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Original Research Article

Strength-based positive youth development for adolescents: A school mental health model grounded in Indian

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Abstract

Background: Adolescents in India face increasing mental health challenges, yet school-based mental health promotion remains fragmented and underdeveloped. This study aimed to develop a culturally grounded, strength-based Positive Youth Development (SPYD) program to enhance adolescent well-being within the school ecosystem.

Materials and Methods: A qualitative exploratory design was employed, using semi-structured interviews with 70 stakeholders (school staff, parents, and mental health professionals) and focus group discussions with 110 adolescents from three schools. Thematic analysis and a content-ranking exercise informed the development of five core modules.

Results: Stakeholders and adolescents reported high levels of emotional distress, stigma, and limited mental health support. The final SPYD framework included five modules: Mental Health and Well-Being, Risk Mitigation, Goal Setting and Personal Growth, Community Engagement, and Strength-Based Competencies. All modules received high ratings for relevance, clarity, and feasibility.

Conclusion: The findings affirm the need for school-based, strength-oriented mental health promotion in India. The SPYD program offers a context-sensitive, scalable model that fosters psychosocial resilience and developmental strengths among adolescents through experiential, teacher-led delivery.

Keywords: Strength-based positive youth development, Mental health, Indian context.

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1. Introduction

India has emerged as the world's most populous nation, surpassing China, with a population of 1,425,775,850.[1] According to United Nations projections, India's population is expected to continue growing for several decades.[2] As of 2021, children and adolescents accounted for 34.8% of the Indian population, the largest such demographic globally.[3,4] Childhood and adolescence are critical developmental periods for mental health, during which environmental quality significantly shapes well-being and future growth.[5] Developmental disabilities, defined as conditions resulting from impairments in physical, cognitive, or behavioral functioning, represent a major concern during these years.[6] Commonly observed conditions include attention deficit hyperactivity disorder (ADHD), sensory impairments (hearing and vision loss), cerebral palsy, epilepsy, intellectual disability, specific learning disorders, and autism spectrum disorder (ASD), as well as mental health problems such as depression, anxiety, and behavioral difficulties.[7,8]

The current population of India is 1,465,818,656 as of August 27, 2025, based on Worldometer's elaboration of the latest United Nations data. This represents 17.78% of the global population, ranking India first worldwide, with the

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mid-year 2025 population estimated at 1,463,865,525. Given this demographic context, the mental health of Indian children and adolescents assumes particular importance. A UNICEF–Gallup survey conducted in 2021 revealed that only 41% of young people aged 15–24 years in India believed it was helpful to seek professional support for mental health concerns, reflecting widespread hesitancy in help-seeking behavior.[9] At a global level, about 10% of children and adolescents are affected by mental disorders, with one in seven individuals aged 10–19 years experiencing such conditions. Together, these disorders contribute to 13% of the global disease burden in this age group.[5,8]

In 2016, an estimated 52.9 million children under five years of age were identified with developmental difficulties, with boys accounting for 54% of cases. Autism spectrum disorder affected around one in every hundred children, and 95% of all children with developmental problems resided in low- and middle-income countries.[10,11] The State of the World's Children Report 2021 highlighted that South Asia, East Asia, and the Pacific together accounted for the highest numbers of adolescents with mental health problems.[12] Data from India reinforce this concern. Malhotra et al. reported prevalence rates of 23.33% in school-based samples and 6.46% in community-based samples of children and adolescents.[13] The National Mental Health Survey (2016) found an overall prevalence of 7.3% among adolescents, with no significant gender difference. However, urban metropolitan areas demonstrated higher prevalence, with anxiety disorders accounting for 3.6% and depression for 0.8%.[14]

The responsibility for nurturing children's mental health lies with parents, educators, policymakers, and society at large.[15] Failure to address mental health problems during adolescence can lead to long-term consequences for both physical and psychological well-being, limiting one's potential for a fulfilling adult life.[8] Evidence suggests that integrating mental health education into school curricula can foster resilience and positive youth development, provided interventions are grounded in evidence-based practice.[15] Despite this, numerous barriers persist. Children often hesitate to disclose problems due to stigma or fear of victimization, lack trust in adults owing to adverse experiences at home, or encounter structural challenges such as the absence of dedicated counseling spaces, limited cooperation from school authorities, inadequate counselor availability, and lack of privacy.[15] Mental health conditions such as anxiety and depression have also been shown to impair school attendance and academic performance.[8]

