

Integrating Healthcare, Education, and Social Care to Promote Psychological Resilience and Mental Health Among Adolescents

Nidhi parihar^{1*}, Tosendra Dwivedi², Dr. Jyotsana Kaushik³, Dr. S Nabiya Banu⁴, Dr Ruttuja Karkhanis More⁵, Manish kumar Verma⁶

¹*Research Scholar, Department of psychology, lovely professional university, Phagwara, Pin code: 14440, Email Id: 1988.nidhiparihar@gmail.com, Orcid Id: 0009-0005-3534-4350

²Professor Department of Psychology, IILM University, Greater Noida, 201308, India, Email Id:tosendra.dwivedi@iilm.edu, Orcid Id: 0000-0002-5766-0363

³Assistant Professor, Specialization in Psychology, Government P. G. College, Sector- 1, Panchkula, Pin code: 134109, Haryana, Email Id: kaushikjyotsna59@gmail.com, Orcid Id: 0009-0000-6444-6333

⁴Lecturer in English, Specialization in English language and literature, SBTET, Dept. of Higher Education, Govt. Polytechnic for Women, Kadapa, Andhra Pradesh
Email ID: snabiyanbanu@gmail.com⁵Assistant Professor, Department of Psychology, Narsee Monjee Institute of Management Studies, Email Id: ruttuja.karkhanismore@nmims.edu

⁶Professor, Department of Psychology, Lovely Professional University, Phagwara, Pincode:14440, Email Id: manish.23960@lpu.co.in, Orcid Id :0000-0002-4814-6987

Abstract

Adolescent mental health is influenced by interactions among healthcare services, educational environments, families, and social support systems, and coordinated support across these sectors may strengthen psychological resilience and mental well-being. This study assessed adolescents' perceptions of healthcare, educational, and social support and their integration, examined their relationships with psychological resilience and mental well-being, and determined whether perceived support and integration predicted these outcomes. A quantitative cross-sectional questionnaire-based study was conducted among 80 adolescents aged 13–18 years using a structured 20-item questionnaire comprising four demographic questions and 16 five-point Likert-scale items. Data were analyzed using descriptive statistics, Cronbach's alpha, Pearson correlation, multiple linear regression, and independent-samples t-tests. All questionnaire domains demonstrated good to excellent internal consistency. Significant positive relationships were observed among perceived support, integration and coordination, psychological resilience, and mental well-being, with resilience showing the strongest association with mental well-being. Regression analysis indicated that both perceived support and integration significantly predicted psychological resilience and mental well-being, while integration showed the stronger association with mental well-being. No significant gender differences or age-related associations were identified. Overall, the findings suggest that integrated healthcare, educational, and social support is positively associated with adolescent resilience and mental well-being and may provide a useful framework for strengthening adolescent mental health support.

Keywords: Adolescents; Integrated care; Mental well-being; Psychological resilience; Social support.

1. Introduction

Adolescence is an important stage of development marked by numerous psychological, social, educational, and emotional changes. At this stage of life, individuals face academic demands, family changes, peer relationships, identity formation, and increased independence, and all these changes have the potential to impact their psychological wellbeing. Psychological problems in adolescence could impact individuals' emotional processes, interpersonal relationships, education, and further development. Therefore, psychological resilience has become an important area of research since it helps adolescents to adapt to challenging situations, recover from failures, and continue functioning despite the hardships. It is important to note that resilience should not be considered merely an individual personal resource since it depends on relationships, environment, and access to protection resources. Hardships can make individuals psychologically vulnerable, while favorable environments can help to develop coping skills (Soleimanpour et al., 2017). Modern literature points out the significant relationship between resilience and mental wellbeing among children and adolescents and identifies the context in which it develops (Mesman et al., 2021).

The need for adolescent psychological health services may encompass several institutional contexts at once. On the one hand, healthcare systems provide evaluation, counseling, treatment, and referral. On the other hand, school is a significant context where psychological problems can be detected and assistance provided. Given that adolescents spend much time in educational institutions, school personnel such as teachers and counselors can help to detect signs of psychological problems and refer individuals to necessary services. Resilience interventions carried out in schools have shown that educational institutions have the potential to develop the ability of adolescents to cope with various challenges, especially if they experience economic and psychosocial hardship (Ijadi-Maghsoodi et al., 2017). Policies involving psychological support can increase the readiness of educational institutions to provide

psychological assistance in case of increased stress (Wiedermann et al., 2023). Furthermore, an interdisciplinary approach which includes education psychology and public health views can demonstrate how advantageous it can be to address both educational and psychological needs of adolescents (Liu et al., 2025).

