental health and social category**
  - i. Teachers belonged to Other backward classes (OBC) social category showed higher awareness in identifying emotional problems among children compared to its other counterparts.
  - ii. Teachers belonged to Other backward classes (OBC) social category showed higher awareness in identifying peer relationship problems among children compared to its other counterparts.
  - iii. Teachers belonged to Other backward classes (OBC) social category showed higher awareness in identifying hyperactivity problems among children compared to its other counterparts.
  - iv. Teachers belonged to Other backward classes (OBC) social category showed higher awareness in identifying conduct problems among children compared to its other counterparts.
  - v. Teachers belonged to Other backward classes (OBC) social category showed higher awareness in identifying pro-social deficit problems among children compared to its other counterparts.
  - vi. Teachers belonged to Other backward classes (OBC) social category showed higher awareness in identifying learning problems among children compared to its other counterparts.
  - vii. Teachers belonged to Other backward classes (OBC) social category showed higher awareness in identifying others' problems among children compared to its other counterparts.
  - viii. Teachers belonged to OBC category appeared with high awareness of mental health of children than teachers belonged to General, SC and ST categories the found difference was statistically significant.
  
- **Relationship between perception of teachers on child mental health and their teaching experience.**
  - Pearson correlation between teachers' awareness and teaching experience was negatively correlated ( $r = -0.027$ ) and there is no statistically significant correlation at the 0.05 level. Therefore, it is evident that increase in teaching experience led to lower awareness of child mental health and vice-versa.

- Lastly, A negative correlation found between teachers' mental health awareness of children and their teaching experience.

## 5.2 Discussion

Understanding primary teachers' perceptions of children's mental health is essential for shaping effective policies, practices, and professional development. When we delve into teachers' views, we can better equip policymakers and educators with strategies to support children's mental well-being in schools. Research can uncover gaps in teachers' knowledge and training, guiding the creation of tailored professional development programs that enhance teachers' abilities to support their students effectively. Moreover, examining teachers' perceptions can shed light on barriers to early intervention and identify ways to improve the detection and response to mental health issues in educational settings. Addressing any stigmatizing attitudes or misconceptions among teachers can foster more positive attitudes and greater awareness about mental health. Additionally, considering factors like school culture and available resources can help in developing supportive learning environments. Research findings can also promote collaboration among educators, mental health professionals, and other stakeholders, ultimately enriching the professional knowledge base. This collaborative approach is crucial for fostering the well-being and academic success of all students. By humanizing these insights and making them actionable, we can create a more supportive and understanding educational landscape.

Findings showed that Majority of teachers have low to moderate awareness of child mental health, with only 25.45% having high awareness. This may be because they don't get enough training or professional development in this area. Mental health isn't always a priority in their education programs, and there can be stigma or misunderstandings about it. Schools also might not provide enough resources and support to help teachers learn more about child mental health.

Findings revealed that female teachers appeared with high awareness of mental health of children than male teachers and the found difference was statistically significant, possibly due to traditional gender roles emphasizing nurturing and caregiving. Women may have more exposure to discussions about mental health in their personal and professional lives. This observed difference was statistically significant in the study. Ni Chorcora and

Swords (2022) discovered that female teachers and those with more experience in mental illness were more concerned about children's mental health. No other studies showed directly comparable results to these findings.

Findings showed that private school teachers possessed high awareness of mental health of children than Govt. school teachers but the found difference was statistically not significant due to better access to resources, training, and professional development opportunities. Private schools often have smaller class sizes, allowing teachers to focus more on individual student needs. No handful studies found with similar findings but Gorsy et al. (2015) found that teachers in urban (often better-resourced) schools had better mental health levels compared to those in rural schools, which may imply private schools potentially having better resources and training.

Findings revealed that teachers from semi-urban habitation showed high awareness of mental health of children than teachers from rural and urban habitation and the found difference was statistically significant due to a balanced exposure to both advanced resources and community-oriented practices. Semi-urban regions often benefit from proximity to urban centers while maintaining strong community ties, facilitating better mental health awareness. No handful studies found with similar findings but the general trend often indicated rural teachers having less access to resources and training, as seen in Kulkarni et al. (2019), where rural teachers had different levels of knowledge compared to urban teachers.

Findings showed that teachers who have any kind of mental health related training showed high awareness of mental health of children than that of who were non-trained and the found difference was statistically significant because their education equips them with specific knowledge and skills. This training enables them to recognize and address mental health issues more effectively. Mahmoud et al. (2018) showed that awareness programs significantly enhance teachers' understanding of mental health disorders. Similarly, Kerebih et al. (2018) highlighted the importance of increased mental health awareness among teachers through training.

Findings revealed that teachers who usually taught students using both English and Bengali medium, they showed high awareness of mental health of children than teachers who taught in either Bengali or English medium and the found difference was statistically

significant because they are likely more adaptable and culturally attuned. Their bilingual teaching approach may enhance their ability to understand diverse student needs and perspectives. No studies showed directly comparable results to these findings.

