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Learning About Well-Being: Academic Pressure, Silent Emotional Distress and School-Based Mental Health Literacy in Bangladesh

Fakrul Ilam Badu*

Department of HKU Space, Hong Kong University, Hong Kong

Correspondence to: Fakrul Ilam Badu, Department of HKU Space, Hong Kong University, Hong Kong; Email: rtn.dr.fibabubd@gmail.com

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ABSTRACT

Adolescent mental health is becoming an increasingly important public health and education concern, especially in examination-oriented education systems. This challenge is particularly visible in many low-and middle-income countries where structured mental health support within schools remains limited. In Bangladesh, secondary education is strongly shaped by high stakes examinations and strong family expectations. However, empirical research examining the relationship between academic pressure, silent emotional distress, and preventive mental health literacy within school settings is still limited.

This multi stakeholder cross sectional study with a pre and post component was conducted across eight administrative divisions of Bangladesh. The study included 5,612 participants consisting of 3,856 students, 352 teachers and 1,156 parents. Students completed structured questionnaires measuring perceived academic pressure, emotional vulnerability, disclosure behaviour and mental health literacy before and after a standardized awareness session. Teachers and parents completed parallel perception surveys.

Results show that 86 percent of students reported that academic pressure negatively affected their mental wellbeing.

Forty five percent of students reported experiencing passive thoughts that they might be better off not being alive, and 92 percent of those students reported that they had not shared these experiences with anyone. Perceived academic pressure showed a significant association with emotional vulnerability. Baseline student mental health awareness was 26 percent, which increased to 87 percent after the intervention. Higher post session literacy was also associated with greater reported willingness to seek help.

These findings suggest a structural pattern in which high academic pressure exists alongside substantial silent emotional distress and low baseline mental health awareness. The results indicate that structured school based mental health literacy initiatives may offer a feasible and scalable preventive strategy within examination oriented secondary education systems in Bangladesh.

Keywords: Adolescent Mental Health; Emotional Distress; Help-Seeking Behavior; Psychological Wellbeing; Mental Health Literacy

INTRODUCTION

Academic pressure and silent emotional distress in South Asia

Across South Asia, secondary education systems are strongly shaped by high stakes public examinations. These examinations often act as key gatekeeping points for academic progression, university admission and future employment opportunities [1,2]. In such examination-oriented systems, academic performance is closely connected with personal identity, family expectations and perceived social mobility. Although these systems are designed to reward merit and academic achievement, they also create sustained psychological pressure among adolescents.

Research from the region shows that academic stress is one of the most commonly reported mental health concerns among secondary school students in South Asia [3,4]. Preparation for examinations, fear of failure, parental expectations and

competitive comparison with peers together create a constant pressure on students. In many situations, students begin to view academic success as a reflection of their personal value. When academic results are seen as a determining factor for future life opportunities, normal school demands can gradually turn into long term psychological strain. Global public health research indicates that mental health problems among adolescents represent one of the leading contributors to disability and long-term wellbeing challenges worldwide [5].

At the same time, emotional distress among adolescents in South Asia often remains unnoticed or underreported. According to the World Health Organization, around one in seven adolescents globally lives with a mental health condition, with a large share of these adolescents living in low-and middle-income countries [1]. However, access to structured mental health support remains limited in many South Asian settings. Emotional symptoms such as anxiety, sadness, hopelessness or social withdrawal are often seen as temporary reactions to academic stress rather than warning signs that require support. Adolescence is widely recognized as a critical developmental period during which many mental health conditions first emerge, making schools an important environment for early identification and prevention [4,6].

An important issue discussed in the regional literature is the problem of silent emotional distress. Many adolescents experience psychological pressure but do not share their feelings with parents, teachers or health professionals. Fear of judgement, social stigma, uncertainty about available support and limited mental health literacy can discourage help seeking [2,7]. Cultural expectations that emphasize resilience, discipline and academic dedication may further reduce the likelihood that students openly express emotional difficulty. As a result, emotional distress often remains internalized and hidden.

The interaction between academic pressure and non-disclosure creates a structural risk pattern. When strong academic expectations exist together with limited emotional literacy and weak communication channels, students may continue to function academically while experiencing serious internal distress. This situation makes early identification difficult. Teachers may notice declining concentration, fatigue or irritability without fully understanding the emotional causes behind these changes. Parents may also interpret examination related stress as a normal part of schooling and therefore overlook early warning signs. Research has shown that education systems emphasizing high stakes examinations often generate sustained academic stress that can affect emotional wellbeing and student development [8]. The structural interaction between academic demand and silent emotional distress can be summarized as shown in Table 1.

Table 1: *Structural interaction between academic pressure and silent emotional distress in South Asia.*

Structural feature	Potential psychological effect	Systemic consequence
High stakes examinations	Persistent performance anxiety	Chronic stress normalization
Strong parental expectations	Fear of disappointing family	Emotional suppression
Competitive peer comparison	Self-evaluation tied to rank	Reduced self-worth after failure
Limited mental health literacy	Poor recognition of distress	Delayed help seeking
Stigma surrounding mental illness	Reluctance to disclose emotions	Silent suffering

This pattern suggests that emotional distress in examination-oriented education systems should not be seen only as an individual problem. Instead, it reflects a wider issue within the structure of the education system itself. Academic pressure, family expectations and limited emotional communication often interact in ways that shape students' wellbeing. Because of this, addressing adolescent mental health in South Asia requires attention not only to individual symptoms but also to the broader academic environment and social norms that influence student experiences [1,9]. Studies on competitive schooling environments suggest that intense academic expectations may contribute to psychological strain when emotional development is not addressed alongside academic achievement [3].

Schools therefore become an important place for early intervention. They are the primary institutional setting where academic expectations, social interaction and emotional development come together. As a result, school based approaches to mental health awareness and support can play an important role in identifying distress early and encouraging help seeking among students.

Bangladesh context and structural risk factors

Bangladesh operates within a strongly examination centered secondary education system. Public board examinations at key academic stages act as major transition points for higher secondary progression and university admission. Academic results are widely viewed as indicators of family pride and future opportunity. Within this structure, students often experience continuous academic demand while receiving very limited formal education related to emotional wellbeing.

National data and regional studies indicate increasing mental health concerns among adolescents in Bangladesh. The National mental health survey of Bangladesh reported a significant burden of mental health conditions across age groups, with large treatment gaps particularly visible outside major urban areas [10]. Research focusing on adolescents has also found notable levels of depression, anxiety and stress symptoms among school going students [11]. Despite this growing concern, structured mental health support within secondary schools remains limited.

Several structural factors shape adolescent vulnerability within the Bangladeshi context: First, academic success holds a central place within family life. Educational achievement is widely seen as one of the main pathways to social mobility in a densely populated and competitive society. Parents often invest significant financial and emotional resources in their children's education and expectations may be communicated both directly and indirectly. While such commitment reflects aspiration and care, it may also increase performance related pressure on students.

Second, stigma surrounding mental health continues to influence help seeking behaviour. Emotional difficulties are

often misunderstood or minimized and discussions about psychological vulnerability may be avoided due to concerns about reputation or social misunderstanding [12]. Adolescents may fear being labelled weak or unstable if they express distress. As a result, open conversations about emotional struggles remain limited within many families and school environments.