Resilience and psychological wellbeing among teenagers are influenced by relationships beyond the confines of health care institutions and schools as well. Caregivers, mentors, friends, community-based sources, and social-care practitioners can provide reassurance, support, mentoring, and chances for teenagers to voice out their worries. Social connections have therefore been regarded as an integral part of resilience and psychological wellbeing during adolescence (Adeyemi & Okoye, 2025). The role of social-care practitioners is especially critical for those teenagers who come from problematic families and social backgrounds as supportive social relationships with social workers can help develop resilient personalities (Sulimani-Aidan, 2018). Family support, coping mechanisms, and social relationships in the student population have provided proof of the significance of interpersonal connections for psychological wellbeing (Yang et al., 2022). It means that a protective social environment can supplement health care and school services and serve as yet another source where teenagers can receive help.

Despite the significance of separate sources of support, fragmented care might reduce the efficiency of such assistance in cases when the needs of adolescents are psychologically, educationally, socially, and family-related. The idea of integration offers a chance for healthcare providers, educators, families, and social workers to communicate and cooperate regarding the adolescent. For this reason, integrated strategies for providing care and improving the health status of children and adolescents were suggested as an essential step in the contemporary healthcare system (Fazel et al., 2021). In addition, there is evidence supporting the notion that approaches combining school and family environments allow for building resilience and promoting better mental well-being because of the cooperation between various approaches (Basu et al., 2020). Such coordination may facilitate earlier recognition of difficulties, continuity of support, appropriate referrals, and a more comprehensive response to adolescents experiencing psychological challenges. Although integrated interventions are increasingly recognized, little is known about how adolescents see their coordinated support and the connection between such perceptions and resilience and psychological well-being. Supportive relationships have the potential to affect psychological adjustment for vulnerable adolescents (Mohamed & Thomas, 2017), whereas resilience-based interventions could be beneficial in improving mental well-being (Bosqui & Marshoud, 2018). Studying the combination of healthcare, education, and social care could be helpful in comprehending adolescents' support systems.

Objectives of the Study

To assess adolescents' perceptions of healthcare, educational, and social support and the integration and coordination of these support systems.

To examine the relationships between perceived support, integration and coordination, psychological resilience, and mental well-being among adolescents.

To determine whether perceived support and integration and coordination significantly predict psychological resilience and mental well-being among adolescents.

2. Methodology

2.1 Research Design

An exploratory research design was used in the investigation of the relationship between integrated healthcare, educational and social support, and psychological resilience and mental well-being of adolescents using a questionnaire. The design allowed for the evaluation of the perceptions held by participants and the exploration of possible connections between the study variables at one particular point in time.

2.2 Study Population and Sample Size

The study population comprised adolescents aged between 13 and 18 years. Eighty participants took part in the study. The recruitment of participants was conducted in appropriate locations where adolescents belonging to the targeted age group could be reached. The selected sample size was deemed adequate for an exploratory questionnaire-based study.

2.3 Sampling Technique

A convenience sampling method was applied in the selection of qualified participants. Adolescents who satisfied the

eligibility criteria and provided the needed assent in addition to parents'/guardians' consent where applicable were selected for the study.

2.4 Participant Eligibility

Individuals were eligible for inclusion in the study if they were between the ages of 13-18 years old, were currently attending school or participating in the selected community setting, could comprehend the questionnaire, and provided their informed consent to participate in the research. The adolescents outside of the stated age range, individuals who did not give consent or assent, as well as questionnaires with missing data, were excluded from the final analysis.

2.5 Research Instrument

Data was collected through a 20-items structured questionnaire which was developed in line with the research objectives. The questionnaire was divided into five parts. Part A comprised four demographic questions on age, gender, level of education and experience in seeking emotional and mental support. Part B comprised Questions 5-8 and evaluated perceived healthcare, education and social supports. Part C comprised Questions 9-12 and evaluated integration and coordination of healthcare systems, schools, families and social support systems. Part D comprised Questions 13-16 and evaluated psychological resilience, whereas Part E comprised Questions 17-20 and evaluated perceived mental wellbeing.