Findings showed that teachers belonging to OBC category appeared with high awareness of mental health of children than teachers belonging to General, SC and ST categories the found difference was statistically significant due to potentially greater emphasis on social and community issues within their own experiences. This background might foster a deeper understanding of mental health challenges. No studies showed directly comparable results to these findings.

Findings revealed that teachers with a Doctor of Philosophy (PhD) degree demonstrated higher mental health awareness of children compared to its other counterparts and found difference statistically significant because their advanced education likely includes extensive research and training in various educational and psychological aspects. This higher level of academic exposure equips them with deeper insights into mental health issues. No studies showed directly comparable results to these findings.

Lastly, findings showed that a negative correlation between teachers' mental health awareness of children and their teaching experience may indicate that more experienced teachers rely on outdated knowledge or established routines. Over time, they might have fewer opportunities for updated training in mental health. This trend suggests that continuous professional development is crucial to maintain awareness. The study found this correlation to be statistically significant. Ni Chorcora and Swords (2022) found that more experienced teachers were less likely to offer help, indicating that greater experience might not always correlate with higher mental health awareness. Apart from that, no studies showed directly comparable results to these findings.

### **5.3 Educational Implications**

Present research has several educational implications as follows –

- i. Schools can provide specific training to help teachers understand and manage children's mental health, making sure all teachers are prepared to support their students' emotional needs.

- ii. With increased awareness, teachers can spot mental health issues early and provide help quickly, preventing more serious problems and aiding students' overall growth.
- iii. Knowledgeable teachers can create a classroom environment that is supportive and welcoming, helping all students, especially those with mental health concerns, to feel safe and ready to learn.
- iv. Research findings can guide policymakers to create school policies that prioritize mental health, ensuring there are resources and support for both teachers and students by providing school-based mental health services.
- v. When teachers are aware of mental health issues, they can work better with parents and the community, creating a strong support network for children's mental well-being at school and at home.

#### **5.4 Scope for further study**

The present research, while comprehensive, has certain limitations that must be acknowledged. Despite some constraints, the findings provide valuable insights and pave the way for further research as –

- i. The research was carried out on teachers employed in primary educational institutions. Additional research might be conducted on secondary level and tertiary levels.
- ii. The current investigation was specifically focused on teachers hailing only from the state of West Bengal. Further research may be conducted by a comparative study including other states and countries.
- iii. In the present study, Bi-lingual (Bengali-English) Perception of primary school teachers on children's Mental Health Questionnaire developed by Kerebih et al. (2016) was used. Further studies can be done taking other scales.



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# **APPENDIX INDEX**

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## **BASIC INFORMATION AND DEMOGRAPHIC DATA SCHEDULE**

(Put tick ✓)

Age:.....(in years) Gender: (Male/Female) Habitation: (Rural/Semi-Urban/Urban)

Marital Status: (Unmarried/Married) Work Experience: ..... (in years)

Teacher Training Qualification: (PTTI/D.Ed./D.El.Ed./B.Ed./M.Ed.)

Type of Institution: (Government/Private)

Medium of Instruction in which you take class: (Bengali/English/Both)

Highest Educational Qualification: (H.S./Bachelor Degree/Master Degree/ M.Phil./ Ph.D.)

Social Caste: (General/Scheduled Caste/Scheduled Tribe/Other Backward Classes)

Mental Health related training: (Yes/No) Minority Status: (Non-Minority/Minority)

### **Perception of primary school teachers on children's Mental Health**

Developed by

**Habtamu Kerebih, Hailay Abrha, Reiner Frank and Mubarek Abera**

**(2016)**

মহাশয়/মহাশয়া,

আমি প্রতীক্ষা গোস্বামী, (গবেষক, শিক্ষাবিজ্ঞান বিভাগ, যাদবপুর বিশ্ববিদ্যালয়) আন্তরিকভাবে অনুরোধ করছি যে আপনি এই প্রশ্নমালাটি সম্পূর্ণভাবে পূরণ করবেন। প্রদত্ত তথ্য কঠোরভাবে গোপন রাখা হবে এবং কেবলমাত্র গবেষণার উদ্দেশ্যে ব্যবহার করা হবে। নিচে দেওয়া বিবৃতি গুলো মনোযোগ দিয়ে পড়ে যদি আপনার মনে হয় এগুলি শিক্ষার্থীদের মানসিক সমস্যাগত লক্ষণ তাহলে নির্দিষ্ট জায়গায় চিহ্নিত করুন। প্রথমে হ্যাঁ ও না এর মধ্যে চিহ্নিত করবেন, না মনে হলে শুধু না তে চিহ্নিত করবেন। হ্যাঁ মনে হলে সেটির ভিত্তিতে 1,2,3,4,5 এর মধ্যে চিহ্নিত করবেন, নিচে দেওয়া উত্তর গুলির মধ্যে 1= ততটা সমস্যা নয়, 2= খানিক সমস্যা, 3= মাঝারি সমস্যা, 4= গুরুতর সমস্যা, 5= অতি গুরুতর সমস্যা।

