



Complete mental health in elementary school children: Understanding youth school functioning and adjustment

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Abstract

Complete mental health is characterized by the presence of well-being and the absence of psychopathological symptoms. Studies on the influence of complete mental health on general school functioning and school adjustment among youth is limited, but existing literature has shown its potential positive effects. The purpose of this study is to investigate how complete mental health status influences school functioning and adjustment among elementary school children. The study included 362 grade 5–8 students (10–14 years of age) from a public school in an urban city of Turkey. A series univariate analysis of variance (ANOVA) was performed to investigate the differential effects of mental health status on youth school functioning and adjustment. The largest proportion of the participants was classified into the complete mental health group ($n = 246$, 68%), followed by vulnerable, troubled, and symptomatic-but-content groups. Post hoc comparison results showed that the complete mental health group felt greater connection to their school, had better academic functioning, showed more prosocial behaviors, and reported less bullying and victimization in school than the other groups. These results suggest that identifying both psychological distress and wellbeing is integral to understanding the overall adjustment and functioning of students in school settings.

Keywords Complete mental health · School adjustment · School functioning · Positive psychology · Youth

During the past decades, positive indicators of mental health have received increasing attention from both researchers and practitioners (e.g., Arslan 2018a; Arslan and Renshaw 2018; Furlong et al. 2013). Mental health has historically been conceptualized in terms of a unidimensional understanding, which is characterized by the absence of social, emotional, and behavioral problems (Payton 2009; Renshaw et al. 2016). Mental ill health, on the other hand, is a broad term that refers to a wide range of difficulties experienced by individuals, from milder circumstances such as stress, worries, and loneliness to more serious conditions such as clinically significant depression, psychosis, and substance abuse (Allen and McKenzie 2015; Glozier 2002; Spiker and Hammer 2019). However, the absence of these psychopathological factors alone is not a

sufficient indicator of mental health (Arslan 2019a; Payton 2009). For instance, the World Health Organization (WHO 2003) has stressed the importance of positive indicators of mental health and noted that mental health is “a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity” (p. 7). Given this definition, mental health is associated with not only the lack of psychopathological symptoms, but also the presence of social, emotional, and psychological wellbeing (Keyes 2014; Seligman and Csikszentmihalyi 2000).

Complete mental health is defined as the absence of mental illness and the presence of flourishing (Keyes 2002), and thus requires both high levels of flourishing and low levels of psychological symptoms (Arslan 2019a; Suldo and Shaffer 2008). Flourishing is a multidimensional construct that refers to a combination of positive feelings and functioning well in both social and psychological contexts (Keyes 2002). The traditional mental health screening approach aimed to identify students with psychological problems, placing mental illness and wellbeing on opposite ends of a single continuum (Greenspoon and Saklofske 2001; Moore et al. 2015). The complete mental health model, by contrast, suggests that both illness and wellbeing should be assessed in order to provide a comprehensive picture of student wellbeing (Moore et al.

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2015; Keyes 2005) and to promote positive functioning and adjustment in youth in a school context (Dowdy et al. 2015).

The complete mental health approach is more useful than a unidimensional mental health approach for identifying and cultivating youth school adjustment and functioning (Arslan 2018b; Moffa et al. 2016; Renshaw and Cohen 2014; Suldo and Shaffer 2008; Telef and Furlong 2017). For example, youth with complete mental health (i.e., low in psychopathology and high in wellbeing) have better school adjustment and quality-of-life outcomes compared with their peers, who have a more vulnerable mental health status (i.e., low in both psychopathology and wellbeing). Specifically, students with complete mental health were more successful in terms of general school functioning (e.g., adaptive thoughts, feelings, and behaviors related to higher academic achievement, greater school belonging, and better school attendance), social relationships (e.g., higher social connectedness, better family relationships, and higher social acceptance), and healthy psychological adjustment (e.g., as indicated by low adjustment problems, such as bullying victimization, internalizing problems, and substance use; Arslan 2018b; Antaramian et al. 2010; Greenspoon and Saklofske 2001; Moffa et al. 2016; Renshaw and Cohen 2014; Suldo and Shaffer 2008). These findings have mostly been substantiated in secondary school contexts with a disproportionately smaller amount of research conducted in elementary school settings (e.g., Kim et al. 2017) indicating a clear gap in literature.