2.6 Likert Scale and Scoring

Demographic questions, Q1-Q4, were measured using categorical responses. Questions Q5-Q20 were measured on a five-point Likert scale; 1 referred to Strongly Disagree, 2 to Disagree, 3 to Neutral, 4 to Agree, and 5 to Strongly Agree. Higher scores implied more perceived support, service integration, psychological resilience, and mental well-being. Composite domain scores were computed using the average values of the corresponding items in each section.

2.7 Validity and Reliability

Validity and appropriateness of the questionnaire in terms of wording and content were verified before data collection. Internal consistency of the questionnaire domains was measured using Cronbach's alpha with a value of 0.70 or above regarded as acceptable.

2.8 Data Collection Procedure

Before data collection, necessary permission to conduct the research in the chosen setting was obtained. Participants eligible for the study were provided with information regarding the purpose of the survey, its voluntary nature, confidentiality, and the right to stop participation at any stage. Where applicable, parental/guardian consent and adolescents' assent were acquired. Questionnaire was conducted according to a specific protocol and without collecting any personal information from participants.

2.9 Study Variables

The independent variables were perceived health care, educational and social support, and integration and coordination of the support systems. The dependent variables were psychological resilience and mental well-being. Demographic factors were considered descriptive or grouping variables.

2.10 Statistical Analysis

Responses from the 80 participants were coded and statistically analyzed. Demographic factors were described by frequency distribution. Likert scale items and composite scores for domain were described using mean and standard deviation. The reliability of the questionnaire domains was determined through Cronbach's alpha. Pearson correlation analysis was employed to study the association between perceived support, service integration, psychological resilience, and mental well-being. Multiple linear regression analysis was conducted to investigate whether perceived support and integration were related to psychological resilience and mental well-being. Independent-samples t-test was employed to compare domain scores between demographic groups. The level of significance was set at $p < 0.05$.

2.11 Ethical Considerations

The ethical guidelines for adolescent research were strictly adhered to during this research process. The participation was voluntary and anonymity was ensured. Consent and assent was obtained from the participants where necessary. The participants were made aware that they were free to decline answering any question or even terminate their participation in the research without consequences. Due to the nature of the questionnaire which pertained to the mental and emotional wellbeing of the participants, relevant information was provided if needed.

3. Results

3.1 Demographic Characteristics of Respondents

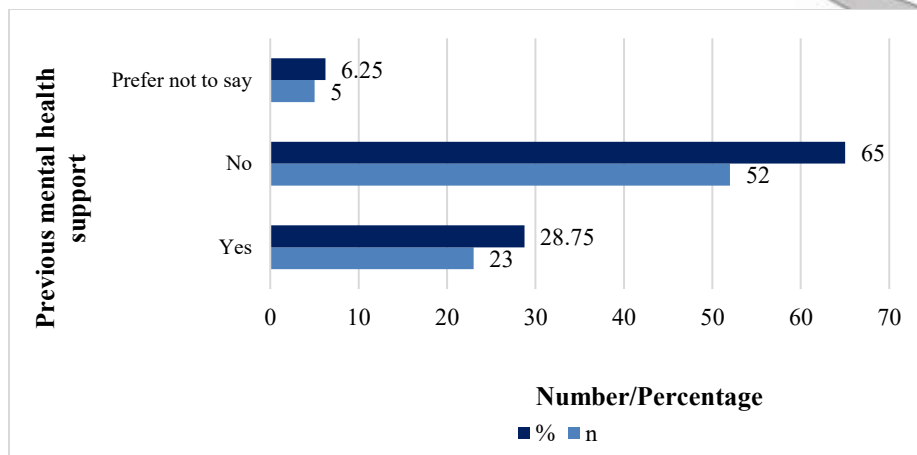
The demographic characteristics of the participants according to age, gender, and educational level are presented in Table 1.

Table 1. Demographic characteristics of the study participants (N = 80)

Characteristic	Category	n	%
Age (years)	13	12	15.00
	14	14	17.50
	15	15	18.75
	16	14	17.50
	17	13	16.25
	18	12	15.00
Gender	Male	38	47.50
	Female	38	47.50
	Other	2	2.50
	Prefer not to say	2	2.50
Educational level	Grade 8 or below	11	13.75
	Grade 9	15	18.75
	Grade 10	19	23.75
	Grade 11	10	12.50
	Grade 12	25	31.25

Participants were relatively evenly distributed within the selected ages of adolescents, with an equal number of males and females being included in the sample. The largest group was grade 12 students. Moreover, the majority of participants have never sought or received any help regarding their mental health issues. The distribution of participants by their previous experience of seeking or receiving mental health support is shown in Figure 1 below.