Although referrals to mental health professionals are commonly recommended for children identified with potential difficulties, these strategies frequently fall short, particularly when families encounter barriers such as language differences, financial constraints, transportation challenges, or occupational inflexibility that prevents regular consultations.[15] Schools, therefore, have a crucial role in addressing the psychosocial needs of students, particularly in times of crisis or emergency.[12]

According to the World Health Organization (WHO), mental health in children and adolescents refers to the ability to achieve optimal psychological functioning and well-being, closely linked to the development of social and emotional competence.[16] Globally, increasing attention is being placed on the primary prevention of mental illness and on reducing the risk factors that contribute to mental health disorders. Programs implemented in high-income countries have demonstrated promising outcomes, including reductions in bullying and violence, improvement in self-esteem, enhanced emotional and social awareness, better teacher-student relationships, and promotion of core life skills.[17-21]

In India, however, despite the inclusion of child mental health in national policies such as the National Health Policy,[18] the National Mental Health Program,[19] and the Integrated Child Development Scheme, there is no unified or stand-alone policy exclusively addressing child and adolescent mental health. Existing services remain largely urban-centric and reactive, often limited to hospital-based psychiatric care. Consequently, many preventable mental and behavioral concerns among adolescents remain unaddressed until they escalate.

Given that schools provide a structured and consistent platform for early and sustained contact with adolescents, they are well-positioned for the implementation of universal, promotive mental health programs. Competency-building interventions delivered in school settings have demonstrated long-term value in strengthening protective factors and reducing risky behavior.[22,23] Programs that use teachers as facilitators—with appropriate training and resources—can offer scalable, sustainable, and cost-effective models for mental health promotion.[22]

The present initiative titled *"Promotion of Mental Health and Psychological Well-Being of Adolescents in Schools"* was developed as part of a district-level project funded by the Government of Karnataka, with implementation support from the District Administration, Kolar. This program employed a life skills-based, resilience-oriented, and experiential learning approach aimed at building psychological competencies among school-going adolescents. The primary goals included:

1. Developing a structured mental health promotion model for schools,
2. Creating a comprehensive training manual for facilitators (primarily teachers)

2. Materials and Methods

2.1. Proposed PYD program

The aim of this study was to develop a culturally grounded, develop a framework for school-based Strength-Based Positive youth development (SPYD) program to promote the mental health and psychosocial well-being of adolescents within the school setting. Informed by an extensive review of literature on Positive youth development (PYD) and adolescent mental health promotion, the initial framework was further refined through field observations, stakeholder engagement, and consultations with experienced clinical and community-based mental health professionals.

A preliminary version of the program was conceptualized to reflect key developmental themes relevant to Indian adolescents. Drawing on the PYD framework, the program sought to foster peer connectedness, self-efficacy, future orientation, and civic participation. strength-based components emphasized identifying and cultivating adolescents' internal assets, such as emotional resilience, self-regulation, interpersonal empathy, emphasizes of personal efficacy, while encouraging proactive coping and positive identity development. Special emphasis was placed on adolescent participation in the design process, with students contributing insights into the preferred structure, content, and delivery mode of the intervention.

Based on these inputs, the study aimed to develop a strength-based Positive youth development (SPYD) program framework to promote the psychosocial well-being and developmental strengths of adolescents, using trained teachers as facilitators.

2.2. Study sample

The exploratory phase employed a purposive, criterion-based sampling approach to recruit a heterogeneous and representative group of participants relevant to the school ecosystem and adolescent mental health landscape. The sample comprised three primary stakeholder groups—school authorities, parents, and mental health professionals—along with a parallel adolescent sample engaged through Focus group discussions (FGDs). Together, these samples enabled a triangulated understanding of the anticipatory needs, feasibility concerns, and thematic priorities surrounding the development of a school-based Positive youth development (PYD) program.

