Vol : 1
Issue : 1
July - December, 2026
(in English)

ISSN No.: 3139-7670

Journal of Indian Sign Language

(Biannual)



INDIAN SIGN LANGUAGE RESEARCH AND TRAINING CENTRE
(An Autonomous body under the Department of Empowerment of Persons with Disabilities (Divyangjan), Ministry of Social Justice & Empowerment, Govt. of India)
Module No. 403-406, 4th Floor, NSIC Business Park, Okhla Industrial Estate, New Delhi - 110020
Telephone No: 26327558/50, Email: islrtcnewdelhi@gmail.com, Web: www.islrtc.nic.in

Journal of Indian Sign Language

Contact details of Editorial Board

EDITOR-IN-CHIEF

Dr. Abhishek Kumar Srivastava
Assistant Professor,
Indian Sign Language Research and Training Centre (ISLRTC)
Module No. 403–406, Fourth Floor, NSIC Business Park, Okhla Industrial Estate, New Delhi – 110020
Official Email ID: abhishek.aks@islrtc.nic.in
Profile Link: https://islrtc.nic.in/whos-whos/

EDITORIAL BOARD MEMBERS

Dr. Asmita Huddar
Principal,
Hashu Advani College of Special Education
Chembur Colony Yuvak Mandal, 64-65, Collector's Colony,
Chembur, Mumbai – 400074
Official Email ID: ccym4@hotmail.com
Profile Link: https://www.hashuadvanismarak.org/staff.html

Dr. Andesha Mangala
Assistant Professor,
Indian Sign Language Research and Training Centre (ISLRTC)
Official Postal Address: Module No. 403–406, Fourth Floor, NSIC Business Park, Okhla Industrial Estate, New Delhi – 110020
Official Email ID: aps1islrtc-depwd@gov.in
Profile Link: https://islrtc.nic.in/whos-whos/

Dr. Sibaji Panda
Founder
Happy Hands School for the Deaf
Shikha Eco Learning Village, Lakhanpur, Near Chadeipank
Ulunda, Subarnapur, Odisha – 767062
Official Email ID: sibajip@gmail.com
Profile Link: http://happyhandsschool.in/about-duplicate-961/

Dr. Renuka Rameshan
President,
Association of Sign Language Interpreters
Flat C-303, Shriram Vijaya Hyde Apartments, Bharathi Colony,
Peelamedu, Coimbatore – 04, Tamil Nadu
Official Email ID: contactsignasli@gmail.com
Profile Link: https://signasli.com/

Dr. Gayatri Ahuja
Reader & Head,
Department of Education, AYJNISHD (D)
Ali Yavar Jung National Institute of Speech and Hearing
Disabilities (Divyangjan), K.C. Marg, Bandra (W) Reclamation,
Mumbai – 400050
Official Email ID: gayatri.nishd@ayjnihh.nic.in
Profile Link: https://ayjnishd.nic.in/department-of-education/

Dr. Ratan Sarkar
Assistant Professor,
Department of Education, Tezpur University
Department of Education, Tezpur University (A Central
University), Napam, Tezpur – 784028, Assam, India
Official Email ID: ratan91@tezu.ernet.in
Profile Link: https://www.tezu.ernet.in/dedu/faculty.php

Dr. Pettala Ramakrishna
Assistant Professor, Jamia Millia Islamia
Department of Teacher Training & Non Formal Education (TT&NFE), Institute of Advanced
Studies in Education (IASE), Gate No. 20, Faculty of Education, Jamia Millia Islamia,
Maulana Mohammad Ali Juhar Marg, Okhla
Official Email ID: pramakrishna@jmi.ac.in
Profile Link: https://www.jmi.ac.in/upload/employeeresume/pramakrishna.pdf

Editorial Office

Journal of Indian Sign Language (JISL)
Director, ISLRTC
Indian Sign Language Research and Training Centre (ISLRTC)
Under DEPwD, MSJE, Government of India
Module No. 403–406, Fourth Floor, NSIC Business Park, Okhla Industrial Estate,New Delhi – 110020
Email: islrtc-dir@gov.in, abhishek.aks@islrtc.nic.in, islrtcnewdelhi@gmail.com

Join with us

https://www.facebook.com/islrtc/

https://www.instagram.com/islrtcofficial

https://www.youtube.com/@ISLRTC

https://x.com/islrtc

INDEX

	Editorial	**i-ii**
1.	**Walking the Talk: Inclusion from a Super Micro Lens: Class Dynamics with Sign Language Users** *Dr. Asmita Huddar, Principal, CCYM's Hashu Advani College of Special Education, Mumbai*	**1-3**
2.	**Indian Sign Language: A Personal History** *Madan Vasishta, Former Professor, Gallaudet University, USA*	**4-7**
3.	**Addressing Social and Emotional Wellbeing Challenges For Deaf and Hard of Hearing Students** *Nimmy Shamnad, Associate Coordinator - Social and Emotional Wellbeing,Centre of Excellence and Team*	**8-26**
4.	**Communication Barriers Leads to Depression among Deaf Adolescents: A Review** *Sonia Chawla, Research Scholar in Department of Yogic Science and Human Consciousness, Dev Sanskriti Vishwavidyalaya, Haridwar* *&* *Dr. Gayatri Gurvendra Assistant Professor in Dept. of Yogic Science, Dev Sanskriti Vishwavidyalaya, Haridwar*	**27-37**
5.	**Need for Curriculum and Text Adaptation in Education of Deaf Learners** *Harish Soni, Assistant Professor, ISLRTC, New Delhi*	**38-40**

EDITORIAL

It gives me immense pleasure to present the first issue of Volume 1 of the Journal of Indian Sign Language (JISL). This is an important moment for Indian Sign Language (ISL) and the wider field of Deaf Studies. The launch of a dedicated academic journal provides a platform for research and scholarly discussion on Indian Sign Language, Deaf education, interpretation, accessibility, linguistics, technology and the lived experiences of Deaf people.

The need for such a platform has been felt for a long time. Indian Sign Language is not merely a means of communication. It is a complete language with its own linguistic structure, cultural significance and social identity. Therefore, the development of knowledge about ISL requires systematic research, documentation and academic discussion. This journal is an effort in that direction.

The first issue brings together diverse perspectives related to Indian Sign Language and the Deaf community. The contributions reflect areas such as the development of ISL, experiences from the field, language access, Deaf education, social and emotional well-being, and emerging approaches to supporting Deaf and Hard of Hearing learners. Together, they provide an understanding of both the progress made and the challenges that continue to exist.

One important theme emerging from this issue is language access. Early and meaningful access to language is fundamental for cognitive, emotional and social development. The question is therefore not simply whether a child can hear or speak. The more important question is whether the child has access to a complete and accessible language at the right time. For many Deaf children, access to sign language can play an important role in communication, learning and overall development.

The issue also highlights the social and emotional well-being of Deaf and Hard of Hearing students. The experiences presented in the contributions show the importance of communication, emotional expression, family relationships and social participation. Communication barriers can affect much more than academic learning. They can influence confidence, relationships, emotional well-being and participation in society. Better communication between Deaf children and their parents can also strengthen emotional connections and mutual understanding within the family.

Another important area is curriculum, technology and accessibility. Curriculum development for Deaf learners cannot be limited to changing textual content. It needs to consider language, visual presentation, learning materials, assessment and the mode of communication. Digital and emerging technologies can provide new opportunities through sign language resources, captioning, translation and interactive learning materials. However, technology should support—not replace—qualified teachers, human interaction and the linguistic needs of Deaf learners.

A recurring message across the contributions is that inclusion begins with language access. Accessibility is not only about physical infrastructure or assistive devices. For a Deaf learner, communication access is a basic requirement for meaningful participation in education and society. This requires teachers, interpreters, researchers, counsellors and other professionals to understand the linguistic and cultural dimensions of Deafness.

Indian Sign Language Research and Training Centre (ISLRTC), under the Department of Empowerment of Persons with Disabilities (DEPwD), Ministry of Social Justice and Empowerment (MSJE), Government of India, remains committed to promoting Indian Sign Language through research, documentation, standardization, capacity building and the development of accessible resources, and to strengthening the recognition and use of ISL in education and wider society.

As the first issue of JISL, this volume should be seen as a beginning rather than an endpoint. The field needs continued research on ISL grammar, vocabulary, discourse, regional variation, language acquisition and use. There is also a need for research on Deaf education, interpretation, teacher education, assessment, accessibility, technology and the lived experiences of Deaf people across India.

The journal welcomes researchers, Deaf scholars, educators, interpreters, practitioners and students to contribute to this growing body of knowledge. We particularly encourage research that is evidence-based, ethically conducted and relevant to the Indian context. We also believe that Deaf people's voices must have an important place in research about Deaf people and their language.

I sincerely thank all the contributors to this inaugural issue for sharing their research, experiences and perspectives. I also acknowledge the efforts of everyone who has contributed to bringing the journal to its first volume.

I hope this first issue will encourage further research, dialogue and collaboration. More importantly, I hope it will contribute to strengthening the academic recognition of Indian Sign Language and building a stronger research base for the Deaf community in India.

Welcome to the first issue of the Journal of Indian Sign Language. This is our beginning, and we look forward to building this journey together.

Dr. Abhishek Kumar Srivastava
Chief Editor

WALKING THE TALK: INCLUSION FROM A SUPER MICRO LENSE: CLASS DYNAMICS WITH SIGN LANGUAGE USERS

Dr. Asmita Huddar

Abstract

This article is a reflection on the experience of a few hours of teaching to a batch having a learner with D/deafness and 2 Indian Sign Language (ISL, henceforth) interpreters. The module the author taught this batch was in project mode. The article lists the micro level challenges and observations made by the teacher on account of having a learner with D/deafness in the class. It, more importantly, describes how most of the concerns can be resolved with patience, systematic problem solving and tiny thoughtful actions carried out consistently on a regular basis. The article briefly discusses the experience of a single teacher (the author) along with her learners in terms of: a) identifying the challenges in any of the as communicatively demanding situation as a classroom having a student with D/deafness (SwD, henceforth) and ISL interpreters. This classroom functioned differently from the prototype class in our minds where listening and speaking conventionally are the primary modes of communication. b) Narrating small steps taken to resolve the listed concerns. These two points are discussed by breaking down a typical class functioning into 5 areas: Orientation of hearing classmates; tuning learning spaces, adapted communication style of the teacher, interpreters' academic well-being and managing online sessions with these dynamics. All four partners in similar situation (Teacher, SwD, ISL interpreter, hearing classmates) may drive home a few learning points after reading this experience. That would be a 'yet another' tiny piece falling into its place in a large jigsaw puzzle called inclusive education for individuals with atypical hearing.

Key terms: Inclusive practices in higher education, Indian Sign Language, ISL interpretation, learners with D/deafness, Communicative access and inclusion.

Educational inclusion is a global super macro issue. Tons of resources are available on what, how and why of its implementation in mainstream classrooms. These are more than adequate to hand hold a passionate teacher in her / his journey towards translating global goal into classroom practices. Yet, with all the theory back up and pragmatic 'Dos and Don'ts' the author as a teacher felt that the journey has more challenges in store than expected. At super micro level, in a real-life classroom, each of the real-life teachers is left to oneself to walk the talk. Striking the balance between romantic ideas of equity / justice for all learners and the timelines of teaching the modules within the pressing academic deadlines is quite a task. Higher education classes are no exceptions to this balancing task. Obviously, ultimately, human grit and willingness to change do pave the path. Several such paths bring about visible change in daily practices.

Here is an account of author's tiny journey through challenges and solutions.
Program: post graduate professional program
Module: Research Methods
Learners' profile: 25 adult learners, one of them having D/deafness requiring interactions in ISL, 2 ISL interpreters.
Hours: 80 hours spread over one semester (60% classroom learning and 40% self -learning)

Mode of learning experience: Project mode (A typical course in project mode involves a variety of interactive experiences like self-paced learning, group / paired / individual tasks, submissions, presentations, games, hands-on skill development etc). With no theory examination at the end of the semester, grades are assigned to students on the basis of the semester long participation, reflective journal and presentation on learning points.

A typical routine in the class included, a quick intro cum recap with Kahoot or other tools followed by teacher describing and interacting alongside power point presentation and a smart board. It also included sharing tasks and probes on active WhatsApp group specially created for the learners of this course.

Challenges and solutions experienced during these learning hours are discussed here.

1. **Peer orientation and skill development into rolling the interactive group communication when having SwD and the ISL interpreters in the class:** Soon after the induction hours, a learning disconnect was felt in the class. Hearing classmates, SwD, interpreters in general did not know how to interact in groups when a person with Deafness with the interpreter is also a member. We had a quick session on opening up dialogue on the issue. Classmates were made aware about expected eye contact and body language in such a situation. Most importantly, they were asked to avoid overlapping conversations which made interpretation difficult. Students were told to take a 5/10 seconds pause when they began talking to ensure that the interpreters were looking at the talker. It was ensured that at least one of the two interpreters were in the sub-group where the person with deafness belonged during the grouping tasks. Last but not the least, all students had to be alert to pace up or pace down with the interpreter to avoid speed mismatch between spoken and signed expressions. Eventually the hearing students got adequate hold over the situation without losing the focus on learning.

