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# EXPLORING MENTAL HEALTH AND WELL-BEING AMONG CHILDREN IN RURAL AND LOW SOCIO-ECONOMIC ENVIRONMENTS IN ROMANIA AND KOSOVA


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# 1. EXECUTIVE SUMMARY

This mixed-methods study examines the mental health and well-being of children and adolescents in Kosovo and Romania to inform the development of culturally relevant, school-based interventions.

## Background Objectives

Both countries face rising youth mental-health challenges amid economic hardship, stigma, and uneven service availability. Kosovo's population is one of Europe's youngest, with high youth unemployment and lasting effects of wartime trauma; Romania's demographic shifts and rural–urban disparities similarly impact young people's psychosocial health. The study aimed to:

1. Explore perceptions, practices, and barriers around child and adolescent mental health in rural and low-SES settings.
2. Assess how gender and vulnerability factors influence these perceptions.
3. Develop evidence-based resources and protocols (the IMPACT model) to enhance resilience and emotional intelligence in schools.

## Methodology

- **Qualitative Phase:** 138 participants in focus groups across urban and rural sites (73 in Romania; 65 in Kosovo), including schoolchildren (grades 5–9), parents, teachers, and stakeholders. Sessions probed definitions of mental health, coping strategies, stigma, and system-level supports.
- **Quantitative Phase:** Surveys administered to 924 Romanian and 407 Kosovar students, measuring mental-health knowledge, attitudes, stigma, values, help-seeking behaviors, psychological distress (Kessler-6), health-related quality of life (KIDSCREEN), and experiences of victimization.

## Key Findings

- **Knowledge & Attitudes:** Overall strong basic literacy (>80% correct on core items), with Kosovo excelling in emotional-regulation concepts and Romania outperforming on early warning signs and stigma definitions. Attitudes were similarly positive across countries, with modest advantages for Kosovar students in help-seeking and community collaboration.
- **Stigma & Inclusion:** Both samples believe in recovery and equal respect but report discomfort with proximity to peers experiencing mental-health issues (27% Kosovo; 13% Romania). Endorsement of danger myths was higher in Kosovo (26%) than Romania (18%).
- **Help-Seeking & Support:** Kosovar youth are more likely to turn to family and professionals, whereas Romanian students rely more heavily on peers. Approximately half in both countries know where to find services.

- **Well-being & Distress:** Kosovo reported slightly higher overall well-being and lower anxiety symptoms, while Romanian adolescents exhibited more frequent nervousness and motivational strain. Severe distress levels were comparable.
- **Victimization:** Physical and verbal bullying occurred more frequently in Romania; cyberbullying rates were similar. Urban–rural and gender differences were negligible across most measures.

## Recommendations

- **Curriculum & Training:** Implement interactive stress-management and peer-mentoring workshops, anti-stigma modules, and digital-safety education tailored to each country's needs.
- **Capacity Building:** Increase the number and training of school psychologists; integrate service-learning to normalize help-seeking and strengthen confidentiality.
- **Cross-National Collaboration:** Leverage Romania's expertise in early sign-recognition and Kosovo's strengths in emotional regulation through joint workshops and resource sharing.
- **Resource Awareness:** Launch targeted campaigns to raise visibility of available mental-health services, with user-friendly guides for students and families.

By balancing broad generalizability with local specificity, this study provides a robust foundation for the IMPACT Curriculum Development Protocol, aiming to improve access, awareness, and outcomes for vulnerable youth in both Kosovo and Romania.

# 1. INTRODUCTION

## Background and rationale

According to the latest UNICEF (2024) report it is estimated that 13% of children aged up to 19 experience some form of mental health issues, whereas suicide is one of the leading caueses of mortality for this age group, for around one in six deaths.

Over the past three decades, both Romania and Kosovo have gone through complex challenges, accompanied by dramatic social changes, urbanization, migration and evolving family structures. All these changes have shaped young people's lives. In Romania, EU accession in 2007 spurred workforce mobility and left many rural communities with aging parents and adolescents feeling isolated from traditional support networks (European Commission, 2007). Today, only about 17 % of Romania's population is under age 25 (United Nations, 2022), while in Kosovo nearly half of residents are younger than 25 (United Nations, 2022). Both countries face high youth unemployment, approximately 20 % in Romania (Eurostat, 2023) and 40 % in Kosovo (World Bank, 2023), a well-known risk factor for depression and anxiety. Mental-health services remain uneven: Romania's community mental-health centres vary widely in resources (Ministry of Health Romania, 2015), and in Kosovo child and adolescent psychiatry is concentrated almost entirely in Pristina, with NGOs stepping in elsewhere in limited fashion (WHO Regional Office for Europe, 2018; UNICEF Kosovo, 2020). Cultural stigma around mental illness further suppresses help-seeking, fewer than one in ten young people with a diagnosable disorder ever access care (European Commission, 2019).

This research is part of Work Package 2 (WP2), which focuses on gaining insights into the lived experiences, perceptions, and systemic obstacles impacting the mental health of children in rural and economically disadvantaged areas of Romania and Kosovo. The insights gained from WP2 will serve as a crucial foundation for the creation of the IMPACT Curriculum Development Protocol in Work Package 3 (WP3). This will help ensure that future school-based interventions are relevant to the local context, inclusive, and rooted in service-learning strategies that empower educators in supporting student mental health.

## Mental health and well-being of children and adolescents in Kosovo and Romania an overview

### Romania

Mental health concerns among Romanian children and adolescents are both widespread and under-addressed. Approximately 9 percent of youth require clinical care each year, with conduct disorders (24.19 %), attention-deficit/hyperactivity disorder (22.65 %), anxiety disorders (19.23 %), autism spectrum disorders (14.47 %), and depressive episodes (9.14 %) the most common diagnoses (Kovess et al., 2015; UNICEF, 2023). Romanian adolescents report sadness and suicidal ideation at rates far above their European peers: 33 percent feel sad more than once a week (versus 13 percent elsewhere), 48.9 percent have had suicidal thoughts at least once, and 27.1 percent feel persistently sad (Ciucă & Băban, 2016; UNICEF, 2020).

Despite legal entitlement to care, services remain unevenly distributed. Resources cluster in urban centers while rural areas face severe professional shortages, and the public system emphasizes treatment over prevention (Ciucă & Băban, 2016; UNICEF, 2020). Many

families must turn to private providers or go without support due to low mental-health literacy, pervasive stigma, and practical barriers such as cost and travel time (Eurochild, 2024; Manescu et al., 2023).

Vulnerable subgroups include children of migrant workers (about 8 percent of rural households), refugees and unaccompanied minors, and those with a family history of psychiatric illness. These youth face language barriers, institutional gaps, and social isolation that increase risky behaviors and unmet needs (Aurelia Brînduşe et al., 2024; OECD, 2023; UNICEF, 2020). Social-media–related problems, loneliness, depression, body-image concerns, perfectionism, internet addiction, and risky behaviors, further erode well-being (Iovu et al., 2019; Maftei & Dan, 2023; Roșioră et al., 2025).

At the organizational level, schools largely lack systematic mental-health promotion or psychoeducational programs. School psychologists or counselors [1]are scarce (often one per 800 students), training for teachers and parents is minimal, and preventive activities are sporadic and unmonitored (Mareci & Tudoricu, 2024; UNICEF, 2022). Community-level barriers, cultural stigma and service deserts in rural regions, combine with a policy environment marked by chronic underfunding, reliance on institutional care, and weak anti-stigma initiatives (European Union, 2025; Manescu et al., 2023).

## Kosovo

Mental health among Kosovo's youth is shaped by demographic, historical, and socio-economic factors. As Europe's youngest nation, with one-third of its population under 25, Kosovo faces high rates of poverty that compound chronic stress and impede basic needs (World Bank, 2022; UNICEF, 2024). The legacy of the 1999 war continues to affect families: children of parents with PTSD exhibit significantly elevated anxiety, depression, and trauma symptoms, and maternal wartime trauma is linked to neuroendocrine and epigenetic changes in offspring (Duraku et al., 2023; Muench et al., 2022).

Internalizing disorders are especially common among adolescents, with up to 40% of girls aged 15–17 reporting anxiety, depressive, or psychosomatic complaints (Shahini et al., 2015). Risk factors include early puberty, chronic sleep problems, excessive screen time, low self-esteem, and nighttime fears (Fanaj & Melonashi, 2014; Krasniqi et al., 2024). Suicidal ideation and attempts have risen sharply: ideation climbed from 8% in 2011 to 20% in 2024, and attempts from 3% to 10%, with girls disproportionately affected and even higher rates among those exposed to bullying, substance use, or depression (Arënliu et al., 2014, 2025; ESPAD, 2019; Haskuka et al., 2024).

Digital engagement is pervasive, 97.8% of adolescents own smartphones and average 2–3 hours daily on social platforms, which brings both connection and risk. Nearly one in four report harmful online interactions (e.g., exclusion, threats, contact with strangers), with some incidents escalating to sexual abuse or physical harm (Saliu et al., 2021). Online harassment (13.8%) and rumor-spreading (10.8%) further erode well-being, while high social media use is linked to reduced family interaction and growing intergenerational digital divides (Arënliu et al., 2020; Kalisi & Kadriu, 2020).

Schools are key sites of both vulnerability and opportunity: 77% of students experienced peer victimization in the past month, and over 25% reported emotional or physical victimization by teachers or staff (Arënliu et al., 2022; Kelmendi et al., 2023). Although Kosovo employs around 180 school psychologists, their preventive potential remains under-

[1] In this document, the terms school psychologist and school counselor are used interchangeably to reflect country-specific titles—e.g., school counselor or counselor in Romania and school psychologist in Kosovo.

utilized as referrals are driven by behavioral and academic concerns rather than emotional distress (Arënliu et al., 2022).

Persistent social inequalities, among Roma, Ashkali, and Egyptian communities, and children with disabilities who are largely excluded from mainstream schooling, exacerbate isolation and marginalization (Koha.net, 2023; Terre des hommes, 2022). Despite strong youth interest in shaping well-being initiatives, many lack basic knowledge of where to seek help for depression, violence, or unfair treatment (Save the Children, 2024). Cultural and familial stigma further suppresses help-seeking: although over half recognize needing care, only about 15% access services (Hyseni Duraku, 2025; Shkëmbi et al., 2015).

Overall, underfunding (under 1.5% of health expenditure), fragmented services, and limited anti-stigma efforts leave Kosovo's young people with high unmet needs and few accessible, youth-friendly supports (Arënliu et al., 2024; WHO, 2023).

## Study objectives and research questions

This study used an exploratory sequential mixed method design, combining both qualitative and quantitative methods to explore the mental health challenges of Romanian and Kosvam children and adolescents. The first qualitative phase was conducted to gain an understanding of perceptions and concerns related to mental health, stigma, and help-seeking, as well as resources available, from the perspectives of adolescents, teachers, parents, and local stakeholders through focus group discussions. The knowledge gained through the qualitative phase informed the development and design of the survey on the mental health of children and adolescents in larger populations.

This approach ensured that the mental health programs designed for schools were based on the real experiences and needs of young people in Romania and Kosovo, making them culturally appropriate and relevant. The study collaborative approach involving children, teenagers, educators, and mental health professionals, which fosters a sense of ownership among participants, but also boosts the likelihood of successfully executing and sustaining the interventions.

Overall, the research design provided a strong methodological way to create effective school-based mental health programs, aiming to improve access, awareness, and outcomes for the vulnerable group.

### The study objectives were:

1. Explore perceptions, practices, challenges and concerns regarding children's mental health and well-being among children, caregivers, and educators in rural and low socio-economic settings, in Romania and Kosovo.

2. Assess the impact of gender and vulnerabilities (e.g., SES, disabilities, children in alternative care) on perceptions, practices, and concerns regarding children's mental health and well-being, identifying associated risks and opportunities.

3. Develop methodologies, mechanisms, and resources aimed at enhancing self-confidence, and social-emotional intelligence among children to overcome mental health barriers and foster resilience in school and home environments, through active child participation model called IMPACT clubs.

# 2. METHODOLOGY

## Research Design

This study employed a participatory sequential mixed methods design, starting with qualitative data to explore experiences in depth, followed by quantitative data to validate findings broadly. Engaging stakeholders early ensured culturally relevant tools and fostered trust, supporting the development of effective mental health programs for Romanian children and adolescents (Fetters, Curry, & Creswell, 2013; Jones et al., 2020).

## Qualitative Phase

The overall objective of the qualitative phase was to provide a comprehensive overview of barriers, perceptions, practices, challenges, and concerns regarding children's mental health and well-being in rural and low socio-economic settings in Romania and Kosovo.

- Explore perceptions, practices, challenges, and concerns regarding children's mental health
- Assess the impact of gender and vulnerabilities (e.g., SES, disabilities, alternative care).
- Use the information from focus groups to develop methodologies and resources for enhancing resilience and emotional intelligence.

In order to gain in depth understanding, the focus group included four main target groups: children, parents, teachers, and stakeholders.

The focus groups aimed to explore various aspects of mental health among children, adolescents, and their support networks. The first focus group consisted of children and adolescents and focused on their understanding of mental health, help-seeking behaviors for mental health issues, the influence of the social model on mental health, sources of support and stress, and the stigma associated with mental health. The second focus group included parents and teachers, and it aimed to delve into their perceptions of children's mental health issues. This group discussed the importance of communication and emotional support, the impact of school and academic pressure on young people's mental health, and ways to identify and address mental health challenges while promoting overall mental well-being. The stakeholders involved in these focus groups sought to gain an in-depth understanding of the current state of mental health among children and adolescents, assess access to services, and highlight the importance of school and community support activities, as well as family involvement.

## Sampling and participant selection

### Romania

Data were gathered through seven focus-group sessions across three Romanian counties and one online forum:

- **Cluj (urban, March 2025):** Three separate in-person groups, with schoolchildren, parents, and teachers, explored local definitions of mental health, perceived needs,

stigma, and common coping practices.

- **Hunedoara (small urban, April 2025):** A second set of in-person focus groups with students, parents, and teachers mirrored the Cluj discussions, enabling comparison between larger and smaller urban contexts.

- **Iași (rural, March 2025):** An in-person session with schoolchildren probed the unique challenges of rural life, including service shortages and social isolation.

- **Combined Stakeholder Forum (online, April 2025):** Representatives from schools, local health services, NGOs, and county education offices across all three sites convened digitally to integrate broader policy and program perspectives.

Each session was led by the principal researcher in Romania, who guided the dialogue, ensured alignment with research objectives, and encouraged open participation, and supported by an assistant charged with detailed note-taking and logistical coordination.

In total, 73 individuals shared their experiences and perspectives during the qualitative phase (See table 1). This included 31 schoolchildren, 10 from Dej (urban), 10 from Lupen (small urban), and 11 from Parcovaci (rural), of whom 22 were girls, providing a balance of voices across settings. Another 31 participants were parents and teachers, organized into three mixed groups (11 in Dej, 10 in Lupen, 10 in Parcovaci), with 15 parents and 16 teachers contributing insights on family and classroom dynamics. Finally, an 11-member online stakeholder forum brought together representatives from county education offices, local health services, and NGOs, ensuring that system-level challenges and opportunities were captured alongside on-the-ground experiences.

## Kosovo

Data was collected through a series of focus group discussions conducted in different urban and rural settings. In Gjakova and Hani i Elezit, a total of 8 focus groups. Focus groups in each city were conducted with school children in grades 6 to 9 in urban and rural areas, another joint focus group with parents, teachers, and stakeholders was held in March 2025.

Across Kosovo, 65 individuals participated in our qualitative inquiry, providing their perspective on youth mental-health experiences from the classroom to the policymaking table. Four youth groups, two in Hani i Elezit and two in Gjakova, brought together 32 schoolchildren (ages 11–15), each evenly split between girls and boys, to contrast urban and rural perspectives on stress, support, and stigma. Two mixed parent–teacher discussions (six participants in Hani i Elezit; eight in Gjakova) revealed the challenges families and educators face in nurturing emotional well-being. Finally, a pair of stakeholder forums (13 attendees in Hani i Elezit; seven in Gjakova) convened school psychologists, municipal officials, and NGO representatives, school directores ensuring that system-level barriers and opportunities informed our understanding on mental health related issues. This purposive, gender-balanced sample across both municipalities provided a rich, multi-layered portrait of mental-health needs and resources in Kosovo's diverse settings.

TABLE 1. FOCUS GROUP PARTICIPANTS, BY COUNTRY, SITE AND GROUP

| COUNTRY | LOCATION/REGION | GROUP | TOTAL (N) | FEMALE | MALE |
|---|---|---|---|---|---|
| KOSOVO | Hani i Elezit | Urban Youth | 8 | 4 | 4 |
| | | Rural Youth | 8 | 4 | 4 |
| | | Parents & Teachers | 6 | 3 | 3 |
| | | Stakeholders | 13 | 6 | 7 |
| | Gjakova | Urban Youth | 7 | 3 | 4 |
| | | Rural Youth | 8 | 4 | 4 |
| | | Parents & Teachers | 8 | 4 | 4 |
| | | Stakeholders | 7 | 3 | 4 |
| ROMANIA | Cluj (Urban) | Children | 10 | 6 | 4 |
| | | Parents & Teachers | 11 | 8 | 3 |
| | Hunedoara (Small Urban) | Children | 10 | 9 | 1 |
| | | Parents & Teachers | 10 | 7 | 3 |
| | Iași (Rural) | Children | 11 | 7 | 4 |
| | | Parents & Teachers | 10 | 9 | 1 |
| | All Regions | Stakeholders (combined) | 11 | - | - |

## Analytical approach (e.g., thematic analysis)

The methodology of this part of the study employed a qualitative approach using thematic analysis to systematically identify and interpret patterns within the collected data. Data consisting of focus group discussions were analyzed following the six-step process outlined by Braun and Clarke (2006): familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the final report. This approach was chosen for its flexibility and effectiveness in capturing rich, detailed insights relevant to the research questions. An inductive coding process was applied, allowing themes to emerge naturally from the data without imposing preconceived categories. Throughout the analysis, reflexivity was maintained to minimize researcher bias and ensure credibility of findings. Focus group notes translated to English were coded and analyzed using ATLAS.ti software to identify key themes and patterns related to the study objectives.

Main themes that emerged from qualitative research in both countries were: perception (understanding) of mental health; coping strategies toward mental health; bullying and social exclusion; school environment; collaboration between school and family; support outside school, stigma and sources of stress.

## Ethics and consent

Informed consent was obtained from all participants, assuring them of their anonymity and the confidentiality of their contributions. Particularly, parental consent was essential, and consent forms were distributed and collected 1-2 days prior to data collection. This timeframe allowed parents ample opportunity to understand the study's objectives and implications before granting consent for their children's participation. Participants were made aware that they could withdraw from the study at any time without consequence.

# Quantitative Phase

A sequential exploratory research design begins with a qualitative phase to explore a phenomenon in depth, which then informs the development of the subsequent quantitative phase. This approach allows qualitative findings to guide the creation of instruments or hypotheses for quantitative testing, enhancing the validity and relevance of results. It is especially useful when existing theory or measures are limited (Creswell, 2014; Creswell & Plano Clark, 2017). Therefore, findings from qualitative phases of the study informed the design of the questionnaire, which included a section on knowledge, attitudes, stigma, and values related to mental health. Additionally, help-seeking behaviors, violence, and cyberbullying, as well as psychological distress, were also measured.

## Measures used in the study

**Mental health literacy** and social-emotional learning (SEL) assessment tool was used to assess different dimensions related to mental health (O'Conor & Casey, 2015), including:

**Knowledge-related questions** were developed based on the PERMA model, a theoretical framework introduced by Martin Seligman to understand and promote well-being. The model encompasses five key elements: **Positive Emotions**, **Engagement**, **Relationships**, **Meaning**, and **Accomplishment**. It posits that enhancing these dimensions can lead to increased happiness and overall well-being (Seligman, 2011). In addition to questions aligned with the PERMA model, the questionnaire included items assessing participants' knowledge of mental health, service learning, and engagement. All questions were structured as multiple-choice with a single correct answer.

Ten **attitude-related questions** were developed by the researchers in order to assess participants' views on mental health, empathy, and engagement within their communities as an important component of current project and services learning. The items explore key attitudes such as comfort in seeking help, respect for individuals regardless of their mental health status, and the belief that helping others and working together can enhance collective well-being. Additionally, they assess emotional awareness, such as the ability to recognize when someone is struggling, and personal responsibility in standing up against bullying or exclusion. Other items reflect self-regulation and agency, including the use of peaceful communication and goal-setting to support emotional health. Together, these questions capture a multidimensional view of attitudes that support mental health, prosocial behavior, and community-oriented thinking.

**Stigmatizing attitudes towards mental health** were measured with seven items adapted from the Adolescent Attitudes Toward Serious Mental Illness Scale, Adolescent Version (ATSMI-AV) developed by Watson, Miller, and Lyons (2005). Each statement was rated on a 5-point Likert scale ranging from *1 = Strongly Disagree* to *5 = Strongly Agree*, with higher scores reflecting stronger stigma. Illustrative items include "Most people with mental illnesses

can recover if they get help," "I would feel nervous sitting next to someone with a mental health problem," and "People with mental health problems are usually dangerous."