Stakeholder interview sample (N = 70)

A total of 70 adult stakeholders participated in one-to-one, semi-structured interviews. The sample included:

1. 25 school authorities, comprising 5 principals, 2 vice-principals, and 18 teachers, representing both administrative and classroom-level perspectives. Participants had a mean professional experience of 11.72 years (range: 2–25 years), ensuring seasoned insights into both student development and institutional functioning.
2. 23 parents (9 males and 14 females), aged between 35 and 55 years, all of whom were caregivers to adolescents enrolled in grades 8 through 12. The inclusion of parents allowed for the integration of familial and cultural factors that influence adolescent mental health.
3. 22 mental health professionals, including 7 psychiatrists and 15 clinical psychologists registered with the Rehabilitation Council of India (RCI). All professionals had a minimum of five years of experience in youth-focused clinical or community mental health services, thereby providing specialized and practice-informed perspectives on adolescent wellbeing and intervention design.

These stakeholders were recruited through a combination of school-based referrals, professional networks, and snowball sampling. Interviews were conducted on school premises or clinical settings, based on participant convenience, and were audio-recorded with prior written consent.

To strengthen transparency, recruitment followed a stepwise process: An initial list of 11 schools was prepared, out of which 7 granted permission for interviews and FGDs. Contact details of eligible parents were shared by participating schools, and parents were approached directly via telephone and email, of whom 23 consented. Mental health professionals were identified through institutional directories and professional networks; 22 out of 27 contacted professionals agreed to participate, yielding a response rate of 81%. Similarly, school authorities were approached through formal letters followed by in-person visits; 25 of the 30 contacted agreed (83% response rate). These response rates reflect strong institutional and community willingness to engage with the study.

Adolescent focus group sample (N = 110)

In parallel, 110 school students participated in a series of Focus Group Discussions (FGDs) conducted across three secondary schools (1 private and 2 aided) located in Southern India. These schools were purposively selected based on administrative willingness, logistical feasibility, and demographic diversity. The adolescent sample included:

1. 37 males (33.6%) and 73 females (66.4%), with a mean age of 14.5 years (SD = 2.1), spanning grades 8 to 12.
2. Participants came from diverse religious backgrounds: 45.5% Hindu, 40% Muslim, and 14.5% Christian, offering a pluralistic view of cultural norms and beliefs around mental health.
3. 80% were day-scholars, and 20% were hostel residents, reflecting both home-based and residential schooling contexts.

Students were recruited through classroom announcements and voluntary registration, with an effort to ensure representation across grades, gender, and living arrangements. Across the three schools, 210 students expressed initial interest; after screening for grade eligibility and availability, 110 were included, resulting in a response rate of 52.3%. Each FGD group consisted of 8–10 participants and was conducted in a quiet, familiar classroom space within school premises. Participation was voluntary, and informed assent (along with parental consent) was obtained for all student participants.

2.3. Need assessment

The need assessment in the exploratory phase was designed to investigate the perceived necessity, relevance, and contextual appropriateness of a school-based, strength-oriented Positive youth development (SPYD) program for adolescents in Southern India. This phase drew upon rich, qualitative insights from multiple stakeholders—students, school authorities, parents, and mental health experts—to understand both the urgency and thematic contours of adolescent mental health needs. The findings were triangulated across data sources to ensure that the subsequent intervention design was grounded in context-sensitive and developmentally aligned priorities.

2.4. Stakeholder interviews (N = 70)

Among school authorities, parents, and mental health professionals, there was a strong consensus regarding the pressing need for structured mental health promotion programs in schools. A majority of interview participants (70%) unequivocally endorsed the idea of implementing a universal SPYD program for all students, rather than restricting it to those identified as at-risk. This view was motivated by an understanding of adolescence as a formative period where early, school-based interventions could preempt the onset of psychological distress and enhance developmental trajectories.

Stakeholders expressed concern over the limited scope of existing interventions (e.g., yoga classes, awareness talks) that tended to be sporadic, non-systematic, and insufficiently targeted. Many argued that these activities, although well-intentioned, lacked the depth and continuity required to build long-term psychological competencies. A principal noted, *"Mental health has always been on the sidelines. We teach biology but not emotional survival. That has to change."*

In addition to strong general support, several interviewees offered domain-specific recommendations regarding the content of the proposed program. Mental health literacy emerged as the most endorsed theme, particularly the need to raise awareness about common psychological challenges, debunk myths, and encourage help-seeking behaviors. This was followed closely by calls for de-stigmatization of emotional distress and management of depressive symptoms, which many educators observed among students but felt ill-equipped to address.