2. **Tuning learning spaces with focus on appropriate class arrangement and furniture:** The class had a white board and an LCD TV side by side which pushed white board in a rather darker corner. Otherwise, I as a teacher used the white board and talking simultaneously making students learn in spite of darker areas of the white board. With a SwD in the class, all well-lit areas were to be used for active teaching avoiding darker pockets. Teacher avoided moving into these darker areas or standing against the light while talking. Desks were moved to create a circle rather than the typical 'one after the other' back-to-back seating style. Desks for SwD marked to face the window so that faces of the classmates and teachers are seen clearly. Position of the interpreter was marked so as to make it convenient for the SwD without visually distracting the hearing classmates. Initially a few hearing classmates felt distracted due to signing of the interpreters basically because they had never experienced such a situation earlier. Soon everyone involved got used to the dynamics and could focus on learning.

3. **Adapting teacher's communication style:** To begin with, I had to slow down my usual speed of talking. Although being well versed with the communicative needs of such a situation, I rarely had to deal with the situation in a formal classroom teaching learning process. It was a tricky skill since to be able to tune in my speed, I had to maintain frequent eye contact with the interpreters. Overdoing of such more than necessary eye contact with one learner was not in the interest of all the three categories of the learners: SwD, interpreters and hearing classmates. I wanted to - like any other teacher, keep all students in the loop of learning by maintaining equal distribution of the eye contact over all the learners. Hence the external support of keeping the speed appropriate by maintaining eye contact with the interpreter exclusively for the majority part was not an option here. Matching up talking speed with ISL interpreter (no rocket science) was possible eventually by internal controls of constantly being alert of the need. Things worked out once the mind gotconditioned for a particular speed of talking. This was followed by the reduced need to look at interpreters for the confirmation of the speed being appropriate. Secondly, the alertness that someone is carefully interpreting every bit of what is being said led to some discipline in my thinking process. For better interpretation, the speaker has to consciously repair communicative barriers (like half said sentences, changing topic in mid- sentence, taking unnecessary pauses, get distracted or choose unacceptable vocabulary). I became aware of this which helped me present the thoughts and points more cohesively and effectively.

4. **Interpreter's academic well-being:** Thankfully there were 2 interpreters undergoing the program and hence they could take turns. Earlier, each one was doing interpretation for a longer slot. We reduced the time slots drastically leading to exchange of the baton more often. This reduced the cognitive load and eased out attention fatigue by the interpreters. I was aware that the interpreters were playing dual role in the class. They themselves were learners and plus were managing ISL interpretation. To ease out the load, I gave most of the significant instructions on common WhatsApp group which did not require

interpretation. It served another purpose which helped all the students – my instructions were documented for multiple access. That just endorsed what we special educators believe in: 'good' quality teaching though practiced keeping the persons with special needs in mind, ensures equitable benefits to the typically functioning class fellows as well.

5. **Online classes with captioning:** Once a week a session was held in online mode for this course. That option posed lesser challenges basically due to interpreters keeping their video mode turned on (or sitting next to the SwD) and SwD availing captioning option of the platform. Online lectures too were very interactive and chat box was used aggressively by students to respond to the interactive points raised by me. Some pace management strategies were needed that time as well. This was because both reading the chats and seeing the interpretation are visual skills and cannot be done simultaneously by the SwD. Pausing the interpretation to allow space to read chat box was needed. Teachers took adequate pauses so that interpretation can stop and the SwD can focus on reading the chat box (and responding by writing or signing).

As a special educator working in higher education, I always thought including a learner with D/deafness can be a comparatively easier process than it is in a school set up.

Particularly when I noted initially that this learner is a signer and two interpreters too are a part of the class, I assumed the situation to need no intervention from my side. I had expected it to be smoother than the real experience. However, as is said often, the God lies in details. We as a class, motivated to achieve our learning objectives together faced challenges and we could overcome these together. The article expects teachers - whether a special or a mainstream, experiencing similar situation to draw some inspiration and a few tips to deal with the communicative dynamics at ground zero. An alertness about ensuring access to communication and the urge to reach out to ALL the learners sitting in front of the teacher are adequate reasons to experiment and learn. At a micro level, in a real life classroom situation, these are the keys to successful inclusive education.

References:

Lynas, W. (1999). Supporting the Deaf Child in the Mainstream School: is there a best way?

Support for Learning, 14(3), 113–121. https://doi.org/10.1111/1467-9604.00115

Mahshie, J. J. (2005). Enhancing Communication Skills of Deaf & Hard of Hearing Children in the Mainstream. Singular.

Marie, A., & Friedner, M. (2021). Entangled Interdependence: Sign Language Interpreting without Recognition in India and Vietnam. PoLAR: Political and Legal Anthropology Review, 44(2), 192–206. https://doi.org/10.1111/plar.12450

Merrick, R. (2021). Inclusive Teamwork for Pupils with Speech, Language and Communication Needs. Routledge.

Ralabate, P. K. (2011). Universal Design for Learning: Meeting the Needs of All Students. ASHA Leader, 16(10), 14. https://doi.org/10.1044/leader.ftr2.16102011.14

Waksler, R. (1996). Teaching Strategies for a Barrier-Free Classroom. Journal on Excellence in College Teaching, 7(2), 99–111.

INDIAN SIGN LANGUAGE
A PERSONAL HISTORY

Madan Vasishta

I will, first start with my own learning of what we call "ISL" now. After I became deaf at the age of 11 and spent the next nine years working on the farm, I moved to New Delhi. In the small class of four people in the Photography Institute for the Deaf (PID), I saw two students moving hands and gesturing wildly. I wondered what they were doing, so I gestured like a hearing person to them "what is this?" Deaf people do not like being asked strange questions and both rudely gestured for me to get out. I asked again and they stopped signing. I gave up and went into the office of AIFD (which was right there, and I had to jump through a window) and asked the guy there what those deaf students were doing. I spoke and the guy there gave me a small card and told me to learn these. That card had fingerspelling pictures on it. I took it home and learned the shapes and then practiced staying awake half the night. By next morning, I could fingerspell very fast.

When I arrived at the PID next morning, I went to those two students and very proudly fingerspelled "Hello, my name is Madan Mohan, and I have learned your language. Both stared at me wild-eyed and puzzled. To make the long story short, I learned that fingerspelling is not signing, and these two guys did not now any English. I was so embarrassed and felt stupid.

I learned to sign fast by talking to them and making some deaf friends outside the PID. I was fluent like them and could communicate. This was a HUGE revelation for me. There was a language for the deaf! I had been communicating with all my hearing relatives by speaking to them. They wrote on their palms in Hindi or Urdu. I had become very skilled in reading these tracing. However, when all of them were talking to each other, I was lost and wished there was a way, I could communicate with them equally.

Fast forward! I went to America to attend Gallaudet in 1967. I could not understand even one sign of their sign language. They did not call it ASL then. This nomenclature started much later. Gallaudet people called it "sign language' or "simultaneous method" as people who could speak signed and talked at the same time. However, most deaf students signed without voice. Gallaudet offered classes in signs to new students, and I was so happy to learn in the class. It took a long time, but finally I could understand the teachers in classrooms.

I noticed that in addition to sign language classes, they had sign language books. Sign language was just another subject like history or physics. I thought about India. We did not have those resources and thought about developing those when I would return to India.

Soon as I finished my MA, I started to work on it. I sent letters to all 120 school s for the deaf in Inda at that time. These letters were sent by airmail. I asked the principals about sign language in India. Only a few replied. They said, there was NO sign language in India and all schools were oral. That was a shock for me. I had used signs with my friends, and those friends had attended schools for the deaf where everyone signed. It showed clear opposition to sign language use. More details about this attitude follow.

Even though Sign Language has been used as the main language of Deaf community and was used by students and staff in schools for the deaf for over a century, teachers and principals of schools for the deaf denied its existence even in 1975 (Vasishta 1978). They called it "a collection of gestures" and not a language. These doubts persisted among many educators even after research proved that ISL is a bona fide language with its own grammar, syntax, vocabulary and other linguistic attributes (Vasishta et al 1978).

The oral lobby in India has been very strong ever since the first school for the deaf was established in 1885. Any efforts by deaf groups or teachers to introduce sign language into classrooms in various schools were thwarted. This strong opposition to using sign language for over 150 years has been one of the main forces to discourage approval of laws and policies to support use of ISL.

In 1995, the first act related to disabled people—the Persons with Disabilities Act, 1995—was passed by the Parliament of India. This Act did not refer to sign language at all. The word "deaf" was omitted. Instead "hearing impairment" was used to cover hard of hearing and deaf people. However, both "blind" and "visually impaired" were in play when describing blindness. References to ramps and other modifications to accommodate orthopedically disabled are clearly made and provision of braille for the blind and visually impaired are made. There is no mention of sign language. This is one example of deaf people and sign language being short-changed when laws related to disabled persons were passed.

The next effort at policy of use of sign language was mentioned in the position paper presented by the National Focus Group on Education of Children with Special needs in 2006. In Section on IV of the paper, they suggested using sign language in all public functions to create a barrier-free environment.

This statement might mean use of interpreters in public meetings. It does not refer to use of sign language in classroom, however, this was just a suggestion by a focus group. There was no provision for a budget or using interpreter as a requirement. In other words, the National Focus Group' actions were limited to what was written on paper and did not benefit deaf people. Were there any interpreters at public meetings? It is a good question.

Hopes for recognition of sign language were raised greatly when India signed the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) on March 30, 2007 and ratified it on October 1, 2007. The UNCRPPD in its section on education made it clear that the government must facilitate the "learning of sign language and promotion of linguistic identity of deaf community." In addition, it also requires the government to "take appropriate measures to employ teachers, including teachers with disabilities, who are qualified in sign language." (UNCRPD Article 24).

There is no data available on implementation of the UNCRPD articles in India. The author's asked few active educators about it to glean out real life benefits of UNCRPD.

Based on their cumulative observations and close work with various schools in India, they felt that the implementation of UNCRPD Article 24 has been partial at best. While there have been some efforts to recognize ISL and promote its use, such as the establishment of ISLRTC and the canter making contracts with Deaf-led organizations to promote bilingual education, the main challenges remain. There's still a lack of qualified teachers fluent in ISL. Deaf educators or those with disabilities face systemic barriers to employment. One example of this barrier is the requirement to take course work in audiology, speech science and other course that depend on hearing acuity. In the US and other countries where more and more deaf teachers who are fluent in sign language have substituted other course work (bilingualism, deaf culture) to substitute speech and audiology. This helps deaf people get certification in teaching. In India, the promotion of linguistic identity for the Deaf community is limited to a few initiatives and hasn't fully permeated mainstream education policies. So, while steps have been taken, there's much more to do to truly align with the spirit of Article 24. (Personal communication with Arathy Manoharan and Pallavi Kulshreshta).

To sum up, the efforts to implement the Article 24 regarding use of ISL were half-hearted and inconsistent.

One major positive development was the establishment of Indian Sign Language Research and Training Center at IGNOU.

INDIAN SIGN LANGUAGE RESEARCH AND TRAINING CENTRE (ISLRTC)

In the 2000s, the Indian deaf community led by the National Association of the Deaf (NAD) requested the government to sponsor an institute to focus on research on ISL and providing training to ISL teachers and interpreters. They were encouraged when some concerned officials acknowledged that the needs of people with hearing disabilities had been relatively neglected and envisaged the development of a sign language research and training center. The finance minister announced the setting up of ISLRTC in the Union Budget speech of 2010-11. The 11th Five Year Plan (2007-2012).

As a result, in 2011, the Ministry of Social Justice and Empowerment approved the establishment of the Indian Sign Language Research and Training Center (ISLRTC) as an autonomous center of the Indira Gandhi National Open University (IGNOU), Delhi. The foundation stone of the center was laid at IGNOU campus on 4th October 2011.

I was appointed director of ISLRTC at IGNOU, however, due to age and citizenship factors, the position was changed to Chief Advisor. I had the full responsibility for developing the program and supervising the staff. A director was appointed to take care of the budget. This was an awkward arrangement and was like getting two swords in one scabbard, but we survived it for two years.

To exacerbate the situation, there was a change in the administration and the new VC of IGNOU was against having an onsite program on campus. This resulted in the ISLRTC being closed at IGNOU in 2013. The DPWD decided to move ISRTC under it and later, in an order dated 20th April 2015, the Ministry decided to integrate ISLRTC with the regional center of the Ali Yavar Jung National Institute of Hearing Handicapped (AYJNIHH) at Delhi.

This caused a major unrest among the deaf community. The NAD called and over 500 deaf people from all over India gathered in Delhi to demonstrate this decision.

This decision was atrocious. I flew to Delhi to join the protest and managed to get an appointment with the PM's Office. Mr. Naraynan, the NAD president, Dr. Surinder Randhawa, an independent consultant and I explained the basics of deaf education and communication system. To get the point home, I clearly stated that asking NIHH to supervise ISLRTC would be analogous to asking a Muslim priest to head a Hindu temple. This analogy did help, and they decided to keep ISLRTC autonomous.

The protests and meeting resulted in the Union Cabinet approving the setting up of ISLRTC as a Society under the Department of Empowerment of Persons with Disabilities, MSJE, in a meeting held on 22nd September 2015. An order to this effect was issued by the MSJE on 28th September 2015, leading to the establishment of ISLRTC.

There is a light (or lights) at the end of the tunnel. Several new developments at government level are pointing to the possibility of ISL getting its rightful status. One of these is Prime Minister Narendra Modi announcement to give Indian Sign Language (ISL) the status of a language subject. According to it, students will be able to study ISL like any other language in schools. National Institute of Open Schooling NIOS) has been ordered to start ISL as a subject for different classes starting from 3rd grade. It will be developing course material for teaching ISL up to 12th grade level. Only a few countries around the world have provided opportunity of hearing students to study the country's sign language as a subject.