Figure 1. Previous mental health support status among adolescent respondents



More participants had no prior experience receiving any form of mental health assistance, compared to those who did have such experience. This is important background information regarding adolescents' perceptions of healthcare, educational, and social support.

3.2 Questionnaire Reliability

Cronbach's alpha was employed in assessing the internal consistency of the four domains of the questionnaire, as shown in Table 2.

Table 2. Internal consistency of the questionnaire domains

Domain	Items	Cronbach's α	Interpretation
Healthcare, educational, and social support	4	0.810	Good
Integration and coordination	4	0.814	Good
Psychological resilience	4	0.869	Good
Mental well-being	4	0.902	Excellent

All four domains demonstrated good to excellent internal consistency, indicating that the questionnaire items measured their respective constructs reliably.

3.3 Descriptive Statistics of Study Domains

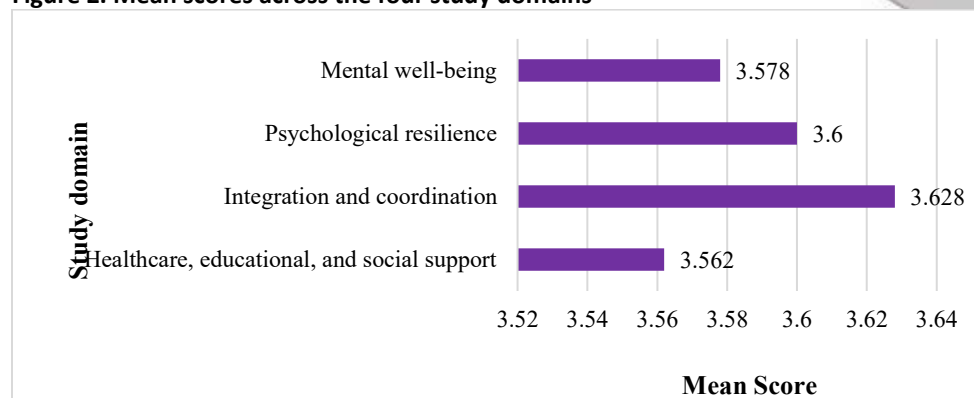
Descriptive statistics of healthcare, education, and social services, integration and coordination, psychological hardiness, and mental health can be seen from Table 3.

Table 3. Descriptive statistics of the major study domains

Domain	Mean	SD	Minimum	Maximum
Healthcare, educational, and social support	3.562	0.735	1.50	5.00
Integration and coordination	3.628	0.730	2.00	5.00
Psychological resilience	3.600	0.789	1.50	5.00
Mental well-being	3.578	0.962	1.00	5.00

All the four domains had scores higher than the neutral point of the five-point scale. The highest average scores were in integration and coordination domains, whereas the other two domains had comparable good scores. The mean scores for all the four study domains are shown in Figure 2 below.

Figure 2. Mean scores across the four study domains



There were comparable mean scores between the four domains, suggesting generally positive attitudes towards support and integration in addition to some resilience and mental well-being.

3.4 Correlation Among the Study Domains

Correlation among the variables such as support and integration, resilience, and mental well-being was analyzed using Pearson correlation analysis. The results are provided in Table 4 below.

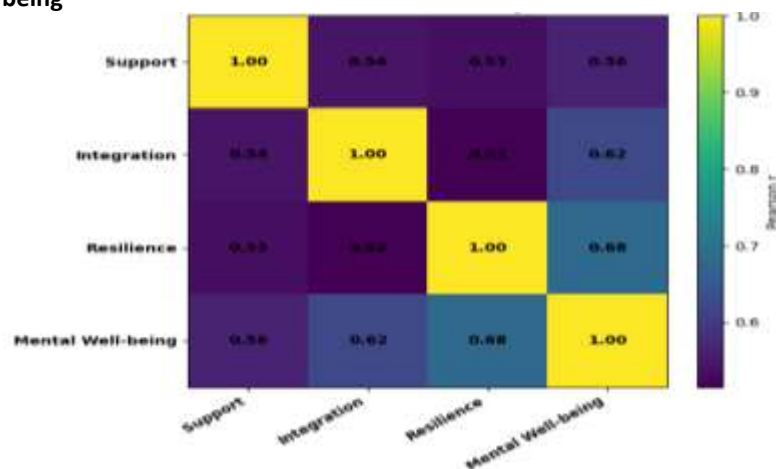
Table 4. Pearson correlations among the major study domains

