Exploring Primary School Teachers' Perspectives on the Mental Health Education for Primary School Children

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ABSTRACT

The quality of mental health education for primary school students is closely related to teachers' ability to judge students' emotional changes, peer relationships, and family influences. This article, based on semi-structured interviews with 36 primary school teachers from six primary schools in Jinan City, uses the phenomenological qualitative research approach to analyze teacher role positioning, educational challenges, and improvement strategies. The participants included head teachers, subject teachers, PE and arts teachers, and teachers with mental health education experience, which helped present more diverse school-based perspectives. It is found that teachers in daily teaching undertake responsibilities such as emotion recognition, class adjustment, and home-school communication. However, problems such as unclear role boundaries, insufficient professional training, detached course activities, and weak support chains make it difficult for mental health education to be stably integrated into students' real lives. Primary school mental health education should further clarify the list of teachers' responsibilities, establish a hierarchical training and early identification process, integrate psychological support into classroom interactions, class management, and home-school communication, and rely on school-based psychological teachers, parent education, and external professional resources to form a continuous support network. These findings should be understood as context-specific qualitative insights that may inform school-based mental health education practice rather than as statistically generalizable conclusions.

Keywords: Primary school teachers; Primary school students; Mental health education; Teacher perspective; Support system

INTRODUCTION

Mental health problems of primary school students often manifest in details such as classroom behavior, peer interactions, homework responses, and emotional expressions.

As the most frequent adults in the school environment, teachers often undertake the responsibilities of early observation, initial soothing, and home-school communication. As school mental health education continues to enter the curriculum, class meetings, counseling, and activity scenarios, the tasks faced by teachers have extended from knowledge teaching to the identification and support of children's psychological states.

Whether teachers possess stable mental health knowledge, confidence in identification, and communication skills directly affects whether students' psychological problems can be detected in time and receive appropriate

responses [1]. From the perspective of teachers, mental health education for primary school students can present practical obstacles and school-based improvement directions more clearly.

The Realistic Positioning of Teachers' Roles in Primary School Students' Mental Health Education

Emotional Identifier in Daily Observations

Most psychological difficulties among primary school students are not expressed in clear language. They are often hidden in classroom eye contact, hesitation in answering questions, delayed homework, withdrawal during breaks, avoidance of peers, or sudden tearfulness. Teachers' daily observations thus become the earliest point of identification. In continuous situations such as classroom teaching, homework feedback, classroom inspection, and individual conversation, teachers can notice whether a student's emotional change is temporary or has developed into a persistent abnormal state. Continuous silence, frequent absence, loss of interest in group activities, and excessive tension when facing evaluation may indicate academic, interpersonal, or family pressure.

This identification does not require teachers to undertake professional diagnostic responsibilities. Their role is to observe steadily, describe accurately, and record promptly, so that vague impressions such as "something seems wrong" can be converted into specific manifestations, duration, and triggering circumstances. These records provide clearer clues for communication among subject teachers, homeroom teachers, school counselors, and parents, and help early support move from personal intuition to traceable evidence [2].

Relationship Adjuster in Classroom and Peer Life

Classroom and peer life is a concentrated field in which students' psychological states become visible. Peer acceptance, seating arrangements, group division, classroom evaluation, and class interaction all affect children's sense of security and belonging. Teachers maintain classroom order, and they also shape students' relationship experiences through daily decisions. Treating peer rejection, boundary-crossing jokes, unbalanced cooperation, or competition anxiety only as discipline issues may obscure the shame, frustration, and isolation behind students' behavior.

A more appropriate response is to turn conflict into a process of expression, listening, negotiation, and repair. Teachers may guide students to explain feelings, reconstruct what happened, confirm responsibility, and then arrange peer support or group reorganization. Classroom evaluation also has psychological significance. Reducing single performance-based comparison and increasing attention to effort, cooperation, emotional management, and responsibility can give low-achieving or introverted students more opportunities to be noticed. In this sense, classroom rules carry both order and emotional support [3].

Information Connector in Communication Between Home and School

Students' emotions at school are often connected with family expectations, parent-child communication, sleep schedules, electronic device use, and the quality of companionship. Teachers hold school-based observations, while parents hold family-based information. When these two sources remain separated, psychological support may easily become scattered reminders. In communication with parents, teachers need to avoid stimulating judgments such as "the child has a problem" and use verifiable behavioral descriptions instead, such as "reduced classroom participation in the past week," "often staying alone during breaks," "long silence after criticism," or "increased conflicts with fixed peers."

Such descriptions help parents understand what has actually happened at school and provide space for checking recent changes in family routines, parent-child disputes, or cumulative learning pressure. Teachers can then bring family clues back into classroom support and connect students, parents, homeroom teachers, and school

counselors. This role allows mental health education to move from a single conversation to continuous follow-up, while reducing misunderstanding between school observation and family response [4].