In addition to the cross-sectional research, longitudinal outcomes have supported the view that the absence of psychological distress is not sufficient to ensure optimal school functioning and adjustment. Suldo et al. (2011) investigated the longitudinal utility of a complete mental health model in predicting academic functioning and school-based behaviors in middle school students. The outcome of the study showed that the complete mental health youth group had better academic achievement and attendance. A recent study by Xiong et al. (2017) also demonstrated that youth with complete mental health reported more positive academic outcomes, including academic self-efficacy, affective self-regulatory efficacy, and academic emotions, than their vulnerable peers. Moreover, vulnerable youth reported more social problems, worse academic attitudes, poorer physical health satisfaction, and more negative self-perception than their peers with complete mental health (Suldo and Shaffer 2008). Kim et al. (2017) found similar findings for elementary school children in South Korea where higher psychological strengths identified following complete mental health screening were associated with higher life satisfaction in students. However, limited research exists for children outside secondary school contexts. Taken together, these outcomes suggest that adolescents with complete mental health show the highest stability in terms of their school functioning and psychological adjustment and highlights a need for further research at the elementary school

level. Research in this area thus meets a growing interest and need in schools (Allen et al. 2018a, 2018b).

Present Study

Despite the increase in literature exploring the utility of the complete mental health model in predicting a variety of quality-of-life outcomes (e.g., Antaramian et al. 2010; Kim et al. 2017; Suldo et al. 2016), its potential impact on general school functioning and adjustment in youth have remained relatively unexplored. To date, one study has examined the utility of the complete mental health model in relation to youth school functioning in high school students in Turkey and no published research is available in this area for elementary school children in Turkey. Findings of the study reported that complete mental health showed a higher sense of belonging at school, compared with a unidimensional mental health model. Furthermore, students with complete mental health reported greater social acceptance and lower social rejection in the school context (Arslan 2018b). The findings in this study relating to the grouping of members of the sample population show a high degree of continuity with findings from Australia, Canada, and the United States (see, e.g., Antaramian et al. 2010; Lyons et al. 2012).

At the current time, there has been little research into the validity and potential utility of the complete mental health model for school functioning and adjustment among elementary school students. The present study thus seeks to explore the utility of the complete mental health model in relation to general school functioning and adjustment among elementary school students in Turkey. It is hypothesized that youth with complete mental health will have better positive school outcomes (i.e., social acceptance, academic achievement, prosocial behavior, attitude toward teachers, academic self-perceptions, attitude toward school, goal valuation, and motivation/self-regulation), as well as lower school adjustment problems (i.e., social exclusion, victimization, and preparation behavior) than other mental health groups. Based on the findings of this study, the integration of the strength-based approach with the traditional mental health model may provide significant implications for research and practice in developing prevention and intervention strategies for children and adolescents in school settings.

Method

Participants

Participants of the study included 362 students enrolled in Grades 5–8 in a public elementary school in an urban city in Turkey. Students were 47.8% female and 52.2% male with

ages ranging from 10 to 14 years ($M = 12.13$, $SD = .96$). The self-reported socioeconomic status (SES) of the participants were: low SES = 22.5%, medium SES = 42.1%, and upper SES = 35.4%. School administrators and participants were presented with a consent form indicating the study purpose and measures. A paper-pencil survey created using study measures and demographic questions was then administered to the students during free time. The survey was completed in approximately 35 min.

Measures

School Belongingness Scale (SBS) Student school belonging was measured using the SBS (Arslan and Duru 2017) which is a 10-item self-report instrument developed to measure sense of belonging at school in Turkish students. The SBS is comprised of two subscales: social acceptance (e.g., “*I think that people care about me in this school*”) and social exclusion (e.g., “*In this school, my friends, teachers, and managers usually ignore me*”). Previous research indicated that the scale had excellent psychometric properties, strong internal reliability (α range = .83–.86), and convergent validity criterion variables (Arslan and Duru 2017). In this study, descriptive statistics and the internal reliability of the scale are presented in Table 1.