Third, institutional mental health infrastructure within schools is still developing. Most secondary schools do not employ trained counsellors, and referral pathways are often informal. Teachers may notice signs of stress among students but frequently lack formal training in mental health literacy or early response. In rural and semi urban areas, access to professional mental health services is even more limited.

Fourth, rapid social and technological change has introduced additional challenges for adolescents. Urbanization, expanding digital access and increasing educational competition have reshaped the developmental environment of young people. Students now navigate both traditional expectations and modern pressures, including constant social comparison through digital platforms. These combined pressures may intensify academic stress and emotional strain among adolescents. These contextual factors are summarized in Table 2.

Table 2: *Structural risk factors influencing adolescent emotional wellbeing in Bangladesh.*

Structural domain	Contextual feature	Potential impact on students
Education system	Examination centered progression	Sustained academic pressure
Family structure	High parental aspiration	Fear of failure and shame
Cultural norms	Stigma toward mental illness	Non-disclosure of distress
School infrastructure	Limited counselling services	Delayed identification
Health system	Urban rural treatment gap	Restricted access to care

Understanding adolescent wellbeing in Bangladesh therefore requires looking beyond individual symptoms and recognizing the broader structural conditions that shape young people's experiences. Academic pressure does not operate in isolation. It exists within a cultural and institutional environment where stress is often normalized, while open discussion of emotional difficulty is discouraged. The combination of intense examination systems, social stigma around mental health and limited access to formal support services creates a situation in which emotional distress may remain hidden until it becomes severe [1,12].

Within this context, school based mental health literacy has emerged as a practical preventive approach. By introducing basic emotional education, encouraging help seeking, and clarifying available support pathways, schools can help reduce the gap between experiencing distress and seeking support [9,13]. Because schools play a central role in the everyday lives of adolescents in Bangladesh, interventions delivered within the school environment have the potential to address structural risk factors and improve early identification of emotional difficulty.

Theoretical positioning and conceptual model

The present study is grounded in a systems-oriented understanding of adolescent wellbeing within examination centered education environments. Rather than viewing psychological stress only as an individual experience, this perspective considers how academic pressure develops within broader institutional and social structures. Research increasingly suggests that adolescent wellbeing is shaped by the interaction of multiple factors including academic demand, family expectations, social environment and available support systems [4,9]. When these pressures accumulate over time without sufficient emotional support, psychological strain among students may gradually increase.

Ecological models of adolescent development further explain how young people are influenced by interconnected systems such as family, school, peer networks and wider social norms [14]. These models suggest that adolescent wellbeing is not shaped by a single factor but by continuous interactions between multiple social environments. Within examination-oriented education systems, academic performance often becomes a central organizing principle that influences identity formation, parental interaction, and peer comparison. When sustained academic expectations intersect with limited emotional literacy and stigma surrounding mental health, the likelihood of internalized distress may increase.

Mental health literacy theory provides another useful perspective for understanding this problem. Mental health literacy has been defined as knowledge and beliefs about mental disorders that help people recognise, manage or prevent mental health difficulties [15]. When literacy levels are low, adolescents may struggle to recognise emotional distress or may feel uncertain about how to seek support. In contexts where formal counselling services are limited, improving mental health literacy can function as an important preventive strategy. Mental health literacy frameworks highlight that improving knowledge, attitudes and recognition of emotional difficulties can increase the likelihood that individuals seek appropriate support when needed [16]. The conceptual model guiding this study therefore integrates three interrelated domains.

First, academic pressure functions as a structural load. In examination centered education systems, academic demand is not occasional but continuous. It is shaped by examination schedules, parental expectations and competitive ranking among peers.

Second, silent emotional distress emerges when students experience psychological strain but do not disclose these feelings to others. Non-disclosure may occur because of stigma, fear of disappointing family members or uncertainty about available support.

Third, school based mental health literacy acts as a protective factor. By increasing awareness, encouraging open discussion of emotional experiences and clarifying help seeking pathways, literacy-based interventions may reduce the disclosure gap and support earlier identification of distress. These relationships are summarized conceptually in Table 3.

Table 3: Conceptual model linking academic pressure, silent distress and mental health literacy.

Core domain	Mechanism	Expected outcome
Academic pressure	Sustained examination demand and performance expectation	Elevated psychological strain
Silent emotional distress	Internalized stress with limited disclosure	Reduced early identification
Mental health literacy	Knowledge, recognition and help seeking guidance	Increased awareness and support seeking

In this model, mental health literacy does not remove academic pressure. Instead, it changes how students understand and respond to emotional strain. When students are able to recognise emotional difficulties and talk about them openly, distress is less likely to remain hidden. Through improved recognition and communication, emotional challenges may shift from a silent internal struggle to a concern that can be discussed and addressed. In the Bangladeshi context, where strong academic demand is deeply embedded in the education system, literacy based preventive strategies may offer a realistic institutional response. This theoretical framework allows the study to examine not only the prevalence of academic stress but also the interaction between structural pressure, patterns of disclosure, and changes in awareness following an educational intervention.

Research gap and study objectives

Despite growing global attention to adolescent mental health, several gaps remain visible within the South Asian and Bangladeshi research context.

First, much of the existing research in Bangladesh focuses on the prevalence of depression, anxiety or stress symptoms among adolescents [11,17]. While these studies provide important epidemiological insights, fewer investigations examine how academic pressure, non-disclosure of emotional distress and mental health literacy interact within school environments. The relationship between structural academic demand and silent emotional distress therefore remains insufficiently explored.

Second, research on mental health literacy in low- and middle-income countries often focuses on community or clinical populations rather than structured school-based interventions. Evidence from international studies suggests that school based mental health promotion can play an important role in improving awareness and early support among adolescents [1,9]. However, empirical data from large scale, multi division school-based initiatives in Bangladesh remain limited.

Third, existing studies rarely incorporate multiple stakeholder perspectives within the same analytical framework. Adolescents, teachers and parents may hold different perceptions about stress, communication and readiness to seek support. Without comparative evidence, it becomes difficult to identify perception gaps that may influence disclosure behaviour and early intervention.

Fourth, the disclosure gap itself remains poorly documented in Bangladeshi secondary education settings. Although stigma has been widely recognized as a barrier to help seeking, few studies provide empirical estimates of how many students experience serious emotional thoughts but choose not to disclose them [12].

In light of these gaps, the present study seeks to contribute in four main ways: First, the study examines the prevalence of perceived academic pressure and silent emotional distress among secondary school students across multiple administrative divisions of Bangladesh.

Second, it evaluates baseline levels of mental health literacy among students, teachers and parents within the same educational environments.

Third, it assesses short term changes in awareness and help seeking intention following a structured school based mental health literacy intervention.

Fourth, it analyses perception differences between students and parents regarding comfort in discussing emotional concerns, thereby identifying potential intergenerational communication gaps.

The study is guided by the following objectives:

To measure the extent to which students report that academic pressure affects their mental wellbeing.

- To assess the prevalence of non-disclosure among students experiencing emotional distress.
- To determine baseline levels of mental health literacy among students, teachers and parents.
- To evaluate immediate changes in awareness and help seeking intention following a structured school-based session.
- To examine perception differences between students and parents regarding communication about emotional concerns.