Variable	1	2	3	4
1. Support	1.000			
2. Integration and coordination	0.542***	1.000		
3. Psychological resilience	0.535***	0.516***	1.000	
4. Mental well-being	0.561***	0.622***	0.682***	1.000

***p < 0.001

Positive correlations were observed in all study domains. The highest correlation was found to be between psychological resilience and mental well-being, whereas integration and coordination had a relatively high correlation with mental well-being as well. The correlation pattern among the study domains is illustrated below in Figure 3.

Figure 3. Correlation matrix of support, integration and coordination, psychological resilience, and mental well-being



All the four constructs are positively related from the results of the heatmap, with the highest correlation existing between resilience and mental wellbeing.

3.5 Predictors of Psychological Resilience

To test whether psychological resilience is influenced by perceived integration and coordination and perceived support, a multiple linear regression analysis was carried out as presented in Table 5.

Table 5. Multiple regression analysis predicting psychological resilience

Predictor	B	SE	β	t	p
Support	0.388	0.117	0.361	3.325	0.001
Integration and coordination	0.346	0.117	0.320	2.944	0.004

Model: $R^2 = 0.358$; Adjusted $R^2 = 0.341$; $F(2,77) = 21.474$; $p < 0.001$.

The regression analysis proved to be statistically significant as a whole. Both support and integration independently predicted resilience to a statistically significant extent, with support having a slightly greater standardized effect.

3.6 Predictors of Psychological Well-Being

To find out what predicted psychological well-being, a second multiple regression analysis was conducted. The findings are summarized in Table 6.

Table 6. Multiple regression analysis predicting mental well-being

Predictor	B	SE	β	t	p
Support	0.416	0.131	0.318	3.182	0.002
Integration and coordination	0.593	0.131	0.450	4.507	<0.001

Model: $R^2 = 0.458$; Adjusted $R^2 = 0.444$; $F(2,77) = 32.558$; $p < 0.001$.

The two predictors were significantly related to the outcome variable. Coordination proved to have a more significant standardized relationship compared to integration.

3.7 Group Differences and Age Relationship

Group differences according to gender were investigated in each of the main study domains through independent samples comparison tests as illustrated in Table 7.

Table 7. Comparison of study domain scores between male and female respondents

Domain	Male Mean $\pm$ SD	Female Mean $\pm$ SD	t	p
Support	3.395 $\pm$ 0.699	3.704 $\pm$ 0.742	-1.870	0.065
Integration and coordination	3.513 $\pm$ 0.714	3.704 $\pm$ 0.728	-1.153	0.252
Psychological resilience	3.520 $\pm$ 0.796	3.691 $\pm$ 0.718	-0.984	0.328
Mental well-being	3.401 $\pm$ 0.849	3.757 $\pm$ 0.975	-1.693	0.095

The mean scores were somewhat higher for females in all the four domains; however, none of these differences was statistically significant. The relationships between age and the study domains were also assessed by means of Pearson correlation analysis, as depicted in Table 8.

Table 8. Correlations between age and the study domains

Domain	Pearson r	p
Support	-0.071	0.530
Integration and coordination	0.064	0.573
Psychological resilience	0.050	0.658
Mental well-being	-0.055	0.627

Age was not significantly associated with support, integration, resilience, or mental well-being, indicating that the main study relationships were relatively consistent across the 13–18-year age range.

4. Discussion

This study explored the associations between perceived healthcare, education, and social support and system integration and psychological resilience and mental well-being among adolescents. Participants demonstrated moderately positive perceptions for all variables assessed in this study, and there were significant associations between support, system integration, resilience, and mental well-being. The results imply that psychological functioning in adolescents might be related to the effectiveness of not only access to supportive resources but also the integration of those resources. Such an explanation is in line with the concept of resilience development through interaction between individual resources and protective factors in the environment (Soleimanpour et al., 2017; Mesman et al., 2021).