School Attitude Assessment Survey (SAAS) The SAAS (McCoach and Siegle 2003) is a 35-item self-report scale developed to measure students’ school-specific abilities. The survey is comprised of five subscales: academic self-perception (ASP), attitudes toward school (ATS), attitudes toward teachers (ATT), motivation/self-regulation (MSR), and goal valuation (GV; e.g., “*I concentrate on my schoolwork*”, “*I complete my schoolwork regularly*”; McCoach and Siegle 2003). All items are arranged along a

7-point Likert scale (1 = *strongly disagree* to 7 = *strongly agree*). Balkis and Arslan (2016) examined the psychometric properties of SAAS for use with high school adolescents in Turkey. The outcomes confirmed the five-factor structure of the scale, indicating that the measure had good data model fit and adequate-to-strong internal reliability. Given the characteristics of sample in the previous study (Balkis and Arslan 2016), the technical adequacy of the SAAS was examined using the present sample to enhance the scale’s usability for both research and practice in elementary school children. Confirmatory factor analysis outcomes, which structured the 28 observed SAAS items as indicators of five latent constructs, provided adequate data–model fit statistics ($\chi^2 = 919.678$, $df = 345$, $p < .001$, $TLI = .90$, $CFI = .92$, $RMSEA [90\% CI] = .068 [.63, .73]$). The SAAS and its scales had strong factor loadings (ASP λ range = .61–.81; ATS λ range = .81–.88; ATT λ range = .48–.83; MSR λ range = .65–.82; GV λ range = .75–.84), and internal reliability coefficients (SAAS $\alpha = .96$; Scales α range = .80–.89). Findings from these analyses provide further evidence indicating that the SAAS could be used to assess student and school-specific abilities in elementary school children. Descriptive statistics are presented in Table 1.

Social and Emotional Health Survey–Primary (SEHS-P) The SEHS-P (Furlong et al. 2013) is a 16-item self-report scale developed to assess youth positive psychological traits at school: optimism, persistence, gratitude, and zest (e.g., “*I am lucky to go to my school*”, “*I get really excited about my school projects*”, “*I finish all my class assignments*”). All scale items are responded to using a 4-point response scale, ranging from 1 = *almost never* to 4 = *very often* (Furlong et al. 2013). Previous research indicated that the scale had an adequate-to-strong internal reliability and concurrent validity with criterion variables with Turkish student samples (Arslan 2019a; Telef

Table 1 Observed scale characteristics

Scales	Mean	Std. Deviation	Skewness	Kurtosis	α
Social emotional health	52.46	7.69	−.72	.27	.87
Psychological distress	16.49	5.20	1.12	1.29	.83
Prosocial behavior	14.58	1.68	−1.22	.88	.67
Academic achievement	4.20	.86	−.71	−.54	–
Social acceptance	15.62	3.32	−.72	−.12	.85
Academic self-perceptions	28.81	5.42	−1.14	1.32	.85
Attitudes toward teachers	29.44	5.67	−1.63	3.17	.82
Attitudes toward school	31.33	6.13	−2.35	1.75	.88
Motivation/self-regulation	45.07	9.28	−1.37	2.27	.89
Goal valuation	32.89	4.27	−1.60	1.01	.80
Social exclusion	7.63	2.30	1.14	1.49	.89
Victimization	7.76	3.31	1.49	1.56	.78
Perpetration	6.93	2.49	1.61	2.49	.70

2016; Telef and Furlong 2017). Descriptive statistics and internal reliability of the scale with the present sample are presented in Table 1.

Student Prosociality Scale (SPS) The SPS is a 4-item self-report scale developed to measure prosocial behavior within school settings in children and adolescents (e.g., “*I help other kids who seem to be having a hard time*”, “*I am kind to my friends at school*”; Renshaw 2014). All items are scored using a 4-point Likert-type scale (1 = *almost never*, to 4 = *almost always*). Previous research has demonstrated that the scale has adequate latent construct and internal reliability in Turkish students (Arslan and Tanhan 2019). For this sample, descriptive statistics and internal reliability of the scale are presented in Table 1.

Youth Internalizing Behavior Screener (YIBS) The YIBS was developed as a 10-item scale for measuring youth emotional problems (Arslan 2020). The scale is comprised of two five-item subscales: depression and anxiety (e.g., “*I feel depressed and pessimistic*”, “*I generally feel tense and anxious*”). All items are scored using a 4-point Likert-type scale, ranging from *almost always* (4) to *almost never* (1). The scale had strong internal reliability and concurrent validity with criterion variables (Arslan 2020). Descriptive statistics and internal reliability of the scale in this study are presented in Table 1.

Bullying Experiences Scale (BES) The BES is an 8-item self-report measure developed to assess perpetration and victimization behaviors in adolescents (e.g., “*During the past month, how often have you been threatened with injury?*”). All items are scored using a 4-point Likert scale (1 = *never* to 4 = *4 or more times*). The two-factor structure of the BES had adequate internal reliability coefficients (perpetration $\alpha = .78$ and victimization $\alpha = .70$; Arslan 2019b). In the present study, descriptive statistics and internal reliability of the scales are presented in Table 1.

