Frontiers in Economics and Management Volume 6 Issue 11, 2025
ISSN: 2692-7608 DOI: 10.6981/FEM.202511_6(11).0025

A Five-Level Synergistic Psychological Safety Network: A Case Study on Mental Health Education for a Student with Severe Depression

Ling Qiao[1,2]

[1] Department of Student Affairs, Sichuan Vocational College of Information Technology, Guangyuan 628017, China

[2] Visual Computing and Virtual Reality Key Laboratory of Sichuan Province, Sichuan Normal University, Chengdu 610068, China

Abstract

This paper summarizes the full process of psychological intervention for a student with severe depression at a vocational college. Through early screening and classification, intensive attention, real-time tracking, multi-party collaboration, and timely intervention, the crisis was effectively prevented, leading to the establishment of a comprehensive psychological safety network. Through comprehensive data analysis and market research, Such efforts are crucial for improving students' psychological well-being and enhancing the overall quality of higher education.

Keywords

Vocational College; Severe Depression; Mental Health; Five-Level Synergy.

1. Introduction

In 2023, the Ministry of Education and sixteen other departments jointly issued the Special Action Plan for Comprehensively Strengthening and Improving Students' Mental Health Work in the New Era (2023–2025). The plan requires universities and colleges to offer compulsory mental health courses and to establish a four-level early warning network. By 2024, the coverage rate of mental health courses in higher education institutions had risen from 58% to 89%; psychological committee coverage reached 100%; and 72.3% of students were reported to have a mental health level of "good" or above, marking initial success in policy implementation.[1]

However, according to the 2024 Report on the Mental Health Status of Chinese College Students, 5.2% of college students still meet the clinical screening criteria for depressive or anxiety disorders (PHQ-9 ≥ 10 or GAD-7 ≥ 10). Among adolescents, including college students, the detection rate of depression has reached 24%, meaning that roughly one in five suffers from depressive tendencies or clinical symptoms. Depression has thus become the "number one killer" threatening the mental health of college students.[2]

As a common affective disorder, depression is primarily characterized by intense and persistent sadness, inferiority, anxiety, and irritability. In severe cases, self-harm or suicidal thoughts may occur. These negative emotions seriously disrupt students' normal learning, daily life, and social relationships. In the face of the rising prevalence of depression among college students, it is of great importance for mental health educators to accurately identify depressive symptoms, establish a comprehensive and multi-dimensional early warning system, guide students and parents to approach depression scientifically, and prevent extreme behaviors such as suicide or self-injury. Such efforts are crucial for improving students' psychological well-being and enhancing the overall quality of higher education.[3]

ISSN: 2692-7608 DOI: 10.6981/FEM.202511_6(11).0025

2. Case Introduction

Student A, female, enrolled in September 2024. During the freshman sports meeting in October, she suddenly experienced shortness of breath, body tension, and trembling while waiting in line for the group entrance. The crowded and noisy environment caused her to faint, after which the counselor escorted her to the Psychological Health Education Center.

She reported that since her second year of high school, she had been experiencing persistent low mood, a lack of interest in study and life, hypersensitivity, and suspicion. The condition gradually worsened, severely affecting her daily functioning. In class, she felt tense and suffocated due to the crowd, needing to wear headphones constantly to block external sounds in order to stay calm. She experienced continuous feelings of sadness and fatigue, had difficulty concentrating, and tended to overthink trivial matters, often ending up in tears for no apparent reason. Minor setbacks in life were catastrophized; she attributed her misfortunes to bad luck, seeing herself as inferior and timid.

Although she had entered university, she still could not adapt to the new environment. She did not dare to take a leave of absence or work part-time, fearing she could not handle a new social environment. She self-assessed as having severe social anxiety disorder and was unable to interact normally with strangers. Physical symptoms were also evident: she would suddenly freeze while walking, feeling as if a part of her arm had broken off. Insomnia and irritability recurred, and she had even experienced suicidal thoughts. However, because she still had emotional attachments and responsibilities, she restrained herself from taking any extreme actions.