By addressing these objectives, the study aims to generate empirically grounded evidence that can inform education policy and preventive strategies in Bangladesh. Rather than treating mental health as something separate from academic life, this research situates emotional wellbeing within the structural realities of examination-oriented schooling. This perspective allows the study to contribute to ongoing policy discussions on integrating mental health literacy within secondary education systems in Bangladesh.

METHODS

Study design and setting

This study used a multi stakeholder cross sectional design with a pre and post assessment among secondary school students. The main objective was to examine baseline levels of academic pressure, mental health awareness and help seeking attitudes and to observe immediate changes following a structured school based mental health literacy session.

The design included three respondent groups: students, teachers and parents. Students completed structured questionnaires immediately before and after the awareness session. This allowed the study to assess short term changes in knowledge

and intended help seeking behaviour. Teachers and parents completed structured surveys that measured baseline awareness, perceptions of student stress and readiness to support adolescent mental health needs.

The study was conducted across eight administrative divisions of Bangladesh: Dhaka, Rajshahi, Cumilla, Mymensingh, Khulna, Sylhet, Barishal and Rangpur. Schools were selected to ensure geographic diversity and to include urban, semi urban and non-metropolitan settings. Both government and non-government secondary institutions were included. This multi division coverage helped broaden the study context and reduce regional concentration in the findings.

The intervention component consisted of a structured educational awareness session delivered during regular school hours. The session covered basic mental health literacy, recognition of emotional distress, common sources of academic stress, and guidance on appropriate help seeking pathways. The content was standardized across participating schools to maintain consistency in delivery.

The study design focused on measuring short term knowledge and attitude changes rather than long term behavioural or clinical outcomes. The pre and post assessment therefore captured immediate awareness changes following participation in the educational session.

Participants and sampling

The total sample included 5,612 participants from the eight administrative divisions of Bangladesh. Among them, 3,856 were secondary school students, 352 were teachers and 1,156 were parents. Students were enrolled from classes six through twelve, representing both early and late adolescence. Both male and female students were included. Teacher participants represented different subject areas and varied levels of teaching experience. Parent respondents were guardians of enrolled students and participated on a voluntary basis. A multi stage sampling approach was used. In the first stage, schools were included from multiple administrative divisions to ensure geographic diversity. In the second stage, secondary schools within each division were identified through institutional coordination based on accessibility and willingness to participate. In the third stage, students were included through school level organization to ensure representation across different grade levels. Teachers and parents connected with participating students were invited to complete separate structured questionnaires.

The sampling strategy aimed to achieve broad contextual representation rather than strict national randomization. While the sample cannot be considered fully nationally representative, the inclusion of multiple divisions and stakeholder groups strengthens the analytical value of the findings and allows the results to be interpreted across similar examination oriented educational contexts. The distribution of student participants by division is presented in Table 4.

Table 4: *Student distribution by administrative division.*

Division	Number of students
Dhaka	782
Rajshahi	568
Cumilla	492
Mymensingh	387
Khulna	414
Sylhet	298
Barishal	429
Rangpur	486
Total	3,856

The multi division structure allowed examination of academic pressure and awareness patterns across varied educational and socioeconomic contexts. Teachers and parents were recruited from the same institutional settings, enabling comparative analysis of student experience and adult perception within shared school environments.

Measures and psychometric properties

Data were collected using structured self-report questionnaires administered separately to students, teachers and parents. The instruments were designed to assess perceived academic pressure, indicators of emotional distress, mental health literacy, help seeking intention and patterns of intergenerational communication. Student questionnaires included both pre intervention and post intervention components to measure short term awareness change following the mental health literacy session.

Academic pressure was assessed through a direct perception-based item asking students whether academic pressure negatively affected their mental wellbeing. Additional items asked about perceived sources of stress, including examinations, homework, parental expectations, peer competition, and fear of failure. These items were designed to capture students' subjective experience of sustained academic demand within examination-oriented school environments.

Silent emotional distress was assessed through a self-report item asking whether the student had ever felt that it might be better if they were not alive. This item was used as an indicator of serious emotional vulnerability rather than as a diagnostic measure. A follow up question assessed disclosure behaviour by asking whether such feelings had been shared with anyone and, if so, with whom. This allowed the study to estimate the presence of a disclosure gap. Mental health literacy was measured using items assessing familiarity with mental health concepts, awareness of helpline services and perceived confidence in recognizing emotional difficulty. Post intervention items measured understanding of basic mental health concepts and willingness to seek help if experiencing distress. Help seeking intention was assessed through direct questions about whether students would approach trusted adults or contact helpline services when facing

emotional difficulties.

Teacher questionnaires assessed perceived awareness of student mental health concerns, observations of academic pressure related stress, and willingness to guide students toward appropriate support or referral services. Parent questionnaires measured familiarity with adolescent mental health concepts, perceived comfort in discussing emotional concerns within the household and support for school based mental health education.

Content validity was established through expert review within the institutional framework overseeing the study. Questionnaire items were evaluated for clarity, cultural appropriateness, and relevance to the Bangladeshi secondary school context. Before large scale implementation, the instruments were also reviewed for linguistic accessibility and comprehension across different grade levels.

Internal consistency reliability was examined for multi-item domains assessing mental health literacy and help seeking orientation. Cronbach alpha coefficients for these domains were above 0.70, indicating acceptable internal reliability for research purposes. Because several key indicators were single item perception measures intended to estimate prevalence rather than latent constructs, reliability assessment was mainly applied to the multi-item literacy scales.

The use of similar thematic constructs across student, teacher, and parent questionnaires enabled cross group comparison of awareness and perception patterns within the same institutional settings.

Intervention protocol

The intervention consisted of a structured school based mental health literacy session delivered in participating secondary schools during regular academic hours. The session was designed as an educational awareness program rather than a clinical or therapeutic intervention. Its main purpose was to improve basic understanding of mental health concepts, normalize emotional experiences and clarify appropriate help seeking pathways.

The intervention followed a standardized framework to maintain consistency across all eight administrative divisions. Facilitators were oriented using a structured guideline that explained session objectives, key messages and delivery sequence. Minor contextual adjustments were allowed to ensure cultural relevance and age appropriateness, but the core content remained consistent across all participating schools.

The session included four main components:

First, foundational emotional literacy: Students were introduced to basic concepts such as stress, anxiety, sadness and emotional regulation. The goal was to help students distinguish between normal academic stress and persistent emotional distress and to reduce common misunderstandings about mental health.

Second, academic pressure awareness: This part of the session discussed common sources of examination related stress and practical ways to cope within demanding academic environments. Students were encouraged to understand stress responses as normal reactions rather than signs of personal failure.

Third, disclosure and help seeking pathways: Students were encouraged to communicate emotional difficulties with trusted adults, including parents and teachers. Information about available support options, including mental health helplines, was shared to improve awareness of where help can be found.

Fourth, stigma reduction: Facilitators addressed common myths and misconceptions about mental illness and reinforced the idea that seeking help is a responsible and positive step.

The duration of the session ranged from 45 to 60 minutes depending on school scheduling. Delivery methods included guided discussion, practical examples, and interactive question and answer segments to encourage student participation.

Teachers and parents were engaged through separate awareness components designed to improve understanding of adolescent emotional challenges and to strengthen supportive communication. These sessions focused on recognizing early warning signs, responding constructively to student concerns, and understanding the role of schools in preventive mental health education.