The government plans to standardize over 10,000 ISL words, however, this plan appears to be redundant as the ISL dictionary with 10000 terms, which has been released by ISLRTC, a government organization, should be considered as standard. The validation process was done by using deaf participants who reviewed and approved the video copies of signs.

Additionally, the ISLRTC signed an MoU with NCERT to convert school textbooks into ISL to provide educational content to deaf students in their first language, ie ISL. Between 2020 and 2022, 35 textbooks of classes 1-6 were converted into ISL videos and made freely available on multiple platforms.

In 2023, the government published new textbooks based on the National Education Policy 2020. The new textbooks of classes 1-3 have also been recorded in ISL.

In sum, with support from the top, policies about the use of ISL and its role in education of deaf children have been changing, albeit slowly.

The total population of deaf persons in India numbered about 50 lakhs according to the 2011 census. The needs of the huge deaf community have long been ignored. These new developments were long overdue. It is axiomatic to say better late than never and we can look forward to ISL getting its rightful status.

ADDRESSING SOCIAL AND EMOTIONAL WELLBEING CHALLENGES FOR DEAF AND HARD OF HEARING STUDENTS

Nimmy Shamnad

Abstract

When Deaf and Hard of Hearing youth join any educational or vocational institutions around the minimum age of 16 after completing their schooling, they often encounter various challenges and bring with them a multitude of pre-existing issues. Addressing these challenges requires a focused approach that acknowledges the unique experiences and needs of these students. This white paper aims to explore the nature of these challenges, understand their impact on the students' academic and personal development, and propose effective intervention strategies to support their integration and success. By focusing on the specific needs of these students, we can create a more inclusive and supportive environment that empowers them to overcome their individual obstacles and thrive.

This white paper is the result of two years of dedicated study, grounded in direct engagement with over 500+ Deaf and Hard of Hearing (DHH) students, their teachers and parents. Through these extensive interactions, we have collected rich quantitative and qualitative data that shed light on the unique social, emotional, and academic challenges faced by the DHH community, underscoring the urgent need for tailored interventions and support systems.

Our methodology involved one-on-one sessions with over 500+ parents, simultaneously, in-depth sessions with over 500+ students, amounting to 9000+ hours of focused interaction. Additionally, as part of our daily emotional monitoring via the Mood Meter tool, we dedicated 30 minutes per day with 500+ students, leading to thousands of cumulative engagement hours over the two-year period. Beyond these formats, we also held numerous individual follow-ups and informal check-ins with students to ensure a continuous feedback loop and personalized support.

Each component of this study—from holistic pre- assessments, Mood Meter analysis and other areas—are explained in greater detail in the Methodology section of this paper, providing transparency into our approach and the rationale behind each element.

Current Scenario

In today's education system, mental health awareness is increasingly prioritized. However, deaf and hard-of-hearing (DHH) students face unique challenges that go beyond typical mental health concerns. When any student is joining any educational/vocational institution they majorly face communication barriers, emotional isolation, and social misunderstandings which leads to frustration, loneliness, and self-doubt, hindering their self-expression, relationships, and engagement in education.

Deaf and hard-of-hearing (DHH) students often face profound challenges that impact their self-perception and overall well-being. Many struggle with low self-confidence and self-esteem, which can hinder their participation and self-advocacy. Family dynamics play a significant role, particularly when parents or guardians lack the knowledge or ability to communicate effectively with them, leading to further emotional isolation. A major obstacle is the language barrier that prevents DHH students from connecting meaningfully with their parents, family, and society. Despite the importance of sign language, many DHH students lack exposure to it due to various circumstances. In some educational settings, there is a focus on teaching orally rather than using Indian sign language as well, which can worsen communication challenges. Moreover, social and emotional interventions in schools often fall short, failing to provide adequate support tailored to the unique needs of DHH students. This absence of accessible emotional support structures can lead to internalized struggles, affecting not only their academic performance but also their long-term social and

personal development. Without proper intervention, DHH students risk being marginalized in a society that does not fully accommodate their needs.

This white paper introduces the well designed interventions within the Social and Emotional Wellbeing (SEW) Program of TEACH, designed to address these challenges and empower DHH students to navigate life with greater emotional strength and confidence. Through therapeutic activities, group discussions, and personalized guidance, the SEW program offers a holistic approach to mental health, fostering self-awareness, resilience, and social adaptability. By implementing these tailored interventions, we aim to create an inclusive space where DHH students are not only educated but also emotionally and socially equipped to thrive as individuals who can confidently interact with the world around them.

''The rates of attempted suicide in deaf school and college students during the previous year ranged from 1.7% to 18%, with lifetime rates as high as 30%."

Source: https://pmc.ncbi.nlm.nih.gov/articles/PMC2093933

In many cases, infants identified as 'deaf' face systemic neglect of early interventions/options. When families and medical professionals first learn of a child's hearing status, there is often a misplaced emphasis on vocalization over sign language, with some discouraging or outright rejection of sign language exposure under the assumption that it might restrict speech development. This approach forces deaf children into schools without adequate linguistic or social support, leaving them stranded in environments where communication remains inaccessible. As a result, these children experience language deprivation during the critical developmental window for acquisition, which severely limits their ability to engage in incidental learning—the organic process through which hearing peers absorb social norms, contextual cues, and relational skills. Over time, this lack of foundational language access creates challenges: socialization becomes fraught with misunderstandings, leading to frustration and isolation. Without a robust language framework, cognitive development stalls, emotional expression is stifled, and relationship-building skills remain underdeveloped. The systemic prioritization of speech over holistic communication not only denies deaf children the tools to thrive but also perpetuates cycles of social marginalization and emotional distress, highlighting the urgent need for inclusive early interventions that integrate sign language alongside speech therapy.

'Approximately 99% of the overall deaf and hard of hearing children immediately drop out during or after schooling'
Source: https://www.nationaldeafcenter.org

The cumulative effect of these challenges underscores the urgent need for comprehensive and tailored interventions that address the holistic development of DHH students. By implementing structured social and emotional wellbeing programs that focus on language acquisition and social skills training, we can empower these individuals to overcome barriers and thrive in all aspects of life.

Emotional and Psychological Challenges

- Many DHH students face significant challenges in recognizing, articulating, and regulating their emotions effectively. This can lead to misunderstandings and miscommunications, exacerbating emotional distress.
- Negative social perceptions about their capabilities often create a sense of hopelessness and uncertainty in the lives of DHH students. This can undermine their confidence and motivation, affecting their overall well-being.
- Emotional isolation frequently arises due to a lack of accessible support systems, particularly within family dynamics. This isolation can intensify feelings of loneliness and disconnection.

- Handling rejection or exclusion from peer groups can be particularly difficult, leading to feelings of inadequacy and isolation.

- The suppression of emotions often manifests as anger, irritability, or withdrawal from social interactions. This can further complicate their emotional landscape, making it difficult to maintain healthy relationships and engage in constructive communication. DHH students often face challenges due to late language exposure, which can hinder their ability to develop emotional regulation and social skills. This necessitates extra attention in their studies and requires specialized support beyond typical accommodations

- Many DHH students struggle with a lack of self-identity, resulting in confusion about their place within society. This confusion can affect their ability to form meaningful relationships and engage in social interactions

- Low self-esteem and self-confidence are prevalent among DHH students, often stemming from years of being perceived as different or incapable. This perception can lead to hesitation in participation and self-advocacy

- An inferiority complex may develop, particularly when comparing themselves to hearing peers. This can lead to feelings of inadequacy and further erode their self-confidence Dependence on family members can reduce self-reliance and hinder the development of decision-making skills. This dependency can limit their ability to navigate independent life situations effectively

- The risk of emotional breakdowns is heightened due to feelings of isolation, rejection, and a lack of emotional support. DHH students are more likely to experience social -emotional difficulties at a rate two to three times that of their hearing peers

Social Challenges

- DHH students often face significant barriers in accessing physical and mental health services.

- Facilitators, including teachers and counselors, often lack proper training on the social and emotional challenges faced by DHH students. This lack of understanding leads to ineffective support systems, further isolating these students.

- Societal stereotypes and biases against DHH individuals significantly hinder their social integration. These prejudices perpetuate feelings of exclusion and marginalization, making it difficult for DHH students to form meaningful relationships with their peers.

- DHH students often lack exposure to societal norms and social cues, which leads to awkward interactions. This lack of understanding is compounded by limited opportunities for incidental learning, making it challenging for them to navigate various social situations effectively.

- Some Deaf and Hard of Hearing students often face challenges due to late language exposure, necessitating extra attention in their studies. Deafness itself presents unique learning needs, requiring specialized support beyond typical accommodations. However, these students frequently receive insufficient attention to their distinct requirements, underscoring the need for tailored interventions to ensure their academic and personal success.

- Low self-esteem and self-confidence are prevalent among DHH students, often stemming from years of being perceived as different or incapable. These challenges highlight the urgent need for targeted

interventions that address the emotional, social, and psychological needs of DHH students. By fostering an inclusive environment that promotes understanding and support, we can empower these individuals to thrive academically and socially.

Need for an Effective Social and Emotional Wellbeing (SEW)

Proposed SEW Model for Deaf and Hard-of-Hearing (DHH) Students

To address the unique emotional, social, and psychological challenges faced by DHH students, a SEW model must prioritize visual accessibility, cultural inclusivity, and structured skill-building. Traditional therapeutic models often overlook the intersection of language deprivation, societal biases, and delayed emotional development in DHH individuals. Below is a tailored framework aligned with their needs:

Core Components of our Social and Emotional Wellbeing model

1. **Tailored Interventions**
   Individualized approaches that prioritize the unique emotional and social needs of DHH students. These interventions are embedded into everyday academic experiences, creating an inclusive environment that fosters growth and safety.

2. **Visual and Tactile Therapy Techniques**
   Supplement auditory-centric methods with sign language-guided discussions, visual storytelling, and expressive art therapy (e.g., drawing, role-play) to foster emotional articulation.

3. **Safe Spaces for Shared Experiences**
   Establish peer-led support groups moderated by trained facilitators to provide safe environments where students can share and normalize challenges such as isolation, bullying, or family communication gaps.

4. **Emotional Awareness and Self-Expression**
   - Use therapies that help students identify, process, and express complex emotions such as frustration or sadness.
   - Implement guided imagery sessions with picture-based social scenarios to teach coping strategies and improve emotional understanding.

5. **Social Skills Development**
   Conduct structured group activities that focus on turn-taking, empathy, conflict resolution, and building friendships, helping students navigate social settings more confidently.

6. **Parental Engagement**
   Conduct sign language workshops, counselling and group sessions for families to break communication barriers at home and improve parent child relationship.

7. **Language and Identity Reinforcement**
   Integrate Deaf culture narratives into therapy to combat identity confusion and inferiority complexes.

8. **Support for Slow Learners**
   Implement a specialized support program for students with additional learning needs. This includes early identification, creation of IEP's, teachers sensitizations, visual-based academic accommodations, and focused emotional and behavioral therapies to help them thrive at their own pace.

USP of Our Model

- **Addresses Root Causes:** Targets systemic issues like delayed language acquisition, societal exclusion, and inadequate support systems.
- **Reduces Emotional Suppression:** Visual/tactile methods bypass reliance on verbal communication, empowering students to express complex emotions safely.
- **Builds Long-Term Resilience:** Combines skill-building (social cues, self-advocacy) with emotional validation to mitigate risks of emotional distress.
- By centering DHH experiences and leveraging their strengths in visual learning, this model fosters confidence, self-reliance, and meaningful connection - equipping students to thrive in academic, social, and professional settings.

Methodologies

Holistic Pre-Assessment

The Holistic Pre-Assessment is an integral part of our methodology, which we designed to evaluate the overall well-being and development of students across psychological, social, emotional, and cognitive domains. Conducted at the start of the academic year, this comprehensive assessment establishes a baseline understanding of each student's strengths and areas requiring support. It includes three key components:

- The Guardian-Student Bio, which gathers detailed background information, student history.
- Structured student assessments.
- Goal Sheet, where students outline their aspirations.

This multi-level process is applied across all educational stages addressing age-specific areas such as emotional skills, critical thinking, decision-making, and ethics. Students identified as needing additional support are categorized into Intensive Support (students who identified with cognitive delay) or Monitored Support (Students who are struggling with other issues affecting studies) based on their assessment scores. Tailored interventions are then implemented to address challenges like memory retention, processing speed deficits, or emotional barriers. This approach ensures personalized strategies that promote academic success, emotional resilience, and holistic development while preparing students for future challenges.

Mood Meter and Happiness Activity

TEACH offers a tailored program through the Mood Meter app to support students' emotional well-being at the start of their day. Recognizing that students may experience a variety of emotions that can influence their focus and engagement in class, the app facilitates daily tracking of emotional states for students, teachers, and counselors.

Each student selects their emotional state from 20 predefined options, providing valuable insights into their mood. Based on the collected data, reports are generated and shared with class teachers to highlight the emotional climate of the class. Using this information, tailored happiness activities are planned and conducted during the first 30 minutes of class to help students begin their day with positivity and focus.

Need Attention Category

To ensure early identification and intervention for students struggling emotionally, the Mood Meter App also flags students who report negative emotions for three consecutive days. These students are automatically categorized under the "Need Attention" list, prompting immediate intervention:

Facilitator Check-In: A designated facilitator will connect with the student to understand their emotional concerns and offer immediate support.

Counselor Referral: If deeper emotional distress is identified, the case will be escalated to a counselor for a personalized intervention plan, which may include individual counseling, emotional resilience training, or structured therapeutic activities.