During the counselor's conversation with her, she appeared distracted and emotionally flat, answering questions in a subdued tone, with visible hand tremors. When speaking about her father, her emotions became agitated, saying that her father was indifferent to her and even wished her dead. When recalling being bullied and ostracized in junior high school, her entire body would start trembling uncontrollably. She once took a leave of absence during junior high after a close childhood friend in the same village, who was also bullied, committed suicide. She felt intense guilt and remorse for not helping her friend at that time, blaming herself for being cowardly and for indirectly contributing to her friend's death. This traumatic event left a lasting psychological scar, and she was later diagnosed with severe depression by a hospital. After receiving medication, her condition stabilized and she returned to school.

Although entering university offered her a new environment, the guilt over her childhood friend's death persisted. The unfamiliar surroundings, complex interpersonal relationships, academic stress, uncertainty about the future, and worsening parent-child conflict all contributed to the recurrence of her symptoms.

Since the age of three, Student A had been raised by her grandparents. Her parents divorced when she was very young, and she lived with her father. Her father later remarried and had two younger sisters and a younger brother. He worked away from home for many years and rarely showed care for her, sometimes failing to send living expenses on time, which strained their relationship and made her unwilling to communicate with him. Her mother left early in her childhood, and she harbors resentment toward her, believing that no one loves or cares for her, which led to self-abandonment.

Growing up under her grandparents' care, with her biological mother absent throughout her upbringing, she developed a timid and self-effacing personality due to long-term emotional neglect. The family's financial hardship further added to her psychological burden. Although her aunt cared about her, she had her own family to look after and could only provide limited financial support. Her father dismissed her mental health issues as "overthinking" and regarded depression as mere pretentiousness, believing that she could recover simply by changing her mindset without the need for medication.

ISSN: 2692-7608 DOI: 10.6981/FEM.202511_6(11).0025

3. Case Analysis

Based on the student's self-report and communication between the school and the family, the causes of Student A's psychological problems can be summarized as follows:

(1) Personality Factors

Student A exhibits a complex and contradictory personality. She is both introverted, withdrawn, and self-abasing, yet at times also self-confident, proud, and stubborn. These conflicting traits manifest alternately-she fears social interaction and struggles with interpersonal relationships, while simultaneously believing she has strong social skills and that her presence can easily attract others' attention. She is emotionally sensitive and prone to overinterpretation, often inferring from others' tone or facial expressions whether they like or dislike her. Negative emotions are catastrophized: minor setbacks are perceived as devastating events that could drag her into an emotional abyss from which she cannot escape.

(2) Early Experiences

She attended a rural middle school where many students were "left-behind children," whose parents worked away from home. The school atmosphere was poor, and groups of problematic students often bullied younger peers. Many victims, lacking family support since they lived with elderly grandparents, dropped out of school. Such an environment instilled in Student A a profound sense of insecurity and constant fear. Long-term exposure to bullying cultivated her timid and avoidant personality, leading her to internalize problems and endure them in silence.

(3) Family Trauma

In Student A's family, communication was ineffective. She grew up in an environment dominated by her father's neglect and her grandparents' harsh discipline. When facing developmental challenges, she did not know whom to turn to for help and received little emotional support. Moreover, due to the generational gap, her grandparents tended to be overly indulgent, giving in to her demands and fostering self-centeredness. As a result, she developed poor communication and social adaptability skills.

(4) Adjustment to University Life

Upon entering university, Student A experienced significant maladjustment in academic, social, and dormitory contexts. The unfamiliar environment brought psychological pressure, which exacerbated her depressive symptoms.

(5) Social Factors

At present, social misunderstanding of psychological disorders such as depression remains widespread. Many parents still believe that depression simply results from "overthinking" and will resolve itself once the child "cheers up." Others dismiss it as a sign of idleness or weakness, lacking a scientific understanding of mental illness. In this case, although Student A was diagnosed with severe depression in junior high school, both her family and she herself refused medication due to concerns about side effects, despite doctors' and teachers' recommendations for pharmacological treatment.

4. Case Intervention

After careful analysis and assessment, the Psychological Health Education Center activated a five-level coordinated monitoring mechanism to ensure continuous observation and safeguard the student's stability and safety.