The intervention was not intended to replace professional mental health services. Instead, it aimed to improve basic literacy and early identification of emotional difficulties within school communities. Cases indicating significant emotional distress were referred to school authorities in accordance with safeguarding procedures and guidance toward appropriate support pathways was provided when necessary.

The structured nature of the intervention allowed comparison of pre and post awareness indicators while maintaining ethical and contextual sensitivity across different educational settings.

Statistical analysis

Data were analysed using statistical software to produce descriptive and comparative results. The initial analysis focused on descriptive statistics, including frequencies and percentages, to summarize participant characteristics, perceived academic pressure, emotional distress indicators, baseline awareness levels and help seeking intentions across the different stakeholder groups.

Pre and post intervention comparisons were conducted for student awareness and help seeking intention variables. For dichotomous outcomes, paired proportion comparisons were used to examine whether there were statistically significant changes following the structured mental health literacy session. Chi square tests were applied where appropriate to examine associations between categorical variables, including the relationship between academic pressure and reported emotional distress, as well as differences across gender and administrative divisions.

To explore the relationship between academic pressure and silent emotional distress, bivariate analyses were conducted using chi square statistics. Odds ratios with 95 percent confidence intervals were calculated to estimate the strength of association between perceived academic pressure and endorsement of passive thoughts related to not wanting to be alive.

Moderation analyses were conducted to examine whether post intervention mental health literacy was associated with increased help seeking intention. Logistic regression models were used to assess whether higher awareness levels predicted reported willingness to seek help while controlling for gender and division level variation.

Division level comparisons were also performed to explore possible regional differences in baseline awareness and reported academic stress. Statistical significance was determined using a threshold of p less than 0.05.

Given the cross-sectional nature of the baseline data and the short term pre and post design, causal conclusions are interpreted cautiously. The statistical approach is therefore intended to examine associations and immediate awareness change rather than long term behavioural outcomes.

Ethical considerations

The study followed established ethical principles for research involving minors and school communities. Institutional oversight was provided within the organizational framework coordinating the project. Formal permission was obtained from participating secondary schools before data collection began. The study procedures were conducted in accordance with internationally recognized ethical principles for research involving human participants.

Participation was voluntary for all respondent groups, including students, teachers, and parents. Students were informed in age-appropriate language about the purpose of the study, the voluntary nature of participation, and their right to decline or withdraw at any time without academic consequences. Parental consent procedures were implemented in accordance with school level guidelines. Teachers and parents provided informed consent before completing the questionnaires.

No personally identifiable information was collected through the survey instruments. All responses were recorded anonymously and stored securely. Access to the dataset was restricted to authorized members of the research team. Study findings are reported only in aggregated form to protect participant confidentiality.

Because the questionnaire included items related to emotional distress, facilitators were instructed to observe student reactions during both the survey and the awareness session. If a student appeared distressed or requested support, school authorities were informed according to safeguarding procedures, and guidance toward appropriate support services was provided.

The intervention was educational in nature and did not involve clinical diagnosis or treatment. Its purpose was to improve awareness and encourage early identification of emotional difficulties within the school environment. The study design therefore aimed to minimize psychological risk while addressing an important public health concern, consistent with widely accepted ethical standards for research involving adolescents and human participants [18].

RESULTS

Sample characteristics

A total of 5,612 participants were included in the study across eight administrative divisions of Bangladesh. The largest subgroup consisted of 3,856 secondary school students enrolled from classes six through twelve, representing both early and late adolescence. In addition, 352 teachers and 1,156 parents participated in the survey component.

Student participants were distributed across the eight divisions of Dhaka, Rajshahi, Cumilla, Mymensingh, Khulna, Sylhet, Barishal, and Rangpur. This distribution ensured geographic diversity and included metropolitan, semi urban, and non-metropolitan educational settings. The distribution of student participants across the eight administrative divisions is presented earlier in Table 4.

Both government and non-government secondary institutions were represented in the study. Teacher participants varied in their years of professional experience, and parent respondents represented diverse educational backgrounds. The multi stakeholder structure of the sample allowed comparison between student self-report data and the perceptions of teachers and parents within the same institutional environments.

The inclusion of participants from eight administrative divisions enhances the contextual breadth of the study and reduces the likelihood that the findings are limited to a single geographic or socioeconomic setting. Although the sample was not nationally randomized, its scale and diversity provide meaningful analytical insight into examination oriented secondary school environments in Bangladesh.

Academic pressure and silent distress patterns

Academic pressure emerged as a widespread experience among secondary school students. A large majority of respondents, 86 percent, reported that academic pressure negatively affected their mental wellbeing. This high prevalence suggests that perceived academic stress is embedded within routine educational processes rather than being limited to specific examination periods. Similar patterns of sustained academic pressure have been reported in examination-oriented education systems across several countries [4].

Students identified examinations, homework and assignments, parental expectations, peer competition and fear of failure as the primary sources of stress. These findings are consistent with examination-oriented education systems where academic outcomes are closely linked with family expectations and future opportunities.

Alongside academic strain, a considerable proportion of students reported experiences indicative of silent emotional distress. Forty five percent indicated that at some point they had felt that they might be better off not being alive. Although this item does not represent a clinical diagnosis, it reflects a serious level of emotional vulnerability within the student population.

Among students reporting such thoughts, 92 percent stated that they had not shared these feelings with anyone. Only 8 percent reported disclosing these experiences to a trusted person, including parents, teachers, or peers. This pattern highlights a substantial disclosure gap and suggests that emotional distress frequently remains internalized within school and family environments.

Table 5 summarizes the key indicators of perceived academic pressure and silent emotional distress.

Table 5: Academic pressure and silent distress indicators.

Indicator	Percentage
Students reporting academic pressure affecting wellbeing	86
Students reporting passive thought of being better off not alive	45
Students who disclosed such feelings	8
Students who did not disclose	92

Bivariate analysis indicated a significant association between perceived academic pressure and endorsement of passive thoughts related to not wanting to be alive. Students who reported experiencing academic pressure showed a higher likelihood of reporting emotional vulnerability compared to those who did not report such pressure. This relationship suggests that sustained academic strain may be associated with increased psychological distress within examination centered educational settings.

The coexistence of high academic pressure and low disclosure rates highlights an important structural concern. Students may continue participating in academic activities while experiencing considerable internal distress, which may reduce the likelihood of early identification by teachers or parents. Similar patterns of hidden distress among adolescents have been observed in school based mental health research [9].

These findings emphasize the need to examine not only the prevalence of academic stress but also communication patterns and help seeking behaviour within school environments. Understanding these dynamics is important for developing preventive strategies that address both emotional awareness and disclosure barriers.

Association and predictive modelling

To further examine the relationship between academic pressure and emotional vulnerability, inferential analyses were conducted using both bivariate and multivariable models.

Bivariate chi square analysis indicated a statistically significant association between perceived academic pressure and endorsement of passive thoughts related to being better off not alive. Students who reported that academic pressure negatively affected their mental wellbeing were more likely to report such thoughts compared with students who did not perceive academic pressure as harmful. The association remained statistically significant at a threshold of p less than 0.05.

To estimate the magnitude of this relationship, odds ratios were calculated. Students reporting academic pressure demonstrated higher odds of endorsing passive self-harm related thoughts relative to their peers. Because the study design is cross sectional, causal interpretation is not possible. However, the observed association suggests that sustained academic strain may be linked with increased emotional vulnerability in examination-oriented school environments.