Ongoing Monitoring: The student's emotional patterns will be continuously tracked, ensuring sustained support and preventive mental health care.

By integrating emotional awareness, early intervention, and structured well-being activities, this program fosters a supportive and psychologically safe learning environment for all students.

Application available in Play store
https://play.google.com/store/apps/details?id=com.moodmerter.android.alpha

Group Sessions: Psychoeducation, Circle Therapy, Slow Learners Session and Adolescent Education Program.

1. **Psychoeducation Sessions**

   The psychoeducation sessions focus on building awareness and understanding of emotional and social challenges faced by Deaf and Hard of Hearing (DHH) students. These sessions aim to:

   Educate students about the symptoms of emotional and social issues, such as stress, anxiety, anger issues, or feelings of isolation.

   Provide practical strategies for coping with these challenges, empowering students to manage their emotions effectively.

   Foster a deeper understanding of mental health, equipping students with the tools to recognize and address emotional distress in themselves and others.

   By enhancing self-awareness and emotional literacy, these sessions lay the foundation for improved psychological well-being and social adaptability.

2. **Circle Therapy Sessions**

   The Circle Therapy program is a structured group therapy approach designed to create a safe, inclusive space for DHH students. Conducted in small groups of 10–12 participants, these sessions encourage open expression and emotional well-being within a supportive, non-judgmental environment. Each session follows a three-step structure:

   Guided Meditation: Sessions begin with guided meditation to promote relaxation, self-awareness, and focus. Clear verbal instructions are provided before the meditation, supported by a simple numerical

countdown to maintain engagement.

This practice helps students ground themselves emotionally and mentally, preparing them for deeper discussions.

3. **Feelings-Sharing Session**

Students are encouraged to share their emotions in an open and supportive environment.

Counselors model openness to foster trust among participants while emphasizing the importance of confidentiality, non-judgmental attitudes, and acceptance.

This step helps students articulate their emotions while building empathy as they listen to others' experiences.

Group Discussion: The final phase involves a group discussion on predefined or spontaneous topics tailored to the participants.

Discussions focus on themes relevant to students' lives, such as personality development, relationships, identity, or coping with societal challenges.

These conversations promote emotional resilience, social adaptability, and critical thinking.

Through psychoeducation and Circle Therapy sessions, DHH students gain a deeper understanding of their emotional world while developing essential social skills. These programs not only address immediate emotional needs but also equip students with lifelong tools for psychological well-being and social integration.

4. **Slow Learners Sessions**

Our Slow Learners Program is designed to provide personalized support to students who require additional time and guidance to grasp academic concepts. Recognizing that these students do not have cognitive impairments but may process information at a slower pace, we conduct a holistic pre-assessment to identify their unique needs. This comprehensive evaluation assesses psychological, social, emotional, and cognitive development, using tools like the Behavioral Checklist for Screening Learning Challenges (B.C.S.L.D.) and the Montreal Cognitive Assessment (MOCA). Based on these findings, we develop tailored support plans that address specific learning difficulties, emotional challenges such as low self-esteem and anxiety, and foster a supportive learning environment. Our approach ensures that students receive structured guidance at a pace that suits their individual needs, enhancing their academic performance and emotional well-being. By collaborating with teachers, counselors, and parents, we create a cohesive support system that celebrates each student's unique strengths and promotes self-assurance, emotional resilience, and academic success.

5. **Adolescent Education Program (AEP)**

The Adolescent Education Program (AEP) is specifically designed to address the unique developmental and social needs of young deaf adults during the critical period of adolescence. For Deaf and Hard of Hearing (DHH) students, some challenges are compounded by communication barriers, which can limit their access to guidance and awareness typically gained through incidental learning or parental support.

Program Features: Safe Learning Environment: AEP provides a secure and inclusive space where

students can openly explore sensitive topics without fear of judgment or misunderstanding. This environment fosters trust, allowing students to engage meaningfully in discussions about their personal and social development.

Participatory exercises: The program incorporates dynamic activities such as icebreakers, roleplays, and group discussions. These methods encourage active participation and help students internalize lessons through experiential learning. Topics range from foundational concepts like "good touch vs. bad touch" to more complex issues such as sex education, relationships, and personal boundaries.

Bridging Awareness Gaps: Unlike their hearing peers who often acquire social knowledge through incidental learning or parental guidance, DHH students may lack awareness due to communication challenges within their families or communities. AEP addresses this gap by offering structured sessions that provide critical information in an accessible manner.

Through the course of the program, we have come across multiple case situations highlighting the growing influence of social media and boundary-related issues in adolescent relationships. Some students have faced confusion, emotional stress, or peer pressure arising from interactions on digital platforms. Others have shared experiences involving unclear or violated personal boundaries within friendships or romantic contexts. These instances reaffirm the urgent need for focused education around digital literacy, consent, respect, and emotional intelligence in relationships.

The Adolescent Education Program serves as a vital bridge for DHH students, ensuring they receive the guidance and support necessary for their holistic development during adolescence. By addressing gaps in awareness and providing tools for emotional and social growth, AEP empowers young deaf adults to thrive in both personal and societal contexts.

6. Parent Group Sessions

Recognizing the critical role of parent-student attachment in fulfilling a child's emotional needs, we incorporate parent group sessions into our methodology. For Deaf and Hard of Hearing (DHH) children, language barriers can impact early student-parent attachment, underscoring the importance of targeted interventions. Our parent group sessions aim to raise awareness about these challenges and provide guidance on fostering a supportive environment. By engaging parents in discussions on emotional well-being, communication strategies, and social-emotional development, we empower them to better support their children's unique needs. These sessions also address societal stereotypes and biases, helping parents navigate the challenges of raising a DHH child while promoting a collaborative approach to their student's holistic development.

In many of these sessions, we've encountered situations where parents expressed uncertainty about how to handle emotionally complex issues involving their children. A recurring concern—especially for parents of DHH girls—has been around marriage. Several parents shared the belief that because their daughter is deaf, she may not be able to find a suitable partner in the future. This belief has sometimes led to thoughts of discontinuing their child's education early or even considering early marriage, driven by fear and societal pressure.

These conversations highlight how deeply rooted social norms and limited awareness can impact critical decisions in a child's life. Through guided dialogue, community examples, and professional inputs, our sessions help challenge such assumptions and encourage long-term thinking focused on the child's overall growth, autonomy, and future possibilities.

ASSESSMENTS AND SESSIONS

Career Assessment and Guidance

Career assessments are conducted for students after they enter the first year of B.Com. This process includes a detailed analysis of each student's career goals, as outlined in their goal sheets. For students exhibiting confusion or uncertainty about their aspirations, targeted career guidance sessions are provided. These sessions aim to clarify career paths and ensure students are equipped to make informed decisions about their future.

Stress Assessment and sessions

For students preparing for board exams, a stress assessment is conducted beforehand to identify their stress levels and specific areas of concern. Based on the assessment results, tailored sessions are provided to help students develop effective coping strategies, including breathing exercises, guided imagery, progressive muscle relaxation, and time management techniques. These sessions focus on reducing anxiety, improving concentration, and enhancing emotional resilience, ensuring that students approach their exams with a calm and focused mindset. Additionally, students requiring further support receive individual counseling to address deeper stress-related challenges.

Individual Student and Parent Sessions

The Social and Emotional Well-being (SEW) program focuses on creating safe spaces for students, enabling them to feel heard and supported. Through active listening and a positive, non-judgmental approach, counselors build trust with students and empower them to reach their full potential. Students can schedule one-on-one sessions, with followups provided as necessary. Recognizing the critical role of parents in supporting deaf students, SEW also includes parent sensitization sessions. These sessions address challenges faced by parents, provide guidance, and offer emotional support to help them better assist their children in navigating societal stereotypes and other barriers. Regular communication with parents ensures a collaborative approach to the holistic development of each student.

Value and Conduct Credit Score

At TEACH, we believe in evaluating students holistically balancing academic performance with skill development, English proficiency, and their overall values and conduct. The Value and Conduct Credit Score is an integral part of our SEW (Social and Emotional Wellbeing) framework. Through this system, students are assessed at each level based on specific criteria that reflect their behavior, attitude, responsibility, empathy, and personal growth. This approach ensures that we nurture well-rounded individuals who not only excel academically but also grow socially and emotionally.

In conclusion, recognizing that many of our students enter our programs with limited prior exposure to social and emotional interventions, we deliberately structure our group sessions to begin with foundational topics. For instance, our group sessions commence with essential communication skills, teaching students how to express themselves effectively and listen actively, which lays the groundwork for deeper discussions on empathy and interpersonal relationships. Similarly, in the Adolescent Education Program, we start with fundamental yet critical topics such as distinguishing between "good touch" and "bad touch," ensuring that students have a solid understanding of personal boundaries and safety. This approach allows us to build upon these foundational skills, gradually introducing more complex themes that foster comprehensive social and emotional growth. By starting from the basics and progressing in a structured manner, we empower our students to develop a robust foundation for navigating their personal and social lives with confidence and resilience.

FINDINGS AND RESULTS

The implementation of these programs for Deaf and Hard of Hearing Students has resulted in profoundly positive outcomes. These findings are grounded in comprehensive observations from therapy sessions, as well as feedback from students, parents, and facilitators regarding improvements in students' social and emotional well-being, selfexpression, and confidence. Additionally, detailed case studies provide compelling evidence of the program's effectiveness in fostering a supportive and inclusive learning environment.

Access to Mental health services in School

Through direct interactions with DHH students and their parents, we explored the accessibility and quality of mental health services—particularly the availability of counselors and emotional support—within school environments. The insights we gathered revealed significant gaps that require immediate attention.

Many participants shared that their schools did not have a dedicated counselor. In some cases, there were visiting counselors, but their engagement was limited and infrequent. Importantly, when asked whether any of the mental health support provided was tailored to the unique needs of DHH students, every student responded with a clear "No."

These conversations also highlighted a unanimous sentiment: all students strongly felt that access to consistent, DHH-sensitive mental health support in schools would have made a significant difference in their emotional well-being and social development. They expressed a clear desire for structured support systems that could have helped them better navigate emotional challenges and build healthier relationships during their school years. This feedback underscores a critical need for institutional change. Schools must prioritize the integration of trained counselors who understand DHH-specific challenges and implement structured, inclusive emotional development programs. Supporting DHH students isn't just about accessibility—it's about creating environments where they feel heard, understood, and emotionally safe.

Parent–Student Communication

As part of our holistic approach, we conducted focused interactions with students to understand the evolution of their relationships with their parents over time. These conversations explored three key areas: Communication, Expression & Sharing, and Listening & Understanding—tracked at three critical stages:

- ***Bridge -Year: When students first joined the institute: 8%***
- ***SYJC (Second Year Junior College): After participating in the program for a period of time: 36%***
- ***TEACH graduates: After completing their course: 60%***

From our study, we discovered that at the start of the bridge year, only 8% of students felt comfortable expressing themselves or sharing their thoughts with their parents.

However, after completing our intervention, that number rose to 60% by the time students graduated — a sevenfold increase that reflects a significant improvement in parent-child communication and emotional connection.

From our interactions, it became clear that family communication significantly improved as students progressed through the program.

In the early stages (PY), many students shared that they struggled to communicate with their parents, found it difficult to express themselves, and often felt misunderstood at home. However, by the time they reached

SYJC, students began noticing small but meaningful shifts—particularly in how open their parents were to listening and how comfortable students felt expressing their emotions.

The most striking change was evident in conversations with alumni, where students described a much stronger sense of connection with their parents. They spoke of being able to share more openly, engage in healthier discussions, and experience greater empathy and understanding at home.

This positive shift can be attributed to consistent emotional support, structured communication-building sessions involving both students and parents, and personalized student engagement throughout the program. These efforts have helped bridge communication gaps, empowering families to build more trusting and emotionally connected relationships.

Detailed From One to One Connect with parents

Age of Diagnosis: Parental Awareness of Deafness in Children

As part of our continued efforts to understand the early experiences of Deaf and Hard of Hearing (DHH) students, we connected with parents to determine when they first became aware of their child's hearing impairment. Early identification is crucial, as it directly impacts access to timely intervention, language development, and overall social-emotional wellbeing.

Key Insights:

Identification within the 1 Year:

Only 4 % of parents reported identifying their child's deafness between 0–1 year. While this shows some awareness and access to screening or early intervention, the percentage remains worryingly low—especially when compared to international standards that emphasize newborn hearing screening as a critical early intervention strategy. Identification after 1 Year:

A striking 96 % of parents shared that their child's deafness was identified after the age of one, indicating a significant delay in diagnosis. This delay reduces the chances for timely language exposure and often leads to challenges in cognitive and emotional development. Many of these parents noted that they only noticed signs of hearing loss after missing speech milestones or through external advice.

Conclusion: The data clearly reflects an urgent need to strengthen early identification frameworks. Awareness and better support for parents—especially in underserved communities—can play a pivotal role in bridging this gap. Early diagnosis empowers families to begin communication strategies and interventions sooner, giving DHH children a stronger foundation for language, learning, and emotional development.

Additional Initiatives

Enhanced Emotional Awareness

- Increased Self-Awareness: The Mood Meter app provided students with a reflective moment to assess their emotional states, gradually enhancing their self-awareness. This heightened awareness allowed them to better recognize and articulate their emotions, leading to improved emotional regulation. The Circle Therapy sessions offered a deeper understanding of personal emotions and a safe space for expression. Each session emphasized the importance of confidentiality, non-judgmental attitudes, and acceptance, fostering a culture of respect and empathy among participants.