One of the most notable findings was the positive correlation between perceptions of support received in the areas of health, education, and social sphere, and the development of psychological resilience. Adolescents who felt more support also showed higher adaptability to stress and recovery from problems. Basu et al. (2020) highlighted the importance of combining school- and family-based strategies in order to enhance resilience and mental well-being in young individuals. Social workers can do so by acting as supportive persons for adolescents in care (Sulimani-Aidan, 2018), whereas school-based interventions can help develop adaptive psychological resources in the framework of an organized structure (Ijadi-Maghsoodi et al., 2017). Moreover, resilience building in educational environments has been associated with mental well-being and functioning (Eisenberg et al., 2016), whereas community-based educational approaches serve as an example of a connection between education and resilience (Fu & Zhang, 2024).

Integration and coordination were positively correlated with both resilience and psychological well-being and seemed to be of particular significance for the latter in the regression analysis. It means that youth services may gain from cooperation between health care services, education facilities, families, and other social subsystems, and not from fragmented services. In their study, Fazel et al. (2021) promoted integration in youth health care by focusing on interlinked developmental and health issues. Just like that, an interdisciplinary approach linking educational psychology and public health has shown its prospects in solving youth psychological problems (Liu et al., 2025). Additionally, education policies including coordination of mental health services may enhance such environments for adolescents' seeking help (Wiedermann et al., 2023). These findings collectively reinforce the importance of cross-sector coordination in supporting adolescent psychological health.

There was the highest correlation between psychological resilience and mental well-being, signifying that adolescents who had higher ability to adjust and bounce back in case of adversity also exhibited better emotional functioning. This aligns with the literature on the importance of resilience as an important psychological resource for well-being in adolescents (Seok, 2026). The role of social connections may be in facilitating such processes through offering interpersonal resources when adolescents face stressors (Adeyemi & Okoye, 2025). Family support, coping skills, and social support in general have also been found to improve students' mental well-being (Yang et al., 2022). Research conducted with vulnerable youth also provides evidence of relationships between protective resources, resilience, and psychological well-being (Mohamed & Thomas, 2017; Bosqui & Marshoud, 2018). There is similar research in general populations, which highlights the importance of integrative approaches to resilience where the combination of individual and organizational resources is emphasized (Wald, 2020) and the significance of social support for mental well-being in stressful contexts (Hou et al., 2020).

No statistically significant gender and age group associations were found within the main areas of investigation. Therefore, it might be assumed that the relationships revealed between the integrated support, resilience, and psychological well-being of the adolescents were fairly similar for all demographic categories present in the sample. Universal systems of support, thus, can be useful compared to targeting only some sub-groups of adolescents when developing resilience strategies. However, the contexts matter since social support and resilience might manifest themselves in different ways depending on the population and environment (Veronese et al., 2022).

Several limitations need to be taken into account. First, there was no possibility to make any cause-and-effect conclusions due to the cross-sectional design, while the self-reporting format might have led to response or social desirability bias. Second, there were such limitations as convenience sampling and small sample size (80 adolescents). Moreover, the participants' perceptions of integration might not fully reflect reality concerning the collaboration of healthcare, education, family, and social services sectors. Further research should include large and diverse samples, longitudinal design, and multi-informant measures. Intervention-based research should also examine whether deliberately strengthening communication and coordination across these sectors produces sustained improvements in adolescent resilience and mental well-being.

5. Conclusion

This study revealed that healthcare, education, and social support were significantly correlated with psychological resilience and mental well-being in adolescence. It can be stated that, besides the significance of the provision of support, the study stressed the necessity of its integration and coordination between the sphere of healthcare, educational institutions, families, and social support systems in order to foster positive psychological outcomes. Specifically, integrated and coordinated support revealed a strong connection with mental well-being, whereas perceived support and integration had a great impact on psychological resilience. It is also possible to notice that resilience was strongly correlated with mental well-being, which indicates the significance of such a psychological resource in the management of stress and adaptation to challenges for adolescents. Lack of age- and gender-based differences implies the universal character of the studied phenomenon. These results provide justification for an integrated effort whereby healthcare professionals, educators, parents, and social service providers come together in order to handle the psychosocial needs of adolescents. Nevertheless, the limitations associated with the cross-sectional study design and the limited sample size necessitate a cautious interpretation of results. Generally, this study demonstrates the possible benefits that might be gained through better communication and integration of adolescent support systems. Longitudinal and intervention studies are needed in order to establish the effects of such efforts on the resilience of adolescents.