A logistic regression model was constructed to examine whether perceived academic pressure predicted endorsement of silent emotional distress while controlling for gender and administrative division. The results showed that academic pressure remained a significant predictor after adjustment for these covariates. Gender differences were observed, with female students reporting slightly higher levels of emotional vulnerability, although the main predictive effect was associated with perceived academic pressure. Division level variation did not substantially change the overall pattern of association.

In addition to examining risk associations, predictive modelling was also applied to post intervention help seeking intention. A second logistic regression model assessed whether post session mental health literacy predicted willingness to seek help if students experienced emotional distress. Students demonstrating higher literacy scores following the session were more likely to report an intention to seek help. This relationship remained statistically significant after controlling for gender and division level factors. Table 6 summarizes the key predictive relationships identified in the analysis.

Table 6: Summary of predictive modeling findings.

Predictor variable	Outcome variable	Direction of association	Statistical significance
Perceived academic pressure	Passive thought of being endorsement better off not alive	Positive association	$p<0.05$
Post intervention mental health literacy	Willingness to seek help	Positive association	$p<0.05$
Gender	Passive thought of being endorsement	Slightly higher among females	$p<0.05$
Division	Emotional vulnerability	No consistent pattern	Not uniformly significant

These findings support the conceptual positioning of academic pressure as a structural stressor associated with increased emotional vulnerability among students. At the same time, the results suggest that mental health literacy may act as a protective factor that influences students' intention to seek help when experiencing emotional difficulty.

It is important to interpret the predictive models within the limitations of the study design. The cross-sectional nature of the baseline data does not allow causal conclusions to be drawn, and the post intervention analysis reflects short term attitudinal change rather than long term behavioural outcomes. However, the consistent patterns observed in the analysis provide empirical support for examining academic pressure and mental health literacy within an integrated school-based framework.

Impact of mental health literacy

The structured school based mental health literacy session was associated with substantial short-term improvements in awareness and reported help seeking intention across the participating stakeholder groups.

Among students, baseline familiarity with basic mental health concepts was 26 percent before the intervention. Following the session, 87 percent of students reported understanding core mental health concepts, representing a 61-percentage point increase. This change was statistically significant at p less than 0.05 based on paired proportion comparison. The magnitude of this change suggests that the low baseline awareness was more likely related to lack of exposure rather than resistance to mental health education.

Awareness of formal support pathways also improved. Before the session, only 14 percent of students reported awareness of mental health helplines. Post intervention responses indicated increased recognition of available support options and clearer understanding of whom to approach in case of emotional difficulty.

Help seeking intention demonstrated a similar pattern of improvement. After the session, 78 percent of students reported that they would seek help if experiencing emotional distress and 62 percent indicated willingness to contact a helpline if necessary. Logistic regression analysis showed that higher post intervention literacy scores were significantly associated with greater likelihood of reporting intention to seek help, even after controlling for gender and division level factors. Improvements were not limited to students. Among parents, baseline awareness of adolescent mental health concepts was 15 percent. Following participation in the awareness component, parental awareness increased to 88 percent, representing a 73-percentage point increase. Teachers demonstrated relatively high baseline recognition of student mental health concerns at 83 percent. After the session, teachers showed near universal agreement regarding the importance of school based mental health literacy initiatives.

Table 7 summarizes the pre and post intervention awareness changes across the different stakeholder groups.

Table 7: *Pre and post mental health literacy indicators.*

Stakeholder group	Baseline awareness	Post session awareness	Percentage point change
Students	26	87	61
Parents	15	88	73
Teachers	83	100	17

Despite these improvements, the intervention did not remove all communication barriers. Although help seeking intention increased, previously identified perception gaps between students and parents regarding comfort in discussing emotional concerns remained evident. This suggests that improving awareness is an important step, but it may not be sufficient on its own to fully address the dynamics of emotional disclosure.

Overall, the findings indicate that brief and structured mental health literacy sessions delivered within secondary school environments can produce meaningful short-term improvements in awareness and stated readiness to seek support. Although long term behavioural outcomes were not assessed in the present study, the scale of awareness change supports the feasibility of integrating literacy based preventive approaches within examination-oriented education systems.

Subgroup differences

Subgroup analyses were conducted to examine variation in academic pressure, silent emotional distress and post intervention awareness across gender and administrative divisions.

Gender based comparisons indicated that both male and female students reported high levels of perceived academic pressure. However, female students showed slightly higher rates of endorsement of passive thoughts related to being better off not being alive. This gender difference was statistically significant in bivariate analysis at a threshold of p less than 0.05. Despite this variation in emotional vulnerability, improvements in awareness following the intervention were observed across both genders, with no statistically significant difference in the magnitude of improvement. These findings suggest that the literacy intervention was similarly effective for male and female students in terms of short-term knowledge acquisition and reported help seeking intention.

Division level comparisons showed that perceived academic pressure remained consistently high across all eight administrative divisions, with no region demonstrating substantially lower prevalence. Although minor differences were observed in baseline mental health awareness between divisions, these variations did not change the overall pattern of limited pre session literacy. Post intervention awareness increases were observed across all divisions, indicating that the structured session was effective in a range of geographic and socioeconomic contexts.

Table 8 summarizes subgroup patterns in emotional vulnerability and awareness change.

Table 8: *Subgroup patterns in emotional distress and awareness.*

Subgroup variable	Academic pressure high	Passive thought endorsement	Post intervention awareness increase
Male students	High prevalence	Lower than female students	Significant increase
Female students	High prevalence	Slightly higher prevalence	Significant increase
All divisions	Consistently high	Present across regions	Uniform improvement

Additional analysis examined whether administrative division moderated the association between academic pressure and emotional distress. No consistent regional moderation effect was observed, suggesting that the relationship between perceived

academic pressure and silent emotional vulnerability was broadly similar across divisions.

Similarly, subgroup analysis of help seeking intention indicated that post intervention willingness to seek help increased across both gender and divisions without significant disparity. This pattern further supports the generalizability of the literacy intervention effect within the sampled population.

Taken together, these subgroup findings suggest that academic pressure and silent emotional distress are not limited to specific demographic or regional groups. Rather, they appear to be widely distributed within examination oriented secondary education environments in Bangladesh. The consistent improvement in awareness across subgroups also supports the potential scalability of school based mental health literacy approaches across diverse educational settings.

DISCUSSION

Principal findings

This study examined academic pressure, silent emotional distress and mental health literacy within secondary schools across eight administrative divisions of Bangladesh. Several principal findings emerge from the analysis.

First, academic pressure appears to be pervasive within the examination oriented secondary education environment. A substantial majority of students reported that academic demands negatively affect their mental wellbeing. This pattern was consistent across divisions and gender groups, suggesting that perceived academic strain is not episodic or region specific but structurally embedded within routine schooling. Similar patterns of sustained academic stress among adolescents have been documented in examination focused education systems in other contexts [4].

Second, a considerable proportion of students reported experiences indicative of serious emotional vulnerability, including passive thoughts related to being better off not being alive. The prevalence of such experiences is concerning in itself. More critically, the vast majority of students who reported these thoughts indicated that they had not disclosed them to anyone. This disclosure gap represents a central structural concern. Emotional distress may coexist with continued academic participation, thereby limiting early detection within both school and family settings. Previous research has similarly identified stigma and communication barriers as important obstacles to help seeking among adolescents [7].