Statements (বিবৃতি)	Your Response	
Thinks things out before acting (কোনো কিছু করার আগে বেশি ভেবে নেওয়া)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Restless, overactive, cannot stay still for long (অস্থির, অতিরিক্ত সক্রিয়, বেশিক্ষণ স্থির থাকতে না পারা)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Quarrelling and bullying other children (ঝগড়া করা এবং অন্য শিশুদের সাথে গুণ্ডামি করা)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Often lies or cheats (প্রায়ই মিথ্যা বলা বা প্রতারণা করা)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Constantly fidgeting or squirming (ক্রমাগত বিরক্ত করা এবং ছলনা করা)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5

Often does not offer to help others (parents, teachers, children) (প্রায়শই অন্যদের সাহায্য করতে না চাওয়া)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Poor attention span, does not see work through to the end (অমনোযোগী, কোনো কাজে শেষ পর্যন্ত মনোযোগ ধরে রাখতে না পারা)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Often complains of headaches, stomach-aches or sickness (প্রায়ই মাথাব্যথা, পেটব্যথা বা অসুস্থতার অভিযোগ করা)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Easily distracted, concentration wanders (সহজেই বিভ্রান্ত হওয়া, মনোযোগ দিতে না পারা)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Not kind to younger children (নিজেদের চেয়ে ছোট বাচ্চাদের প্রতি সদয় না হওয়া)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Often unhappy, depressed or tearful (প্রায়ই অসুখী, বিষণ্ণ বা কাঁদো কাঁদো থাকা)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Uses obscene words (অশ্লীল ভাষা ব্যবহার করা)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Often loses temper (প্রায়ই মেজাজ হারানো)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Picked on or bullied by other youth (সহজে চিহ্নিত করে অন্যদের দ্বারা অপদস্ত হওয়া)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Would rather be alone than with other children (অন্য বাচ্চাদের থেকে আলাদা বা একা একা থাকতে চাওয়া)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Generally not well behaved, usually does not do what adults request (সাধারণত ভাল আচরণ করে না, বড়রা যা অনুরোধ করে না করতে চাওয়া)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Many fears, easily scared (সহজেই ভয় পেয়ে যাওয়া)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Nervous in new situations, easily loses confidence (নতুন পরিস্থিতিতে ভয় পাওয়া, সহজেই আত্মবিশ্বাস হারিয়ে ফেলা)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Generally not liked by other children (সাধারণত অন্যান্য শিশুদের দ্বারা পছন্দ না হওয়া)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Not helpful if someone is hurt, upset or feeling ill (কেউ আহত, বিষণ্ণ বা অসুস্থ বোধ করলে তাকে সাহায্য না করা)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Many worries or often seems worried (প্রায়শই কাউকে চিন্তিত থাকতে দেখা)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Has not at least one good friend (অন্ততপক্ষে একজনও ভালো বন্ধু না থাকা)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Refuse to share readily with other youth, e.g. books, games (সহজেই অন্যদের সাথে কিছু ভাগ করে নিতে না চাওয়া, যেমন - বই, খেলা)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Gets along better with adults than with other youth (সমবয়সীদের তুলনায় বড়দের সাথে বেশি মিশতে চাওয়া)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Is untidy in personal hygiene (ব্যক্তিগত স্বাস্থ্যবিধি মানতে অনিয়মিত)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5

Not considerate of other people's feelings (অন্যদের অনুভূতিকে গুরুত্ব না দেওয়া)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Truancy from school (বিদ্যালয় থেকে পালিয়ে যাওয়া)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Spelling problems (বানান করতে অসুবিধা)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Mathematics problems (অঙ্ক করতে অসুবিধা)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Writing problems (লিখতে অসুবিধা)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Steals from home, school or elsewhere (বাড়ি, বিদ্যালয় বা অন্য কোথাও থেকে চুরি করা)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Speech and language problems (কথা বলতে বা ভাষা ব্যবহারে অসুবিধা)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Reading problems (পড়তে অসুবিধা)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Substance use (cigarette, khat, etc.) (মাদকাসক্ত হয়ে পড়া)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Is suspicious (সন্দেহজনক আচরণ করা)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5
Day time wetting of clothes (যখন তখন মূত্রের কারণে জামাকাপড় ভিজিয়ে দেওয়া)	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, then how much 1 2 3 4 5

# PRIMARY TEACHERS' AWARENESS OF CHILDREN'S MENTAL HEALTH

*By Pratiksha Goswami*

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