**Values-based behavior was measured with three short, multiple-choice scenarios covering** (1) including a peer with a mental-health problem, (2) healthy ways to cope with stress, and (3) respectful conflict resolution. In each scenario, one option matched the desired value, standing up for the excluded peer, talking to a trusted person, and using non-violent communication, respectively. Answers were scored 1 for the value-consistent choice and 0 for any other, then summed to a total of 0–3, where higher scores show stronger support for these prosocial, adaptive values.

**Help-seeking:** The four items assess intentions in seeking help for mental health concerns, including (talking to friends, family, teacher and knowing where to ask for help (Whilson, et al., 2005)

**Violence** was measured using instruments on school victimization from Benbenishty and Astor (2005) study. Physical ("A student has pushed or shoved you"), verbal ("Insulted you"), relational ("Someone has spread rumors about you in school"), and sexual ("made sexual comments"). The frequency categories shown in prior tables ("Did not happen last month / Once or twice / Three or more times" or similarly "Never / Once or twice / Several times")

**Cyber- bullying** was also measured via instruments developed by Benbenishty and Astor (2005). Items such as "Someone teased, disturbed or threatened you through phone/internet," "Someone has spread gossip/rumors (internet, emails, social media). The reported frequency categories ("Did not happen last month / Once or twice / Three or more times")

**Psychological distress** was measured using The Kessler Psychological Distress Scale (K6+). This is a 6-item self-report measure of psychological distress intended to be used as a quick tool to assess risk for serious mental illness in the general population. On the first critical item, participants indicate how often they have had six different feelings or experiences during the past 30 days using a 5-point Likert scale: 4 (All of the time), 3 (Most of the time), 2 (Some of the time), 1 (A little of the time), and 0 (None of the time).

The **KIDSCREEN** questionnaires (N-10 items) was used to assess the subjective health and the psychological, mental and social well-being of children and adolescents (HRQoL). Participants indicate whether they experienced these feelings, using 5- point Likert scale, from not at all (1) to extremely (5). A major strength of the KIDSCREEN questionnaires is their simultaneous development in 13 European countries, which allows meaningful cross-cultural comparisons of health-related quality of life.

The quantitative aspect of this study employed a structured approach to gather measurable data regarding student experiences and outcomes across grades 5 to 8 (Romania), and 6 to 9 (Kosovo). Using purposeful sampling, data were collected from all 10 schools involved in the project, and the requirements were:

- Each school is required to administer the questionnaire to at least one class per grade level (grades V–VIII in Romania and VI-IX in Kosovo).
- It is essential that both boys and girls are represented at each level.
- The minimum number of students to be included is 60 for schools in rural areas and 90 for schools in urban areas, to have an equal split.

## Sampling strategy and sample size

In each country, we selected six public schools to represent both urban and rural settings across multiple regions, then used a two-stage sampling process to recruit students:

School Selection (Purposeful Sampling):

- Kosovo: Six schools were chosen across two municipalities, Gjakova and Hani i Elezit, with three urban schools and three rural schools to capture geographic and community diversity.
- Romania: Six schools were drawn from three regions, each contributing one urban and one rural school, ensuring coverage of distinct socio-economic and cultural contexts.

## Student Selection (Random Sampling):

At each school, we targeted students in four consecutive grades (grades 6–9 in Kosovo; grades 5–8 in Romania), corresponding to ages 11–15. Within each randomly selected grade, approximately 20 pupils were invited to participate, yielding approximately 80 students per school and a robust overall sample for quantitative analysis.

Table 2 presents a side-by-side comparison of key demographic characteristics for the Romanian (N = 924) and Kosovo (N = 407) survey samples. Both countries achieved nearly equal gender representation and similar grade-level distributions across early secondary years. Parental education varies: Romanian mothers and fathers more frequently hold post-secondary degrees, whereas Kosovo families report higher proportions of primary-level schooling. Maternal employment is substantially higher in Romania (73 % vs. 38 %), while paternal workforce participation is uniformly strong in both contexts (88 % and 92 %). Missing data are minimal across all categories. This table illustrates both shared patterns, balanced gender and grade spread, strong paternal employment, and country-specific contrasts in maternal education and employment.

TABLE 2. DEMOGRAPHIC CHARACTERISTICS OF ROMANIAN AND KOSOVO SURVEY SAMPLES

| VARIABLE | CATEGORY | ROMANIA N (%) | KOSOVO N (%) |
|---|---|---|---|
| Gender | Girls | 475 (51.4) | 201 (49.4) |
| | Boys | 403 (43.6) | 203 (49.9) |
| | Prefer not to declare/respond | 42 (4.5) | 3 (0.7) |
| | Other | 4 (0.4) | - |
| Grade Level | V (5th) | 225 (24.3) | - |
| | VI (6th) | 207 (22.4) | 102 (25.1) |
| | VII (7th) | 246 (26.6) | 102 (25.1) |
| | VIII (8th) | 246 (26.6) | 97 (23.8) |
| | IX (9th) | - | 106 (26.0) |
| Mother's Education | No formal education | 6 (0.6) | 9 (2.2) |
| | Primary | 73 (7.9) | 24 (5.9)<br>156 (38.4) [1] |

| | | | |
|---|---|---|---|
| | **High school** | 390 (42.2) | 117 (28.8) |
| | **BA / MA / PhD** | 277 (30.0) | 100 (24.6) |
| | **Don't know / Missing** | 172 (18.6) [2] | - |
| **Father's Education** | **No formal education** | 4 (0.4) | 10 (2.5) |
| | **Primary** | 17 (1.8) | 16 (3.9)<br>90 (22.2) [3] |
| | **High school** | 515 (55.8) | 163 (40.1) |
| | **BA / MA / PhD** | 184 (19.9) | 127 (31.3) |
| | **Don't know / Missing** | 208 (22.5) [4] | - |
| **Mother Employment** | **Yes** | 671 (72.6) | 152 (37.7) |
| | **No** | 237 (25.6) | 249 (61.8) |
| | **Missing** | 20 (2.2) | 2 (0.5) |
| **Father Employment** | **Yes** | 815 (88.1) | 373 (92.3) |
| | **No** | 76 (8.2) | 29 (7.2) |
| | **Missing** | 37 (4.0) | 2 (0.5) |

[1] Kosovo "Primary" split into 1–4/1–5 (5.9 %) and 5–8/6–9 (38.4 %) levels
[2] Romania "Don't know" (17.6 %) + "Missing" (1.0 %)
[3] Kosovo "Primary" split into 1–4/1–5 (3.9 %) and 5–8/6–9 (22.2 %) levels
[4] Romania "Don't know" (21.1 %) + "Missing" (1.4 %)

## Statistical analyses (descriptive, inferential)

The data gathered from the questionnaires were analyzed using statistical software to identify trends, relationships, and patterns among the variables. Descriptive statistics provided a comprehensive overview of the participant demographics, while inferential statistics assessed the impact of interventions across urban and rural settings.

# 3. FINDINGS

## Qualitative Results

### Perceptions of Mental Health

Commonality: Youth in both countries primarily define mental health through negative emotional states, yet a minority begin to articulate more positive notions.

- Kosovo children describe panic and trauma under school stress:
  "Panic attacks happen to some of us, especially in a foreign-language class when the pressure gets too much."

- Romanian children similarly report only "feeling sad, stressed, or 'not myself,'" worrying that opening up will breach confidentiality:
  "I don't know what it means. I've heard teachers talk about it , our head teacher tells us not to get angry and to find ways to calm down."

- Glimpses of positivity emerge:

    - Kosovo pupil: "Sometimes I write in a notebook or talk to a chatbot, at least it listens."

    - Romanian peer: "Most children associate mental health with ideas like being at peace with yourself or doing things you enjoy that help you grow."

- Parents and teachers note rising stress but debate whether it reflects real increases or greater awareness. In Kosovo, a teacher observes,
  "They are more stressed than before… maybe they just know more now and talk about it."
  In Romania, parents add that high grades are often conflated with well-being:
  "Children don't have real problems… High grades bring well-being."

- Stakeholders confirm growing visibility but lament lack of systematic measures. Kosovo's school psychologist warns,
  "We see more anxiety and depression every year, but we don't have any proper measures to assess what's happening."

### Negative Coping and Withdrawal

Commonality: Withdrawal, emotional or physical, is the default strategy in both settings.

- Children

    - Kosovo: "When I'm upset, I stay quiet and keep to myself."

    - Romania: "I don't talk about my sadness because it just makes me feel worse."

- Parents and Teachers
    - Kosovo teachers note students “skipping classes” after episodes of distress.
    - Romanian parents report children “spend a lot of time on the phone, they don’t know how to manage their time.”

## Bullying and Social Exclusion

Commonality: Bullying is so routine it becomes background noise in corridors and online.

- Children
    - Kosovo: “It’s like background noise, you’re always expecting someone to say something mean.”
    - Romania: “Bullying is routine in school corridors and online spaces.”
- Parents and Teachers
    - Kosovo: Teachers describe exclusion as “like you’re invisible.”
    - Romania: “Disclosure can trigger victimization, sharing personal stories often becomes ‘fuel’ for further ridicule.”
- Stakeholders
    - Kosovo NGO rep: “We need more school-based programs, especially for minorities like the RAE community…”

## Rising Cyberbullying

Commonality: Girls are disproportionately targeted online; digital abuse often spills into school life.

- Children
    - Kosovo: “They made memes out of her photo and shared them everywhere.”
    - Romania: “Online bullying is common, people can be more aggressive online than in real life.”
- Parents and Teachers
    - Romania: Parents worry that “their role models are those from the internet… aggressive models.”

## Self-Directed Coping Strategies

Commonality: In the absence of formal support, children turn to creative or physical outlets.

- Children

- Kosovo: “Drawing, acting, playing football, or reading helps me relax and manage stress.”
- Romania: “I put on my headphones and the music calms me.”
- Romania: “In class I close my eyes and imagine I’m at the beach.”

## Hobbies as Well-Being Tools

Commonality: Hobbies serve as everyday self-care, coping, improving mood and belonging.

- Children
  - Kosovo: “After school we play football or volleyball; that’s our favourite time.”
  - Romania: “Drawing, sports, and gaming serve as emotional outlets for stress and promote overall well-being.”

## Silence Around Sensitive Issues

Commonality: Fear of gossip in tight-knit communities suppresses talk of violence, self-harm, or suicide.

- Children
  - Kosovo rural: “If you talk about violence or suicide here, everyone knows the next day.”
  - Romania: “Mental health isn’t talked about at school, not even during homeroom.”

## School Environment and Help-Seeking

Commonality: Students want empathetic, confidential support but mistrust and capacity gaps block access.

- Children
  - Kosovo: “Most students were aware of the school psychologist but rarely approached them; stigma was the main barrier.”
  - Romania: “Some kids go to a private psychologist because they don’t trust the school one.”
- Teachers and Stakeholders
  - Kosovo psychologist: “We don’t have any proper measures to assess what’s happening related to mental health.”
  - Romania NGOs call for service-learning and monitoring frameworks to improve equitable access

## Family and Peer Support

Commonality: Family and close friends are primary confidants, though deep sharing is limited by fear of judgment.

- Children
    - Kosovo: “When we feel bad, we talk to family members or close friends; only two teachers feel approachable.”
    - Romania: “Hugs, affection, and sincere encouragement are seen as strong support resources.”
- Parents
    - Kosovo: “I speak very often with my daughter… she has no hesitation to speak to me.”
    - Romania: Parents & teachers recognize peer bonds but note that “children don’t feel heard when they try to speak up.”

## Information Sources and Stigma

Commonality: Knowledge is fragmented, school talks, social media, family, and stigma still deters open discussion.

- Children
    - Kosovo: “Sometimes I write in a notebook or talk to a chatbot, at least it listens.”
    - Romania: “I’ve heard teachers talk about it… but no one asks us to go into the class.”
- Stakeholders
    - Romania: “Mental health isn’t talked about at school… although we have materials, no one asks us to go into the class.”

**TABLE 3. MAIN THEMES**

| Main Theme | Romania Children | Kosovo Children | Romania Teachers & Parents | Kosovo Teachers & Parents | Romania Stake-holders | Kosovo Stake-holders |
|---|---|---|---|---|---|---|
| **Perception of Mental Health** | Define mental health as “sad,” “stressed,” or “not normal”; few positive views; worry that counselors will tell parents. | Limited understanding, linked to negative emotional states like sadness and stress; few positive views; stigma remains. | Link mental health to negative emotions; some conceptual awareness, but stigma and lack of resources present. | Link mental health to negative emotions; some awareness, but stigma and lack of resources present. | Note growing visibility of youth mental health issues, but limited intervention tools. | Stakeholders note growing visibility of mental health issues among children, with increasing awareness but limited intervention tools. |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Negative Coping** | "Bottle it up," withdraw alone when upset; no guided support available. | Avoidance and withdrawal from emotions, often isolating themselves to manage discomfort. | Worried about students withdrawing but unsure how to intervene effectively. | Teachers express concerns about students withdrawing but are unsure of how to intervene effectively | Acknowledge avoidance but lack preventive systems. | Stakeholders acknowledge negative coping strategies like isolation and avoidance but lack preventive systems. |
| **Bullying & Exclusion** | Teasing, exclusion and social exclusion seen as part of daily school life. | Bullying as a normalized part of school life; exclusion and teasing are common. | Bullying frequent but teachers lack tools to address it properly. | Teachers note bullying as frequent but often lack tools to address it properly | Emphasize need for structured anti-bullying programs. | Stakeholders emphasize the need for greater intervention in bullying, particularly among marginalized groups. |
| **Rising Cyberbullying** | Encounter online rumors and exclusion; uncertain where to turn for help. | Cyberbullying through social media is common, with girls more often targeted. | Concerned about social-media risks but uncertain how to educate students. | Social media is seen as both a learning tool and a risk for mental health, especially among girls. | Call for digital-safety curricula and stronger enforcement. | Stakeholders call for stronger action against cyberbullying, with some even requiring legal intervention. |
| **Self-Directed Coping** | Use music, drawing, walks, simple mindfulness exercises on their own. | Students use creative and physical activities like drawing, football, and walking to manage stress. | See students relying on solitary hobbies but unsure how to offer effective support. | Teachers notice students relying on solitary activities but are unsure of how to offer effective support. | Stress the gap between informal coping and professional services. | Stakeholders highlight that many children use creative strategies to cope but stress the need for more formal support. |
| **Hobbies as Well-Being Tools** | Drawing, sports, and gaming serve as emotional outlets and mood lifters. | Hobbies such as drawing, sports, and gaming serve as emotional outlets for stress and promote overall well-being. | Value extracurriculars but lack resources to expand offerings. | Some teachers believe in more training for handling mental health issues but feel limited | Endorse partnerships with NGOs for after-school activities. | Stakeholders advocate for creating more accessible extracurricular activities to support emotional well-being. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | by time and resources. | | |
| **Silence on Sensitive Issues** | Violence, self-harm, and suicide rarely discussed; fear of gossip. | Silence around violence and suicide, especially in rural areas, due to gossip and fear of judgment. | Parents and teachers avoid broaching topics without guidance. | Some teachers believe in more training for handling mental health issues but feel limited by time and resources | Point to cultural taboos hindering open dialogue. | Stakeholders point to cultural barriers in rural areas preventing open discussion on mental health. |
| **School Environment** | Appreciate caring moments but mistrust counselors; large caseloads dilute support. | Positive emotions linked to supportive relationships and engaging activities. Students want more interactive learning. | Identify lack of training and time to build trust with students. | Teachers recognize positive emotions tied to engagement but face challenges in providing the necessary support. | Advocate lower counselor-student ratios and preventive programs. | Stakeholders agree on the need for a better school environment to foster mental well-being, emphasizing supportive relationships. |
| **Suggestions for Resilience** | Want stress-management workshops, peer-mentoring, interactive lessons on emotions. | Students want interactive, kinder, and non-judgmental teaching methods. They advocate for stress-management programs. | Ask for mental-health first-aid training and classroom coping techniques. | Teachers advocate for more resources for well-being and mental health support but struggle to implement changes. | Recommend service-learning modules and regular well-being check-ins. | Stakeholders push for resilience-building through preventive efforts, focusing on outreach and education. |
| **Other Themes** | Confuse “stigma” with “anti-stigma” actions; rely on peer myths. | Limited engagement with mental health topics; relying on peer support; fear of judgment prevents seeking help. | Desire more mental-health time in curriculum but constrained by exam demands. | Some teachers believe in more training for handling mental health issues but feel limited by time and resources. | Stress importance of data monitoring to track impact. | Stakeholders emphasize the need for more school-based mental health programs and the importance of early intervention. |

TABLE 4. CONTEXT-SPECIFIC NUANCES IN QUALITATIVE THEMES

| Theme | Romania | Kosovo |
|---|---|---|
| **Perception of Mental Health** | Define mental health as “sad,” “stressed,” or “not normal”; few positive views; worry counselors will tell parents. | Limited understanding, linked to negative emotional states like sadness and stress; few positive views; stigma remains. |
| **Negative Coping** | “Bottle it up,” withdraw alone when upset; no guided support available. | Avoidance and withdrawal from emotions, often isolating themselves to manage discomfort. |
| **Bullying & Exclusion** | Teasing, exclusion and social exclusion seen as part of daily school life. | Bullying as a normalized part of school life; exclusion and teasing are common. |
| **Rising Cyberbullying** | Encounter online rumors and exclusion; uncertain where to turn for help. | Cyberbullying through social media is common, with girls more often targeted. |
| **Self-Directed Coping** | Use music, drawing, walks, simple mindfulness exercises on their own. | Students use creative and physical activities like drawing, football, and walking to manage stress. |
| **Hobbies as Well-Being Tools** | Drawing, sports, and gaming serve as emotional outlets and mood lifters. | Hobbies such as drawing, sports, and gaming serve as emotional outlets for stress and promote overall well-being. |
| **Silence on Sensitive Issues** | Violence, self-harm, and suicide rarely discussed; fear of gossip. | Silence around violence and suicide, especially in rural areas, due to gossip and fear of judgment. |

| | | |
|---|---|---|
| **School Environment** | Appreciate caring moments but mistrust counselors; large caseloads dilute support. | Positive emotions linked to supportive relationships and engaging activities. Students want more interactive learning. |
| **Suggestions for Resilience** | Want stress-management workshops, peer-mentoring, interactive lessons on emotions. | Students want interactive, kinder, and non-judgmental teaching methods. They advocate for stress-management programs. |
| **Other Themes** | Confuse “stigma” with “anti-stigma” actions; rely on peer myths. | Limited engagement with mental health topics; relying on peer support; fear of judgment prevents seeking help. |

# Quantitative Results

## Knowledge about mental health

Across both Kosovo and Romania, young people demonstrate a solid foundation of mental-health knowledge, with clear majorities correctly answering most of the fifteen core questions. The two items with the highest correct-response rates in both samples are the definition of non-violent communication (over 87 % in each country) and the functional definition of mental health, “how we think, feel, and handle life’s challenges” (over 83 % in Kosovo and 88 % in Romania). These results suggest that basic concepts of respectful communication and the broad, strengths-based understanding of mental health have been successfully conveyed through school curricula or public campaigns in both contexts.

Romanian respondents outperform Kosovo on twelve out of fifteen items, often by sizeable margins. The largest gaps appear around recognizing early warning signs of unhealthy relationships (67 % correct in Romania versus just 43 % in Kosovo), understanding how social media can harm mental health through stress and social comparison (68 % vs. 58 %), and defining self-awareness as knowing one’s own feelings, strengths, and needs (81 % vs. 69 %). These differences point to potential areas where Kosovo’s mental-health education could be strengthened, particularly in helping adolescents identify controlling or coercive behaviors in friendships and in fostering digital-literacy skills around online emotional well-being.