2.5. Focus group discussions with adolescents (N = 110)

The FGDs with students further substantiated the need for a targeted, adolescent-friendly intervention. Across all five focus groups, students reported significant emotional distress related to academic pressure, low confidence, and lack of institutional mental health support. A recurring theme was the absence of safe spaces within schools to discuss emotional struggles or seek guidance. One participant remarked, *"Even if we are suffering, we don't know whom to talk to. We just keep it in."*

Another emergent theme was the stigma around mental health, particularly the perception that acknowledging stress or sadness was a sign of weakness or failure. This finding was consistent across gender and age groups, indicating a systemic silence around mental health discourse in school environments. Students also voiced a strong preference for programs that employed interactive and experiential formats (e.g., role-plays, storytelling, group discussions), rather than didactic or lecture-based models.

Table 1: Composition of the study sample

Group	N	Sub-Groups / Roles	Gender (M/F)	Age Range / Mean	Key Characteristics
School Authorities	25	5 Principals, 2 Vice-Principals, 18 Teachers	13-Dec	Experience: 2–25 years (M = 11.7)	Represented administrative and classroom-level perspectives
Parents	23	Parents of students from Grades 8–12	14-Sep	35–55 years	Offered familial and cultural insights
Mental Health Experts	22	7 Psychiatrists, 15 Clinical Psychologists (RCI-Registered)	12-Oct	Minimum 5 years' experience	Clinical and youth mental health experts
Students (FGDs)	110	Grades 8–12; from 3 schools (1 private, 2 aided)	37 / 73	10–19 years (M = 14.5, SD = 2.1)	Diverse religious and socio-educational backgrounds

A particularly notable insight from student FGDs was the link between mental health and academic performance. Several students articulated that improved emotional regulation, self-motivation, and stress management could lead to better academic engagement and outcomes. This reflects a developmental understanding among adolescents that academic and psychological well-being are not mutually exclusive but interdependent.

2.6. Data collection methods

The data collection for Phase I of the study employed a qualitative, exploratory design informed by constructivist principles and aligned with the PRECEDE phase of the PRECEDE–PROCEED model.[1] Two primary qualitative methods were used—semi-structured interviews and focus group discussions (FGDs)—to gather in-depth and context-sensitive insights from key stakeholders in the school mental health ecosystem.

2.7. Semi-structured interviews

A total of 70 adult stakeholders participated in one-to-one, semi-structured interviews, including school authorities (n = 25), parents (n = 23), and mental health professionals (n = 22). The interview guide, developed from literature and field inputs, explored four core domains: perceived adolescent needs, awareness of mental health initiatives, feasibility of school-based programming, and suggestions for content and delivery. Interviews were conducted in English or Malayalam, based on participant preference, and typically lasted 30–45 minutes. Sessions were held in schools, clinics, or virtually, with prior written consent for audio recording and transcription.

2.8. Focus 2.9. (FGDs)

Five FGDs were conducted with 110 students from grades 8 to 12 across three schools. Each group (8–12 participants) was guided by a semi-structured FGD schedule focused on students' emotional stressors, help-seeking barriers, preferences for intervention format, and content relevance. Discussions were held in school classrooms, facilitated in English (with bilingual support when needed), and lasted 45–60 minutes. Field notes captured non-verbal and contextual cues alongside audio recordings. Icebreakers and group facilitation techniques were used to promote openness and comfort.

2.10. Data analysis

Data analysis utilized thematic analysis (Braun & Clarke framework),[25] frequency and percentage calculations, and weighted ranking scores to quantify theme endorsements, with data collected until saturation was achieved.

2.11. Content ranking exercise

Following each FGD, participants completed a content ranking task. A curated list of 20 proposed program themes was shared, and students were asked to identify relevant topics and rank their top five preferences. This exercise yielded both frequency data and subjective prioritization, enriching the thematic planning of the SPYD curriculum.