Self-Report Academic Achievement (SAA) Youth academic achievement was measured using a single-item scale (WestEd 2017; “*During the past year, how would you describe the grades you received in school?*”). The scale was scored using a 5-point grade-range response scale (1 = *mostly 0–44*, 2 = *mostly 45–54*, 3 = *mostly 55–69*, 4 = *mostly 70–84*, 5 = *mostly 85–100*). Higher scores refer to higher levels of academic achievement by students. For the present sample, descriptive statistics of the measure are presented in Table 1.

Data Analyses

Prior to examining the primary analyses, observed scale characteristics were investigated to understand the nature and

distribution of the study variables. Skewness and kurtosis and their cut-off scores were used to examine the normality assumption (Kline 2005a, 2005b). Pearson product-moment correlation analysis was conducted to investigate the associations between the variables of the study. Participants were classified according to their levels of psychological distress and wellbeing. High psychological distress was determined using the cut-off scores of the YIBS. A cutoff score of 23 is suggested to identify youth who are at risk for clinical-level internalizing problems (Arslan 2020). Composite scores of the SEHS-P were used to classify participants according to two levels of wellbeing: high wellbeing (total scores ≥ 48) and low wellbeing (total scores ≤ 47 ; see Furlong et al. 2013). Consistent with the methodological approach utilized in previous research (e.g., Arslan 2018b; Keyes 2009; Suldo et al. 2016), participants were classified into four groups based on their scores for psychological distress (YIBS) and wellbeing (SEHS-P): complete mental health (low psychological distress + high wellbeing), vulnerable mental health (low psychological distress + low wellbeing), troubled mental health (high psychological distress + low wellbeing), and symptomatic-but-content mental health (high psychological distress + high wellbeing). A series univariate analysis of variance (ANOVA) was performed to investigate the differential effects of mental health status on youth school functioning and adjustment. Moreover, post hoc analyses using a Bonferroni adjustment were conducted to compare the mental health groups across school-based quality-of-life outcomes. All data analyses were conducted using SPSS version 25.

Results

Descriptive Statistics and Intercorrelations

Findings from observed scale characteristics revealed that all variables had relatively normal distribution (skewness and kurtosis scores $\leq |3|$; see Table 1) and adequate-to-strong internal reliability coefficients with the present sample (α range = .67-to-.89). Correlation analysis results showed small-to-large associations between social-emotional health and positive school outcomes (i.e., academic achievement, social acceptance, prosocial behaviors, academic self-perceptions, attitudes toward teachers/school, motivation/self-regulation, and goal valuation), while small-to-moderate relationships have been found between social-emotional health and negative school outcomes (i.e., social exclusion, victimization, and perpetration). Moreover, there were significant and small-to-moderate negative associations between psychological distress, social-emotional health, and school outcomes (see Table 2).

Table 2 Bivariate correlations between variables

Scales	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.
1. Social emotional health	–												
2. Psychological distress	-.49**	–											
3. Academic achievement	.27**	-.27**	–										
4. Prosocial behavior	.53**	-.32**	.11*	–									
5. Social acceptance	.49**	-.44**	.24**	.32**	–								
6. Academic self-perceptions	.44**	-.48**	.33**	.41**	.35**	–							
7. Attitudes toward school	.50**	-.36**	.10	.39**	.38**	.44**	–						
8. Motivation/self-regulation	.63**	-.41**	.30**	.42**	.27**	.67**	.57**	–					
9. Attitudes toward teachers	.46**	-.28**	.19**	.30**	.31**	.52**	.61**	.60**	–				
10. Goal valuation	.34**	-.17*	.18**	.31**	.21**	.57**	.64**	.64**	.56**	–			
11. Social exclusion	-.24**	.40**	-.14*	-.27**	-.47**	-.27**	-.30**	-.19**	-.25**	-.21**	–		
12. Victimization	-.27**	.43**	-.14*	-.30**	-.23**	-.24**	-.22**	-.26**	-.20**	-.19**	.23**	–	
13. Perpetration	-.36**	.26**	-.11*	-.35**	-.10	-.16*	-.26**	-.29**	-.22**	-.17*	.09	.48**	–

Note. * $p < .05$, ** $p < .001$

Primary Analyses

Primary analysis outcomes demonstrated that the largest proportion of the participants was classified into the complete mental health group ($n = 246, 68\%$), followed by vulnerable ($n = 59, 16.3\%$), troubled ($n = 30, 8.3\%$), and symptomatic-but-content groups ($n = 27, 7.5\%$). Prevalence rates for mental health groups derived from the psychological distress and wellbeing are presented in Table 3.