- Emotional Expression and Belonging: The therapy sessions allowed students to express frustrations openly, realizing they were not alone in their experiences. This shared understanding created a sense of belonging, as students recognized that they were part of a supportive community navigating similar challenges together.

- Psychoeducation and Group Sessions: Through these sessions, students gained valuable insights into managing their emotions effectively, further enhancing their emotional intelligence.

Improved Self-Expression

- Facilitated Communication: Group therapy sessions encouraged open communication, enabling students to express their feelings and thoughts more effectively. This environment also taught them the importance of active listening and respectful dialogue.

- Training in Effective Expression: Students learned to articulate their emotions when given the opportunity, indirectly training them in patience and effective communication. This process fostered a sense of belonging as students felt heard and understood.

- Focus and Grounding through Meditation: The use of counting techniques in meditation helped students develop greater focus and grounding. The subsequent discussion sessions further reinforced these benefits, addressing emotional challenges and promoting holistic well-being.These observations highlight the program's success in enhancing emotional awareness and self-expression among students, providing them with essential tools for emotional regulation and effective communication.

Enhanced Social Well-being

- Improved Understanding of Adolescent Issues: The Adolescent Education Program (AEP) provided a structured and safe environment for students to explore critical issues related to identity, relationships, and societal expectations. Through interactive activities such as roleplays and icebreakers, students gain self-awareness and develop strategies to navigate life transitions. These sessions not only address gaps in incidental learning caused by communication barriers but also offer essential guidance on topics crucial for their social development.

- Narrative-Based Learning: Incorporating personal narratives into sessions allows students to share their lived experiences, fostering a sense of connection and empathy within the group. Listening to peers' stories helps students realize they are not alone in their struggles, creating a supportive environment where mutual understanding and encouragement thrive. This approach enhances emotional bonding and builds a strong sense of community.

- Development of Empathy and Respect: Circle Therapy sessions emphasize core values such as confidentiality, non-judgmental attitudes, and acceptance. These principles encourage students to respect others' emotions and perspectives. Group discussions further reinforce active listening skills by teaching students to focus on one speaker at a time, thereby improving interpersonal communication and fostering empathy.

- Sense of Belonging: Shared discussions in group settings help students recognize that others face similar challenges, reducing feelings of isolation. This collective understanding strengthens peer relationships and creates a supportive community where students feel valued and included.

- Enhanced Social Skills Through Psychoeducation: Psychoeducation sessions provide students with practical tools to manage emotions effectively, which translates into improved interactions with peers. By focusing on appropriate social behaviors, these sessions help reduce awkwardness in social interactions and build confidence in navigating various social contexts.

- Grounding Techniques for Focus: Meditation sessions integrated with counting techniques enhance emotional grounding and focus. These practices help students remain calm during social interactions, while post-meditation discussions reinforce emotional regulation skills, enabling them to approach social situations with greater composure.

- Positive Impact on Social Well-being: By addressing communication barriers, fostering empathy, teaching emotional regulation, and providing platforms for self-expression, these programs have significantly contributed to the social well-being of DHH students. They are now better equipped to form meaningful connections, collaborate effectively, and navigate social environments with confidence. These interventions not only enhance their current social interactions but also prepare them for long-term success in personal and professional relationships.

Enhanced Psychological well-being and Cognition

- Reduced Psychological Distress: While studies indicate that DHH individuals are at risk for mental health challenges like anxiety and depression, structured interventions have mitigated these risks. For instance, mindfulness practices and group discussions have been effective in lowering stress levels and improving overall well-being.

- The Slow Learners Program has demonstrated significant positive outcomes in supporting students who require additional time and guidance to process information. Through personalized interventions based on holistic pre-assessments, tailored strategies have been implemented to address specific challenges such as memory retention, attention span, and information processing. These sessions have shown measurable improvements in foundational skills, such as comprehension and recall, as well as enhanced decision-making and emotional regulation. By fostering a nurturing environment with structured support plans, students have displayed increased confidence, resilience, and academic engagement. Furthermore, interventions targeting emotional challenges like anxiety and frustration have helped slow learners build selfesteem and develop a positive attitude toward learning. This comprehensive approach has empowered students to thrive both academically and socially while celebrating their unique potential.

- Guided meditation sessions using tactile cues and counting techniques have improved students' ability to concentrate. This grounding practice has positively impacted both academic performance and emotional stability.

- Roleplays and interactive activities in AEP have strengthened critical thinking and decision-making abilities. These exercises encourage students to analyze situations, consider multiple perspectives, and develop effective solutions.

DISCUSSION

The findings from our program highlight a significant positive impact on the social and emotional well-being of Deaf and Hard of Hearing (DHH) students. By addressing the unique challenges faced by these students, our interventions have not only improved emotional regulation and self-expression but also fostered a sense of belonging and social integration.

Emotional Resilience and Self-Awareness

Our data indicate that students who participated in the program demonstrated enhanced emotional resilience, as evidenced by their ability to manage stress and anxiety more effectively. The use of tools like the Mood Meter app and group therapy sessions helped students develop a deeper understanding of their emotional states, allowing them to articulate their feelings more clearly. This heightened self-awareness is crucial for navigating complex social situations and forming meaningful relationships.

Social Integration and Empathy

The Group sessions and Adolescent Education Program (AEP) played a pivotal role in enhancing social skills by addressing topics relating to identity, relationships, and societal expectations. Interactive activities like roleplays and group discussions encouraged empathy and mutual respect among participants. By recognizing that others face similar challenges, students feel less isolated and more connected to their peers, fostering a supportive community that values inclusivity and understanding.

Communication Skills and Empowerment

Our group sessions, which began with basic communication skills, empowered students to express themselves confidently. This foundational approach ensured that students could effectively engage in discussions, share their experiences, and listen actively to others. As a result, they became more adept at navigating diverse social contexts, from academic settings to personal relationships.

Holistic Development

The program's comprehensive approach, combining mood meter and happiness activity, individual sessions, psychoeducation, Circle Therapy, Slow learners sessions and AEP, ensured that students received well-rounded support. By addressing emotional, social, and cognitive development simultaneously, we observed significant improvements in students' overall well-being and their ability to cope with life's challenges. This integrated strategy not only enhanced their current quality of life but also equipped them with essential skills for long-term success and personal fulfillment.

RECOMMENDATIONS

1. Importance of Early Intervention for DHH Children

Child & Parent Perspective: Delayed identification of hearing loss—especially in rural and underserved areas—can significantly impact a child's social, emotional, and academic development. Without early language exposure and communication tools, DHH children may struggle with building relationships, understanding academic concepts, and expressing emotions.
Parents often lack awareness of how to support their DHH child, both emotionally and educationally. This disconnect can lead to communication barriers within the family and missed opportunities for early learning and bonding.

Recommendations:

Hospitals and healthcare providers must:

- Mandate early hearing screening for infants.
- Provide parental education on communication methods (like sign language) and available resources.
- Offer emotional support services to help families understand and respond to their child's needs.

Policy Gap: Currently, there is no national mandate for universal hearing screening or structured parental guidance post-diagnosis. The Ministry of Health and Family Welfare must implement mandatory infant screening policies, while the Ministry of Social Justice and Empowerment should partner with health systems to provide DHH-specific parental education programs.

Solution: Our Parent-focused training modules which can be used as interactive toolkits that cover early social-emotional development, practical communication strategies, and guidance on nurturing DHH children. These modules can be integrated into hospital counseling services and community health programs, creating a strong foundation for both child and family.

2. Tailored Interventions for Deaf and Hard-of-Hearing (DHH) Students

Recommendation: Educational institutions across all levels—schools, vocational training centers, colleges, and universities—must embed Social and Emotional Wellbeing programs as an integral part of their curriculum. SEW should be designed with accessibility and inclusivity at its core, ensuring DHH students receive age-appropriate, context-specific support throughout their educational journey. This includes hiring specialized counselors trained in DHH-specific challenges and providing tailored group sessions and one-on-one emotional support sessions.

Why This Matters: Our findings underscore the critical importance of early and continuous intervention to support the social-emotional development of DHH students. SEL fosters foundational awareness—such as communication, self-awareness, and social interaction skills—which prepares students to better engage academically and socially.

Policy Gap: There is a pressing need for a cross-ministerial approach to ensure SEL for DHH students is mandated and implemented with accountability:

The Ministry of Social Justice and Empowerment should develop clear guidelines requiring institutions to hire trained counselors and mandate specialized SEL interventions for DHH students.

The Ministry of Education, University Grants Commission (UGC), and Ministry of Skill Development and Entrepreneurship should collaborate to ensure that SEL is formally embedded across school,

college, and vocational training curricula.

Alignment with the National Education Policy (NEP) is essential, as it emphasizes holistic development, inclusive education, and emotional well-being.

Solution: Existing educational institutions should be mandated by the Ministry of Social Justice and Empowerment and/or UGC to leverage the Teacher/Counsellor Training Model to build capacity of their existing faculty, counsellor or any other personnel who is dealing with DHH students. This model will focus on creating more inclusive educational institutions that value the social and emotional needs of DHH students. By leveraging our expertise in social-emotional programs and inclusive education practices, TEACH can help equip educators with the necessary tools to support DHH students effectively.

This structured approach will ensure that educators are not only aware of the linguistic needs of DHH students but also equipped to foster an environment that promotes their overall well-being and academic success. By addressing these policy gaps and implementing targeted recommendations, we can create a more inclusive educational landscape for Deaf and Hard-of-Hearing individuals in India.

3. Creating an Accessible workplace and society for Deaf and Hard of Hearing Individuals

(A) Workplace Accessibility

Recommendation: Ensure that any workplace counselors are trained to understand the unique needs of Deaf and Hard of Hearing (DHH) individuals.

Despite the presence of disability quotas and special reservations for hearing impairment, many workplace counselors lack training on the specific challenges faced by DHH employees. This gap in knowledge can hinder effective support and integration. Just as workplaces have made strides in physical accessibility for individuals with mobility impairments—such as ramps and wheelchairs—it is equally important to address the invisible challenges associated with hearing impairments.

All workplace counselors should be required to attend training sessions focused on the psychosocial and emotional needs of DHH individuals, ensuring they can provide appropriate support and accommodations.

Why This Matters: Creating an inclusive workplace goes beyond physical adjustments; it requires a comprehensive understanding of the diverse needs of all employees. By equipping counselors with the necessary skills and knowledge, organizations can foster a more supportive environment that enables DHH individuals to thrive professionally.

Policy Gap: The Ministry of Labour & Employment, Ministry of MSME, Ministry of Corporate Affairs and the Ministry of Commerce & Industry should establish mandatory training requirements for workplace counselors regarding DHH issues.

Solution: To enhance workplace accessibility for DHH individuals, organizations can seek support from TEACH to implement a comprehensive Sensitization and Inclusion Model. This model goes beyond basic awareness to provide immersive training for all employees. By equipping teams with the right mindset and tools, TEACH helps bridge the gap between policy and practice - ensuring DHH employees feel understood, supported, and empowered within their professional settings.

(B) Accessibility in Social Settings

Recommendation: Implement basic sign language training for key personnel in social settings, including healthcare staff, doctors, social workers, psychologists, police officers, and public servants. Providing minimal training in sign language will enhance communication between DHH individuals and service providers, making social environments more accessible and inclusive.

This training should focus on effective communication techniques with the Deaf community, and recognizing the specific challenges faced by DHH individuals in various contexts.

Policy Gap: The Ministry of Social Justice and Empowerment, should mandate comprehensive sign language training programs for all professionals who interact with Deaf and Hard of Hearing (DHH) individuals. This training should be a requirement as part of their continuing education and professional development.

Why This Matters: Improving accessibility in social settings is crucial for fostering a sense of belonging and community among DHH individuals. When healthcare providers and public servants are equipped with sign language skills, they can better serve DHH clients, reducing barriers to accessing essential services.

Solution: Our sensitization workshop can be leveraged by individuals/any organizations across sectors. These sessions focus on practical communication skills, awareness, and scenariobased learning to help healthcare providers, social workers, law enforcement, and public servants engage more effectively and respectfully with the DHH community.

4. Training for Psychology Students and Social Workers

Recommendation: Introduce an additional certificate program within psychology and social work courses that focuses specifically on the communication styles, social-emotional needs, and psychological challenges faced by Deaf and Hard of Hearing (DHH) individuals. This program should include modules on Deaf social and emotional needs and challenges, and sign language training.

Integrating such specialized training into academic curricula will better prepare future professionals to offer empathetic, informed, and accessible mental health and social support to the DHH community.

Policy Gap: Regulatory bodies such as the Rehabilitation Council of India (RCI), in collaboration with the Ministry of Education and Ministry of Social Justice and Empowerment, should mandate the inclusion of DHH-focused training modules in psychology and social work programs as part of national education standards and professional licensure requirements.

Solution: Our SEW model training should be mandated into courses like B.Ed, M.Ed, and curriculum specifically designed for psychology students and social workers. This includes tailored modules, practical case studies, expert-led sessions, and immersive learning experiences that equip future professionals with the skills and sensitivity needed to support DHH individuals effectively in therapeutic and community settings.

SUMMARY OF WHAT WE OFFER

For Students : A well-structured Social and Emotional Wellbeing (SEW) Program tailored specifically for Deaf and Hard of Hearing (DHH) students, focusing on emotional literacy, social wellbeing, self-awareness, relationship-building, and mental health support.