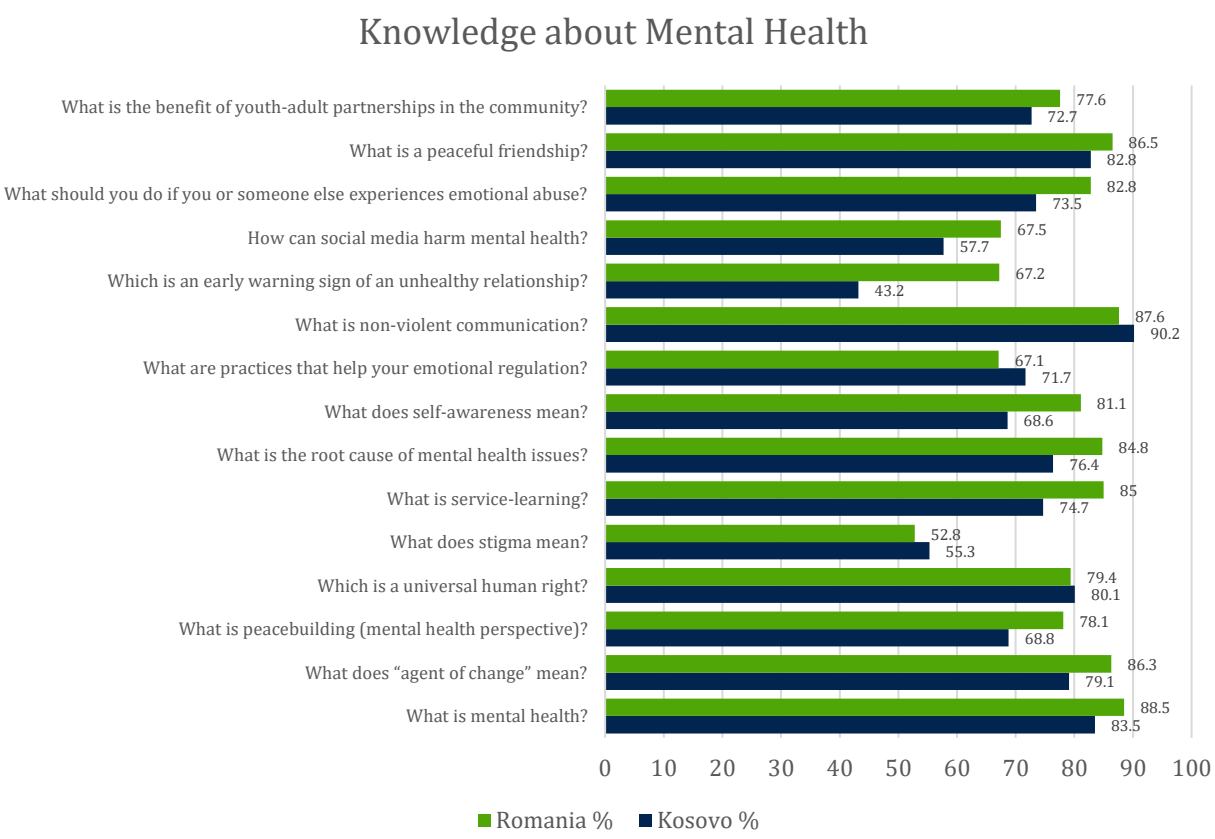
Conversely, Kosovo holds a narrow lead on three items. Students in Kosovo slightly outperform their Romanian peers when it comes to identifying healthy emotional-regulation practices, “controlling and managing your emotions in healthy ways” (72 % vs. 67 %), and, by a hair’s breadth, in recognizing mental health care as a universal human right (80 % vs. 79 %). Kosovo also edges out on non-violent communication, suggesting that classroom or community programs there place particular emphasis on emotional self-management and the importance of calm, respectful dialogue.

Both countries show room for growth in certain mid-range areas (60 %–80 % correct), especially peacebuilding as emotional healing (68 % in Kosovo, 78 % in Romania), the

concept of service-learning (75 % vs. 85 %), and the idea of root causes behind mental health issues (76 % vs. 85 %). Meanwhile, the lowest overall score in Kosovo is on early warning signs of unhealthy relationships (43 %), and in Romania on the definition of stigma itself (53 %). These focal points could guide the next phase of program development: relationship–health modules in Kosovo, and stigma-clarification components in Romania.

In practical terms, educators and youth-serving organizations might consider peer exchanges or joint workshops where each country can share its strengths, Romania's expertise in early sign-recognition and self-awareness, and Kosovo's emphasis on emotional-regulation techniques. By building on these complementary assets, both contexts can move toward a more comprehensive, mutually informed approach to mental-health literacy among adolescents.

**FIGURE 1: KNOWLEDGE ABOUT MENTAL HEALTH, COMPARISONS BY COUNTRIES**




## Attitudes toward mental health

Across nearly every item, Kosovo students show a slightly stronger "Agree" response than their Romanian peers, suggesting marginally higher overall positive endorsement of these mental-health attitudes.

- **Comfort asking for help (Q1):** 58.6 % of Kosovars agree versus 47.8 % of Romanians, with Romania's larger neutral share (30.7 % vs. 21.7 %) hinting at more ambivalence.

- **Respect and dignity (Q2):** Over 85 % of Kosovars agree that everyone deserves respect, compared to about 79 % in Romania, both very high, but Kosovo edges ahead.
- **Community collaboration (Q3):** 72 % of Kosovars agree community work enhances well-being, versus 59 % of Romanians; again, Romania shows a larger neutral segment.

When it comes to **helping others (Q4/Q5)**, both countries cluster in the mid-50s to mid-60s for "Agree," with Romania slightly higher on Q5 (64 % vs. 57 %), suggesting Romanian youth feel a bit stronger about the personal mental-health benefits of service.

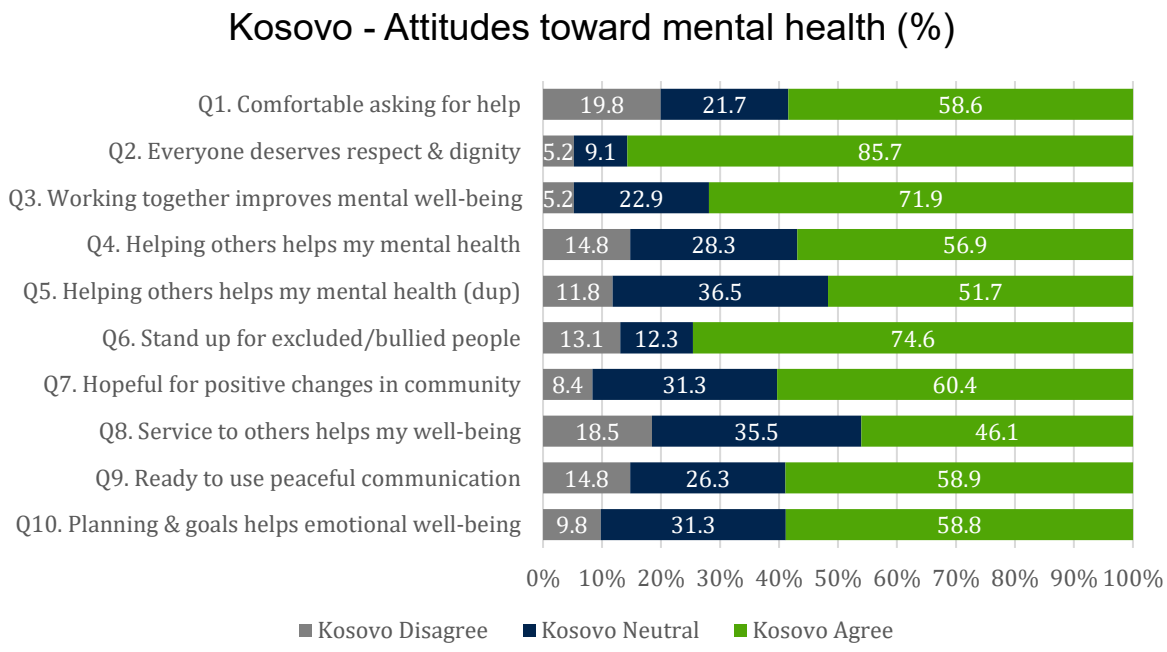
- **Standing up for excluded peers (Q6):** Agreement is high in both samples (75 % vs. 72 %), reflecting broad anti-bullying norms.

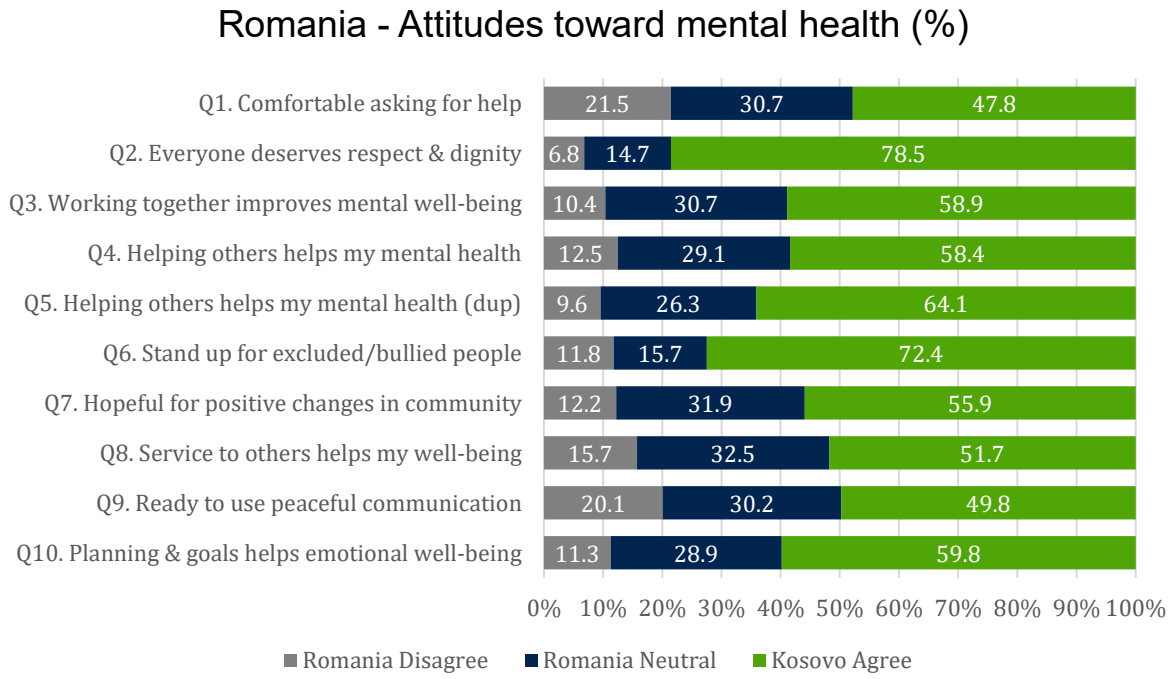
- **Hope for change (Q7):** About 60 % of Kosovars and 56 % of Romanians agree they can make a difference, Kosovo again shows a modest lead.

- **Service and well-being link (Q8):** This is the most mixed item, with only 46 % of Kosovars and 52 % of Romanians agreeing, and very large neutral groups (35 % and 32 %), indicating many are undecided on whether serving others directly helps their own wellness.

For **peaceful communication (Q9)** and **goal-setting (Q10)**, 59 %–60 % of Kosovars agree in each case versus about 50 % of Romanians, with Romania again showing higher neutrality. In sum, Kosovo students consistently report higher agreement and lower neutrality than Romanian students across nine of ten items, particularly on help-seeking, collaboration, and communication. Romania's larger neutral segments suggest areas where more clarity or engagement could boost confidence and buy-in, especially around the personal benefits of service and the power of peaceful dialogue.

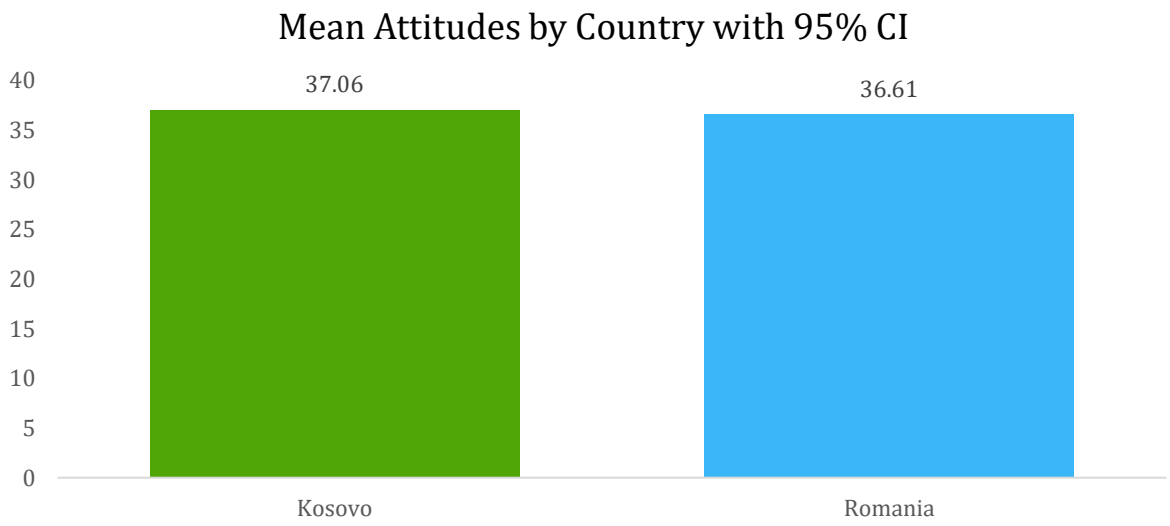
**FIGURE 2. ATTITUDES TOWARD MENTAL HEALTH, COUNTRY COMPARISONS**






We looked at whether students in Kosovo and Romania differed in their overall attitude scores. On average, Kosovo students scored 37.06 and Romanian students scored 36.61 on the same scale. Although Kosovo's average was a little higher, statistical test showed this difference (0.45 points) could easily happen by chance (p = .18, and the confidence interval from, 0.20 to 1.10 crosses zero). In plain terms, there's no clear evidence that one group's attitudes are stronger than the others, both sets of students have very similar overall attitudes.

**FIGURE 3. MEAN COMPARISONS ON ATTITUDES TOWARD MENTAL HEALTH, BY COUNTRY**



## Values about mental health

Across both Kosovo (KS) and Romania (RO), young people overwhelmingly favor positive, prosocial responses in three everyday social–emotional scenarios. The consistency between the two countries is striking: in each case, the first-choice strategy commands a clear majority, while less constructive or avoidant options remain the exception.

### Intervention When Witnessing Exclusion (V1)

When asked what they would do if they saw someone being left out because of a mental-health problem, over 70 percent of students in both samples chose to “help include the person and stand up for them” (KS 71.2 %, RO 73.4 %). This dominant preference underscores a robust sense of peer solidarity and willingness to challenge stigma in both contexts.The second most common reaction, “stand by without doing anything”, garnered only about 14 percent in Kosovo (14.3 %) and 13 percent in Romania (13.1 %), suggesting that passive bystanding is far less prevalent than active intervention. Roughly 9 percent would simply ignore the incident (KS 8.9 %, RO 8.5 %), and just 5–6 percent admitted they might join in excluding the peer (KS 5.7 %, RO 5.0 %).
In the context of implications, anti-bullying and mental-health stigma reduction programs can build on this strong baseline of peer advocacy, focusing coachable moments on shifting the small minority from indifference or exclusion toward supportive action.

### Coping Strategies for Stress (V2)

When experiencing stress, students most commonly turn outward: “talk to a friend or trusted adult” ranks first (KS 41.2 %, RO 42.1 %). Yet nearly as many choose inward coping, “keep everything inside” comes second, at 36.5 percent in Kosovo and 33.9 percent in Romania, revealing a tension between help-seeking and self-reliance. Hiding feelings without sharing them was the third choice (KS 16.6 %, RO 18.6 %), indicating that a substantial minority manage stress privately rather than reaching out. Only about 5 percent in both countries reported blaming others when stressed (KS 5.6 %, RO 5.3 %), suggesting externalizing coping is rare.Findings show, that  while peer-and-adult support is well understood, the nearly equal pull toward solitary coping highlights an important gap: programs should reinforce the value of emotional disclosure and equip students with safe, accessible avenues for expressing distress.

### Handling Disagreements with Friends (V3)

Conflict resolution skills are strongly ingrained. The clear favorite, “use non-violent communication and listen respectfully”, was selected by 74.2 percent of Kosovars and 75.5 percent of Romanians. This preference signals a shared cultural norm around respectful dialogue and active listening. The next most common tactic, “walk away without talking”, was chosen by 18.1 percent in Kosovo and 17.0 percent in Romania, reflecting a moderate tendency to avoid escalation by taking a break. Only 5.6 percent in each sample said they would yell and get angry, and fewer than 2 percent would post about it online (KS 2.1 %, RO 1.8 %).  With aggressive or public shaming strategies nearly absent, interventions can pivot from promoting basic civility to refining advanced communication skills, such as constructive feedback and collaborative problem solving.

### Commonalities

**Strong Prosocial Baseline.** In all three questions, the first-choice behavior is a constructive, community-oriented action, standing up for excluded peers, seeking supportive

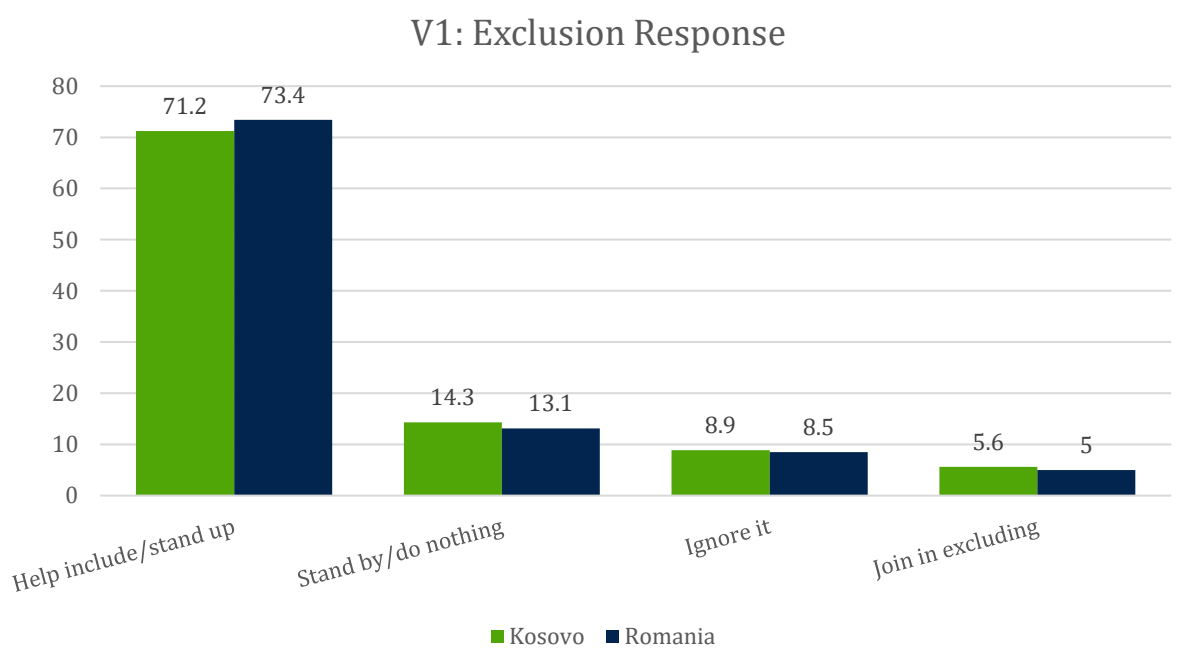
conversation, and using respectful communication, demonstrating a healthy social-emotional foundation in both Kosovo and Romania.

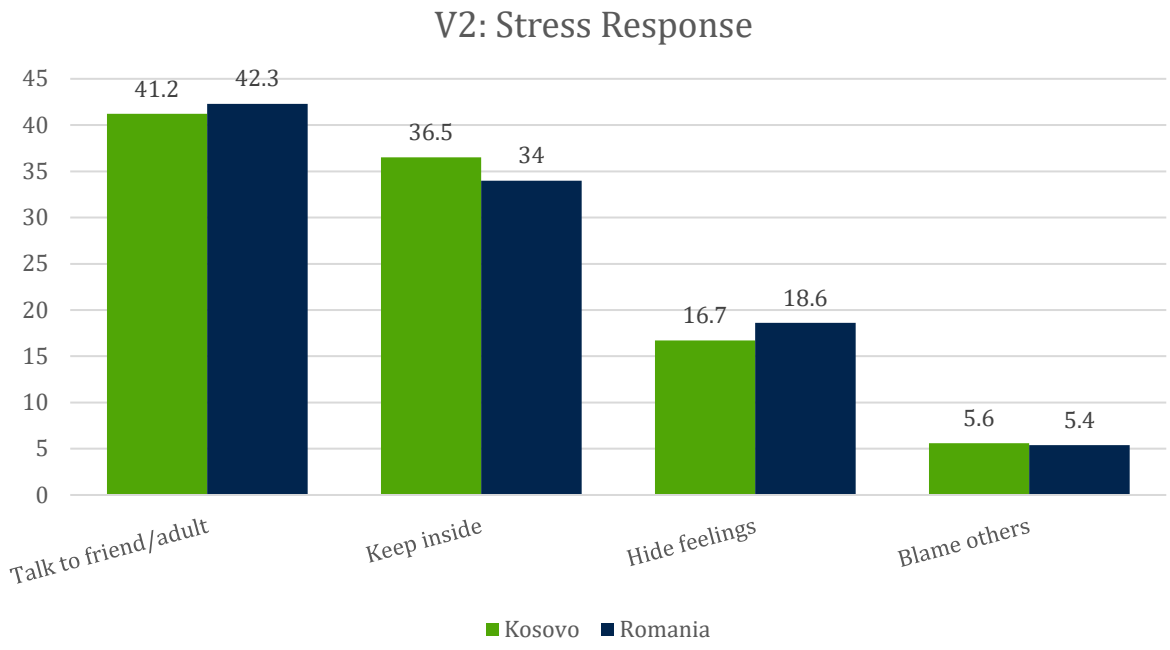
## Areas for Growth

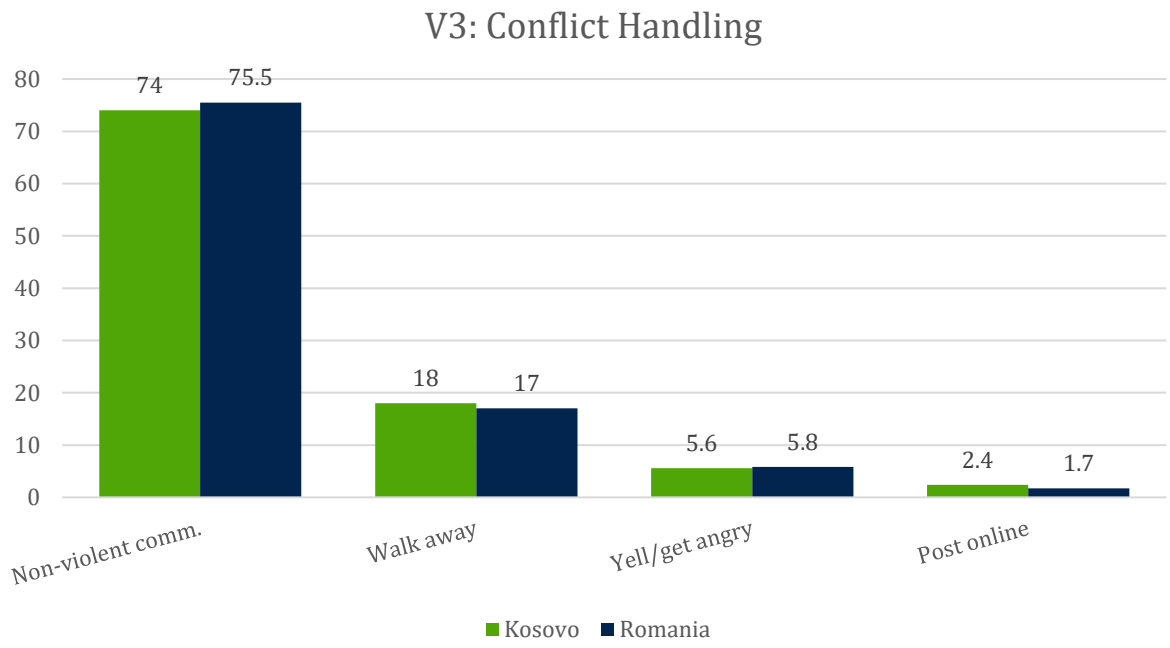
- **Emotional Disclosure:** The sizeable “keep inside” response to stress (one-third of students) signals that despite valuing talk-based coping, many adolescents default to internalizing stress. Targeted curricula or peer-support programs could normalize emotional sharing.
- **Bystander Inaction:** Although only a small minority, the fact that up to 14 percent would do nothing when witnessing exclusion suggests room to strengthen bystander intervention training.