Third, a statistically significant association was observed between perceived academic pressure and endorsement of silent emotional distress. Students who reported academic pressure were more likely to report emotional vulnerability, even after controlling for gender and regional variation. While causality cannot be established within the present design, the strength and consistency of this association support the conceptual positioning of academic pressure as a meaningful correlate of adolescent psychological strain within examination centered education systems.

Fourth, baseline mental health literacy was limited among students and parents, despite relatively higher awareness among teachers. Awareness of core mental health concepts and formal support pathways was low before the intervention. This pattern suggests that informational barriers may contribute to non-disclosure and delayed help seeking within school communities.

Fifth, the structured school based mental health literacy session was associated with substantial short-term improvements in awareness and reported help seeking intention across students, teachers and parents. The scale of awareness increase indicates that limited literacy may be linked more to lack of exposure than to resistance toward mental health education. Improved literacy was significantly associated with increased stated willingness to seek help, suggesting that knowledge enhancement may influence readiness to seek support. Evidence from school based mental health programs in other contexts also indicates that literacy interventions can improve awareness and help seeking attitudes among adolescents [9].

Finally, subgroup analyses demonstrated that academic pressure and emotional vulnerability are widely distributed phenomena rather than being confined to particular divisions or demographic groups. The intervention effect was observed consistently across gender and regional subgroups, supporting the potential scalability of school-based literacy approaches.

Taken together, the findings reveal a structural pattern characterized by high academic demand, substantial silent emotional distress, limited baseline literacy and strong short-term responsiveness to educational intervention. This pattern highlights both the vulnerability and the opportunity present within examination-oriented school systems. While academic pressure appears deeply embedded in the education structure, the results suggest that structured literacy initiatives may offer a feasible pathway toward early recognition of emotional distress and improved help seeking within secondary education environments.

Academic pressure as systemic load

The findings of this study suggest that academic pressure within Bangladeshi secondary education operates not merely as an episodic stressor but as a systemic load embedded within examination oriented institutional structures. A large majority of students reported that academic pressure negatively affects their mental wellbeing and this perception was consistent across divisions and demographic groups. Such uniformity indicates that academic strain is structurally normalized rather than individually idiosyncratic.

Examination centered systems tend to concentrate academic evaluation within high stakes assessments that influence educational progression, institutional placement, and perceived life opportunities. In such environments, academic performance often becomes closely tied to identity formation and family expectations. The Organization for Economic Cooperation and Development has emphasized that sustained academic pressure without parallel attention to emotional development may undermine long term educational outcomes [8]. UNESCO has similarly highlighted the psychological consequences of intense academic competition within South Asian education systems [3].

The present findings are consistent with these concerns. The statistically significant association between perceived academic pressure and endorsement of passive self-harm related thoughts suggests that sustained performance demand may be linked with increased emotional vulnerability among adolescents. Although

the cross-sectional design does not allow causal conclusions, the consistency of this association across subgroups indicates that academic strain functions as a major contextual factor shaping adolescent wellbeing.

Conceptualizing academic pressure as a systemic load shifts the analytical focus from individual coping failure toward the broader educational environment. In examination-oriented settings, stress is often normalized as a necessary component of academic achievement. However, when persistent academic strain combines with limited mental health literacy and low disclosure rates, emotional distress may remain hidden from adults within both school and family contexts. The World Health Organization has noted that many adolescent mental health conditions emerge during the secondary school years and frequently remain unrecognized within educational environments [1].

Within the Bangladeshi context, academic performance carries significant social value and is closely linked with family aspirations. Students may therefore experience pressure not only from formal assessment systems but also from implicit expectations regarding social mobility and future success. The combined influence of institutional evaluation, family expectations and competitive peer comparison may intensify psychological strain beyond what is visible through academic performance alone.

Importantly, recognizing academic pressure as a systemic factor does not imply opposition to academic standards or merit-based evaluation. Rather, it highlights the need for structural balance within education systems. International evidence increasingly supports the integration of social and emotional learning within academic curricula to promote both wellbeing and sustained academic performance [8].

The present findings therefore contribute to a growing body of literature recognizing the interdependence of academic and emotional development. By identifying a clear association between perceived academic pressure and silent emotional distress, the study reinforces the importance of embedding preventive mental health literacy within examination-oriented school systems. Without such structural adaptation, academic load may continue to operate as a persistent risk correlate within adolescent developmental trajectories.

Mental health literacy as protective mechanism

While academic pressure appears structurally embedded within examination-oriented education systems, the findings of this study suggest that mental health literacy may function as a protective mechanism within this context. Substantial short-term increases in awareness and help seeking intention were observed following the structured school-based literacy session, indicating that informational and attitudinal barriers are potentially modifiable through educational intervention. Evidence from school based mental health programs indicates that structured educational interventions can significantly improve students' awareness, attitudes toward mental health, and readiness to seek help [19].

Mental health literacy has been defined as knowledge and beliefs that support the recognition, management or prevention of mental health conditions [15]. In low- and middle-income settings, where specialist services are limited and stigma often remains influential, literacy becomes a foundational component of early prevention rather than an optional educational addition. Without basic understanding of emotional distress, adolescents may misinterpret symptoms as personal weakness, moral failure, or temporary academic fatigue. Such misinterpretation may contribute to non-disclosure and delayed support.

The marked increase in post session awareness observed in this study suggests that baseline limitations in knowledge may reflect lack of exposure rather than resistance to mental health education. Students demonstrated improved understanding of mental health concepts and greater willingness to seek help. Logistic regression analysis further indicated that higher post intervention literacy scores were significantly associated with increased reported intention to seek support. Although intention does not necessarily translate directly into behaviour, attitudinal readiness represents an important early step within preventive frameworks.

International guidance increasingly emphasizes whole school approaches that integrate mental health promotion within routine educational practice. The World Health Organization recommends school based preventive interventions that focus on awareness, stigma reduction and early identification of emotional difficulties [1]. UNICEF similarly highlights the importance of integrating mental health literacy into systems that reach adolescents collectively rather than relying only on clinical referral pathways [2].

Within the Bangladeshi context, where formal counselling services are limited in many secondary schools, literacy-based approaches may offer a scalable and contextually appropriate strategy. By normalizing discussion of emotional wellbeing and clarifying help seeking pathways, literacy initiatives may help reduce the disclosure gap identified in the present findings. The persistence of communication differences between students and parents indicates that awareness improvement alone may not remove all relational barriers. However, shared exposure to mental health concepts may create a common language that supports communication between adolescents and adults. Research on adolescent help seeking behaviour suggests that young people often delay or avoid seeking support because of stigma, uncertainty about available services or concerns about social judgement [20].

Importantly, mental health literacy does not remove structural academic pressure. Rather, it influences how students interpret and respond to that pressure. When students understand stress responses and recognize early signs of emotional difficulty, they may be more likely to seek timely support. When teachers and parents share literacy exposure, they may become more attentive to early warning signs and more responsive to student disclosure.