To provide clarity, the ranking sheet was structured across five broad categories: (a) Mental Health and Fitness, (b) Risk Reduction, (c) Goal Setting and Pursuit, (d) Community Engagement, and (e) Strength-Based Domains. Students were encouraged to select at least one theme from each category before finalizing their top five choices, ensuring balanced representation. The ranking was administered individually after the FGDs to avoid group influence, allowing students to freely indicate their personal priorities.

2.12. Expert validator criteria, selection, and validation process

Expert validators were chosen through professional networks based on the following criteria: a minimum of five years' experience in youth mental health promotion, advanced qualifications in psychiatry or clinical psychology, demonstrated expertise in research, training, or program development, and active engagement in adolescent-focused clinical or community work. The panel comprised one psychiatrist with over 20 years of clinical and community experience and two clinical psychologists with doctoral degrees and 6–10 years of experience in research and youth mental health promotion. The selected experts reviewed the draft SPYD modules using a structured validation form that assessed content alignment with objectives, suitability for adolescents, sequencing of modules, adequacy and relevance of activities, and overall presentation. Ratings were provided on a five-point Likert scale, alongside qualitative feedback, which was incorporated to refine and strengthen the final program.

3. Results

Table 2 summarizes the evolution of SPYD program themes, showing how an initial list of 20 content areas was refined through stakeholder interviews and student focus groups. The table highlights which themes were most frequently endorsed by each group and how they were synthesized into five final program domains. The high level of agreement between sources supports the thematic relevance, feasibility, and participatory basis of the final SPYD structure.

Table 2: Consolidated theme development for the SPYD program (N = 70 Stakeholders + 110 students)

Source	Total Themes Considered	Shortlisted Themes	Final Program Themes	Frequency (n)	Percentage (%)
Stakeholder Interviews (N = 70)	20	Mental health awareness, stigma reduction, emotional regulation, suicide prevention, goal setting, substance abuse prevention, tech balance, self-confidence	Mental Health and Well-Being, Risk Mitigation, Goal Setting and Personal Growth	60	85.70%
Student FGDs (N = 110)	20	Academic stress, low confidence, emotional distress, help-seeking barriers, motivation, relevance of peer-led formats	Mental Health and Well-Being Strength-Based Competencies	92	83.60%
Combined Review	20	Themes common to both stakeholders and students: mental health education, resilience, stress management, peer support, civic engagement, self-motivation	Final 5 Program Themes: 1. Mental Health and Well-Being 2. Risk Mitigation 3. Goal Setting and Personal Growth 4. Community Engagement 5. Strength-Based Competencies	152 (merged count)	84.4% (avg)

The selected 10 themes were then systematically organized under five comprehensive and developmentally grounded program modules: Mental health and well-being, Risk mitigation, Goal setting and personal growth, Community engagement, and strength-based competencies. Each module drew from theoretical frameworks including Positive Youth Development (PYD), Character strengths (CS), and empirical findings from interviews and FGDs.

To clarify the consolidation process, the 20 initial themes were systematically clustered into 5 final modules through an iterative procedure. First, themes with strong conceptual overlap were merged into broader categories; for instance, “time management,” “goal setting,” and “self-discipline” were integrated under personal growth and goal pursuit, while “stress management” and “emotion regulation” were subsumed within socio-emotional well-being. This clustering was then triangulated with stakeholder perspectives: student frequency rankings were cross-validated with insights from parents, teachers, and mental health professionals. For example, while adolescents emphasized peer pressure management, parents and teachers highlighted family relationships, which were combined into a broader module of relationships and social connectedness. The initial theme list had already been organized into five categories (Mental health and fitness, risk reduction, goal setting, community engagement, and strength-based domains), and care was taken to retain representation from each category. Following this, consensus discussions with the research team confirmed the grouping of themes such as creativity, leadership, and community participation into community engagement and leadership, and the integration of physical health and risk prevention within health and risk management. Through this process of merging overlaps, triangulating perspectives, and consensus validation, the 20 themes were distilled into five integrative modules—Personal strengths and character building, socio-emotional well-being, health and risk management, relationships and social connectedness, and community engagement and future orientation. This approach preserved the breadth and richness of the original themes while yielding a parsimonious, feasible, and contextually relevant program structure.