**Consistency Across Contexts.** The near-parallel percentages between Kosovo and Romania indicate that similar youth-development or mental-health promotion strategies may be effective in both settings, allowing cross-national collaboration on program design. Overall, students in Kosovo and Romania largely share a commitment to supportive, non-violent, and communicative approaches in social and emotional challenges. Prevention and skill-building efforts should capitalize on these strengths, reinforcing prosocial norms, while also addressing the pockets of bystander passivity and inward stress coping that persist in both countries.

**FIGURE 4 VALUES ABOUT MENTAL HEALTH, COUNTRY COMPARISON**






## Stigma about mental health

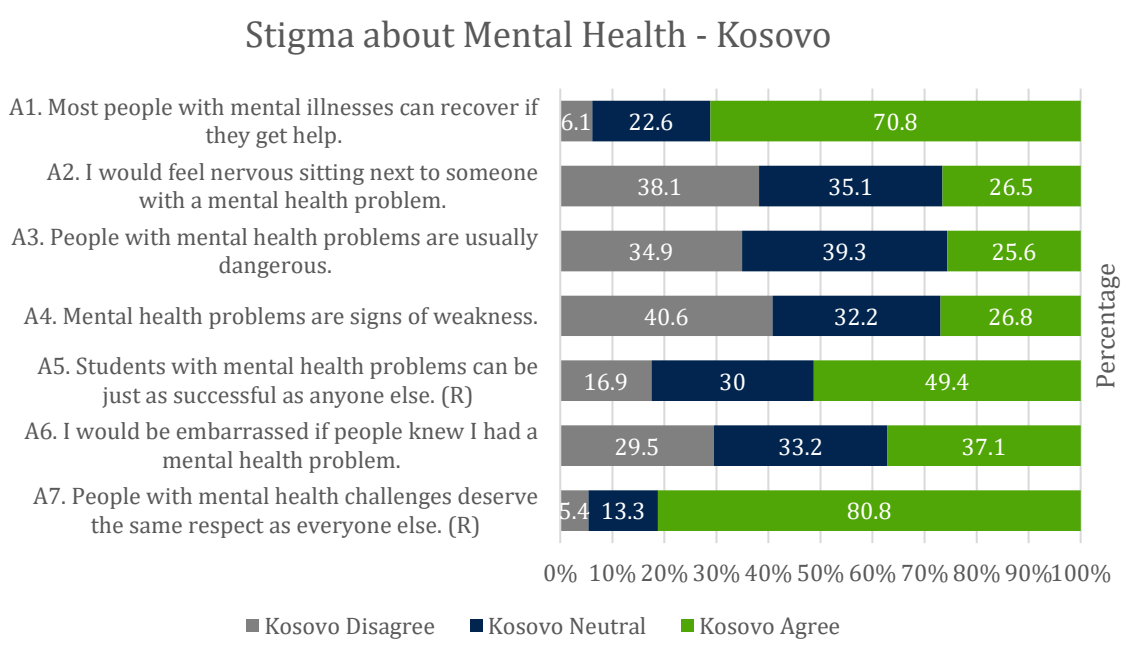
Students in both Kosovo and Romania demonstrate strong foundational beliefs about mental health, yet subtle differences in specific stigma attitudes point to targeted opportunities for intervention.

First, belief in recovery is high in both samples, with roughly three-quarters of adolescents agreeing that “most people with mental illnesses can recover if they get help” (KS 71%, RO 64%). Kosovo’s students are even more optimistic, while in Romania a quarter remain undecided. This widespread confidence suggests that framing mental-health support as

effective and accessible will resonate in both contexts, particularly by spotlighting local success stories and easily reachable resources.

When it comes to everyday inclusion, comfort simply sitting next to a peer with a mental-health challenge, the gap widens. Only 27% of Kosovars and a mere 13% of Romanians feel

**FIGURE 5. STIGMA ABOUT MENTAL HEALTH KOSOVO AND ROMANIA**

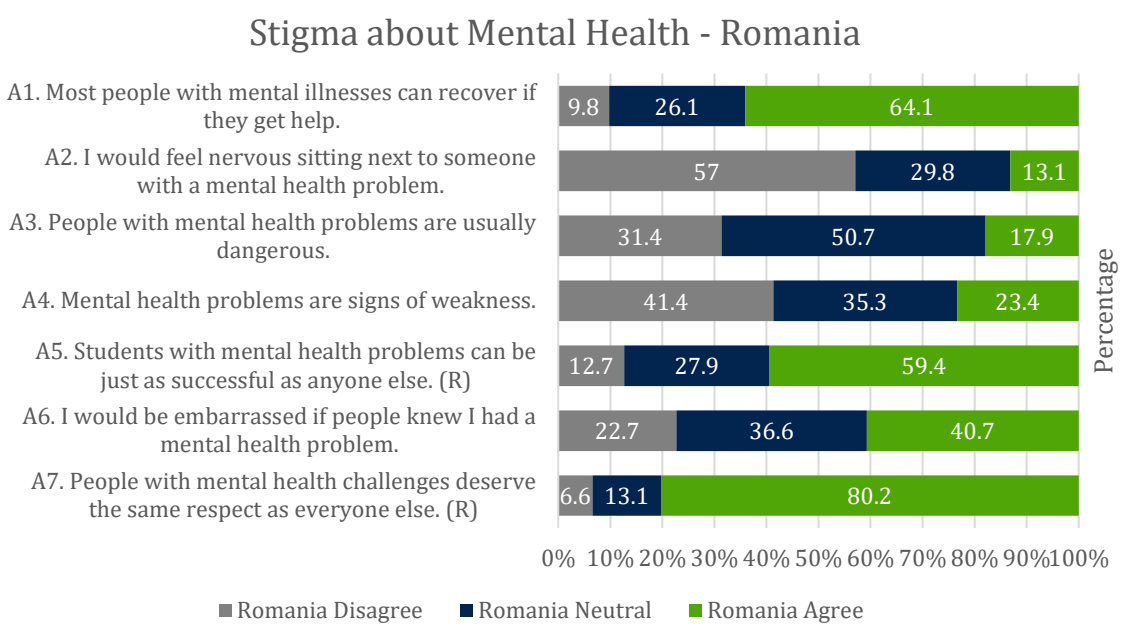



entirely at ease. In Romania, more than half (57%) actively disagree that they'd be comfortable, compared with 38% in Kosovo. These figures reveal a clear barrier to the most basic form of social acceptance: physical proximity. School programs might therefore prioritize low-stakes, peer-to-peer icebreakers and scripted "inclusion invitations" that normalize sharing space with classmates who are managing mental-health issues.

Perceptions of danger also diverge. Over a quarter of Kosovars (26%) endorse the stereotype that "people with mental-health problems are usually dangerous," versus 18% in Romania; however, over half of Romanian respondents chose the neutral midpoint, indicating uncertainty rather than outright rejection. This suggests that in Kosovo, direct myth-busting around violence and mental illness is essential, while in Romania, educators may first need to build basic knowledge before students feel confident enough to reject the stereotype entirely.

Attribution of mental-health problems to personal weakness remains a sticking point for about one in four young people in both countries, with roughly 27% agreeing with the statement and another 32–35% neutral. This ambivalence underscores the need for curricula that convey the complex biological, psychological, and social contributors to mental-health challenges, emphasizing that seeking help is a sign of strength, not weakness.

FIGURE 5. STIGMA ABOUT MENTAL HEALTH KOSOVO AND ROMANIA



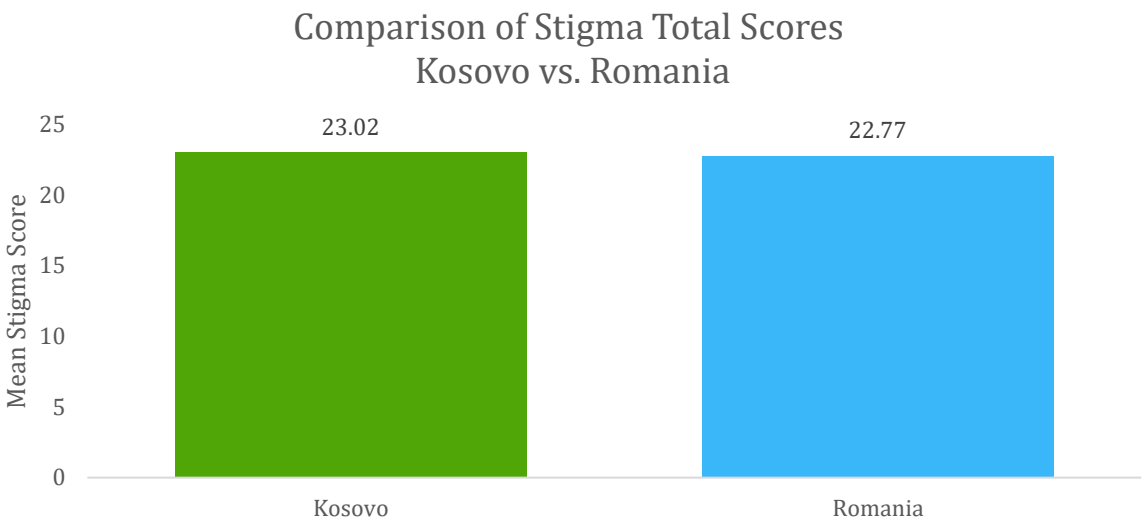

On a more positive note, beliefs about equal opportunity and deserving respect are well ingrained. Around 80% of students in both samples agree that peers with mental-health problems can be just as successful and deserve the same respect as anyone else. Romania edges Kosovo on equal-success beliefs (59% vs. 49% agree), suggesting Romanian students may be slightly more convinced of equal potential. Both countries can leverage this strong anti-stigma norm to deepen empathy training and leadership opportunities for youth with lived experience.

Finally, self-stigma, the fear of shame if one's own mental-health struggles were known, is still reported by over a third of students (KS 37%, RO 41%). Normalizing mental-health conversations in classrooms, through student-led "check-in circles" or anonymous peer-support platforms, could help knock down these walls of embarrassment.

In summary, while both Kosovo and Romania boast solid anti-stigma foundations, optimism about recovery and firm beliefs in respect and equal opportunity, each country shows unique areas for growth. Kosovo may focus on dispelling danger myths and strengthening beliefs in equal success, whereas Romania should concentrate on reducing social anxiety around proximity and internalized shame. Tailored, context-sensitive programming that builds on these insights will be key to fostering truly inclusive school communities across both nations.

We compared overall stigma-score averages between students in Kosovo (N = 389) and Romania (N = 927). On our composite stigma scale (higher = more stigmatizing attitudes), Kosovars scored 23.02 (SD = 3.11) and Romanians 22.77 (SD = 3.45). A test for equal group variances was non-significant (Levene's F = 0.95, p = .33), and the standard two-sample t-test yielded t(1314) = 1.23, p = .22, with Kosovo just 0.25 points higher (95 % CI – 0.15 to 0.65). Because the p-value is above .05 and the confidence interval spans zero, we conclude there is no reliable difference in overall stigma between the two samples. In practical terms, young people in both countries show virtually the same average level of stigma as measured by this scale.

FIGURE 6. MEAN COMPARISON ON STIGMA RELATED TO MENTAL HEALTH, BY COUNTRY




## Help seeking behaviors

This analysis examines four dimensions of help-seeking, turning to friends (HS1), family members (HS2), professionals (HS3), and knowing where to find support (HS4), among secondary-school students in Kosovo (KS) and Romania (RO). Responses were recoded into three categories: Agree (Agree + Strongly Agree), Neutral, and Disagree (Disagree + Strongly Disagree).

### HS1: Talking to a Friend

- **Kosovo:** 55 % Agree, 24 % Neutral, 21 % Disagree
- **Romania:** 52 % Agree, 28 % Neutral, 21 % Disagree

A clear majority in both countries feel comfortable discussing stress or sadness with a friend. Romanian students show slightly more ambivalence (higher Neutral), suggesting peer-to-peer outreach could reinforce this existing strength.

### HS2: Talking to a Family Member

- **Kosovo:** 64 % Agree, 19 % Neutral, 18 % Disagree
- **Romania:** 54 % Agree, 24 % Neutral, 22 % Disagree

Kosovo youth are notably more inclined to seek family support than their Romanian counterparts, who are nearly one-quarter neutral or opposed. Family-engagement initiatives, such as parent–teen communication workshops, could help Romanian students feel more secure reaching out at home.

### HS3: Talking to a Professional

- **Kosovo:** 56 % Agree, 25 % Neutral, 19 % Disagree
- **Romania:** 44 % Agree, 28 % Neutral, 28 % Disagree

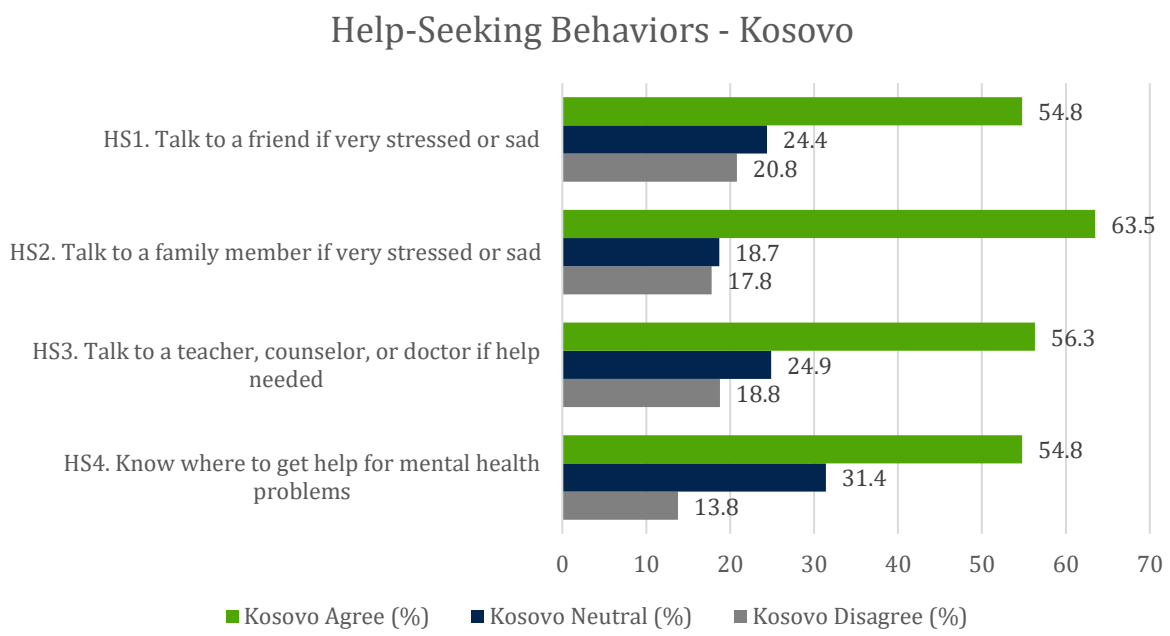
There is a pronounced gap in willingness to consult a teacher, counselor, or doctor: Kosovars are substantially more open to professional help. In Romania, over a quarter actively disagree, indicating potential distrust or access barriers. School-based mental-health services and awareness campaigns could demystify professional supports for Romanian students.

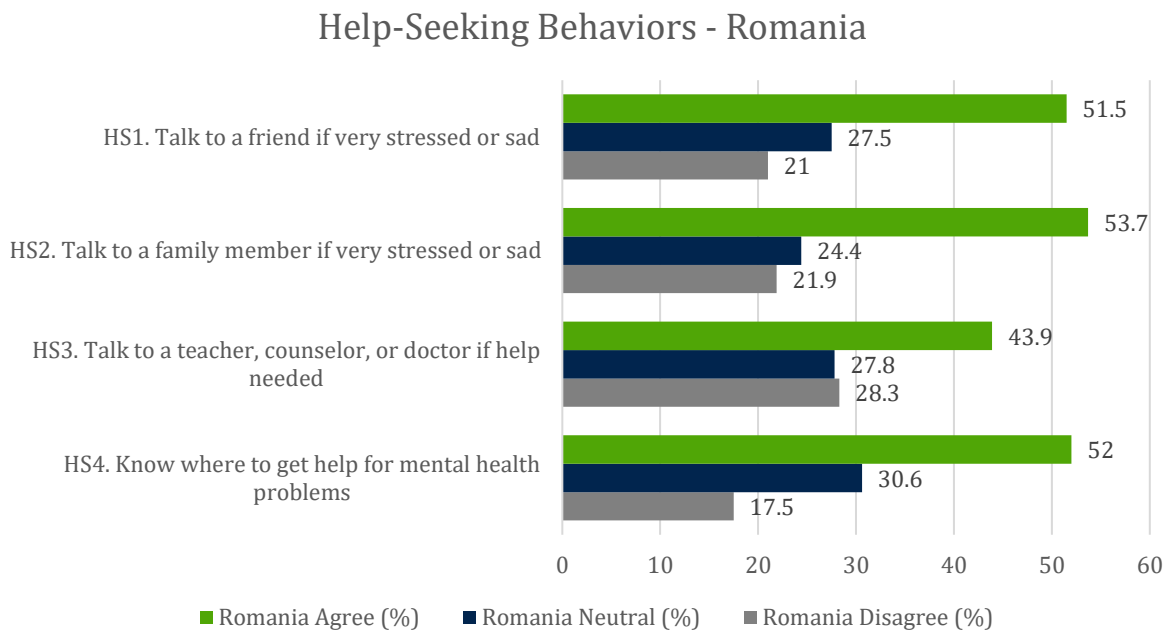
### HS4: Knowing Where to Get Help

- **Kosovo:** 55 % Agree, 31 % Neutral, 14 % Disagree
- **Romania:** 52 % Agree, 31 % Neutral, 18 % Disagree

About half of students in both countries report clear knowledge of where to obtain mental-health assistance. Romania's higher "Disagree" proportion suggests that more visible information on hotlines, counseling centers, and online resources may be needed there. Overall, students in both Kosovo and Romania overwhelmingly rely on friends when they're feeling stressed, but Kosovars are notably more likely to turn to family members and professionals for support. Roughly half of all students know where to access mental-health services, leaving significant room to boost resource awareness. While Romania shows greater ambivalence around family and professional help, Kosovo's stronger uptake in those areas offers a model for targeted outreach. By building on shared strengths in peer support, closing gaps in family and professional engagement, especially in Romania, and universally promoting clear, accessible information on help sources, both countries can create more resilient, help-seeking youth communities.