The findings therefore support the positioning of mental health literacy as a protective buffer within examination-oriented school systems. While structural academic demands may remain, literacy initiatives offer a feasible institutional mechanism to reduce silence, improve recognition of distress, and encourage early help seeking. In resource constrained settings, such approaches may serve as an important bridge between school environments and broader mental health support systems. Mental health promotion initiatives implemented within school environments have been shown to support both emotional wellbeing and academic engagement among adolescents [21].

Policy and systems reform implications

The findings of this study carry important implications for education policy and system level reform within examination oriented secondary education contexts. The coexistence of high academic pressure, substantial silent emotional distress, limited baseline literacy and strong responsiveness to structured awareness intervention suggests that mental health cannot remain peripheral within educational planning.

First, structured mental health literacy should be integrated into secondary school curricula. The substantial improvement in awareness following a brief session indicates that foundational knowledge gaps can be addressed through relatively low intensity educational interventions. International guidance from the World Health Organization recommends whole school approaches that integrate mental health promotion into routine educational practice rather than relying only on specialist referral systems [22]. In Bangladesh, such integration could occur through life skills education modules, co-curricular activities, or structured advisory sessions without reducing academic instructional time.

Second, teacher capacity building is essential. Although teachers in this study demonstrated relatively high baseline recognition of student stress, formal training in identifying early warning signs and initiating supportive conversations remains limited. Education policy frameworks should therefore include basic mental health literacy training within teacher professional development programs. Such training does not require clinical specialization but should focus on recognition, initial response and referral awareness. Evidence from OECD education research indicates that systems supporting both academic and socio emotional competencies are more likely to sustain long term student performance and wellbeing [8].

Third, parent engagement mechanisms should be strengthened. The perception gap identified between student comfort and parental assumptions highlights the need for structured communication support. School based parent orientation sessions, informational resources and dialogue platforms may help improve mutual understanding between adolescents and caregivers. UNICEF has emphasized that adolescent mental health promotion is most effective when family and school systems operate in coordination rather than isolation [2].

Fourth, clear referral pathways linking schools with local health services should be institutionalized. While resource limitations restrict rapid expansion of specialist services, structured referral protocols can improve early response when serious distress is identified. The National Mental Health Survey of Bangladesh highlights a substantial treatment gap in the country [10]. Strengthening coordination between education and health sectors may help reduce this gap without placing clinical responsibilities directly on schools.

Fifth, monitoring and evaluation mechanisms should accompany implementation. Regular assessment of student wellbeing indicators, awareness levels, and help seeking behaviour can support continuous program refinement. Systematic monitoring also reduces the risk that mental health literacy becomes a symbolic initiative rather than an operational component of educational practice.

Importantly, system reform does not imply lowering academic standards or reducing performance expectations. Instead, it requires recalibrating institutional priorities to recognize the close relationship between academic achievement and emotional wellbeing. Education systems that treat psychological resilience as foundational rather than supplementary are more likely to sustain equitable and long-term learning outcomes.

Depressive symptoms frequently emerge during adolescence and may remain unnoticed within educational settings when emotional distress is not openly discussed [23].

International policy frameworks increasingly recommend integrating health promotion within school systems in order to strengthen both educational outcomes and student wellbeing [24].

The present findings therefore support a systems-oriented reform perspective in which mental health literacy is integrated within secondary education infrastructure. In examination-oriented contexts such as Bangladesh, preventive school-based approaches may represent a practical and scalable strategy for addressing silent emotional distress while maintaining academic integrity [25].

Strengths and limitations

This study has several notable strengths. First, it draws on a large multi division sample comprising students, teachers, and parents across eight administrative divisions of Bangladesh. The inclusion of 5,612 participants improves statistical stability and enables examination of adolescent mental health within diverse geographic and institutional contexts. The multi stakeholder design also strengthens analytical depth by allowing comparison between student self- report data and adult perceptions within the same school environments [26].

Second, the study integrates both prevalence assessment and intervention evaluation within a single analytical framework. By combining cross sectional baseline data with a pre and post literacy component, the research moves beyond descriptive epidemiology and provides empirical evidence regarding the short-term responsiveness of school based mental health education. This dual design enhances the policy relevance of the findings.

Third, the study situates adolescent mental health within an educational systems perspective rather than treating it solely as a clinical issue. By examining academic pressure, disclosure patterns, literacy gaps and stakeholder perspectives simultaneously, the analysis contributes to a more integrated understanding of examination-oriented school environments [27].

Despite these strengths, several limitations should be acknowledged: First, the sampling strategy, although geographically broad, was not nationally randomized. Schools participated based on accessibility and institutional approval. As a result, the findings should not be interpreted as nationally representative prevalence estimates. Caution is therefore required when generalizing the results to all secondary schools in Bangladesh.

Second, the data rely on self-reported responses. Sensitive items assessing emotional vulnerability may be subject to underreporting due to stigma or fear of judgement, even within anonymous survey formats. Conversely, post intervention responses may reflect elements of social desirability bias,

particularly in relation to stated willingness to seek help [28-30].

Third, the pre and post design captures short term changes in awareness and intention but does not assess long term behavioural outcomes or sustained help seeking patterns. The present study therefore cannot determine whether increased literacy leads to measurable reductions in emotional distress over time.

Fourth, the measure of passive thoughts related to being better off not being alive was used as an indicator of emotional vulnerability rather than a diagnostic instrument. The study does not include clinical assessment or psychiatric evaluation. Interpretation of this indicator should therefore remain within a public health and preventive framework rather than a diagnostic context.

Finally, although subgroup analyses were conducted, the study did not include in depth qualitative interviews that might provide deeper insight into family communication dynamics or classroom level experiences [31,32]. Future mixed methods research could help expand understanding of disclosure barriers and contextual influences.

These limitations do not diminish the relevance of the findings but clarify the scope within which the conclusions should be interpreted. Future research incorporating longitudinal follow up, nationally representative sampling, and behavioural outcome measurement would further strengthen the evidence base for large scale policy implementation.

CONCLUSION

From silent distress to structural prevention

This study examined academic pressure, silent emotional distress, and mental health literacy within secondary schools across multiple administrative divisions of Bangladesh. The findings reveal a structural pattern characterized by high perceived academic strain, substantial levels of undisclosed emotional vulnerability and limited baseline mental health awareness among students and parents. At the same time, the results demonstrate that structured school based mental health literacy sessions are associated with significant short-term improvements in awareness and reported help seeking intention.

The coexistence of persistent academic demand and low disclosure rates suggests that emotional distress within examination-oriented systems often remains hidden rather than absent. Students may continue academic participation while experiencing considerable internal strain, which reduces opportunities for early identification within both school and family environments. The statistically significant association between perceived academic pressure and emotional vulnerability further highlights the importance of considering educational structure alongside individual coping capacity.

Importantly, the scale of post intervention awareness improvement indicates that informational and attitudinal barriers are modifiable. Mental health literacy does not eliminate academic pressure, but it may influence how students interpret, communicate, and respond to emotional distress. Within resource constrained settings, literacy based preventive strategies delivered through schools represent a feasible and scalable pathway for strengthening early recognition and support.

The transition from silent distress to structural prevention requires reframing mental health as an integral component of educational sustainability rather than an external or secondary concern. Integrating mental health literacy within secondary education systems does not diminish academic standards. Instead, it strengthens the foundation upon which sustained learning and resilience depend.