(1) Timely Medical-School Collaboration and Rapid Response

The Psychological Health Education Center promptly contacted its partner medical institution and initiated a "green channel" referral system. The student was referred to a professional hospital for evaluation and treatment. Physicians conducted a comprehensive assessment of

ISSN: 2692-7608 DOI: 10.6981/FEM.202511_6(11).0025

her symptoms and personal background and immediately arranged for inpatient care to provide systematic treatment.

(2) Joint Educational Support from the School and the College

Upon learning about the student's family and financial difficulties, the secondary college implemented targeted financial aid measures to alleviate her immediate stress. Guided by national student assistance policies, the college provided material support through state grants and on-campus work-study opportunities. Beyond financial relief, the intervention emphasized "supporting both morale and intellect," fostering responsibility, independence, and resilience through both material aid and psychological encouragement.

(3) Peer Psychological Support and Companionship

Class leaders, dorm monitors, psychological committee members, and close friends of Student A provided continuous companionship, monitoring her emotional state and physical condition. They actively encouraged her to participate in class and group activities to enhance her social engagement and build harmonious relationships with her peers.

(4) Family–School Collaboration and Joint Management

The school maintained close communication with the student's guardians and established a parent-school communication group to ensure timely information sharing. The psychological center offered psychoeducation sessions for the parents, explaining the nature of depression, medication management, symptom relapse, and potential crisis situations. Counselors guided the parents in repairing the parent–child relationship and encouraged joint exploration of the underlying issues to identify reasonable solutions through tripartite collaboration among the student, parents, and school.

(5) Continuous Psychological Counseling and Resource Exploration

The center provided regular psychological counseling sessions to Student A, helping her explore the underlying causes of her distress and adopt effective coping strategies. During the counseling process, continuous risk assessment was conducted to ensure that any emergencies could be handled through immediate referral. A personalized psychological profile ("one-on-one case file") was established for long-term tracking, with ongoing dynamic observation of her emotional state. This comprehensive, multidimensional support system ensured the steady improvement of her mental health.

Under the protection of this five-level synergistic psychological safety network, and after more than six months of pharmacological treatment, psychological intervention, and material assistance, Student A's sleep improved, her social functioning largely returned to normal, and no self-harm or suicidal thoughts had reappeared in the past half year. She now maintains harmonious relationships with her classmates and currently serves as an assistant in her department's studio, demonstrating stable performance and satisfactory adaptation to work responsibilities.

5. Conclusion

Mental health education in higher education institutions should place students' life, health, and safety at its core. It is essential to fully leverage the joint responsibilities of schools, parents, and hospitals to build a collaborative psychological recovery network. By establishing a five-level crisis intervention system that integrates peer support, secondary colleges, the psychological center, hospitals, and families, a comprehensive force can be formed to prevent and manage psychological crises among students. Through the joint efforts of families, schools, and society, proactive and effective psychological crisis prevention, intervention, and follow-up can be implemented, thereby providing continuous, multidimensional support to promote students' healthy growth and holistic development.

ISSN: 2692-7608 DOI: 10.6981/FEM.202511_6(11).0025

Acknowledgments

This project is supported by funding of Visual Computing and Virtual Reality Key Laboratory of Sichuan Province (No. scvcvr2023.01vs).

References

[1] Miao, Ruikai, Zhang, Shu, & Li, Meiyu. (2023). Cumulative ecological risk and depression among college students: The mediating role of negative automatic thinking and the moderating role of psychological resilience. Chinese Journal of Health Psychology, 31(8), 1197–1201.

[2] Yan, Ling, & Wang, Zhengjun. (2021). A Case Study of Home-School Cooperation for High-Risk Students in Long Tracking. Proceedings of the 2021 International Conference on Diversified Education and Social Development, 569, 83–86.

[3] Zhang, Ping. (2021). A Case Report on Counseling for Severe Social Anxiety Disorder. Campus Psychology, 19(2), 196–198. https://doi.org/10.19521/j.cnki.1673-1662.2021.02.030