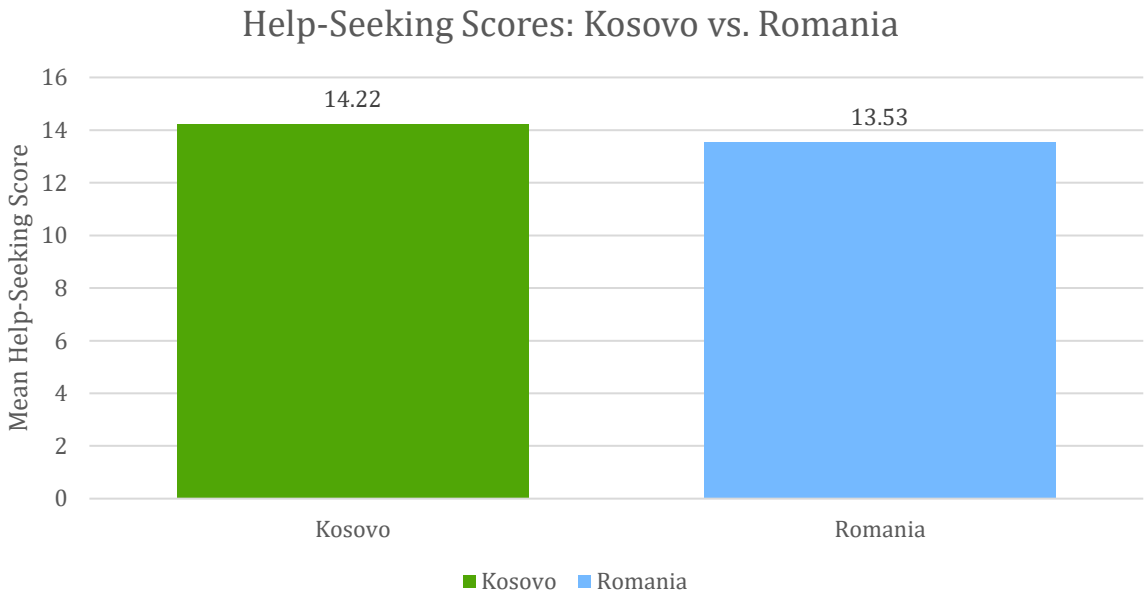
**FIGURE 7. HELP-SEEKING BEHAVIORS, BY COUNTRY**






Students in Kosovo scored 14.22 on our help-seeking scale, compared with 13.53 in Romania. The gap of 0.69 points is statistically significant (p = .001), meaning it's very unlikely to be just chance. In plain terms, while young people in both countries show a fair willingness to reach out when they're struggling, Kosovars are a bit more likely than Romanians to ask for help, from friends, family, or professionals.

**FIGURE 8. MEAN COMPARISONS SCORES ON HELP-SEEKING BEHAVIORS, BY COUNTRY**



## KIDS SCREEN - Wellbeing

Kosovar children report more extreme highs and fewer complete lows of well-being across every domain, while Romanian children cluster toward the middle of the scale.

- **Physical Health and Energy:** Only about 3–4 % of Kosovars say they never feel fit or energetic, compared with 7–8 % of Romanians, yet nearly one-third of Kosovars describe themselves as “extremely” fit (28 %) or energetic (35 %), versus roughly one-quarter of Romanians.

- **Mood and Belonging:** Kosovars are twice as likely to “not at all” feel sad (30 % vs. 20 %), yet they also report higher peaks of loneliness (9 % vs. 6 % “extremely”). Romanians, by contrast, remain in the middle more often.

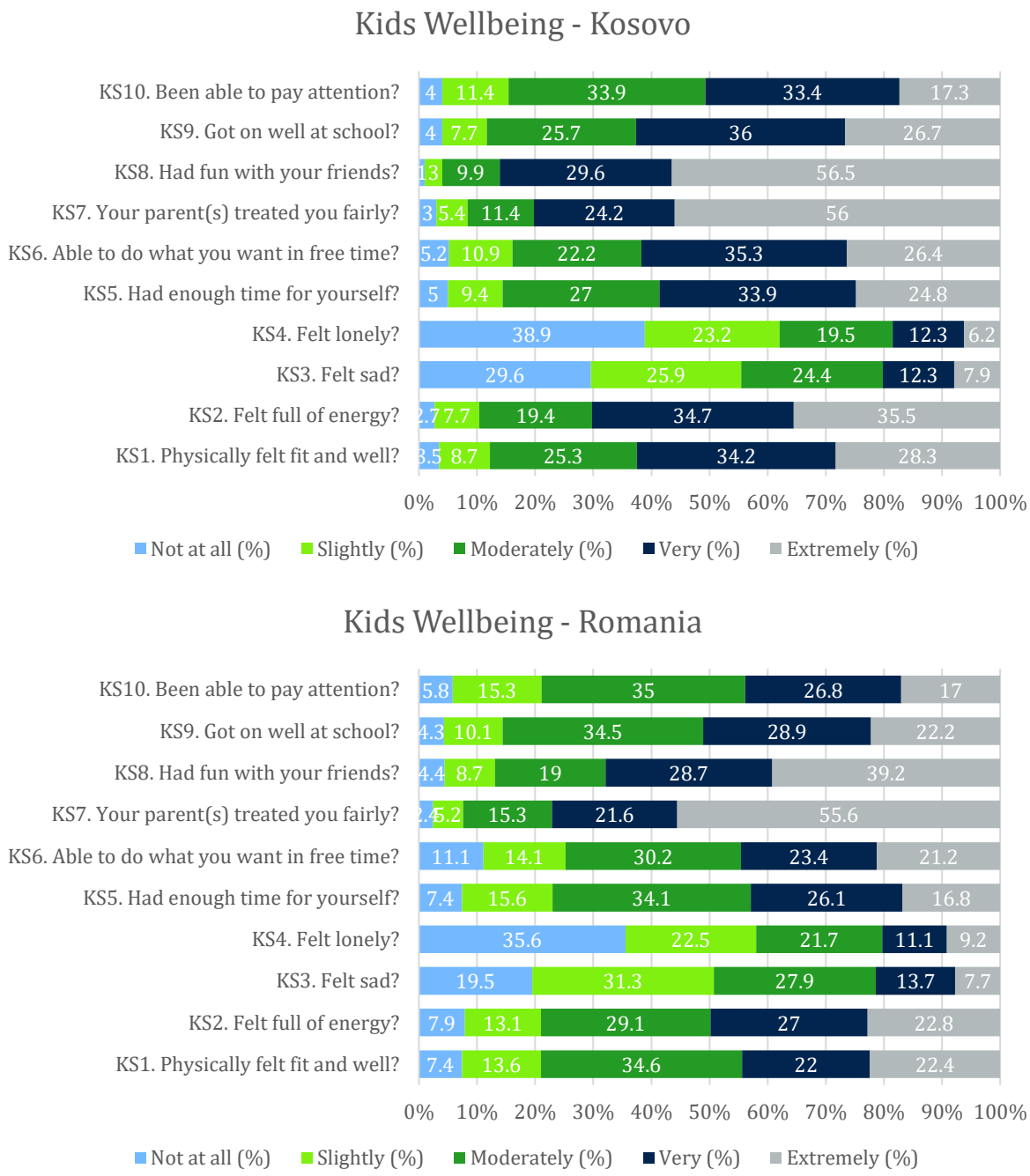
- **Personal Time and Activities:** Only 5 % of Kosovars say they never have enough time for themselves (vs. 7 % of Romanians), and 25 % feel they “extremely” have enough time, eight points above Romanians. The same extreme-high pattern holds for free-time activities.

- **Social Support and Enjoyment:** Both groups overwhelmingly feel fairly treated by parents, but 57 % of Kosovars “extremely” enjoy time with friends, compared with 39 % of Romanians, and almost none of them report having no fun at all.

- **School Engagement and Focus:** Kosovars again show stronger peaks, 27 % get on exceptionally well at school (vs. 22 %), and only 4 % say they never can pay attention (vs. 6 %), while Romanians hover in mid-ranges.

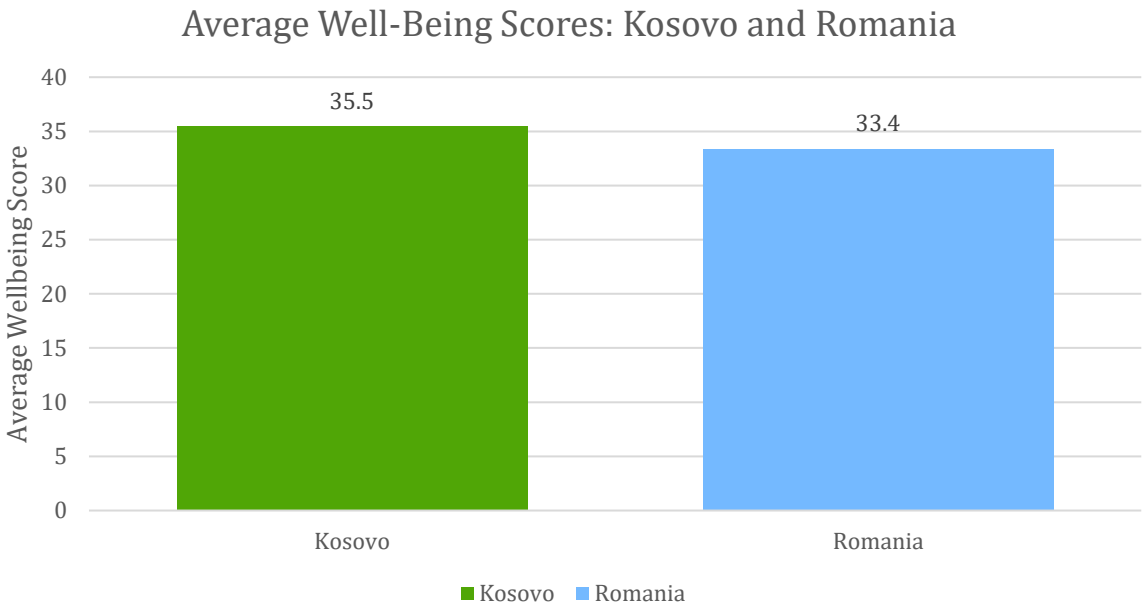
In sum, Kosovar children’s responses are more **polarized**, swinging between strong well-being and its absence, whereas Romanian children’s responses form a **gentler, middle-of-the-road** profile. This suggests that in Kosovo, efforts should help sustain positive peaks and buffer occasional lows, while in Romania, initiatives might aim to lift moderate well-being toward consistently high levels.

FIGURE 9. KIDS WELLBEING, BY COUNTRY




On average, children in Kosovo scored **35.5** on our well-being survey, while children in Romania scored **33.4**. That 2.1-point gap means Kosovars feel just a bit better, roughly a 4–6% lift, than Romanian peers on the same questionnaire. In everyday terms: both groups report similar mid-level well-being, but Kosovo's average sits slightly higher.

FIGURE 10. MEAN COMPARISON BY COUNTRY




When analyzing the findings from one question, that asked about how children in overall rate their health.

**Over half** of kids in Kosovo rated their health as **"Poor" (52%)**, compared to **only 8%** in Romania. Conversely, **Excellent** health ratings were rare in Kosovo (1%), but common in Romania (23%). Romania's responses skew toward **"Good" to "Excellent",** whereas Kosovo's cluster around **"Poor" and "Fair."**

An independent-samples t-test was conducted to compare the mean self-rated health scores (1 = Poor to 5 = Excellent) between children in Kosovo and Romania. Kosovo's sample (N = 406) had a mean of **1.70** (SD = 0.89), whereas Romania's sample (N = 928) had a mean of **3.52** (SD = 1.16).

Levene's test indicated unequal variances between groups ($F = 46.32$, $p < .001$), so the "equal variances not assumed" row was used. The t-test revealed a highly significant difference, $t(\approx 992) = -31.13$, $p < .001$, with a mean difference of –1.82 points (95% CI [–1.93, –1.70]).

Romanian children rate their general health nearly two points higher on a five-point scale than Kosovar children, and this difference is statistically significant.

## Psychological Distress

When we examine how often children in Kosovo and Romania experience six core distress symptoms, a clear contrast emerges in the intensity and frequency of their emotional struggles.

- **Anxiety Symptoms (Nervousness and Restlessness):**
  Romanian children report feeling nervous almost constantly, nearly 75% say "some" or "most of the time", whereas only 35% of Kosovars endorse those levels. Similarly, over 60% of Romanian youth describe themselves as restless or fidgety at least "some of the time," compared with just 38% in Kosovo. This suggests that day-to-day

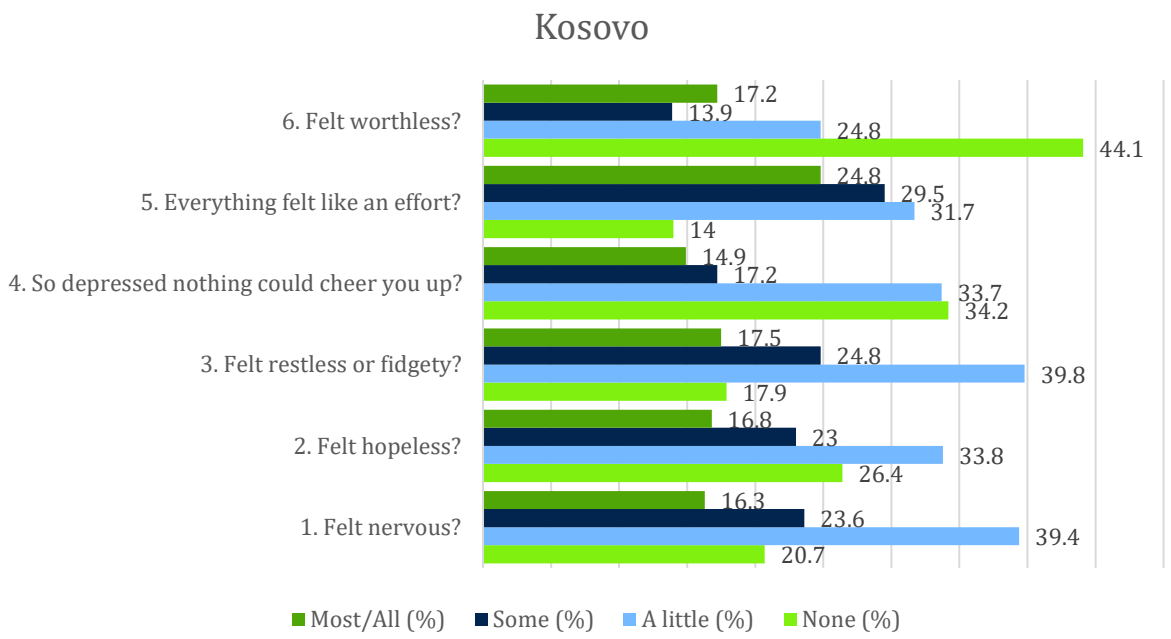
anxiety and agitation are far more prevalent among Romanian adolescents.

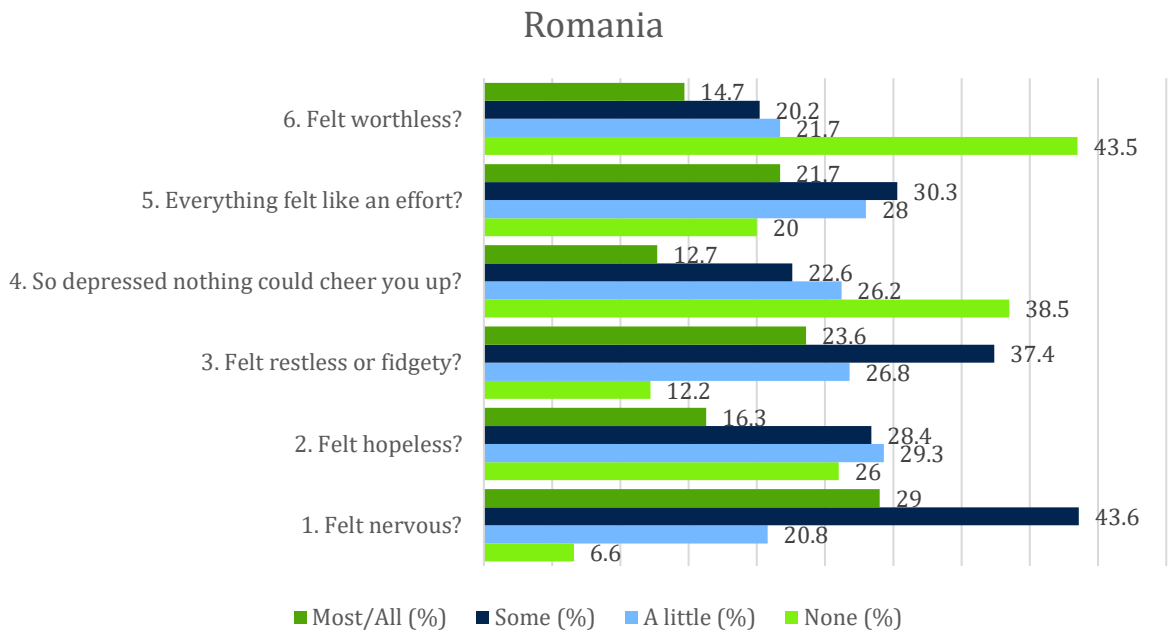
- **Depressive Feelings (Hopelessness and Deep Sadness):**
  Both samples cluster around low levels of severe despair: roughly one-quarter in each country say they "never" feel hopeless, and about two-thirds report they are only rarely "so depressed that nothing could cheer them up." However, Romania shows a slightly higher proportion at the extreme end ("most of the time" hopelessness: 17% vs. 10% in Kosovo), indicating a small subgroup of Romanian youth experiencing persistent hopelessness.

- **Motivational Strain and Self-Worth (Effort and Worthlessness):**
  Kosovars most commonly report that "everything is an effort" only occasionally ("some of the time" = 30%), whereas Romanian children spread their responses more evenly across occasional to frequent effortless (59% "some" or "most"). On feelings of worthlessness, both groups share a strong "none of the time" response (~44%), but Romania again edges higher in the "some" and "most" categories (35% vs. 26%), pointing to more frequent self-doubt among Romanian youth.

Romanian adolescents exhibit a significantly higher burden of anxiety-related symptoms, especially nervousness and restlessness, and register greater motivational and self-worth challenges than their Kosovar peers. In contrast, severe depressive symptoms show more parity across both groups, with most children in each country experiencing deep sadness or hopelessness only infrequently. These insights underscore the need for targeted anxiety-reduction interventions in Romania, while support for self-esteem and sustained motivation may benefit young people in both countries.

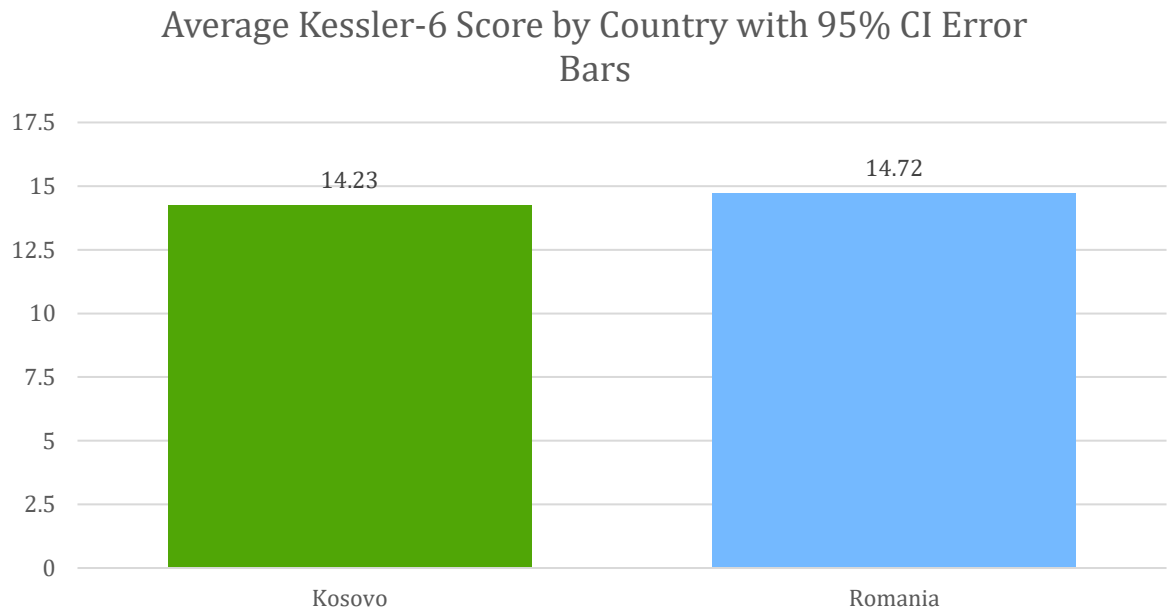
**FIGURE 11. PSYCHOLOGICAL DISTRESS, BY COUNTRY**






Children in Kosovo averaged a Kessler-6 total score of **14.23**, while Romanian children averaged **14.72** (higher scores indicate more frequent distress symptoms). The independent-samples t-test yielded p-values of .074 (equal variances assumed) and .086 (unequal variances), both above the conventional .05 threshold. There is **no statistically significant difference** in overall psychological distress (Kessler-6) between children in Kosovo and Romania. While Romania's mean is slightly higher by 0.49 points, this difference falls within the margin of error.In summary, both groups report **similar levels** of general distress symptoms, indicating comparable well-being profiles on the Kessler-6 measure.