Table 3: Average ratings of SPYD program modules based on validation criteria

Module	Program Themes	Framework	AM	AT	LS	SA	AA	UFM	IT	OA
Mental Health and Well-Being	Emotional awareness, stigma reduction, help-seeking, stress management	PYD, Emerged in IW & FGD	4.7	4.8	4.6	4.5	4.7	4.6	4.8	4.67
Risk Mitigation	Safe tech use, suicide prevention, substance abuse awareness, peer influence	PYD, Emerged in IW	4.5	4.4	4.3	4.2	4.4	4.3	4.5	4.37
Goal Setting and Personal Growth	Self-efficacy, motivation, planning, academic focus	PYD, CS, Emerged in IW & FGD	4.8	4.6	4.5	4.6	4.7	4.6	4.7	4.64
Community Engagement	Empathy, civic responsibility, inclusion, collaboration	PYD, Emerged in FGD	4.3	4.4	4.2	4.1	4.2	4.3	4.3	4.26
Strength-Based Competencies	Character strengths, resilience, gratitude, positive identity	CS, PYD, Emerged in IW & FGD	4.6	4.7	4.5	4.6	4.7	4.6	4.6	4.61

Framework: Indicates theoretical and empirical sources (PYD = Positive Youth Development; CS = Character Strengths; IW = Interview; FGD = Focus Group Discussion), AM = Adequacy of Module Content, AT = Appropriateness for Target Audience, LS = Logical Sequencing of Sessions, SA = Sufficiency of Activities, AA = Alignment of Activities with Learning Objectives, UFM = User-Friendliness of Materials, IT = Informativeness of Takeaways, A = Overall Average Rating

Table 3 summarizes the average evaluation ratings of these five modules across seven key dimensions: adequacy of module content (AM), appropriateness for the target audience (AT), logical sequencing (LS), sufficiency of activities (SA), alignment of activities with learning objectives (AA), user-friendliness of materials (UFM), and in formativeness of takeaways (IT). The evaluation was conducted by two groups—expert validators (a psychiatrist and two clinical psychologists with experience in youth mental health and program delivery) and student evaluators (selected from the original FGD cohort). Due to the close alignment of ratings across these two groups, the results were aggregated to produce overall module scores.

The findings indicate uniformly high approval across all five modules, with overall average (OA) scores ranging from 4.26 to 4.67 on a 5-point scale. The Mental Health and Well-Being and Goal Setting and Personal Growth modules received the highest average ratings, reflecting strong perceived relevance and practical utility. The Community Engagement module received slightly lower—but still favorable—ratings, suggesting that while the content was appreciated, some activities may require further contextual adaptation or clarification.

Importantly, no module scored below 4.2 on any parameter, indicating that all modules met or exceeded the evaluators' expectations for quality, clarity, and relevance. This comprehensive validation underscores the strength of the co-design approach adopted during the exploratory phase and provides empirical support for advancing the SPYD program into its implementation and pilot evaluation phases.

4. Discussion

This study presents the development of a Strength-Based Positive Youth Development (SPYD) program designed to enhance the psychosocial well-being of adolescents within Indian school settings. The findings from the exploratory phase affirm both the necessity and contextual relevance of a structured, culturally grounded intervention that moves beyond traditional, fragmented approaches to adolescent mental health promotion.[26,27]

The integration of diverse stakeholder perspectives—school authorities, parents, mental health professionals, and adolescents—enabled a holistic understanding of existing gaps and priorities. Notably, there was strong convergence across data sources on the need for universal, developmentally appropriate mental health initiatives rather than selective or remedial models.[28] Stakeholders expressed concern over the inadequacy of existing interventions, which were often limited to awareness talks or one-off activities lacking continuity and depth. This aligns with existing critiques of school mental health services in India, which

remain under-resourced and poorly integrated into educational ecosystems.