A series of univariate analysis of variance was conducted to compare the effect of mental health status on youth school outcomes. Overall univariate ANOVA outcomes yielded a significant main effect of mental health status for all of the school functioning and adjustment outcomes: social acceptance ($F = 27.29, p < .001, R^2 = .19$), prosocial behavior ($F = 30.08, p < .001, R^2 = .20$), academic achievement ($F = 6.82, p < .001, R^2 = .06$), academic self-perceptions ($F = 24.01, p < .001, R^2 = .17$), attitudes toward teachers ($F = 18.40, p < .001, R^2 = .14$), attitudes toward school ($F = 37.17, p < .001, R^2 = .24$), motivation/self-regulation ($F = 45.10, p < .001, R^2 = .28$), goal valuation ($F = 8.05, p < .001, R^2 = .06$), social exclusion ($F = 14.73, p < .001, R^2 = .11$), victimization behavior ($F = 26.05, p < .001, R^2 = .18$), and perpetration behavior ($F = 14.19, p < .001, R^2 = .11$), ranging from moderate to large effect size (see Table 4).

Post hoc comparisons using a Bonferroni adjustment showed that participants in the complete mental health group had significantly higher positive school outcomes, with the exception of academic achievement (i.e., social acceptance at school, prosocial behavior, academic self-perceptions, attitude toward teachers and school, goal valuation, and motivation/self-regulation) than the vulnerable and troubled adolescents. Cohen’s d effect sizes ranged from .581 for goal valuation to 1.919 for attitude toward school. For academic achievement, youths with complete mental health reported greater academic achievement than their peers in troubled mental health group, with moderate effect size (Cohen’s $d = .77$). Complete mental health adolescents also had significantly higher social acceptance, prosocial behaviors, and academic self-perceptions than the symptomatic-but-content youth, with effect sizes of .78, .80, and 1.07, respectively. Moreover, the troubled group had lower attitude toward teacher, attitude toward school, and motivation/self-regulation than the symptomatic-but-content group. Cohen’s d effect sizes ranged from 1.03 for attitude toward teacher to 1.33 for motivation/self-regulation. The symptomatic-but-content group also had higher motivation/self-regulation than the vulnerable group, with effect sizes of .86, respectively. Finally, troubled youth reported lower attitudes toward school than adolescents in the vulnerable group (d effect size = .77), see Table 5.

Table 3 Complete mental health groups

	Psychological Distress		Wellbeing	
	Low	High	Low	High
Low	Vulnerable ($n = 59, 16.3\%$)		Complete mental health ($n = 246, 68\%$)	
High	Troubled ($n = 30, 8.3\%$)		Symptomatic-but-content ($n = 27, 7.5\%$)	

Table 4 Youth school outcomes and mental health status

School adjustment outcomes	Mental health status									
	Complete mental health		Vulnerable		Troubled		Symptomatic– but–content		ANOVA	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>F</i>	<i>R</i> ²
Social acceptance	16.54	2.94	14.34	2.78	12.00	3.98	14.75	2.72	27.29**	.19
Prosocial behavior	15.09	1.21	13.35	1.84	13.33	2.32	14.03	1.95	30.08**	.20
Academic achievement	4.34	.79	4.01	.86	3.70	1.05	4.03	.93	6.82**	.06
Academic self-perceptions	30.29	4.69	26.44	4.94	24.41	6.08	25.18	5.99	24.01**	.17
Attitudes toward teachers	30.60	5.04	26.66	5.75	24.31	7.08	30.38	4.08	18.40**	.14
Attitudes toward school	32.98	4.37	28.73	5.92	22.68	9.43	31.11	6.49	37.17**	.24
Motivation/self-regulation	47.99	7.50	38.42	8.68	33.60	10.38	45.38	6.64	45.10**	.28
Goal valuation	33.46	4.08	31.05	4.47	30.96	5.16	33.88	2.47	8.05**	.06
Social exclusion	7.19	2.11	7.79	1.89	9.27	2.86	9.40	2.56	14.73**	.11
Victimization	6.94	2.50	8.28	3.10	10.43	4.07	11.18	5.06	26.05**	.18
Perpetration	6.38	1.94	8.37	3.10	7.76	3.13	7.85	3.00	14.19**	.11