Although further longitudinal research is needed to examine long term behavioural outcomes, the present findings provide multi division empirical evidence supporting the institutional integration of mental health literacy within examination-oriented school environments in Bangladesh. In doing so, the study contributes to the broader discussion on balancing academic aspiration with psychological wellbeing in rapidly evolving education systems.

DECLARATIONS

Ethics approval and consent to participate

The study was conducted in accordance with established ethical principles for research involving minors and school communities. Institutional oversight was provided under the organizational framework coordinating the project. Formal permission was obtained from participating secondary schools before data collection began. All study procedures were implemented in accordance with recognized ethical standards for research involving human participants.

Participation was voluntary for all respondent groups, including students, teachers, and parents. Students were informed in age-appropriate language about the purpose of the study, the voluntary nature of participation and their right to decline or withdraw without academic consequences. Parental consent procedures were implemented in accordance with school level guidelines. Teachers and parents provided informed consent prior to completing the questionnaires.

No personally identifiable information was collected, and all responses were recorded anonymously.

Consent for publication

All data were collected anonymously and are presented in aggregated form. No personally identifiable information is included in this manuscript. Consent for publication was obtained through institutional approval procedures.

Availability of data and materials

The datasets generated and analysed during the current study are available from the corresponding author upon reasonable request, subject to institutional approval and ethical considerations.

Competing interests

The author declares that there are no competing interests.

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Author contributions

The author conceptualized the study, designed the research framework, supervised data collection, conducted the data analysis, and prepared the manuscript.

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REFRENCES

1. Helping Adolescents Thrive Toolkit. World Health Organiz. 2021
2. The State of the World's Children 2021. UNICEF. 2021.
3. UNESCO Strategy on Education for Health and Wellbeing. UNESCO. 2022.
4. Patton GC, Sawyer SM, Santelli JS, Ross DA, Afifi R, Allen NB, et al. Our Future: A Lancet Commission on Adolescent Health and Wellbeing. Lancet. 2016;387(10036):2423-2478.
5. Kieling C, Baker-Henningham H, Belfer M, Conti G, Ertem I, Omigbodun O, et al. Child and Adolescent Mental Health Worldwide: Evidence for Action. Lancet. 2011;378(9801):1515-1525.
6. Sawyer SM, Azzopardi PS, Wickremarathne D, Patton GC. The Age of Adolescence. Lancet Child Adolesc Health. 2018;2(3):223-228.
7. Kutcher S, Wei Y, Coniglio C. Mental Health Literacy: Past, Present and Future. Can J Psychiatry. 2016;61(3):154-158.
8. Beyond Academic Learning: First Results from the Survey of Social and Emotional Skills. OECD Publish. 2021.
9. Fazel M, Patel V, Thomas S, Tol W. Mental Health Interventions in Schools in Low-Income and Middle-Income Countries. Lancet Psychiatry. 2014;1(5):388-398.
10. Bangladesh National Mental Health Survey 2018-2019. Nat Inst Ment Heal. 2020.
11. Islam MS, Rahman ME, Moonajilin MS, van Os J. Prevalence of Depression, Anxiety and Associated Factors among School Going Adolescents in Bangladesh: Findings from a Cross-Sectional Study. Plos One. 2021;16(4):e0247898.
12. Anjum A, Hossain S, Hasan MT, Alin SI, Uddin ME, Sikder MT. Depressive Symptom and Associated Factors Among School Adolescents of Urban, Semi-Urban and Rural Areas in Bangladesh: A Scenario Prior to COVID-19. Front Psychiatry. 2021;12:708909.
13. Kutcher S, Wei Y, Morgan C. Successful Application of a Canadian Mental Health Curriculum Resource by Usual Classroom Teachers in Significantly and Sustainably Improving Student Mental Health Literacy. Can J Psychiatry. 2015;60(12):580-586.
14. Bronfenbrenner U, Morris PA. The Bioecological Model of Human Development. Handbook Child Psychol. 2007;1.
15. Jorm AF. Mental Health Literacy: Empowering the Community to Take Action for Better Mental Health. Am Psychol. 2012;67(3):231-243.
16. Wei Y, McGrath PJ, Hayden J, Kutcher S. Mental Health Literacy Measures Evaluating Knowledge, Attitudes and Help-Seeking: A Scoping Review. BMC Psychiatry. 2015;15(1):291.
17. Shrestha S, Phuyal R, Chalise P. Depression, Anxiety and Stress among School-Going Adolescents of a Secondary School: A Descriptive Cross-Sectional Study. JNMA J Nepal Med Assoc. 2023;61(259):249-251.
18. Mental Health Action Plan 2013-2020. World Health Organiz. 2013.
19. Barry MM, Clarke AM, Jenkins R, Patel V. A Systematic Review of the Effectiveness of Mental Health Promotion Interventions for Young People in Low and Middle Income Countries. BMC Public Health. 2013;13(1):835.
20. Rickwood D, Deane FP, Wilson CJ, Ciarrochi J. Young People's Help-Seeking for Mental Health Problems. Aus E-J Advanc Ment Heal. 2005;4(3):218-251.
21. Weare K, Nind M. Mental Health Promotion and Problem Prevention in Schools: What does the Evidence Say?. Health Promotion Int. 2011;26(Supply 1):i29-i69.
22. Adolescent Mental Health. World Health Organiz. 2021.
23. Thapar A, Collishaw S, Pine DS, Thapar AK. Depression in Adolescence. Lancet. 2012;379(9820):1056-1067.
24. Making Every School a Health-Promoting School: Implementation Guidance. World Health Organiz. 2021.
25. Barry MM, Clarke AM, Petersen I. Promotion of Mental Health and Prevention of Mental Disorders: Priorities for Implementation. East Mediterr Health J. 2015;21(7):503-511
26. Barry MM, Jenkins R. Implementing Mental Health Promotion. Edinburgh Church Living. 2007.
27. Hadlaczky G, Hökby S, Mkrtchian A, Carli V, Wasserman D. Mental Health First Aid is an Effective Public Health Intervention for Improving Knowledge, Attitudes and Behaviour: A Meta-Analysis. Int Rev Psychiatry. 2014;26(4):467-475.
28. Loades ME, Chatburn E, Higson-Sweeney N, Reynolds S, Shafran R, Brigden A, et al. Rapid Systematic Review: The Impact of Social Isolation and Loneliness on the Mental Health of Children and Adolescents in the Context of COVID-19. J Am Acad Child Adolesc Psychiatry. 2020;59(11):1218-1239.
29. Mcluckie A, Kutcher S, Wei Y, Weaver C. Sustained Improvements in Students' Mental Health Literacy with Use of a Mental Health Curriculum in Canadian Schools. BMC Psychiatry. 2014;14(1):379.
30. Patel V, Flisher AJ, Hetrick S, McGorry P. Mental Health of Young People: A Global Public-Health Challenge. Lancet. 2007;369(9569):1302-1313.
31. Guidelines On Mental Health Promotive and Preventive Interventions for Adolescents: Helping Adolescents Thrive. World Health Organiz. 2020.

32. Reavley NJ, Jorm AF. Recognition of Mental Disorders and Beliefs About Treatment and Outcome: Findings from an Australian National Survey of Mental Health Literacy and Stigma. Aust N Z J Psychiatry. 2011;45(11):947-956.