The adolescents' input was especially pivotal. FGDs revealed high levels of emotional distress, driven by academic pressure, stigma, and limited institutional support. Students highlighted the absence of safe, non-judgmental spaces to express emotional struggles, coupled with a reluctance to seek help due to fear of being labeled weak. These insights underscore the urgency of interventions that normalize emotional discourse and promote help-seeking behaviors, starting at the school level.[29,30]

The final SPYD framework, comprising five modules—Mental health and well-being, risk mitigation, goal setting and personal growth, community engagement, and strength-based competencies—reflects a balanced integration of psychological, social, and developmental needs.[31,32] The modules were not only grounded in the Positive Youth Development and Character Strengths frameworks but also refined through participatory design and empirical validation.[33] High average ratings across all modules suggest strong content validity, age-appropriateness, and pedagogical clarity.[34,35]

The program explicitly integrates the Positive Youth Development (PYD) framework and character strengths by aligning its five modules with the 5Cs (Competence, Confidence, Connection, Character, and Caring). The first module fosters Competence and Caring through mental health literacy and empathy-building activities. The second enhances Competence by teaching risk mitigation and emotional regulation. The third directly targets confidence and character by helping adolescents identify and apply personal strengths like perseverance and kindness, using structured tools. The fourth promotes Confidence and competence through goal-setting and self-efficacy exercises. The fifth strengthens Connection and Caring by encouraging peer collaboration and community engagement, aligning with PYD's focus on relational and prosocial development. This integration ensures a holistic approach to cultivating internal assets and resilience in Indian adolescents.

Of particular note is the prioritization of experiential, peer-engaged formats—such as role-plays, group activities, and discussions—which were consistently favored by adolescents over lecture-based models.[36,37] This preference reflects a broader shift in educational psychology toward learner-centered, dialogic approaches to mental health education.[38]

Overall, this study contributes to the growing recognition of schools as critical sites for mental health promotion and positive youth development. The SPYD model offers a feasible, scalable, and culturally sensitive intervention that can be integrated into school curricula through trained educators. By building developmental assets and emotional resilience, the program has the potential to not only improve individual well-being but also foster a more inclusive and emotionally supportive school climate.[39]

This exploratory phase, while methodologically rigorous, had certain limitations. First, the qualitative data were drawn from a purposively selected sample limited to three schools in a specific region, which may affect generalizability. The study's limitation to three schools in one region and English-speaking participants significantly constrains generalizability, potentially overlooking diverse socio-cultural and linguistic contexts. Second, student focus groups were conducted only with English-speaking adolescents, potentially excluding voices from vernacular backgrounds. Additionally, the reliance on self-reported perspectives may have introduced social desirability bias. Finally, while expert and student evaluations informed module refinement, real-time classroom delivery was not tested at this stage.

The findings from Phase I offer a strong foundation for designing, refining, and piloting school-based mental health interventions. Future research should include:

1. A structured pilot trial with a pre-post control group design to evaluate feasibility and initial effectiveness.
2. Implementation across diverse school settings (urban/rural, aided/private/government) to assess contextual adaptability.
3. Examination of program dosage and delivery structure, including ideal session duration (e.g., 45–60 mins) and frequency (weekly or bi-weekly) within school timetables.
4. Use of mixed-method evaluations, including validated psychological scales and post-session feedback, to capture both outcomes and process variables.
5. Future work will focus on defining session duration and frequency, incorporating structured teacher training, and ensuring adequate resource allocation for implementation.
6. Sustainability will be strengthened through integration into school systems and ongoing evaluation with stakeholder feedback.
7. The use of validated instruments such as the Positive youth development (PYD) Index.[40] To assess confidence, competence, support, and service engagement, and the VIA youth-96 inventory.[41] To measure strengths, will enhance the reliability and impact of future evaluations beyond the content ranking exercise.
8. A longitudinal follow-up to assess sustained impact on mental health, character strengths, and school engagement.

5. Conclusions

This study, as part of a doctoral research project, successfully identified the contextual, thematic, and structural requirements for a culturally relevant, strength-based

Positive youth development (SPYD) program for Indian adolescents. Through triangulated insights from students, educators, parents, and mental health experts, the study offers a validated and stakeholder-informed framework for promoting school-based adolescent mental health. The outputs of this phase directly inform the next stages of the doctoral work, including manual finalization and a pilot evaluation trial.

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7. Ethical Approval

The study was accorded Ethical Approval Ref. No. AUC/RO/Ph.D. RT/2023/5748 dated 31/03/2023. Written/Verbal Informed Consent was taken from all the participants.

The study was carried out in accordance with the principles as enunciated in the Declaration of Helsinki.

8. Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

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