**FIGURE 12. MEAN COMPARISON, BY COUNTRY**

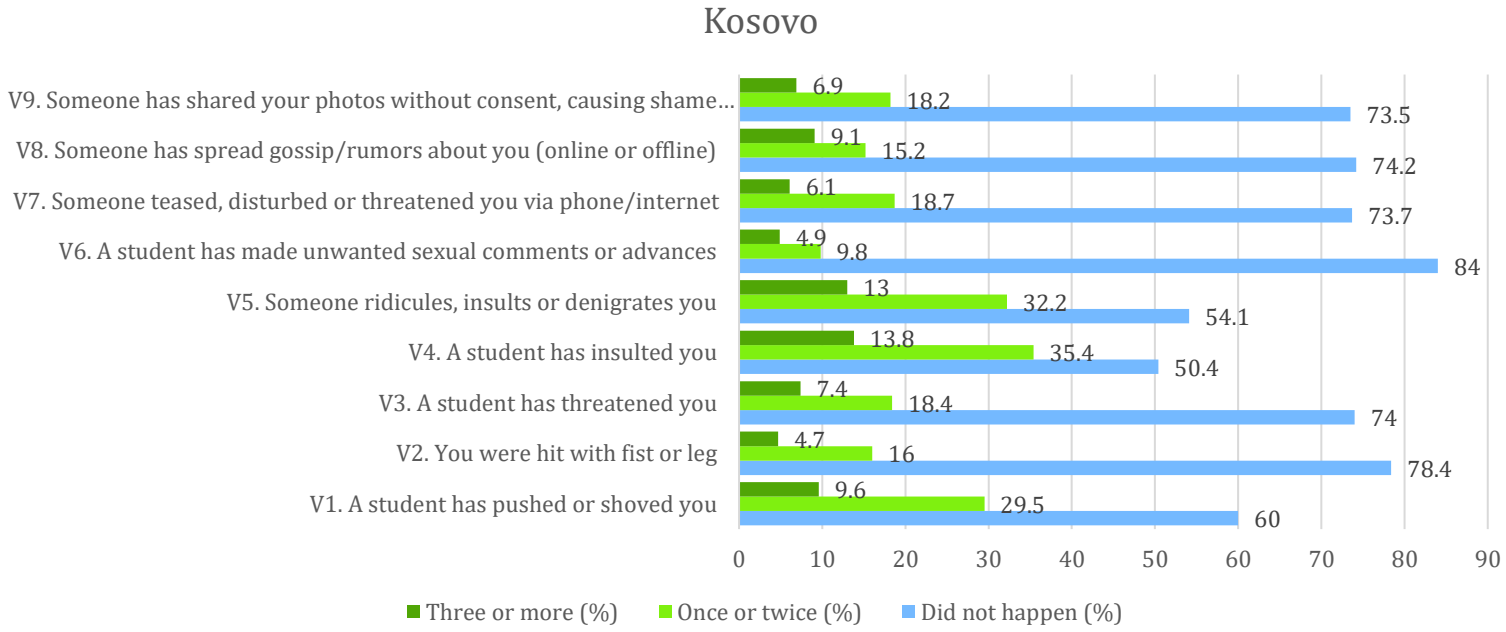


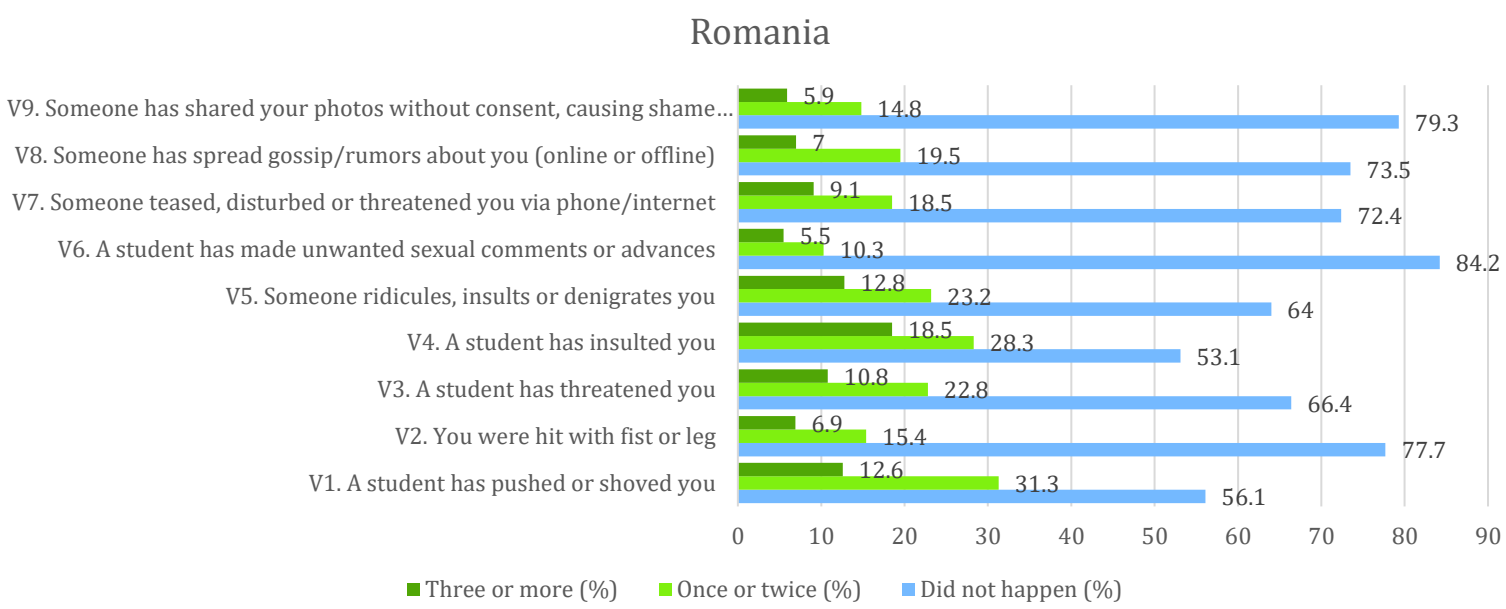
## School victimization and cyberbullying

- **Physical aggression (V1–V3):** Romanian students experience more frequent pushing/shoving (12.6% vs. 9.6% at ≥3 times) and threats (10.8% vs. 7.4%) than Kosovars, though both groups report similar "hit with fist or leg" rates.
- **Verbal and relational aggression (V4–V5):** Insults occur more often in Romania (18.5% vs. 13.8% at ≥3 times), while gossip/denigration shows similar "three or more" rates (Kosovo 13.0%, Romania 12.8%).
- **Sexual harassment (V6):** Unwanted sexual comments are rare but comparable (around 5% at ≥3 times).
- **Cyberbullying (V7–V9):** Romania reports slightly higher rates of online teasing (9.1% vs. 6.1%) and image-sharing without consent (5.9% vs. 6.9% for Kosovo), while gossip spreading is roughly equal.

Overall, Romanian students report higher repetition (three or more times) of most aggression types, especially physical and verbal. Kosovars show marginally higher repeated photo-sharing incidents. This suggests a need for targeted anti-bullying interventions addressing physical and verbal aggression in Romania, and privacy protection education in Kosovo

**FIGURE 13. SCHOOL VICTIMIZATION AND BULLYING BY COUNTRY**

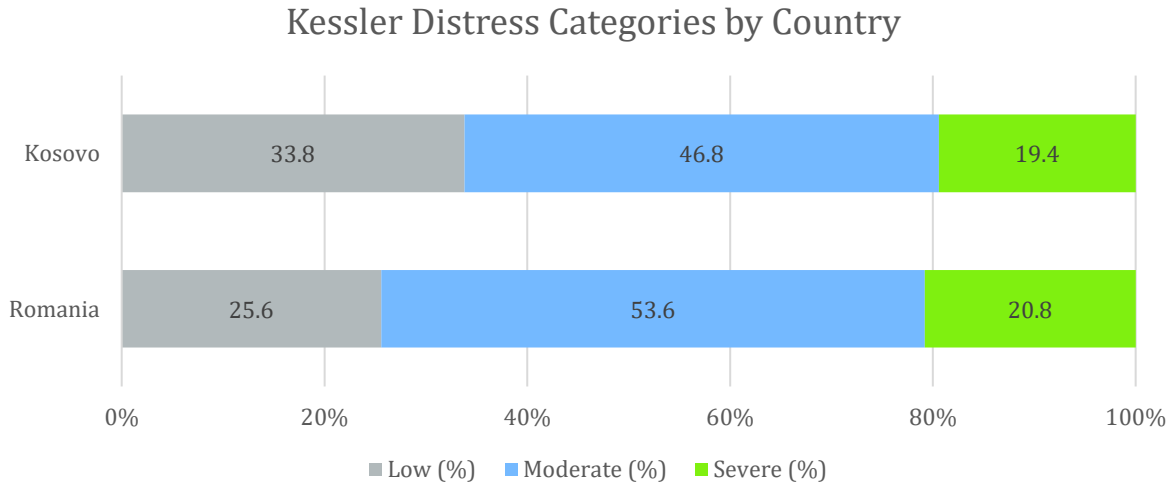





## Comparative analyses

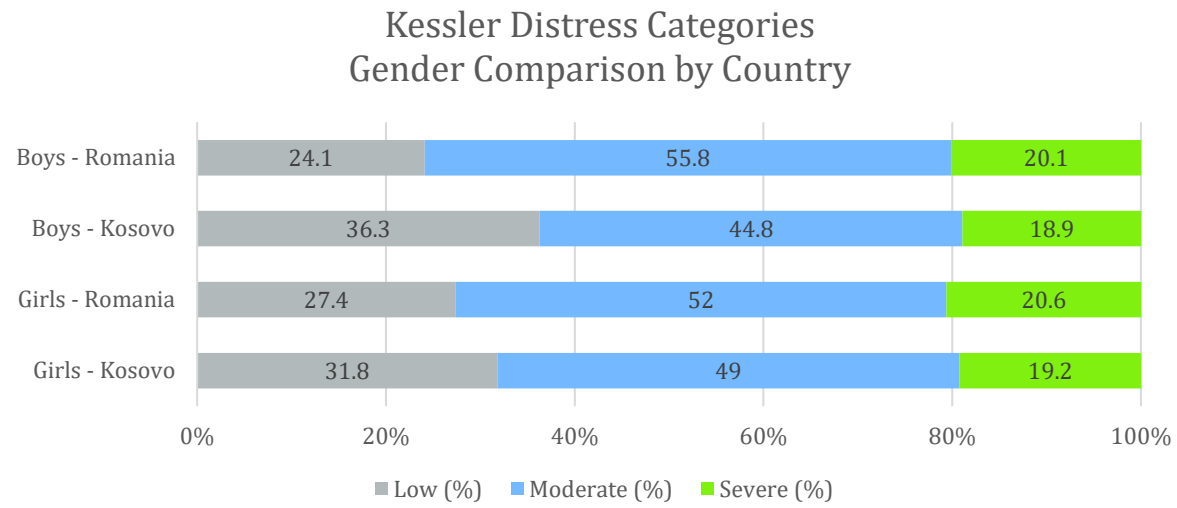
Across the combined sample of 1,330 adolescents, country was a small but statistically reliable correlate of psychological-distress level (Kessler-6). As depicted in Figure 11, one-third of Kosovar students reported *low* distress (33.8 %), compared with one-quarter of Romanian students (25.6 %). Conversely, just over half of Romanian adolescents fell in the *moderate* band (53.6 %) versus 46.8 % in Kosovo. The prevalence of *severe* distress was nearly identical in the two groups (≈ 20 %). A Pearson chi-square test confirmed that this distributional shift is unlikely to be due to chance, $\chi^2(2, N = 1{,}330) = 9.46$, $p = .009$, although the accompanying Cramér's V of .06 indicates a small effect. In practical terms, Romanian youth exhibit a modest tendency toward higher distress, primarily an expansion of the moderate category, while Kosovar youth have a slightly larger well-being (low-distress) segment; the proportion experiencing severe distress is comparable in both contexts.

**FIGURE 13. KESSLER PSYCHOLOGICAL DISTRESS CATEGORIES, BY COUNTRY**



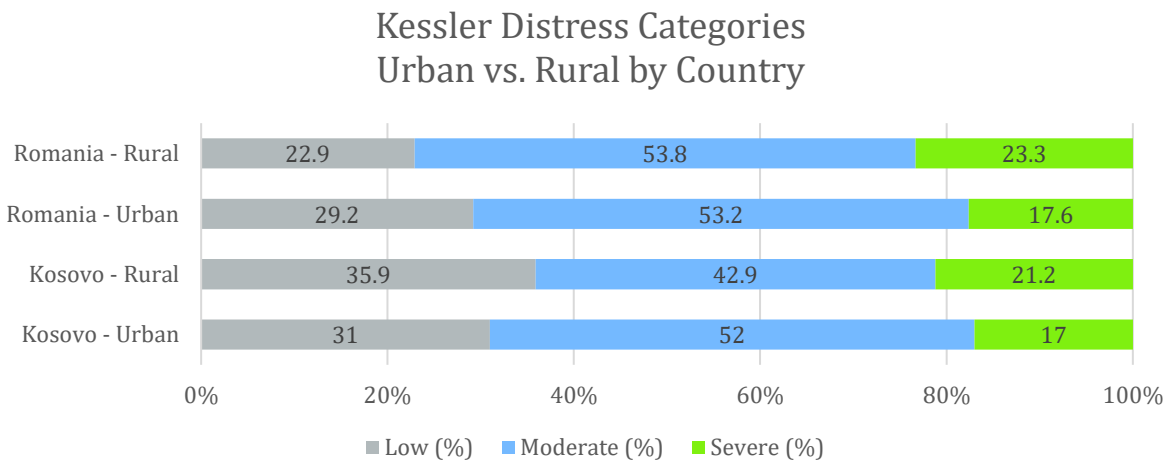
Inside each country, gender does not appear to shape adolescents' placement along the Kessler distress continuum (Figure 12). In Kosovo the Pearson $\chi^2(4) = 5.60$, $p = .231$ (Cramér's $V \approx .08$), indicating that the proportions of girls, boys and the very small "prefer-not-to-respond" group across low, moderate and severe categories differ no more than would be expected by chance; each gender shows roughly one-third low distress, about half moderate, and one-fifth severe. Romania mirrors this pattern: $\chi^2(6) = 6.62$, $p = .357$ ($V \approx .06$), with girls and boys displaying nearly identical distributions, around one quarter low, just over half moderate and one fifth severe. Although a few cells in both tables have expected counts below five, which makes the chi-square slightly conservative, the p-values remain far from conventional significance thresholds. Taken together, these results suggest that, for these two national samples, gender accounts for a negligible share of the variance in psychological distress, implying that programme planning and resource allocation can focus on other determinants (such as socioeconomic status or school context) rather than gender specific differences.

**FIGURE 14. KESSLER PSYCHOLOGICAL DISTRESS CATEGORIES, BY GENDER**



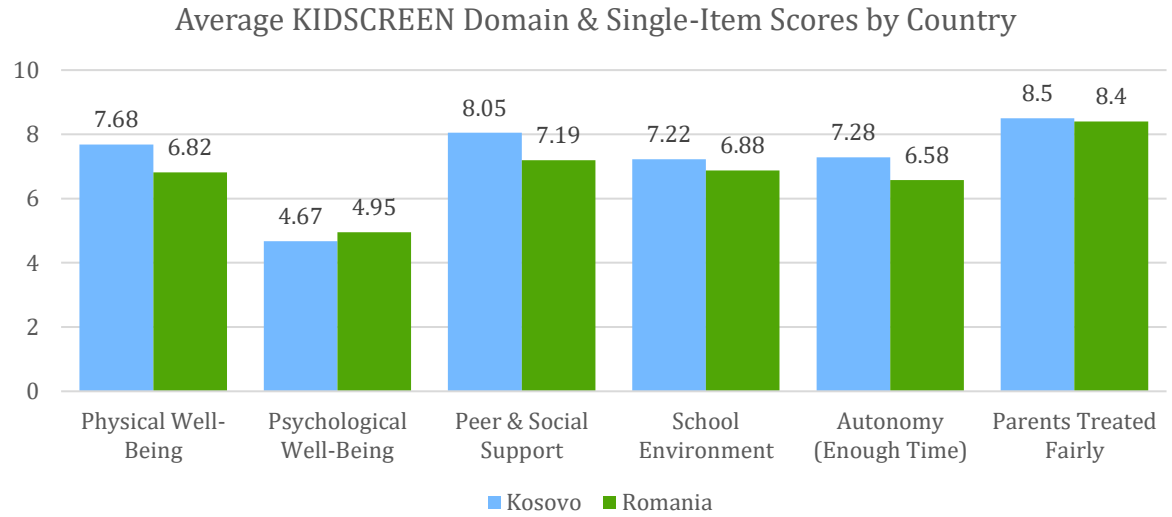

In Kosovo the distribution of Kessler-6 distress levels did not differ by place of residence, $\chi^2(2, N = 402) = 3.40$, $p = .18$, Cramér's $V = .06$, indicating a negligible association between urban versus rural living and psychological distress. By contrast, Romania showed a small but statistically reliable association, $\chi^2(2, N = 928) = 7.01$, $p = .03$, $V = .06$: rural adolescents were modestly more likely to fall into the severe distress category and slightly less likely to report low distress than their urban peers, although the effect size remains small (See Figure 12).

FIGURE 15. KESSLER PSYCHOLOGICAL DISTRESS CATEGORIES, BY COUNTRY




Independent-samples comparisons (Kosovo vs. Romania) showed several small-to-moderate mean differences in KIDSCREEN scores (Figure 13). Kosovo adolescents reported significantly better Physical Well-Being, $t(871.77) = 7.47$, $p < .001$, Cohen's $d = 0.42$, 95 % CI [0.32, 0.52], and stronger Peer & Social Support, $t(964.28) = 8.37$, $p < .001$, $d = 0.46$, 95 % CI [0.36, 0.56]. They also rated the School Environment slightly higher, $t(848.68) = 3.17$, $p = .002$, $d = 0.18$, and felt they had more time for themselves (Autonomy item KS5), $t(792.60) = 5.26$, $p < .001$, $d = 0.31$. By contrast, Romanian adolescents reported marginally better Psychological Well-Being (lower sadness/loneliness), $t(765.31) = –2.09$, $p = .037$, $d = –0.13$. Perceptions of parental fairness (KS7) did not differ, $t(763.22) = 0.34$, $p = .74$, $d \approx 0.02$. Levene's tests indicated unequal variances for three domains; consequently, Welch's $t$ and adjusted degrees of freedom were reported for those comparisons. Overall, effect sizes ranged from trivial (parent fairness) to small–medium, suggesting country plays a modest role in adolescents' perceived quality of life across these domains.

FIGURE 16. KIDS SCREEN WELLBEING COMPARISON BY COUNTRY

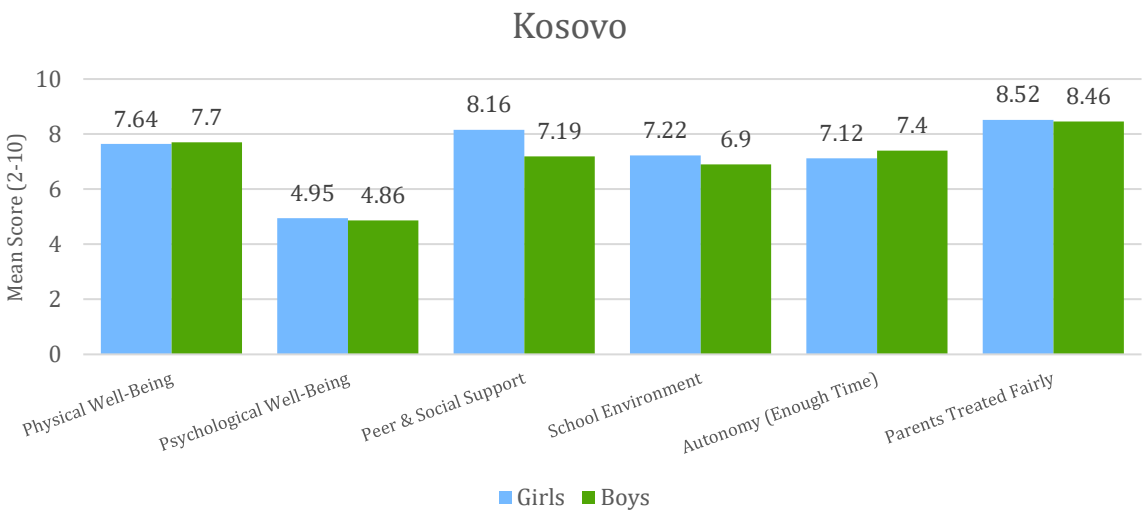



Within Kosovo, girls reported slightly better psychological well-being (M = 4.95, SD = 2.24) than boys (M = 4.41, SD = 2.22), Welch's $t(400.8) = 2.44$, $p = .015$. The mean difference of 0.54 corresponds to a small effect, Cohen's $d \approx 0.24$ (95 % CI ≈ 0.05, 0.44). No other Kosovo domain or item showed a statistically reliable gender gap; all $|t| \leq 1.46$, $p \geq .15$.