References

1. Soleimanpour, S., Geierstanger, S., & Brindis, C. D. (2017). Adverse childhood experiences and resilience: Addressing the unique needs of adolescents. *Academic pediatrics*, 17(7), S108-S114.
2. Liu, C., Gui, J., & Ma, Y. (2025). Interdisciplinary intervention to improve mental health and academic adaptation of adolescents with chronic diseases: integration of educational psychology and public health. *Frontiers in Psychology*, 16, 1732927.
3. Basu, D., Nagpal, S., Mutiso, V., Ndeti, D. M., Lauwrens, Z., Hadfield, K., ... & Bhui, K. S. (2020). Enhancing resilience and mental health of children and adolescents by integrated school-and family-based approaches, with a special focus on developing countries: a narrative review and call for action. *World Social Psychiatry*, 2(1), 7-19.
4. Wiedermann, C. J., Barbieri, V., Plagg, B., Marino, P., Piccoliori, G., & Engl, A. (2023, May). Fortifying the foundations: a comprehensive approach to enhancing mental health support in educational policies amidst crises. In *Healthcare* (Vol. 11, No. 10, p. 1423). MDPI.
5. Mesman, E., Vreeker, A., & Hillegers, M. (2021). Resilience and mental health in children and adolescents: an update of the recent literature and future directions. *Current opinion in psychiatry*, 34(6), 586.
6. Adeyemi, A. O., & Okoye, M. C. (2025). Resilience In Adolescence: The Role Of Social Connection In Mental Health. *POSITIVE PSYCHOLOGY ASSOCIATION OF NIGERIA*, 112.
7. Seok, C. B. (2026). Integrating Mental Health Resilience Into Adolescents: A Psychological Imperative for Well-Being. In *Cross-Cultural Approaches to Psychology, Counseling, and Social Work* (pp. 175-194). IGI Global Scientific Publishing.

8. Fazel, M., Townsend, A., Stewart, H., Pao, M., Paz, I., Walker, J., ... & Sharpe, M. (2021). Integrated care to address child and adolescent health in the 21st century: A clinical review. *JCPP advances*, 1(4), e12045.
9. Mohamed, S., & Thomas, M. (2017). The mental health and psychological well-being of refugee children and young people: An exploration of risk, resilience and protective factors. *Educational Psychology in Practice*, 33(3), 249-263.
10. Sulimani-Aidan, Y. (2018). Promoting resilience among adolescents in care from their social workers' perspectives. *Children and Youth Services Review*, 94, 43-48.
11. Eisenberg, D., Lipson, S. K., & Posselt, J. (2016). Promoting resilience, retention, and mental health. *New Directions for Student Services*, 2016(156), 87-95.
12. Fu, Q., & Zhang, X. (2024). Promoting community resilience through disaster education: Review of community-based interventions with a focus on teacher resilience and well-being. *PLoS one*, 19(1), e0296393.
13. Wald, H. S. (2020). Optimizing resilience and wellbeing for healthcare professions trainees and healthcare professionals during public health crises—Practical tips for an 'integrative resilience' approach. *Medical Teacher*, 42(7), 744-755.
14. Hou, T., Zhang, T., Cai, W., Song, X., Chen, A., Deng, G., & Ni, C. (2020). Social support and mental health among health care workers during Coronavirus Disease 2019 outbreak: A moderated mediation model. *Plos one*, 15(5), e0233831.
15. Bosqui, T. J., & Marshoud, B. (2018). Mechanisms of change for interventions aimed at improving the wellbeing, mental health and resilience of children and adolescents affected by war and armed conflict: a systematic review of reviews. *Conflict and health*, 12(1), 15.
16. Veronese, G., Pepe, A., Diab, M., Abu Jamei, Y., & Kagee, A. (2022). Social support, resilience, and mental health in a low-intensity warfare context: the effects of siege on university students in Gaza. *Journal of Mental Health*, 31(3), 383-391.
17. Ijadi-Maghsoodi, R., Marlotte, L., Garcia, E., Aralis, H., Lester, P., Escudero, P., & Kataoka, S. (2017). Adapting and implementing a school-based resilience-building curriculum among low-income racial and ethnic minority students. *Contemporary school psychology*, 21(3), 223-239.
18. Yang, C., Gao, H., Li, Y., Wang, E., Wang, N., & Wang, Q. (2022). Analyzing the role of family support, coping strategies and social support in improving the mental health of students: Evidence from post COVID-19. *Frontiers in psychology*, 13, 1064898.