The Realistic Challenges Faced by Primary School Teachers in Participating in Mental Health Education

Unclear Role Boundaries

The role of primary school teachers in mental health education has stretched beyond subject teaching, class management, homework feedback, and communication with parents. In daily school life, teachers also face students' sudden tearfulness, silence, withdrawal, refusal to enter the classroom, and peer conflicts, while taking on emotional soothing, preliminary risk judgment, and parent coordination. In the interview narratives of 36 teachers, expressions such as "caretaker," "bridge," and "temporary firefighter" appeared repeatedly, showing that teachers often step in before professional support becomes available. For example, when a student refused to enter the classroom for several days because of peer exclusion, the subject teacher first noticed the abnormal response, and the homeroom teacher then comforted the student and contacted the parents. Teachers had to observe emotions, judge risk, coordinate peer relations, and respond to parents' expectations, which turned unclear boundaries into lasting tension [5].

Insufficient Recognition Ability

Teachers are usually sensitive to changes in students' classroom behavior, yet early support is often limited by the lack of a usable identification framework. Among the 36 teacher participants, 18 had received training related to mental health education, while 6 of them had only attended short workshops or school-based lectures. This uneven preparation led teachers to interpret similar signals differently. Delayed homework, long silence after being called on, putting the head on the desk during class, or avoiding group activities might be read as poor learning attitude by some teachers, while others might continue to check sleep, family pressure, exam anxiety, or peer exclusion. The difficulty lies in the gap between general awareness and practical judgment tools. Without observation sheets, conversation outlines, risk classification examples, and case-based practice, teachers may remain caught between noticing abnormalities and making uncertain judgments [6].

Suspension of Course Activities

Primary school mental health education is often carried out through theme classes, psychological lectures, publicity boards, group games, and reflection records. Although these activities appear complete in form, students' real experiences may remain outside the educational process. In the interviews, some teachers described mental health activities as "islands" separated from classroom life, because many activities focused on completing materials and records around fixed themes, while giving limited attention to peer conflicts, exam frustration, family expectations, and self-denial in students' daily lives. For example, during a "Sunshine Psychology" theme week, students watched videos, created posters, and filled out forms, yet class evaluation after the activity still centered on scores, rankings, and discipline. Students' anxiety, shame, loneliness, and hesitation to seek help were not continuously addressed.

Weak Support Chain

When teachers notice abnormal student behavior, they often face a weak chain of support from identification to follow-up. Some schools have counseling rooms or mental health education positions, but full-time staff remain limited, and part-time arrangements are common. Procedures for consultation appointments, risk assessment, parent communication, external referral, and follow-up are often unclear. Teachers from different school types reported similar difficulties, although the shortage of resources varied across schools. For example, when a student stayed alone during breaks for two consecutive weeks, spoke less in class, and had more conflicts with

regular peers, parents might interpret the situation only as weak learning motivation and ask teachers to strengthen supervision. Without a clear school entry point, the homeroom teacher could only continue observation and conversation, making professional assessment and continuous follow-up difficult.

Improving Paths for Primary School Teachers' Participation in Mental Health Education

Clarify the Responsibility List and Define Support Boundaries

Schools should divide teachers' responsibilities in mental health education into four clear tasks: daily observation, fact recording, preliminary communication, and professional transfer. Subject teachers focus on changes in classroom behavior, homework rhythm, peer interaction, and emotional expression. Homeroom teachers handle individual conversations, home-school verification, and class support arrangements. School counselors take charge of professional assessment, individual counseling, and risk judgment, while grade groups coordinate peer conflicts, parent communication, and resource allocation. This list should be printed as a one-page flowchart and placed in teachers' offices, grade group rooms, and counseling rooms, so that teachers know whom to contact and what materials to prepare when student support is needed [7].

A supporting form named the "Student Psychological Attention Record Sheet" may include student name, class, observation date, behavior change, duration, triggering situation, classroom state, peer relationship, homework changes, previous communication, and transfer suggestions. The form should guide teachers to write observable facts rather than personal judgments. In one interview case, a quiet and withdrawn girl gradually began to share her drawings with her teacher and later spoke up in a group discussion. Such a case shows that early records should include small but meaningful changes, such as eye contact, voluntary sharing, participation in group tasks, and willingness to speak.

Another case involved a student under heavy exam pressure. The teacher first talked with the parents, then referred the student to the counselor, who taught relaxation techniques. After referral, the teacher did not replace the counselor's work. Instead, she set smaller daily Chinese-learning goals, checked the student's feelings each morning, allowed short breaks during class, and communicated weekly with the counselor and parents. This division shows how teachers can continue classroom support after referral while keeping professional assessment within the counselor's role.

Conduct Layered Training to Enhance Identification Skills

Schools should arrange teacher training as a semester-based schedule rather than occasional lectures. In September, all teachers receive a 60-90-minute basic session on common emotional and behavioral signals, including low mood, exam anxiety, peer rejection, classroom withdrawal, impulsive aggression, and long-term homework interruption. In October and November, homeroom teachers attend two 90-minute case-based sessions on individual conversation, parent verification, risk classification, and material transfer. Before mid-term and final examinations, subject teachers receive 30-40-minute short sessions on exam anxiety and classroom pressure responses. Each session should leave one practical product, such as a revised observation sheet, a parent communication script, or a case review note, so that training results return to daily teaching rather than remain as attendance records [8].