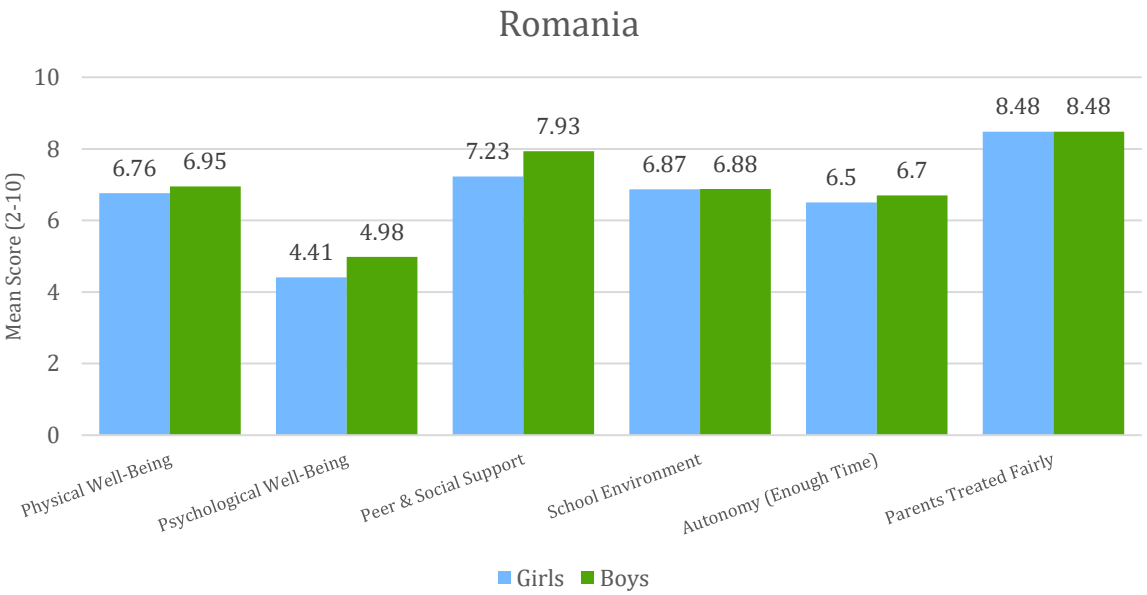
In the larger Romanian sample none of the six scores differed significantly between girls and boys (all $p \geq .18$; $|t| \leq 1.35$), and the largest absolute mean difference was only 0.19 scale points (Physical Well-Being). Effect sizes were trivial ($|d| < 0.10$).

Taken together, gender explains little of the variance in KIDSCREEN outcomes in either country (Figure 13). Only Kosovo shows a modest advantage for girls on the emotional ("sad/lonely") dimension, while all other perceived quality-of-life domains appear broadly equivalent between girls and boys.

**FIGURE 17. KIDS SCREEN WELLBEING COMPARISON BY COUNTRY AND GENDER**



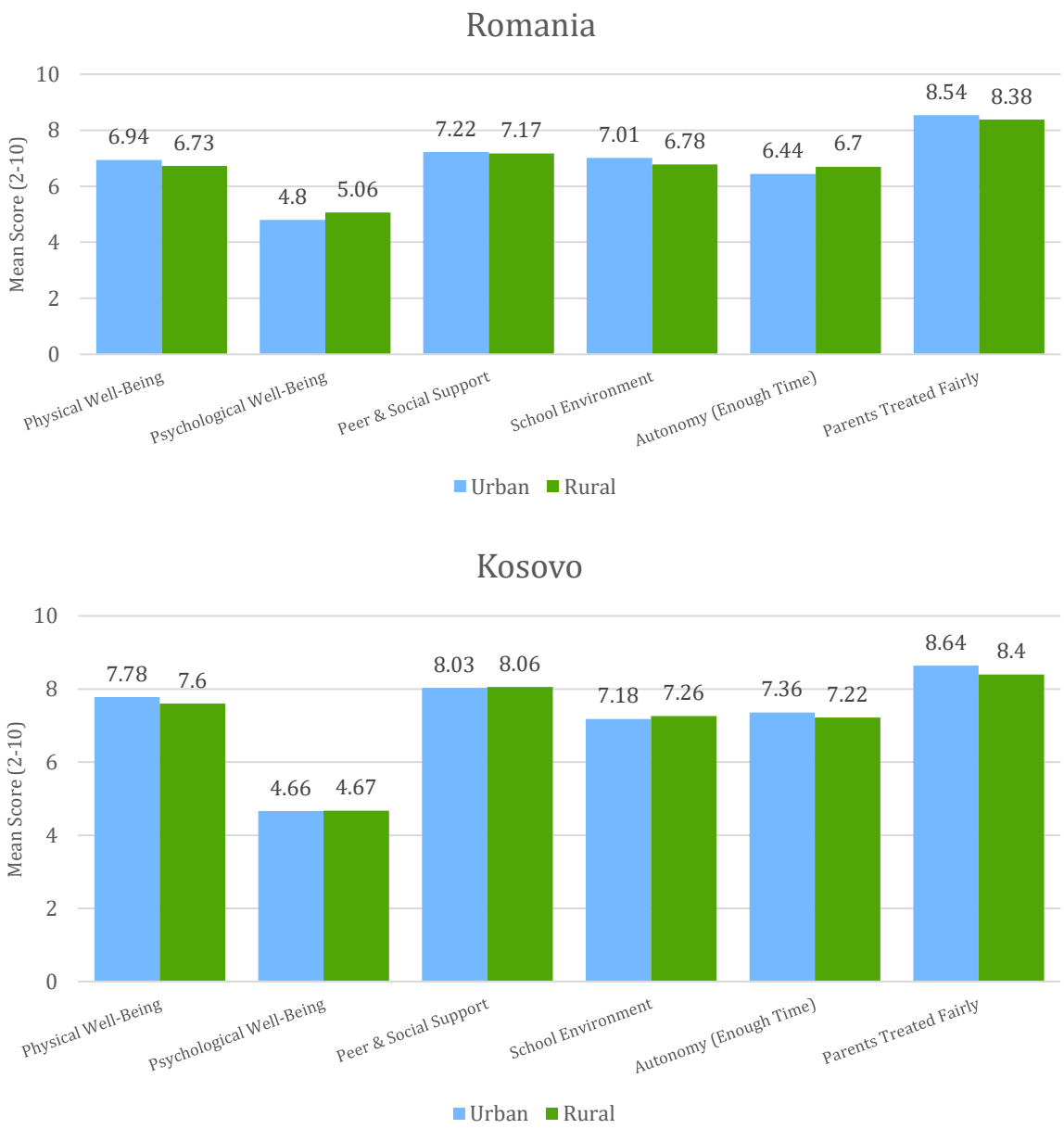

Within Kosovo, none of the six KIDSCREEN scores differed significantly between adolescents living in urban (code 1) and rural (code 2) areas. Welch's tests for unequal variances confirmed that all $|t| \leq 1.28$, $p \geq .20$, and 95 % CIs for the mean differences all spanned zero, yielding trivial effect sizes (|Cohen's $d$| ≤ 0.05). Thus, perceived quality of life and well-being appear homogeneous across place of residence in the Kosovar sample.



In Romania, the pattern was similar: no comparison crossed the conventional α = .05 threshold. The largest differences, slightly higher Physical Well-Being (urban $M$ = 6.94 vs. rural $M$ = 6.73) and a modest trend toward better School Environment ratings for urban youth ($M$ = 7.01 vs. 6.78), approached significance, Welch's $t$(≈ 886–888) = 1.52–1.83, $p$ = .13–.07, but the effects were still small (|$d$| ≈ 0.09–0.11). All other domains and items showed |$t$| ≤ 1.72, $p$ ≥ .07, with effect sizes near zero.

Taken together, these independent-samples tests indicate that urban–rural residence does not meaningfully influence adolescents' self-reported physical, psychological, social, or school-related well-being in either country, with all detected differences falling in the trivial-to-small range and lacking statistical reliability (figure 15).

**FIGURE 18. KIDS SCREEN WELLBEING COMPARISON BY COUNTRY AND RESIDENCE**



## Intercorrelations among psychosocial variables, quality of life, and distress

We conducted a compelling correlational analysis to explore the intricate relationships among psychological variables, quality of life, and psychological distress.

TABLE 5: CORRELATIONAL KOSOVO (N = 400–405)

| | 1. Attitudes | 2. Stigma | 3. Help-seeking | 4. KIDSCREEN | 5. Kessler |
|---|---|---|---|---|---|
| 1. Attitudes | - | .34** | .51** | .40** | -.22** |
| 2. Stigma | .34** | - | .23** | .14** | .05 |
| 3. Help-seeking | .51** | .23** | - | .24** | -.22** |
| 4. KIDSCREEN | .40** | .14** | .24** | - | -.31** |
| 5. Kessler | −.22** | .05 | −.22** | −.31** | - |

TABLE 6. CORRELATIONAL ANALYSIS ROMANIA (N = 927–928)

| | 1. Attitudes | 2. Stigma | 3. Help-seeking | 4. KIDSCREEN | 5. Kessler |
|---|---|---|---|---|---|
| 1. Attitudes | - | .34** | .59** | .42** | -.26** |
| 2. Stigma | .34** | - | .25** | .19** | .09** |
| 3. Help-seeking | .59** | .25** | - | .47** | -.40** |
| 4. KIDSCREEN | .42** | .19** | .47** | - | -.32** |
| 5. Kessler | −.26** | .09** | −.40** | −.32** | - |

***Note.*** **p < .01 (two-tailed). Diagonal entries omitted.

Positive attitudes toward mental-health care were moderately linked to help-seeking intentions in both Kosovo (r = .51) and Romania (r = .59), and to better quality of life (KIDSCREEN) in Kosovo (r = .40) and Romania (r = .42). As expected, attitudes correlated negatively with psychological distress (Kessler), but the association was modest (–.22 Kosovo; –.26 Romania).

Perceived stigma aligned positively with negative attitudes (about r = .34 in both settings) yet showed divergent links with outcomes. In Romania stigma maintained a small positive

correlation with distress (r = .09, p < .01) and a small negative correlation with quality of life (r = –.19), whereas in Kosovo stigma was unrelated to distress (r = .05) and only weakly tied to quality of life (r = –.14). Thus, stigma appears more consequential for Romanian adolescents.

Help-seeking intentions were associated with higher quality of life and lower distress in both samples, but the effects were considerably stronger in Romania (KIDSCREEN r = .47, Kessler r = –.40) than in Kosovo (KIDSCREEN r = .24, Kessler r = –.22). This dovetails with the regression results, where help-seeking emerged as a robust predictor in Romania but not in Kosovo for KIDSCREEN scores.

Finally, the expected negative link between quality of life and psychological distress was moderate and nearly identical across countries (–.31 Kosovo; –.32 Romania), confirming that the two instruments capture overlapping but not redundant aspects of adolescent mental health.

Overall, the correlational evidence reinforces the regression findings: attitudes and help-seeking are key promotive factors across contexts, whereas stigma exerts a discernible, though stronger, influence on Romanian youth (Table 5 & 6). The consistency of the KIDSCREEN–Kessler overlap underscores the value of using both positive-health and symptom-based indicators in programme evaluation.

## Regression analysis

A simultaneous multiple regression examined predictors of psychological distress (Kessler total) in Kosovo (n = 379) and Romania (n = 913). The model explained a small but significant 10% of variance in the Kosovar sample, $R^2 = .10$, $F(10, 368) = 4.19$, $p < .001$, and a substantially larger 23% in Romania, $R^2 = .23$, $F(10, 902) = 27.37$, $p < .001$ (Table 7). In both countries, greater perceived stigma uniquely predicted higher distress, whereas more positive attitudes toward mental-health care and stronger help-seeking intentions predicted lower distress; standardized betas ranged from |.14| to |.39|. Demographic variables were largely nonsignificant. An exception was Romania, where rural residence (β = .08, p = .010) and higher school grade (β = .07, p = .022) were associated with slightly elevated distress. These findings underscore the central role of psychosocial factors, especially stigma and help-seeking readiness, in adolescent mental health across settings. At the same time, demographic effects appear context-specific and modest in size.

TABLE 7: MULTIPLE REGRESSION PREDICTING KESSLER PSYCHOLOGICAL DISTRESS BY COUNTRY

| Predictor | B (SE) Kosovo | β Kosovo | p Kosovo | B (SE) Romania | β Romania | p Romania |
|---|---|---|---|---|---|---|
| Constant | 22.84 (3.36) | , | <.001 | 14.04 (1.65) | , | <.001 |
| Gender (boy=1) | -0.55 (0.47) | -.06 | .245 | 0.18 (0.21) | .03 | .398 |
| Residence (rural=2) | -0.45 (0.55) | -.05 | .411 | 0.68 (0.26) | .08 | .010* |
| Grade | -0.17 (0.21) | -.04 | .424 | 0.27 (0.12) | .07 | .022* |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Mother's education** | -0.54 (0.32) | -.11 | .091 | -0.02 (0.17) | -.01 | .889 |
| **Father's education** | 0.34 (0.32) | .07 | .278 | -0.09 (0.15) | -.02 | .533 |
| **Mother working (yes=1)** | 0.52 (0.48) | .08 | .278 | 0.37 (0.28) | .04 | .183 |
| **Father working (yes=1)** | -0.48 (0.48) | -.07 | .324 | 0.03 (0.37) | .00 | .932 |
| **Attitudes (neg.)** | -0.18 (0.06) | -.19 | .002** | -0.07 (0.03) | -.11 | .004** |
| **Stigma** | 0.21 (0.08) | .14 | .010* | 0.30 (0.04) | .23 | <.001*** |
| **Help-seeking** | -0.23 (0.09) | -.16 | .007* | -0.46 (0.04) | -.39 | <.001*** |

Model $R^2$ / Adj. $R^2$: Kosovo = .102 / .078; Romania = .233 / .224
***Note.*** Reference categories: girl = 0, urban = 1, parent not working = 0. Attitudes and stigma scales: higher = more negative. *p* < .05; **p* < .01; ***p* < .001.

Across the combined cohort of 1,292 adolescents, the simultaneous multiple regression was significant, $F(10, 1281) = 27.47$, $p < .001$, accounting for 17.7 % of the variance in psychological distress (Kessler total), $R^2 = .18$, adj. $R^2 = .17$. Psychosocial variables dominated the prediction: greater perceived stigma (β = .20, $p < .001$) was associated with higher distress, whereas more positive mental-health attitudes (β = –.13, $p < .001$) and stronger help-seeking intentions (β = –.33, $p < .001$) independently predicted lower distress. Among demographics, having a working mother showed a small positive association with distress (β = .04, $p = .035$), and rural residence and fathers' employment were marginal at the .05 level. Gender, grade, and parental education did not uniquely predict distress (Table 8). Overall, the model underscores that modifiable psychosocial factors, especially stigma reduction and enhancing help-seeking, offer the most significant leverage for lowering adolescent psychological distress. In contrast, sociodemographic characteristics explain comparatively slight additional variance.

**TABLE 8. MULTIPLE REGRESSION PREDICTING KESSLER PSYCHOLOGICAL DISTRESS (POOLED SAMPLE)**

| Predictor | B (SE) | β | p |
|---|---|---|---|
| **Constant** | 16.53 (1.48) | , | <.001 |
| **Gender (boy=1)** | 0.08 (0.20) | .01 | .705 |
| **Residence (rural=2)** | 0.43 (0.24) | .05 | .068 |

| | | | |
|---|---|---|---|
| **Grade** | 0.10 (0.10) | .03 | .343 |
| **Mother's education** | -0.05 (0.15) | -.01 | .714 |
| **Father's education** | -0.01 (0.14) | -.00 | .961 |
| **Mother working (yes=1)** | 0.44 (0.21) | .04 | .035* |
| **Father working (yes=1)** | -0.39 (0.21) | -.03 | .063 |
| **Attitudes (neg.)** | -0.10 (0.02) | -.13 | <.001*** |
| **Stigma** | 0.27 (0.04) | .20 | <.001*** |
| **Help-seeking** | -0.42 (0.04) | -.33 | <.001*** |

Model $R^2$ = .177, Adjusted $R^2$ = .170, F(10, 1281) = 27.47, p < .001, Standard error of estimate = 4.13
***Note.*** Reference categories: girl = 0, urban = 1, parent not working = 0. Higher scores on attitudes/stigma = more negative attitudes or greater stigma. *p* < .05; **p* < .01; ***p* < .001.

Across both countries, the KIDSCREEN-10 models captured more variance in adolescents' quality of life than the parallel Kessler-6 models did for psychological distress, 18 % versus 10 % in Kosovo and 28 % versus 23 % in Romania (Table 9). In both settings, more positive attitudes toward mental health care were the most consistent promotive factor for KIDSCREEN scores (β = .39 in Kosovo; β = .22 in Romania, p < .001), mirroring their protective effect on Kessler distress. Help-seeking intentions showed a strong, unique association with better quality of life in Romania (β = .32, p < .001) but were nonsignificant in Kosovo, whereas they lowered distress in both countries. Perceived stigma, which increased Kessler distress, did not predict KIDSCREEN scores, implying that stigma relates more to symptom burden than to positive well-being. Demographic predictors remained weak: gender, residence, and parental factors were trivial; only grade level mattered, predicting slightly poorer well-being in Romanian, but not Kosovar, youth (β = –.12, p < .001). Taken together, these findings suggest that attitudinal change and the facilitation of help-seeking are levers that can simultaneously enhance adolescents' subjective quality of life and mitigate distress. In contrast, stigma-reduction efforts may yield benefits primarily on the distress side of the mental-health spectrum.

**TABLE 9: MULTIPLE REGRESSION PREDICTING KIDSCREEN-10 TOTAL BY COUNTRY**

| Predictor | B (SE) Kosovo | β Kosovo | p Kosovo | B (SE) Romania | β Romania | p Romania |
|---|---|---|---|---|---|---|
| **Constant** | 20.83 (3.44) | , | <.001 | 21.05 (2.10) | , | <.001 |
| **Gender (boy=1)** | -0.20 (0.48) | -.02 | .675 | 0.27 (0.27) | .03 | .313 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Residence (rural=2)** | -0.29 (0.56) | -.03 | .601 | 0.15 (0.33) | .01 | .648 |
| **Grade** | 0.03 (0.22) | .01 | .900 | -0.63 (0.15) | -.12 | <.001*** |
| **Mother's education** | -0.17 (0.33) | -.03 | .615 | -0.02 (0.22) | -.00 | .943 |
| **Father's education** | 0.10 (0.32) | .02 | .760 | 0.08 (0.19) | .02 | .677 |
| **Mother working (yes=1)** | 0.59 (0.49) | .08 | .230 | 0.40 (0.36) | .03 | .257 |
| **Father working (yes=1)** | -0.57 (0.49) | -.08 | .251 | 0.13 (0.47) | .01 | .778 |
| **Attitudes (positive)** | 0.39 (0.06) | .39 | <.001*** | 0.19 (0.03) | .22 | <.001*** |
| **Stigma** | 0.01 (0.08) | .01 | .882 | 0.06 (0.05) | .03 | .260 |
| **Help-seeking** | 0.06 (0.09) | .04 | .486 | 0.50 (0.06) | .32 | <.001*** |

Model fit: Kosovo $R^2$ = .179, Adj. $R^2$ = .157, $F(10, 368) = 8.05$, $p < .001$; Romania $R^2$ = .277, Adj. $R^2$ = .269, $F(10, 902) = 34.59$, $p < .001$.
Note. Higher KIDSCREEN scores indicate better quality of life. Reference categories: girl = 0, urban = 1, parent not working = 0. Attitudes scale: higher = more positive. *p* < .05; **p* < .01; ***p* < .001.

When the same set of predictors was applied to the KIDSCREEN-10 total score, the overall model explained 23 % of the variance ($R^2$ = .233), noticeably higher than the 18 % accounted for in the Kessler distress model. Consistent with the Kessler results, more **positive mental-health attitudes** (β = .26, $p < .001$) and stronger **help-seeking intentions** (β = .26, $p < .001$) were independently associated with better outcomes, reflected in higher quality-of-life scores rather than lower distress. However, **perceived stigma**, which was a significant risk factor for distress (β = .20), did not predict KIDSCREEN scores (β = .03, ns), suggesting that stigma impacts negative mental-health symptoms more than positive well-being (Table 10). Demographic variables again made little unique contribution; only school grade and mother's education approached significance, and their effects were small ($|\beta| \approx .05$). Overall, the pattern reinforces that modifiable psychosocial factors, especially attitudes and help-seeking, are key levers for both reducing distress and enhancing quality of life, whereas stigma appears more salient for distress than for subjective well-being.

TABLE 10: MULTIPLE REGRESSION PREDICTING KIDSCREEN-10 TOTAL (POOLED SAMPLE)

| Predictor | B (SE) | β | p |
|---|---|---|---|
| Constant | 20.54 (1.79) | , | <.001 |
| Gender (boy=1) | 0.13 (0.24) | .01 | .577 |
| Residence (rural=2) | -0.14 (0.28) | -.01 | .634 |
| Grade | -0.23 (0.12) | -.05 | .059 |
| Mother's education | -0.34 (0.18) | -.06 | .056 |
| Father's education | 0.15 (0.17) | .03 | .356 |
| Mother working (yes=1) | -0.04 (0.25) | -.02 | .888 |
| Father working (yes=1) | 0.06 (0.25) | .04 | .806 |
| Attitudes (pos.) | 0.24 (0.03) | .26 | <.001*** |
| Stigma | 0.05 (0.04) | .03 | .255 |
| Help-seeking | 0.41 (0.05) | .26 | <.001*** |

Model $R^2$ = .233, Adjusted $R^2$ = .227, $F(10, 1281) = 38.94$, $p < .001$, Standard error of estimate = 4.98

***Note***. Higher KIDSCREEN scores indicate better health-related quality of life. Reference categories: girl = 0, urban = 1, parent not working = 0. Attitudes scale: higher = more positive; stigma scale: higher = greater stigma. *p* < .05; **p* < .01; ***p* < .001.

# 4. DISCUSSION

## Perceptions and Knowledge Foundations

The current study provides a comprehensive exploration of mental health literacy and knowledge among adolescents in rural and low-socioeconomic settings of Kosovo and Romania, integrating qualitative insights with quantitative evidence.