Educators & Counsellors : Comprehensive Training Modules that enhance understanding of the unique social and emotional needs of DHH students. These modules include communication strategies, inclusive classroom practices, and emotional wellbeing approaches for educational institutes.

Employers : A practical Sensitization Program to help organizations implement inclusive practices in the workplace. This includes awareness-building around DHH communication, and accommodations that foster an accessible and supportive work environment.

For Parents : Early Intervention & Awareness Modules designed to guide parents through understanding deafness, communication techniques (like sign language), emotional support strategies, and how to build a nurturing home environment for their DHH child.

Conclusion

Our program has shown meaningful impact in improving the social and emotional wellbeing of Deaf and Hard of Hearing (DHH) students. Each session is intentionally designed to begin with foundational topics such as communication skills and critical awareness—like "good touch vs. bad touch"—to build a strong base for personal growth and emotional safety.

Recognizing that not all students learn at the same pace, our Slow Learners Program specifically supports those who face additional challenges, often due to limited early intervention and insufficient support during their formative years. By addressing these gaps, we help students regain confidence and develop at a pace that respects their individual needs.

Equally important is our work with parents. Supporting a DHH student is most effective when families are actively involved. By engaging parents and equipping them with knowledge and tools, we help create a more inclusive and emotionally nurturing environment both at home and at school—ensuring that every student has the foundation they need to thrive socially, emotionally, and academically.

Abbreviations

SEW - Social and Emotional Wellbeing
DHH - Deaf and Hard of Hearing
AEP - Adolescent Education Program
SYJC - Second Year Junior College

References

Training and Educational Centre for Hearing Impaired (TEACH). (2025). *Holistic Pre-Test: Baseline assessment of emotional, social, and academic well-being of students TEACH.*

Training and Educational Centre for Hearing Impaired (TEACH). (2025). *Family Communication Scale: Measuring openness of communication between students and families TEACH.*

Training and Educational Centre for Hearing Impaired (TEACH). (2025). *Counsellor Accessibility Survey: Student awareness and access to school counseling TEACH.*

Training and Educational Centre for Hearing Impaired (TEACH). (2025). *Stakeholder interactions: Direct engagement with 500+ Deaf and Hard of Hearing students and families over two years TEACH.*

Stakeholder Interactions

Direct Engagement with 500+ Deaf and Hard of Hearing Students and Their Families over a period of 2 years

Conducted both one-on-one sessions and group interactions to gather comprehensive insights.

Engagements focused on understanding individual experiences, family dynamics, emotional well-being, and academic support needs.

Websites
https://www.nationaldeafcenter.org
https://pmc.ncbi.nlm.nih.gov/articles/PMC2093933

© 2025 TEACH. All rights reserved.

This publication is the intellectual property of TEACH. No part of this material may be reproduced, distributed, translated, or transmitted in any form or by any means electronic, mechanical, photocopying, recording, or otherwise without prior written permission from TEACH.

However, individuals or organizations interested in using, adapting, or referencing this work may do so with express permission. Please contact TEACH for inquiries regarding appropriate usage and permissions.

Training and Educational Centre for Hearing impaired (TEACH)
Non profit organisation registered under The Bombay Public Trust Act, 1950

Registration Number: E/10326/Thane

Registered Office Address: A 803, Swagat Heights, behind GCC International School, Near GCC Club, Mira Road East - 401107

Campus Addresses:

Mumbai : 2nd Floor, AET Centre, 267, Sulochana Shetty Marg, Sheti Marg, Sion West, Mumbai - 400022
Delhi : E-48/3, Block- E, 4th floor, Okhla Industrial Area Phase-II, New Delhi- 110020
Pune : Delight Square, 3rd floor, Opp Arenshywar Park, above Walimbe eye clinic.

COMMUNICATION BARRIERS LEADS TO DEPRESSION AMONG DEAF ADOLESCENTS: A REVIEW

Sonia Chawla & Dr. Gayatri Gurvendra

Abstract

Hearing loss is a multi-dimensional and multi-faceted disability that has significant implications for social, emotional, and cognitive development. Deaf people think about themselves as a cultural minority who use a visual language (i.e., sign language). Deaf people are an overlooked group in depression research. This article explores how communication barriers lead to depression in Deaf people through research findings. We conducted an electronic search of the databases PubMed, Medline, and Science Direct to find relevant articles. We also searched reference lists from articles found in the electronic search. Overall, we retrieved 10 articles: Of the 10 articles reviewed, 7 reported more depression in Deaf people than in hearing people, 3 articles reported no differences between the two groups, and based on the 7 relevant articles, depression, communication barriers, and social isolation were found more often after depression in Deaf people. Deaf students were more likely to have mild depressive symptoms compared to hearing students, but not severe depressive symptoms. There were no reports in the literature examining the adequacy and reliability of the methods for evaluating depressive symptoms in Deaf adults, but none of the studies concluded that Deaf adults do not experience depressive symptoms

Keywords: Adolescence, Anxiety, Deafness, Depression

Introduction

Disability affects the individual, family, and society in numerous ways and has high social and economic implications worldwide. Indeed, disability is a manifestation of limitations of foundational physical, spiritual, and mental capabilities and limitations are foundational for every individual. Deaf children of deaf parents attain better emotional and cognitive development than do deaf children of hearing parents (1). Traditionally, deaf

individuals have been overlooked from general investigations, even though, regardless of an increase in mental health services for individuals with hearing loss, limited empirical investigations into with regards to the prevalence and distribution of disorders of psychiatric symptoms and disorders in the deaf population have remained, literature search highlights some articles, addressing deafness and mental health, the majority of instances addressed mental health and deafness from a practice perspective with limited data added. The deaf patient can be accommodated to ensure a successful medical visit by making arrangements for interpreters before the medical visit and by scheduling extra visit time (2). On the other hand deaf adolescents are often faced with the additional challenge of managing many adaptations in a hearing world(3). Especially fathers, can feel shame and embarrassment in taking their child to social and family gatherings. This can lead to social isolation for the whole family, contributing to further stress (4).

Thus, to understand more about how deafness affects the mental health of deaf individuals, studies that use more representative samples are necessary. One of the disabilities associated with deafness is depression. Depression is an important disorder in mental illness. It is categorized as depression, a disabling clinical diagnosis, because it is the worst until that moment. Theory of mind (ToM) is the mental capacity that allows us to represent the mental states (beliefs, desires, emotions) of other people, infer them from situational cues, and predict their behavior(6). Outward signs of depression can delay to attention, diagnosis, and treatment is important. Since Research into factors affecting mental health of deaf children shows that early access to effective communication with family members and peers is desirable(7).

Hearing impairment

The NAD (National Association for the Deaf) interprets the terminology "deaf" as those who cannot hear well enough to depend on hearing as a means of understanding. Hearing loss usually predisposes sufferers to resentment, hostility, rejection and subtle denial, resulting to a cascading effect on socioemotional development (8). Adolescents must adapt based on developing skills and needs and acclimate to growing environmental pressures(3).

The deaf and hard of hearing are predominantly visually-based, and have a culture which is very different and colorful. This fact is sometimes a little hard for hearing people to fully appreciate. Sensory impairment is significantly associated with negative well-being in older persons(12). The unique treatment needs of psychiatric inpatients who are deaf require added dimensions to their care. Because of the scarcity of specialized units for persons who are deaf, descriptions of these treatment needs are infrequent (13).

Society must be made aware of the special risks that deaf children and adults encounter with respect to mental health(14). Research has indicated that moderate and mild are the most at-risk groups. So much so that almost all of our searches for this review will focus on people with mild to moderate deafness, with onset before they had learned language. Adolescents with Cochlear implanted tended to be more hearing acculturated(16). The use of an interpreter can clarify communication and cultural issues for deaf and hearing children, families, and professionals (19). The adolescent should be directed towards social activities and courses, their positive sides should be supported(20). Sensory impairment's association with depression may differ between males and females(12). Prevalence of anxiety is higher among people with hearing impairment than the general population; our findings indicate that this excess morbidity may be related to the hearing impairment itself, as it was associated with the severity of impairment, and reduced after surgical treatment(23).

The Adolescent Deaf

It is assumed that adolescence is a "difficult" life stage, with adolescents being highly stressed and moody. It is also assumed that adolescents are stressed because they are coping with major life changes. Some of the changes are in sexual behaviors that follow puberty. Other major changes are social, with adolescents spending more time with same-age peers and less time with parents than they did earlier. Adolescents also have to decide their future. Having a hearing disorder would complicate these challenges for adolescents during an already difficult period of development. Indeed, Deaf adolescents are more depressed than their hearing peers. Findings that childhood trauma is a risk factor for depression is not new. There have long been strong associations between childhood adverse life experiences and mental health disorders throughout the life cycle. Childhood negative experiences that may lead to depression include sexual abuse or physical abuse, feeling excluded from family, and becoming ill or disabled.

Adolescents without cochlear implants tended to be more Deaf acculturated (16). While some researchers have identified that staff at nursing homes have insufficient knowledge about hearing loss and hearing aids(24).

Deaf individuals have higher rates of psychiatric disorder than those who are hearing, while at the same time encountering difficulties in accessing mental health services. These factors might increase the risk of suicide(25). This is an important risk factor, as 90%-95% of deaf children are born to hearing families. According to research, deaf children can feel excluded, ignored, or ostracized by the hearing world, which can affect their ability to acquire social skills that are essential for life and which may affect self-esteem. A comprehensive mental health assessment needs to incorporate the medical and cultural model of deafness and adaptations in the assessment process will need to be made(26). Adolescents faced the challenge of communication and access to information, especially about their social world, is often incomplete at best and nonexistent at worst (3). Deafness not only increases a person's vulnerability to mild levels of depression, but

also tends to augment one's tendency toward experiencing boredom (27). Conversely, the communication experiences of deaf children may have made it harder for them to disclose exposure to abuse. Diagnostic delay occurs even though half the children who have impaired hearing are known to be at increased risk (29). Because of this, very few Deaf children are receiving appropriate treatment for their depression. This is even more acute for children who have experienced physical and sexual abuse. The deaf and hard-of-hearing are considered an abandoned and underserved population (8).

An abundant of research demonstrates the importance of ensuring a deaf child's communication needs are understood to promote their psychosocial development regardless if it is through AM mode or FM mode of communication, or the degree of loss. One study reported evidence of hearing impairment in 0.2% of all suicide deaths. Another found that individuals with tinnitus seen in specialist clinics had an elevated rate of suicide compared to the general population(25). Additionally, it was argued that greater use of signed communication at home, related to a decrease in the occurrence of mental health concerns.

Very few studies have focused specifically on suicide in deaf populations. Those studies that were included (n = 13) generally involved small and unrepresentative samples. There were limited data on the rate of suicidal behaviour in deaf people.(25). Little evidence was found to suggest that risk factors for suicide in deaf people differed systematically from those in the general population. (25). In the same study they found that No firm evidence was found regarding the effectiveness of suicide prevention strategies in deaf people, but suggested strategies include developing specific screening tools, training clinical staff, promoting deaf awareness, increasing the availability of specialist mental health services for deaf people(25). Research into factors affecting mental health of deaf children shows that early access to effective communication with family members and peers is desirable(6).

Thirty children with cochlear implants (CI children), age range 3–12 years, and 30 children with normal hearing (NH children), age range 4–6 years, were tested on theory of mind and language measures. The CI children showed little to no delay on either theory of mind, relative to the NH children, or spoken language, relative to hearing norms.(6) The CI children showed a slightly atypical sequence of acquisition of theory of mind concepts. The CI children's theory of mind performance was associated with general syntactic proficiency more than measures of complement syntax, and with time since implantation more than age at implantation. Results suggest that cochlear implantation can benefit spoken language ability, which may then benefit theory of mind, perhaps by increasing access to mental state language.(6) Communication barriers, and low abilities to make demands and express needs can all lead to disengagement with interests and activities and dissociating them from the world pre- disposing them for mental health concerns .

These concerns included depression. The purpose of this article is to examine deaf individuals reported depression found through research result. It's asserted that we expect a higher rate of depression in Children who have early onset severe to profound deafness (mild & mod).

Depression

Some studies showed high rates of depression and anxiety disorders, particularly social phobias, in deaf and hard- of-hearing children and adolescents, most of the studies conclude that the prevalence of affective disorders in hearing-impaired children and adolescents is comparable with estimates of prevalence for hearing young people (1). Depression has been determined by the World Health Organization (WHO) to be the most disabling clinical diagnoses in the world, and it is estimated that there are an estimated 340 million people worldwide that are diagnosed at any one moment in time (6). The deaf students had a significantly higher incidence of depression than the hearing students (27). The results point to the need for focussing more attention on the mental health of deaf children and adults(14). The heightened prevalence of mental health problems in the deaf is reflective of the heightened prevalence of both emotional and conduct problems. The symptoms of depression in Deaf adults are not different from those seen in hearing people. Analyses revealed

that the deaf respondents showed significantly more symptoms of mental health problems than the hearing respondents(20). Deaf professionals have a vital role in mental health services for this population (13). The objective of this article is to disclose the mental health situation among deaf individuals compared to a control sample of hearing individuals. The analyses are based on two separate Norwegian postal surveys, one among the general population (1995-1997) and one among the deaf population (2001). A shortened version of the Hopkins Symptom Checklist was used to disclose the degree of mental distress among the respondents. Three questions common to the studies were analyzed to determine differences between the two groups. (1). Rosenberg Self-Esteem Scale is applied upon the study group, which consists of 30 adolescents with cochlear implants between the ages of 12-19 and upon the control group, which consists of 60 adolescents having the similar characteristics. The scale is used to evaluate the level of depressive emotioning of adolescents with cochlear implant and with normal hearing(20): he scores of these two groups, which they got according to their answers, were compared statistically. When the results were examined, there seemed to be no significant difference statistically between the depressive emotioning values of the cochlear implant group and the control group. Apart from this, in this study, we examined changes in the level of depressive emotioning according to different variables. As a result, it was found out that in both groups level of depressive emotioning was lower for adolescents who had had preschool education, had brothers/sisters, high level of income, whose father and mother had higher levels of education. On the other hand, the birth sequence and the child's father's profession did not seem to have any effect on the child's level of depressive emotioning(20).