Note. ** $p < .001$

In addition, post hoc comparisons indicated that adolescents in the complete mental health group had significantly lower social exclusion at school and lower victimization behavior than the troubled and symptomatic-but-content adolescents, with effect sizes ranging from .94 to 1.49. Furthermore, vulnerable youth had significantly higher victimization and perpetration behavior than complete mental health adolescents, with effect sizes of .51 and .90, respectively (see Table 5). Vulnerable adolescents also reported lower social exclusion and victimization behavior than symptomatic-but-content youth, with effect sizes of .76 and .76, respectively.

Discussion

In the current study, the largest number of participants (68%) was identified as having complete mental health, which was characterized by high psychological wellbeing and low psychological distress. This result was consistent with previous studies conducted in Western countries, including Australia, Canada, and the U.S. (e.g., Antaramian et al. 2010; Lyons et al. 2012). For example, most complete mental health studies reported that the largest group of students, approximately 43%–67%, was classified into the complete mental health group. However, mixed results were found for the other three mental health groups. Some reported similar prevalence rates across the three (e.g., Suldo and Shaffer 2008), whereas others reported symptomatic-but-content or troubled as the second largest (e.g., Antaramian et al. 2010; Lyons et al. 2012; Venning et al. 2013). The current study found 16% vulnerable, 8% troubled, and 7% symptomatic-but-content students, indicating that about 15% of students had high psychological

distress and that 7% of those students still reported having high psychological strength. These findings suggest that the presence of psychological distress does not equate to the absence of psychological wellbeing, providing additional evidence for the multidimensional approach of mental health.

Post hoc comparisons were conducted to assess the mental health groups' school functioning and adjustment. Results confirmed the hypothesis that the complete mental health group performs better in school and that the troubled group performs worse in comparison to the other groups. Specifically, the results demonstrated that the complete mental health group felt more connected to their school, had higher levels of positive attitude towards teachers and school, showed more prosocial behaviors, and had better academic performance, academic self-perceptions, motivation, and academic-related goals, as well as reported less bullying and victimization in school than other groups. Consistent with previous studies investigating the influence of the complete mental health model in youths (Arslan 2018b; Antaramian et al. 2010; Suldo et al. 2016; Suldo and Shaffer 2008), these outcomes emphasize the importance of improving psychological wellbeing and reducing psychological distress among youth. For example, Suldo et al. (2011) investigated the longitudinal utility of the complete mental health model in predicting student educational functioning, and found that youth with complete mental health reported better academic functioning and greater school attendance when compared with other mental health groups. In addition, the complete mental health group was significantly less likely to engage in bullying than any other groups, whereas engagement in bullying behaviors in the other three groups was not significantly different. Complete mental health adolescents reported

Table 5 Post hoc comparisons on school adjustment and functioning among the mental health groups

School outcomes	Group comparison		<i>d</i>
Social acceptance	Complete mental health	Symptomatic–but–content	.78
		Vulnerable	.75
		Troubled	1.47
Prosocial behavior	Vulnerable	Troubled	.72
		Complete mental health	.80
		Symptomatic–but–content	1.27
Academic achievement	Complete mental health	Troubled	1.27
		Symptomatic–but–content	.77
		Vulnerable	1.06
Academic self-perceptions	Complete mental health	Troubled	.81
		Symptomatic–but–content	1.21
		Vulnerable	1.21
Attitudes toward teachers	Complete mental health	Troubled	.76
		Symptomatic–but–content	1.19
		Vulnerable	1.03
Attitudes toward school	Complete mental health	Troubled	.91
		Symptomatic–but–content	1.92
		Vulnerable	1.07
Motivation/self-regulation	Complete mental health	Troubled	.77
		Symptomatic–but–content	1.24
		Vulnerable	1.83
Goal valuation	Complete mental health	Troubled	.86
		Symptomatic–but–content	1.33
		Vulnerable	.58
Social exclusion	Complete mental health	Troubled	.59
		Symptomatic–but–content	–1.02
		Vulnerable	–.94
Victimization	Complete mental health	Symptomatic–but–content	.76
		Symptomatic–but–content	–1.47
		Vulnerable	–.51
Perpetration	Complete mental health	Troubled	–1.29
		Symptomatic–but–content	.76
		Vulnerable	–.62
			–.90

Note. *d* = Cohen's *d* effect size

significantly lower social exclusion at school and victimization behavior than the troubled and symptomatic-but-content adolescents. Furthermore, vulnerable youth had significantly higher victimization and perpetration behavior than complete mental health adolescents. While complete mental health is not the only variable affecting a student's wellbeing, functioning, and adjustment to school, these outcomes suggest the importance of both building psychological wellbeing and treating psychological distress among school-aged students in order to optimize their school adjustment and functioning.