Qualitative data revealed a prevailing negative perception of mental health, with adolescents frequently associating it with feelings of sadness, anxiety, and stress. In Kosovo, students described intense emotional responses linked to academic pressures, exemplified by accounts of panic attacks during demanding lessons. Similarly, Romanian adolescents highlighted ambiguity and discomfort around mental health, expressing fears around confidentiality when discussing such issues with adults. These qualitative findings align closely with quantitative results, showing strong overall awareness but indicating specific gaps in understanding.

Quantitative analyses demonstrated that most students (over 85%) possess a basic grasp of core mental health concepts, including non-violent communication and general well-being definitions. However, notable differences between the two countries emerged. Romanian adolescents displayed higher proficiency in identifying early-warning signs of unhealthy relationships (67% vs. 43%) and understanding digital wellness (68% vs. 58%) compared to their Kosovar peers. These disparities suggest uneven exposure and implementation of mental health curricula, highlighting areas for targeted educational interventions.

Moreover, the gap between students' conceptual knowledge and their lived experiences was evident. Despite adequate knowledge on paper, adolescents consistently reported difficulties translating their understanding into effective coping mechanisms or help-seeking behaviors. Qualitative narratives underscored adolescents' tendency to internalize distress, choosing isolation over seeking professional support. This internalization significantly correlated with elevated distress scores quantitatively measured via the Kessler-6 scale.

To address these issues effectively, school-based programs should integrate strengths-based curricula alongside traditional symptom-focused education, helping adolescents to conceptualize mental health positively and practically. Additionally, enhancing confidential and accessible support platforms, fostering peer-led interventions, and improving the capacity and trustworthiness of professional mental health services are essential steps forward.

Equity considerations must also guide these interventions, prioritizing vulnerable groups such as ethnic minorities and rural populations who face compounded challenges in accessing mental health resources.

## Stigma as a Barrier to Help-Seeking

Qualitative findings reveal that stigma associated with mental health remains a profound obstacle in both Kosovo and Romania, directly affecting adolescents' willingness to disclose emotional struggles. Across both settings, adolescents repeatedly highlighted a pervasive fear of judgment, ridicule, and breaches of confidentiality, significantly curbing their openness toward seeking support. This fear was vividly illustrated by a Kosovar adolescent who explained,

*"If you whisper 'suicide' here, everyone knows by lunch."*

In Romania, adolescents echoed similar concerns about privacy, emphasizing uncertainty about trusting teachers or counselors, with one stating:

*"I don't talk about feeling sad or anxious because I fear everyone at school would find out."*

Quantitatively, our findings underscore the varying impacts of stigma on mental health outcomes across the two contexts. In Romania, stigma significantly correlated with higher levels of distress (Kessler-6) and lower quality-of-life scores (KIDSCREEN-10). Conversely, in Kosovo, stigma was not significantly linked to distress but moderately associated with lower reported quality-of-life, suggesting subtle yet impactful implications for overall well-being. These differences imply that stigma may operate through distinct cultural and social pathways in the two countries, emphasizing the necessity for context-sensitive interventions.

## Informal Help-Seeking and Self-Reliance

Faced with such strong stigma-related barriers, adolescents predominantly turn to informal coping strategies and networks rather than formal mental health services. Over half the youth surveyed in both countries identified family and friends as their primary sources of emotional support, resonating with global literature underscoring adolescents' preferences for informal rather than professional support (Gulliver et al., 2010).

Qualitative data further illuminate this pattern. Romanian and Kosovar adolescents described self-reliant coping methods, such as engaging in artistic expression, sports, and private journaling, as pivotal strategies for managing distress without openly disclosing struggles. A Kosovar student reflected on using writing as an outlet, stating,

*"Sometimes I write in a notebook or talk to a chatbot, at least it listens."*

Romanian adolescents similarly identified self-managed coping mechanisms as central to their emotional resilience, highlighting solitary activities like listening to music, playing sports, or simply engaging in imaginative daydreaming.

Quantitatively, the survey findings strongly affirm these qualitative patterns. Help-seeking intentions significantly correlated with lower psychological distress and higher quality-of-life scores, particularly in Romania. This finding underscores the crucial role informal networks and self-help behaviors play in buffering mental health risks, especially where formal services remain inaccessible or culturally stigmatized.

## Cultural Norms and Confidentiality Concerns

The cultural importance placed on reputation and social acceptance in rural communities further intensifies the negative impacts of stigma on help-seeking behavior. Adolescents' fear of gossip and the rapid dissemination of personal information within tight-knit community networks emerged repeatedly during qualitative discussions. This cultural dynamic creates an environment in which adolescents feel trapped between emotional distress and the perceived risk of social exclusion or embarrassment. Thus, confidentiality and anonymity become critical determinants of adolescents' willingness to seek help and support.

## Dominant Coping Strategies: Silence and Withdrawal

Across both countries, qualitative findings indicate a strong preference among adolescents for internalizing distress, commonly described as “bottling up” emotions. Adolescents repeatedly expressed reluctance or inability to openly discuss their struggles, preferring to withdraw and isolate when experiencing emotional difficulties. A student from Kosovo articulated this pattern vividly:

> *“When I'm upset, I stay quiet and keep to myself.”*

Romanian youth similarly described self-isolation and engaging in solitary distractions, such as excessive phone use and social media scrolling, as mechanisms to avoid directly confronting emotional challenges:

> *“I just scroll endlessly on my phone, rather than talk to someone about feeling sad or anxious.”*

These qualitative accounts align closely with quantitative survey findings. Withdrawal and emotional suppression significantly correlated with higher levels of psychological distress, as measured by the Kessler-6 scale, indicating detrimental mental health consequences associated with internalizing coping strategies. Adolescents who reported limited or no emotional sharing exhibited higher distress scores and lower quality-of-life indicators across both Kosovo and Romania.

## Informal, Creative, and Physical Coping Mechanisms

Despite their predominant reliance on withdrawal, adolescents from both settings also identified various informal self-help strategies. Qualitative data revealed frequent references to artistic activities, physical exercise, music, journaling, and daydreaming as effective ways of independently managing emotional distress. A Kosovar adolescent, for example, described writing and engaging with digital tools as private emotional outlets:

> *“Sometimes I write in a notebook or talk to a chatbot, at least it listens.”*

Romanian adolescents similarly emphasized creative and imaginative methods, explaining how music and imaginative escape (e.g., visualizing relaxing scenes) offered emotional relief during periods of stress. These creative and physical outlets represent important adaptive strategies, facilitating emotional regulation despite limited formal support networks.

Quantitative findings reinforce the beneficial impact of these informal strategies. Adolescents utilizing informal coping mechanisms reported relatively lower distress and improved emotional well-being compared to peers who solely internalized distress without engaging in adaptive behaviors. This protective effect highlights the significant potential of promoting structured creative and physical activities within school and community settings.

## Emotional Regulation and the Role of Social Support

Both qualitative and quantitative findings demonstrate the critical role social support plays in emotional regulation and coping. Although adolescents predominantly rely on informal networks, particularly friends and family, for emotional support, many simultaneously expressed reservations about seeking professional help due to concerns regarding confidentiality and stigma.

Quantitative analyses underline the importance of strengthening informal support channels, as adolescents expressing greater willingness to seek informal help consistently exhibited lower distress and improved emotional health outcomes. This finding emphasizes the necessity of bolstering existing informal networks through structured training in psychological first aid and peer mentoring, enhancing adolescents' capacities to support each other effectively.

While the overall preference for withdrawal and informal coping strategies was consistent across Kosovo and Romania, subtle cross-country differences emerged. Romanian adolescents were somewhat more likely to explicitly describe structured positive coping strategies, such as imaginative techniques or creative expression, whereas Kosovar adolescents placed greater emphasis on discrete, solitary methods like journaling or anonymous online support.

Quantitatively, the association between adaptive coping and emotional well-being appeared stronger in Romania, suggesting a potentially more robust informal support culture or greater availability of accessible coping resources. These differences indicate opportunities for cross-learning, where successful informal coping mechanisms observed in Romania could inform intervention development in Kosovo and vice versa.

## Bullying as "Background Noise": Normalization and Pervasiveness

Qualitative findings clearly demonstrate that bullying is deeply ingrained and widely perceived as an almost inevitable feature of adolescents' everyday lives in both Kosovo and Romania. Students in Kosovo described bullying vividly as:

> *"Background noise, something you just expect every day."*

Similarly, Romanian adolescents expressed resignation to routine teasing and verbal harassment, emphasizing how normalized and invisible bullying had become within their school environments. Qualitative narratives revealed that such normalization severely diminishes adolescents' willingness and confidence to report incidents or seek support, perpetuating cycles of emotional harm and peer exclusion.

Quantitative survey results support this qualitative picture. A substantial percentage of adolescents reported frequent exposure to various bullying behaviors, ranging from verbal taunts and physical intimidation to relational aggression and deliberate exclusion. High rates of exposure indicate that bullying is not merely an occasional incident but an ongoing reality consistently undermining adolescents' emotional safety and overall well-being.

## Cyberbullying: Amplified Harms in Digital Spaces

Our findings highlighted cyberbullying as a particularly acute form of harassment, disproportionately affecting adolescent girls. Qualitative data provided striking examples, with adolescents describing emotionally devastating experiences of public shaming and humiliation through memes and derogatory images circulated widely on social media platforms. A Kosovar student, for example, reported:

> *"They took her photo, turned it into memes, and shared them everywhere. Everyone laughed at her online."*

Romanian students similarly emphasized how online bullying rapidly escalates, compounding emotional distress due to its anonymous nature and wide visibility:

> *"Once it starts online, it never really stops. People join in, it spreads quickly, and you feel helpless."*

Quantitative data corroborate these qualitative accounts, showing that nearly two-thirds of adolescents reported witnessing or experiencing some form of cyberbullying in both contexts. This widespread exposure underscores the critical need for structured digital safety education and targeted support mechanisms, especially for vulnerable groups such as girls or minority adolescents.

## Gap Between Knowledge and Action: Missed Opportunities for Intervention

Interestingly, despite pervasive bullying, quantitative data revealed high levels of conceptual understanding among adolescents regarding non-violent communication and conflict resolution, over 75% demonstrated correct knowledge of appropriate anti-bullying responses. This finding highlights a critical disconnect between adolescents' knowledge and their capacity or willingness to intervene effectively in real-life bullying incidents.

Qualitative data further illuminate barriers preventing knowledge translation into action. Adolescents expressed fears about social repercussions of intervening, uncertainty about effective intervention methods, and concerns regarding adult inaction or confidentiality breaches. These factors create significant hurdles to active peer intervention, despite adolescents' foundational understanding of how to address bullying behavior.

## School Climate: Trust, Resources, and Emotional Safety

### Resource Limitations and Professional Support

Qualitative findings clearly illustrate significant deficits in mental-health-related resources within schools, a critical barrier to timely and effective support. In Romania, the counselor-to-student ratio stands alarmingly high, at approximately one counselor per 800 students, resulting in extensive wait times and limited access. Similarly, Kosovo, despite employing approximately 180 school psychologists nationwide, focuses predominantly on crisis intervention rather than preventive mental health programs. Adolescents frequently expressed frustration and mistrust toward existing counseling resources, highlighting confidentiality concerns and doubts about staff's capacity to provide confidential and empathetic support:

> *"I don't trust that talking to a school counselor will stay confidential. Everyone in school would eventually find out." (Romanian adolescent)*

This narrative aligns closely with quantitative data indicating low confidence levels among adolescents in school-based support systems. The scarcity of counselors, combined with limited preventive programming, directly undermines adolescents' likelihood of seeking formal support, exacerbating reliance on informal and often inadequate coping strategies.

### Safety, Inclusion, and Peer Dynamics

Qualitative narratives vividly depict schools as environments characterized by constant vigilance, anxiety, and emotional insecurity. Adolescents in both countries reported normalized bullying and cyberbullying experiences, describing them as “background noise”, an expected, if distressing, part of everyday school life. The prevalence and normalization of bullying severely compromise adolescents' sense of emotional safety and belonging:

> *“Bullying here happens daily, you just learn to live with it. It’s normal.” (Kosovar student)*

Quantitatively, adolescents from schools perceived as unsafe and unsupportive consistently exhibited higher distress levels (as measured by Kessler-6) and lower quality-of-life ratings (KIDSCREEN-10). Conversely, students who viewed their school environments as proactive in addressing bullying, through clear policies, consistent teacher intervention, and peer-support programs, reported significantly reduced distress and enhanced emotional well-being.

These findings underline the urgent need for school-wide initiatives explicitly designed to foster inclusive, respectful climates. Anti-bullying campaigns, stigma-reduction workshops, and structured peer-support initiatives can transform harmful norms, providing adolescents with safe, trusting environments conducive to healthy emotional development

## Family Climate: Support, Confidentiality, and Expectations

### Family as Primary Support and Source of Stigma

Qualitative findings consistently affirmed that adolescents predominantly rely on family for emotional support, with over half of respondents in both Kosovo and Romania turning first to parents or siblings during distress. However, this reliance on family networks can be a double-edged sword. Many adolescents reported significant anxiety about sharing emotional struggles with family members due to fears of confidentiality breaches, judgment, and misunderstanding:

> *“If you whisper ‘suicide’ here, everyone in the village will know by lunch.” (Kosovar adolescent)*

Further complicating this picture, parents themselves frequently minimize mental health concerns, equating well-being with academic performance or dismissing emotional struggles as trivial:

> *“Children here don’t have real problems. High grades mean they're okay.” (Romanian parent)*

These qualitative insights reflect a critical gap between adolescents’ needs for empathy and confidentiality, and the actual support provided by families. The consequences of such disconnects are quantitatively evident: adolescents who perceived low family confidentiality demonstrated significantly higher distress levels and poorer emotional outcomes compared to peers feeling assured of family privacy and empathy.

### Confidentiality and Emotional Safety at Home

Quantitative data reinforced the crucial importance of confidentiality within family interactions. Adolescents who trusted their parents’ discretion regarding sensitive emotional disclosures showed significantly improved psychological outcomes, with notably lower distress and better quality-of-life scores. Conversely, those uncertain about familial

confidentiality reported higher distress and more frequent emotional suppression, further heightening their vulnerability to prolonged psychological strain.

This finding underscores the critical need to educate parents on sensitive and confidential emotional communication. Structured parent-training workshops focused on active listening, mental health literacy, and confidentiality can empower families to serve effectively as trusted emotional anchors for adolescents.

## Intersection of School and Family Contexts

### Compounded Stigma and Vulnerability

Our findings highlight the compounded impacts when stigma and confidentiality concerns are present in both school and family environments. Adolescents experiencing stigma-related barriers simultaneously at home and school exhibited the highest levels of psychological distress and lowest help-seeking behaviors. This combined burden severely limits available avenues for emotional support, driving adolescents toward solitary coping mechanisms and exacerbating emotional isolation.

### Synergistic Benefits of Aligned Messaging

Conversely, qualitative and quantitative evidence indicates that aligned messaging and consistent confidentiality standards across home and school contexts significantly enhance adolescents' mental health outcomes. Adolescents who perceived cohesive and consistent anti-stigma and confidentiality practices reported dramatically increased willingness to seek help, reduced distress, and improved emotional well-being:

> *“When school and home say the same things, like it's okay to talk openly, it really helps us feel safe.” (Romanian student)*

# 5. RECOMMENDATION AND CONCLUSIONS

## Recommendations for Schools

### 1. Strengthen School-Based Mental Health Services

- Increase the number of school psychologists and counselors to meet recommended ratios, ideally one counselor per 300 students, according to school associations (European Association of School Psychologists,2017; National Association of School Psychologists, 2020)
- Shift counseling services from predominantly crisis-oriented responses to proactive preventive interventions.
- Ensure confidentiality and empathy in counseling to build student trust and encourage help-seeking. Including promotion of school based mental health services.
- Collaborate with teachers to enhance their role in supporting student mental health, including training in basic Psychological First Aid (PFA) and recognizing signs of emotional distress.

### 2. Implement Comprehensive Anti-Bullying and Cyberbullying Programs

- Introduce structured, culturally adapted bystander-intervention training for students to empower active peer involvement.
- Incorporate digital literacy and online safety modules into curricula to reduce vulnerability to cyberbullying, particularly among girls.
- Establish clear, accessible, anonymous reporting channels (e.g., secure online apps, emotional safety kiosks) to improve incident reporting and school responsiveness.

### 3. Promote Inclusive and Positive School Climates

- Conduct regular stigma-reduction campaigns and inclusive-education programs highlighting mental health as a positive and collective responsibility.
- Facilitate peer-mentoring programs to foster empathy, inclusion, and mutual emotional support among students.
- Organize frequent teacher training workshops in psychological first aid and stigma awareness, empowering educators to recognize and respond sensitively to students' emotional struggles.

### 4. Institutionalize Creative and Physical Coping Strategies

- Formalize existing informal coping strategies (art, music, sports, mindfulness) into structured extracurricular and classroom activities.

- Develop accessible after-school “Well-Being Clubs” that provide safe, supervised spaces for creative expression, social interaction, and emotional support.

## Recommendations for Families and Communities

### 1. Conduct Parent and Community Education Workshops

- Provide mental-health literacy training for parents, focusing on active listening, empathy, recognizing signs of distress, social media and screen time, and appropriate confidentiality.
- Equip families with practical skills for supporting adolescents emotionally and reducing stigma within home environments.

### 2. Strengthen Home-School Communication and Alignment

- Establish regular meetings between parents and school staff to ensure consistency in anti-stigma messaging and confidentiality practices.
- Develop joint school-family action plans that clearly outline shared expectations for responding to mental health concerns.

### 3. Implement Community-Based Anti-Stigma Campaigns

- Launch culturally sensitive campaigns involving community members, local leaders, and youth role models to openly discuss mental health, normalize help-seeking, and dismantle negative stereotypes.
- Utilize community events, local media, and social media platforms to amplify positive narratives around mental health and resilience.

## Recommendations for Ministries and Policymakers

### 1. Enact Policy and Budgetary Commitments

- Allocate sufficient funding to support recommended counselor-to-student ratios and preventive mental health programs.
- Mandate regular mental health screening and monitoring (e.g., SDQ, Kessler-6) to systematically identify adolescents at risk and monitor intervention effectiveness.
- Consider use of digital evidence based mental health apps that could be used by schoolchildren on enhancing their knowledge on mental health related issues.

### 2. Develop and Standardize Comprehensive Mental Health Curricula

- Revise national educational curricula to integrate both strengths-based emotional education (e.g., positive psychology, PERMA framework) and practical skills for emotional regulation, conflict resolution, and relationship-building.
- Provide specialized educational resources tailored to marginalized communities and minority populations, addressing specific cultural contexts and linguistic needs.

### 3. Establish Confidential and Accessible Reporting Mechanisms

- Support the creation of national anonymous reporting platforms (e.g., text lines, online reporting portals) to enable safe disclosures of sensitive mental health issues, self-harm, bullying, and cyberbullying.

## Equity and Inclusion Recommendations

### 1. Target Resources and Programs for Marginalized Populations

- Prioritize investment in mental health resources and programs specifically for marginalized adolescents, including Roma, Ashkali, Egyptian communities in Kosovo, rural populations, and economically disadvantaged groups.
- Develop culturally tailored interventions sensitive to unique stigma dynamics and community-specific barriers to help-seeking

### 2. Monitor Equity and Access

- Use ongoing data collection and analysis to ensure equitable service delivery and resource distribution, proactively addressing disparities between rural-urban, socioeconomic, and minority-majority communities.

## Recommendations for Local NGOs and Civil Society

### 1. Foster Community Engagement and Capacity Building

- Lead grassroots initiatives such as peer-mentor training, parent ambassador networks, and community-based listening circles to enhance local capacity for supporting adolescent mental health.
- Advocate for policy reforms and resource allocation at regional and national levels based on collected community-level data and experiences.

### 2. Provide Structured After-School Programs

- Collaborate with schools to deliver structured after-school programs focusing on creative expression, physical activities, emotional literacy, and peer support, filling gaps left by limited school resources.

# 6. LIMITATIONS

While the sequential mixed methods design enables for in-depth exploration followed by broader validation, several methodological limitations must be acknowledged. First, the use of purposive sampling in both qualitative and quantitative phases (selection of schools) limits the generalizability of findings beyond the selected communities. Although diverse settings were included (urban, small urban, and rural), the sample may not fully represent the broader population of children and adolescents in Romania and Kosovo. Second, despite the strength of focus group discussions in eliciting rich, context-sensitive narratives, group dynamics and social desirability may have influenced participants' openness, particularly in mixed groups involving parents and teachers or when discussing sensitive mental health topics. Third, while the qualitative data were systematically analyzed using thematic analysis and ATLAS.ti software, the absence of verbatim transcripts (as analysis relied on translated notes) may have resulted in the loss of some contextual nuance and participant voice. Additionally, the instrument development for the quantitative phase, though grounded in qualitative findings, may carry limitations related to cultural adaptation, particularly for validated tools not previously normed in the study settings. Lastly, while cross-country comparisons provide valuable insights, they should be interpreted with caution due to contextual differences such as cultural norms, post-conflict dynamics in Kosovo, and differing stages in the development of mental health services, factors that may shape perceptions, needs, and support structures in distinct ways.

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