Training content should also be linked with subject scenes. Chinese teachers may use reading responses to notice how students describe failure, loneliness, and conflict; English teachers may observe avoidance of public speaking in role dialogue; physical education teachers may identify withdrawal, irritability, or excessive tension during team cooperation, waiting turns, and failure feedback. After each training, teachers receive a one-page identification card and a 3-minute conversation outline. The card lists signal type, observation cycle, low-risk response phrases, and transfer conditions, while the outline includes questions such as "What made you nervous

recently?" and "Has this affected your sleep or eating?"

One participating school had already embedded mental health training into its teaching calendar. Before examination weeks, the school counselor worked with Chinese and English teachers to prepare short classroom scripts on pressure expression; after sports competitions, PE teachers used a three-item observation note to record students' emotional recovery, peer response, and willingness to rejoin group tasks. Every two weeks, the counselor selected 1-2 anonymous cases for a 30-minute review, helping teachers adjust judgment, refine follow-up questions, and keep records in a shared format.

Integrate into Daily Classes and Restructure Activity Scenarios

Mental health education in daily classes should rely on short and repeatable tasks around emotional expression, stress identification, peer support, and help-seeking practice. These tasks do not require additional independent courses; they may be embedded into existing Chinese, English, physical education, and class meeting periods. In Chinese classes, teachers may use an "event-feeling-cause-response" card after reading narrative texts, asking students to identify emotional clues from characters' language, actions, and inner descriptions, then write one sentence about a similar pressure in their own lives. In English classes, short dialogues around words such as "nervous," "worried," "angry," "lonely," and "help" may guide students to complete the chain of describing emotions, expressing needs, and responding to peers. In physical education classes, 30 seconds of peer affirmation after relay races or team challenges helps students name effort, cooperation, and persistence [9].

One participating school had already placed such tasks into its weekly teaching rhythm. The Chinese teaching group used a "mood line" worksheet after story reading, asking students to mark changes in a character's feelings and then choose one sentence to describe their own recent pressure. The English group designed two-minute help-seeking dialogues before role-play activities, while PE teachers used a three-item note after team games to record whether students could accept failure, encourage teammates, and return to group tasks. These practices kept mental health education close to ordinary lessons and avoided turning it into a separate activity week.

At the class level, teachers may set fixed but lightweight routines. A 5-minute emotional check-in every Monday allows students to mark their state with color cards or word cards, while the homeroom teacher only collects frequent emotional words and unusual changes. Once a month, class relationship discussions may use scenario cards such as "how to explain a misunderstanding," "how to respond after being rejected," and "how to divide work in group cooperation." After each phased test, a 10-minute stress review asks students to write down the task they worry about most, one step they have completed, and the person whose support they need.

Connect Referral Channels and Link with Home-School Resources

Schools should divide student mental health support into six steps: teacher discovery, homeroom teacher review, school counselor assessment, parent communication, external support, and follow-up tracking. Each step needs clear time limits and required materials. When a subject teacher notices persistent withdrawal, frequent tearfulness, escalating peer conflict, or delayed classroom response, an observation record should be completed within 24 hours. The homeroom teacher then conducts a low-pressure conversation within 48 hours to check recent learning, peer, and family stress. The school counselor reviews the record within 72 hours and decides whether the student needs individual counseling, group support, or external professional consultation. The scope of informed staff should remain limited to protect the student from labeling pressure [10].

Schools with limited counseling resources may build the referral channel in stages. In the first stage, subject teachers and homeroom teachers use the same observation form and submit key cases to the grade group. In the second stage, the school counselor reviews selected cases once a week and gives written suggestions on follow-up communication, classroom support, or parent contact. In the third stage, the school gradually builds a referral

contact list with nearby hospitals, community service centers, and professional counseling institutions. This staged arrangement reduces the pressure of building a complete support system at once and helps schools move from informal conversations to traceable support.

One school had already used a simple "weekly case review" practice. Every Friday afternoon, homeroom teachers submitted brief records of students who showed repeated withdrawal, peer conflict, or exam-related anxiety. The counselor selected two cases for review and gave feedback on conversation wording, parent communication, and classroom adjustment. Parent communication followed the sequence of fact description, joint verification, family observation, and follow-up agreement. For students needing continuous attention, an individual student record form included observation date, contact person, support measures, parent feedback, review time, and referral entry.

CONCLUSION

The focus of primary school mental health education lies in students' real school life. From the teacher's perspective, classroom observation, peer relationships, communication between home and school, and professional support are closely connected with students' emotional safety and help-seeking opportunities. Teachers undertake early identification and initial support, and their work requires clear role boundaries, practical training, daily classroom integration, and continuous referral channels. Although the sample was expanded to include 36 teachers from six primary schools, the findings should still be understood as context-specific qualitative insights rather than statistically generalizable conclusions. Future studies may include teachers from different provinces, school systems, and rural-urban settings, and may further examine the feasibility of these strategies through school-based case studies, pilot programs, and long-term tracking of student support outcomes.

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