The traditional deficit-based screening approach by definition fails to identify vulnerable (low symptoms and low wellbeing) and symptomatic-but-content (high symptoms and high wellbeing) groups. Consequently, only a few

recent studies have investigated whether members of the vulnerable group or the symptomatic-but-content group demonstrate better school adjustment and functioning, particularly academic performance (e.g., Antaramian et al. 2010; Suldo and Shaffer 2008). The current study examined more diverse aspects of school functioning, including school belongingness, school attitude, prosocial behaviors, bullying and victimization in school, and academic performance. According to this study's findings, the symptomatic-but-content group was significantly more socially excluded and victimized, but had significantly better positive attitude towards teachers, motivation, and goal valuation than the vulnerable group. These findings may suggest that, despite experiencing adverse experiences

(i.e., social exclusion and victimization), members of the symptomatic-but-content group were better equipped with psychological wellbeing and were more likely to maintain a positive attitude in school settings than members of the vulnerable group who reported significantly lower social exclusion and victimization. Students who are content despite exclusion and victimization may have the resources needed to separate common correlated effects. For example, a child who experiences exclusion and bullying with strong family support may be insulated from the demotivating effects that could be experienced by others (Arslan 2018c; McDougall and Vaillancourt 2015; Rothon et al. 2011). Alternatively, the findings could be explained by potentially flawed perceptions of social exclusion and victimization as mere symptoms of mental ill-health that are related to the cognitive distortions and negative thinking associated with depression and anxiety (Pontillo et al. 2019). Taken together, the outcomes may signal the fact that a single student's experience of school is diverse and multifaceted (Allen et al. 2018c). Socioecological perspectives demonstrate that children are subject to multiple layers of influence within school settings. For example, relationships with their peers, teachers, and parents, students' own personal psychological assets, the context in which they attend school, and school features that steer practices such as policy, capabilities of teachers, and priorities of school leaders (Allen et al. 2018a, 2018b; Allen et al. 2016). Taken together, the results of the present study reiterate the critical role of social and emotional health in improving students' general school functioning adjustment.

Limitations and Implications for Researchers and Practitioners

The present study has limitations that suggest directions for further research and practice. First, student school adjustment was evaluated on the basis of self-reported data, which is often susceptible to social desirability bias. Future studies may collect data from multiple informants, including teachers, parents, and students themselves, to obtain a complete picture of students' school outcomes. Another area of limitation is the lack of diversity in the current sample. Larger and more diverse participant samples (e.g., high school students, undergraduate students) are needed to improve the generalizability of the findings. Future research should seek to explore diverse populations, subgroups, and cultures to genuinely assess the universality of the present findings. One critical area for future research may see this body of work applied to preschool students in order to pave a way for support and intervention in a child's life as early as possible. Additionally, student school outcomes not only result from a child's individual factors, but are often influenced by different layers of the child's

ecological systems. Therefore, potential moderating and mediating factors from family, school, and community environments should be further explored to develop comprehensive plans to help students thrive in schools.

This study offers an initial attempt at identifying the relationship between mental health groups and school functioning among elementary school students in Turkey. The findings of this study suggest the importance of identifying both psychological distress and wellbeing for understanding students' overall adjustment and functioning in school settings. Students' psychological symptoms and wellbeing were uniquely associated with different types of school functioning. Negative school outcomes such as social exclusion and bullying and victimization behaviors were better explained by psychological distress, whereas positive outcomes, such as goal valuation, positive attitude toward teachers, and academic motivation, were more strongly associated with psychological wellbeing. Thus, a complete mental health screening approach can contribute to accurately assessing a child's wellbeing and also the early identification of students with different levels of needs and to the development of appropriate policy, practices, and interventions to promote students' healthy adjustment and functioning in schools, prevent mental health problems, and promote psychological health and wellbeing.

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Compliance with Ethical Standards

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