It was thought that cochlear implantation had a positive effect on life quality, and it was suggested that the adolescents and their families should get assistance from experts about the characteristics and principles ofapproaching the child in this period. (20). An investigation entitled Boredom Proneness and depression among 50 profoundly deaf residential school adolescents using the Boredom Proneness (BP) scale and a version of the Beck Depression Inventory (BDI) that has been modified for use with deaf subjects. In addition, the deaf students were found to be significantly more boredom-prone than the hearing subjects.(27).

In short, the assessment of psychiatric disorders in hearing-impaired children sets some methodological problems. Accurate evaluation is hampered by the immature language exhibited by many hearingimpaired children and by the difficulties that may be encountered in establishing rapport if the child does not understand the examiner's verbal exchanges(1). It would seem loneliness and problem solving are thought to be important in predicting depressive symptoms in the hearing, it was hypothesized that these constructs would also be important predictors of depressive symptoms in the deaf and hard-ofhearing(7). Specialist mental health services should be readily accessible to deaf individuals and specific preventative strategies may be of benefit(25).

Methods

A systematic search of the literature was carried out and included the core databases Cochrane Library, PubMed, PsycINFO, and Science Direct, and a web search with Google Scholar. In addition, reference lists of included articles were checked to find relevant articles not indexed in the databases, and in the databases, searches were undertaken with multiple categories (clinical studies, clinical trials, systematic reviews, and other reviews). The researchers have also used multiple keywords for hearing impairment and deafness. These keywords were combined with keywords related to mental health, for example, "hearing impaired and mental health", "adolescents with hearing impairment and mental health". The WCP worked with the inclusion criteria: a) in English language; b) published from 1989 onwards; c) had new data; d) studied adolescents with hearing impairment, and e) explored areas related to the prevalence and distribution of psychiatric disorders in adolescents with hearing impairment.

Results

The prevalence rates of depression among deaf adults from different research studies. It shows the name of the

(1) Communication problems in hearing children of deaf parents

Schiff NB, Ventry IM studied Fifty-two children who had deaf parents and were thought to have normal hearing were evaluated for speech, hearing, and language problems. Standardized tests, audiological evaluations, and informal conversation and play techniques were used. Of the 52 children of deaf parents, less than half were considered to be developing speech and language normally and 12% had previously undiagnosed hearing loss. The prevalence of speech and language problems and hearing losses is higher in this population than in the population at large. The children appeared to be using two systems to communicate, one with hearing people and one with the deaf. Of the children having some speech and language difficulty, approximately half

had problems that were not associated with other known physiological or environmental factors that might affect speech and language. Although there were no children of intelligible mothers who had speech and language problems, there were children developing normally who had parents whose speech intelligibility was poor. Contrary to indications in the literature, speech and language problems did not disappear after the children entered school. A large number of school-age children as well as preschoolers appeared to be having speech and language problems. The amount of time spent with hearing adults during the preschool years or the presence of older normal-hearing and -speaking siblings did not seem related to speech and language difficulty. However, when an elder sibling had speech and language difficulty, the younger siblings tended to have similar problems. The relationship between sign and oral language development is ambiguous, but there is no indication that the use of sign language deters oral language development. In view of the high incidence of communication problems in this population, annual audiological evaluations and counseling of deaf parents concerning aspects of hearing loss and normal language development are recommended. The problems encountered in providing therapy are discussed(21).

(2) Activity participation on executive functions and well-being of hearingimpaired children

Göktaş A, Üstündağ A, Şahin AZ conducted a study in which total of 69 students attending primary and secondary schools participated in the study. Eighty students were invited to participate in the study, but 69 of them agreed to participate in the study. The ages of the participants ranged between 4 and 12 years (mean: 12.48 ± 3.43 years). There was a statistically significant positive correlation between psychological well-being scale and activity performance ($r = 0.285$, $p = 0.023$). The contribution of age and activity performance variables to the model showing the effect of the Well-being Scale on the total score was statistically significant. The age and activity performance, which were the independent variables in the model, explained 30.9% of the changes in the Well-being Scale score. A one-unit increase of age caused a 0.976 standard deviation decrease in the Well-being scale score and a one-unit increase of the activity performance variable caused a 2.280 standard deviation increase in the Well-being Scale score(9).

(3) Reliability of the BDI-II with deaf persons

Leigh and Anthony-Tolbert examined twenty male and thirty-three female deaf college undergraduate students with the Beck Depression Inventory –
II.40 There was no comparison group. The assessment was made with the participants' preferred mode of communication. Twenty-six percent of the students reported having been severely depressed at some time. This is almost twice the prevalence of positive screens for depression of 13.8 percent reported for hearing undergraduate students by Eisenberg and associates (15).

(4) Early Language Access and STEAM Education: Keys to Optimal Outcomes for Deaf and Hard of Hearing Students

Marie Coppola & Kristin Walker examined an overview of a large study of language and cognitive development in deaf and hard of hearing children. Specifically, we investigated how acquiring a signed or spoken language (language modality) and when a child's access to language begins (i.e., at birth or later in development) influence cognitive development. We conducted in-person behavioral assessments with 404 children 3–10 years old (290 deaf and hard of hearing; 125 typically hearing). The tasks measured a range of abilities along a continuum of how strongly they depend on language input, such as general vocabulary and number words (strongly dependent) vs. skills such as tracking sets of two to three objects and standardized 'nonverbal' picture-similarity tasks (relatively independent of language). Overall, the timing of children's access to language predicted more variability in their performance than language modality. These findings help refine our theories about how language influences development and suggest how a STEAM pedagogical approach may ameliorate the impacts of later access to language. These results underscore children's need for language early in development. That is, deaf and hard of hearing children must receive fully accessible language input as early as possible through sign language, accompanied by hearing technology aimed at improving access to spoken language, if desired. (18).

(5) The lived experience of depression among culturally Deaf adults

Study K. Sheppard & T. Badger, used a hermeneuticphenomenological methodology. Guided by this methodology and philosophy, the researcher sought to understand the nature of the human experience, and language was the data that gave meaning to the experience. The researcher identified her knowledge, expectations and understanding of health care, deafness, and Deaf culture and incorporated these into her analysis. Participants were recruited from large metropolitan areas of California and Nevada. Flyers were posted at clubs, centers and events frequented by Deaf adults. Flyers identified three means of contacting the researcher, including TTY (teletype ,) e-mail and text messaging. Sampling was purposive; the researcher sought participants who could best speak to the experience. Sampling continued until saturation was attained. Steps included: identifying preunderstandings, gaining understanding through dialogue with participants, gaining further understanding through text and establishing trustworthiness of human subjects'. The interviews were co- created by the researcher and the participant. All interviews were conducted in ASL, and each participant was interviewed three times. Analysis was ongoing during the interview process, which allowed for understanding through engagement of text (i.e. dialogue and transcriptions). To increase her awareness during the interviews and subsequent data analysis, the researcher continually used reflection to heighten her awareness of her own preunderstanding (23)

(6) Toward greater understanding of depression in deaf individuals.

Leigh IW, Robins CJ, Welkowitz J, Bond RN compared the prevalence of depressive symptoms among deaf and hearing college students and examined the relationships among depressive symptoms, personality characteristics, and perceived parental attitudes and behaviors in these two groups. Measures were revised to meet the language needs of the deaf subjects. Mild levels of depressive symptoms were more prevalent in the deaf than in the hearing students, but more severe depression was not. In both groups, depressive symptoms were associated with perceptions of lower maternal care and higher maternal overprotection. Deaf and hearing subjects did not differ on these perceived maternal characteristics. Depressive symptoms were associated with socially dependent personality characteristics in the hearing sample only. We discuss the implications of the findings for the role of personality development in depression in deaf individuals(17).

(7) Response by WHO

WHO's Mental health action plan 2013–2030 highlights the steps required to provide appropriate interventions for people with mental disorders including depression. Depression and self-harm/suicide are among the priority conditions covered by WHO's Mental Health Gap Action Programme (mhGAP). The Programme aims to help countries increase services for people with mental, neurological and substance use

disorders through care provided by health workers who are not specialists in mental health. WHO has developed brief psychological intervention manuals for depression that may be delivered by lay therapists to individuals and groups.

An example is the Problem management plus (PM+) manual, which describes the use of behavioural activation, stress management, problem solving treatment and strengthening social support. Moreover, the Group interpersonal therapy for depression manual describes group treatment of depression. Finally, the Thinking healthy manual covers the use of cognitive-behavioural therapy for perinatal depression(28).

(8) Gestural communication in deaf children: the effects and non-effects of parental input on early language development.

In the present study, this phenomenon of gesture creation was replicated in four deaf children aged 1-4 to 3-1 at the time of the first interview. Each child, despite his atypical language-learning conditions (in particular his lack of usable conventional linguistic input, either oral or manual), developed a gesture system comparable in semantic content and structure (specifically, constructional ordering of elements, differential probabilities of production of elements, and recursive concatenation of semantic relations) to the gestural systems of the six deaf children of hearing parents in our original study and comparable as well to the spoken and sign systems of children acquiring conventional languages under typical learning conditions. This phenomenon suggests that the human child has strong biases to communicate in language-like ways. Nevertheless, it is possible that the deaf child's hearing parents, and not the child himself, were responsible for the emergence of the child's structured (yet idiosyncratic) gesture system. To investigate this possibility, we considered three possible parental influences on the child's sentence structures. First, we entertained the hypothesis that the children's sign sentences were merely imitations (perhaps even uncomprehending imitations) of a hearing adult's immediately preceding gestures. Second, we considered the possibility that the regularities underlying the deaf children's structured sign sentences were induced from their hearing parents' gestures taken in toto. Finally, we considered the possibility that the deaf children's sign sentences had been shaped by their parents' responses to those sentences. We found no evidence to support any of these hypotheses. The data reported in this series of studies confirm that deaf children lacking a conventional linguistic input can develop a gestural communication system that shows some of the structural regularities characteristic of early child language. The results suggest that communication with a number of language-like properties can develop in a markedly atypical language-learning environment, even without a tutor's modelling or shaping the structural aspects of the communication. The data are consistent with the hypothesis that the deaf child himself plays a seminal role in the emergence of the structural aspects of these communication systems. (10)

(9) What You Don't Know Can Hurt You: The Risk of Language Deprivation by Impairing Sign Language Development in Deaf Children.

In a study, Hall WC studied A longstanding belief is that sign language interferes with spoken language development in deaf children, despite a chronic lack of evidence supporting this belief. This deserves discussion as poor life outcomes continue to be seen in the deaf population. This commentary synthesizes research outcomes with signing and non-signing children and highlights fully accessible language as a protective factor for healthy development. Brain changes associated with language deprivation may be misrepresented as sign language interfering with spoken language outcomes of cochlear implants. This may lead to professionals and organizations advocating for preventing sign language exposure before implantation and spreading misinformation. The existence of one-time- sensitive language acquisition window means a strong possibility of permanent brain changes when spoken language is not fully accessible to the deaf child and sign language exposure is delayed, as is often standard practice. There is no empirical evidence for the harm of sign language exposure but there is some evidence for its benefits, and there is growing evidence that lack of language access has negative implications. This includes cognitive delays, mental health difficulties, lower quality of life, higher trauma, and limited health literacy. Claims of cochlear implant- and spoken

language-only approaches being more effective than sign language-inclusive approaches are not empirically supported. Cochlear implants are an unreliable standalone first-language intervention for deaf children. Priorities of deaf child development should focus on healthy growth of all developmental domains through a fully-accessible first language foundation such as sign language, rather than auditory deprivation and speech skills. (11).

(10) Longitudinal effects of emotion awareness and regulation on mental health symptoms in adolescents with and without hearing loss

Eichengreen A, Broekhof E, Tsou YT, Rieffe C. Using self- and parent's reports, we assessed 307 adolescents (age 9-15) three times over 18-month period. We found stability over time in development of EA and avoidance ER, increase in approach ER and decrease in worry/rumination. High levels and increases over time in two aspects of EA, emotion differentiation and communication, and in approach and avoidance ER were related to decreases in depressive symptoms. An increase in approach ER was also related to a decrease in anxiety symptoms. Yet, low levels or decreases in worry/rumination were related to decreased levels of depressive, anxiety and externalizing symptoms. Hearing loss did not moderate any of the variables or relations tested. Preliminary tests suggested heterogeneity within the DHH group according to educational placement, language abilities and parental education level. Overall, findings pointed at unique contributions of EA and ER to mental health development, suggesting that DHH adolescents, especially in mainstream schools, do not differ from their hearing peers in their emotion awareness and regulation(5).

Discussion

The deaf and hard-of-hearing face unique challenges during their visits to medical and/or mental health provider(s) that hearing persons take for granted. For example, improved access to health and mental health care can be achieved by provision of specialist services with professionals trained to directly communicate with deaf people and with sign-language interpreters. (7).

For these Deaf individuals, their communication barriers contribute to depressive symptoms. The main risk factors are developmental delays related to an early deprivation of communication. It seems to relate to the quality of life and sense of well- being and happiness for the deaf education student interacting with the hearing population and particularly for the deaf in school-age and adolescence. Communication barriers and lack of ability to express wants and needs may lead to abandoning interests and activities, putting them at risk for mental health issues particularly related to depression.

Research has indicated higher rates of psychiatric disorder in deaf individuals than hearing individuals, while also experiencing barriers surrounding accessing mental health services. While there is no literature to indicate that Deaf youth do not experience depressive symptoms, current screening practices to measure depressive symptoms in this population do not adequately capture depressive symptoms. Many depressive screening instruments may not be reliable for Deaf individuals because they were not validated with a culturally Deaf population. This article discusses the research on several factors that influence a deaf adolescent's adaptation, including quality of life, self-concept, and identity development(3). We aim to evaluate the association between hearing impairment, vision impairment, and their combination (dual sensory impairment) with negative well-being such as depression, subjective poor health and the reduced functional ability in community- dwelling older adults, and to determine whether any association varies by gender(12). We observed gender differences in the association between sensory impairment and depression. Multiple logistic regression analysis revealed that hearing impairment in males (adjusted odds ratio: 2.23, 95% confidence interval; 1.07-4.61) and vision impairment in females (1.91, 1.14-3.21) were related to depression. Vision impairment and dual sensory impairment were also associated with subjective poor health and reduced functional activity in both sexes(12). Sensory impairment is significantly associated with negative well-being in older persons, and its association with depression may differ between males and females(12). The

assessment and treatment of deaf children with psychiatric disorder is intimately related to the individual child's communication, which in turn is affected by a number of factors, medical, social, and cultural(19). Adolescence has long been viewed as a time of rapid change in many domains including physical, cognitive, and social (3).

Based on our research we are suggesting a few things that seem to be effective. These include approaches to reduce communication and relationship issues in deaf people which are: 1) Provide education on healthy relationships to deaf teen; 2) Encourage family members to sign or use the preferred mode of communication even in private situations; 3) Provide deaf mentors and deaf coaches for deaf adolescents. There are similar approaches to reducing depression in deaf people, such as providing ongoing intervention courses, fluent use of ISL (Indian Sign Language), and the provision of mentoring etc.

The society needs to be aware of the very special risks deaf children and adolescents may be at risk of mental health issues. In light of the size of the deaf population in our country, this study assessed. The main findings are that 73% of informants found that many residents need help with their hearing aids. Only one-tenth report that they know enough about the residents' hearing aids. Almost four out of five informants find that the residents become socially isolated as a result of hearing loss. Seventy-eight percent agree to some extent that more residents would benefit from hearing aids.(24).

Conclusion

More mild level of depressive symptoms are more prevalent in the deaf than in hearing students, but not severe levels of depressive symptoms. While there is no evidence in the literature to suggest that Deaf adults do not experience depressive symptoms, current methods of measuring depressive symptoms among the population are insufficient and unreliable.

References

Bailly D, Dechoulydelenclave MB, Lauwerier L.Encephale. Hearing impairment and psychopathological disorders in children and adolescents. Review of the recent literature. 2003 Jul-Aug;29(4 Pt 1):329-37.PMID: 14615703 Review French.

Berry JA, Stewart AJ. Communicating with the Deaf During the Health Examination Visit. The Journal for Nurse Practitioners. 2006; 2(8):509-15.

Brice PJ, Strauss G.Adolesc. Deaf adolescents in a hearing world: a review of factors affecting psychosocial adaptation. Health Med Ther. 2016 Apr 21;7:67-76. doi: 10.2147/ AHMT.S60261. eCollection 2016. PMID: 27186150.

Claudia and M. L. Sandu. Anxiety and depression in parents of disabled children. Technium Social Sciences Journal, Technium Science, 2020. vol. 3, no. 1, pp. 141-150.

Eichengreen A, Broekhof E, Tsou YT, Rieffe C. Longitudinal effects of emotion awareness and regulation on mental health symptoms in adolescents with and without hearing loss. Eur Child Adolesc Psychiatry. 2023 Apr;32 (4): 705-724. doi: 10.1007/s00787-021-01900-9. Epub 2022 Feb 22.PMID: 35192035

E. Remmel et al. Theory of Mind and Language in Children With Cochlear Implants. October 2008. Journal of Deaf Studies and DeafEducation 14(2) : 218-36

Fellinger J, Holzinger D, Pollard R. Lancet, Mental health of deaf people. 2012 Mar 17; 379 (9820): 1037-44. doi: 10.1016/S0140-6736(11) 611434.PMID: 22423884 Review.

Friedman J. Predictors of depressive symptoms in persons with deafness and hearing loss. 2008 Faculty of Drexel University, Philadelphia

Göktaş A, Üstündağ A, Şahin AZ. Activity participation on executive functions and well- being of hearing impaired children. BMC Public Health. 2025 Mar 31;25(1):1215. doi: 10.1186/s 12889-025-22146-z.PMID: 40165163

Goldin-Meadow S, Mylander C. Gestural communication in deaf children: the effects and noneffects of parental input on early language development. Monogr Soc Res Child Dev. 1984;49(3-4):1- 151.PMID: 6537463

Hall WC. What You Don't Know Can Hurt You: The Risk of Language Deprivation by Impairing Sign Language Development in Deaf Children. Matern Child Health J. 2017 May;21 (5):961-965. doi: 10.1007/s10995-017-2287-y.PMID: 28185206

Harada S, Nishiwaki Y, Michikawa T, Kikuchi Y, Iwasawa S, Nakano M, Ishigami A, Saito H, Takebayashi T. Gender difference in the relationships between vision and hearing impairments and negative well-being. Prev Med. 2008 Oct;47(4):433-7. doi: 10.1016/ j.ypmed.2008.06.011. Epub 2008 Jun 20.PMID: 18619483

Haskins BG. Serving deaf adult psychiatric inpatients. Psychiatr Serv. 2004 Apr;55(4):439-41. doi: 10.1176/appi.ps.55.4.439.PMID: 15067159

Kvam MH, Loeb M, Tambs K. Mental health in deaf adults: symptoms of anxietyand depression among hearing and deaf individuals. J Deaf Stud Deaf Educ. 2007;12(1):1-7.

Leigh IW, Anthony-Tolbert. S. Reliability of the BDI-II with deaf persons. Rehabilitation Psychology. 2001;46(2):195-202.

Leigh IW, Maxwell-McCaw D, Bat- Chava Y, Christiansen JB. Correlates of psychosocial adjustment in deaf adolescents with and without cochlear implants: a preliminary investigation. J Deaf Stud Deaf Educ. 2009 Spring;14(2):244-59. doi: 10.1093/deafed/enn038. Epub 2008 Oct 14.PMID: 18854552

Leigh IW, Robins CJ, Welkowitz J, Bon RN. Toward greater understanding of depression in deaf individuals. Am Ann Deaf. 1989 Oct;134(4) :249-54. doi: 10.1353/aad.2012.0662.PMID: 2589142

Marie Coppola, Kristin Walker. Early Language Access and STEAM Education: Keys to Optimal Outcomes for Deaf and Hard of Hearing Students.
Educ. Sci. 2025, 15(7), 915; https://doi.org/10.3390/educsci15 070915

Roberts C, Hindley P. The assessment and treatment of deaf children with psychiatric disorders. J Child Psychol Psychiatry. 1999 Feb;40(2):15167.PMID: 10188699 Review.

Sahli S, Arslan U, Belgin E. Depressive emotioning in adolescents with cochlear implant and normal hearing. International Journal of Pediatric Otorhinolaryngology. 2009;73(12):1774-9.

Schiff NB, Ventry IM. Communication problems in hearing children of deaf parents. J Speech Hear Disord. 1976 Aug;41(3):348-58. doi: 10.1044/jshd.4103.348.PMID: 950794

Sheppard K, Badger T. The lived experience of depression among culturally Deaf adults. J Psychiatr Ment Health Nurs. 2010;17(9):783- 9.

Shoham N, Lewis G, Favarato G, Cooper C. Prevalence of anxiety disorders and symptoms in people with hearing impairment: a systematic review. Soc Psychiatry Psychiatr Epidemiol. 2019 Jun;54(6):649-660. doi: 10.1007/s00127-018-1638-3. Epub 2018 Dec 13.PMID: 30547211

Solheim J, Shiryaeva O, Kvaerner KJ. Lack of ear care knowledge in nursing homes. J Multidiscip Healthc. 2016 Sep 30;9:481-488. doi: 10.2147/JMDH.S113689. eCollection 2016.PMID: 27757038

Turner O, Windfuhr K, Kapur N. Suicide in deaf populations: a literature review. Ann Gen Psychiatry. 2007; 6:26.

Walker R. Child mental health and deafness. Paediatrics and Child Health. 2013;23(10):438-42.

Watt JD, Davis FE. The prevalence of boredom proneness and depression among profoundly deaf residential school adolescents. Am Ann Deaf.
1991 Dec;136(5):409-13. doi: 10.1353/aad.2012. 0470.PMID: 1799178

World Health Organization. The World Health Organization data from: depressive disorder (depression). (2023).
Available at: https://www.who.int/newsroom/fact- sheets/detail/depression.

Wong D, Shah CP. Identification of impaired hearing in early childhood. Can Med Assoc J. 1979 Sep 8;121(5):529-32, 535-6, 538 passim. PMID: 387194

NEED FOR CURRICULUM AND TEXT ADAPTATION IN EDUCATION OF DEAF LEARNERS

Harish Soni

Introduction

Curriculum adaptation is essential to ensure equitable and meaningful education for Deaf and Hard-of-Hearing (DHH) learners. Most education systems have historically been designed around the needs of hearing students, assuming full access to spoken language through listening. As a result, a uniform curriculum and standard textbooks often create significant barriers for DHH learners, particularly in accessing language-rich content, classroom instruction, and assessment processes.

Deaf and hard-of-hearing learners may experience delayed language exposure, differences in language modality, and varied communication preferences such as sign language, spoken language, or a combination of both. When the same curriculum is delivered without modification, learners may struggle with comprehension, concept formation, literacy development, and subject-specific vocabulary. These challenges reflect limited linguistic and instructional access rather than cognitive limitations.

Curriculum and text adaptation address these barriers by making learning materials visually rich, linguistically accessible, conceptually clear, and aligned with learners' communication modes. Adaptation includes simplifying language without diluting concepts, integrating sign language support, using visuals and real-life contexts, restructuring lessons, and providing flexible assessment options. Such practices promote equity, inclusion, and academic success while maintaining high educational expectations.

Why Curriculum and Text Adaptation Is Important

Equal Access to Education
Ensures that learners with hearing impairment receive equitable learning opportunities by reducing linguistic and communication barriers.

Development of Literacy (Reading and Writing)
Adapted texts bridge the gap between sign/spoken language and written language, supporting comprehension and written expression.

Addressing Diverse Learning Needs
Deaf learners follow different communication approaches such as oralism, total communication, and educational bilingualism. Adaptation allows flexibility to support these differences.

Inclusion in Mainstream Education
An adapted curriculum enables meaningful participation of deaf learners in inclusive classrooms through accessible instruction and assessment.

Key Areas for Curriculum and Text Adaptation
Text Adaptation

- Methods of Communication
- Instructional Strategies
- Classroom Environment
- Assessment Adaptation

Text Adaptation: Five Key Areas

Language Adaptation
Focuses on simplifying sentence structure and grammar without reducing academic depth. It includes explaining new vocabulary, avoiding idioms, and using clear and direct language.

Knowledge Adaptation
Ensures learners have adequate background knowledge. Concepts are broken into smaller steps and linked to real-life experiences and prior knowledge.

Presentation Adaptation
Involves organizing content using headings, bullet points, charts, graphic organizers, and logical sequencing. Bilingual presentation (written language and sign language) further enhances comprehension.

Illustration Adaptation
Uses meaningful visuals such as diagrams, pictures, visual sequences, and sign language illustrations to support conceptual understanding.

Assessment Adaptation
Ensures fair evaluation through flexible formats, visual-based questions, extended time, and emphasis on conceptual understanding rather than linguistic accuracy alone.

Role of Communication Methods in Curriculum Adaptation
Communication is central to deaf education, as it directly influences language development, academic achievement, social participation, and identity formation. Over time, different communication approaches have evolved, each based on distinct philosophies. No single method suits all learners; therefore, curriculum adaptation must align with the chosen communication approach and individual learner needs.

Comparative Overview of Major Communication Methods

Communication Method	Key Features	Strengths	Limitations
Oralism	Emphasis on listening, speech, and use of residual hearing; early identification and intervention	Supports speech development; facilitates mainstream integration; better use of residual hearing	Not suitable for all deaf learners; difficult to implement; may create communication gaps
Total Communication	Use of speech along with signs following spoken language grammar; word-to-word translation	Supports reading and writing; helps explain grammar, articles, and prepositions; complete sentence understanding	Weak development of natural sign language; difficulty with abstract concepts; partial transfer of meaning
Educational Bilingualism	Sign language as first language and written/spoken language as second; cultural model of deafness	Strong language foundation; supports identity and conceptual development; natural language access	Requires trained teachers and resources; challenges in implementation and teacher preparation

This comparative perspective highlights the need for flexible curriculum design that respects linguistic diversity and learner choice.

Role of Digital and AI-Based Tools in Curriculum Adaptation

Advances in digital technology and artificial intelligence (AI) offer new opportunities to enhance curriculum accessibility for deaf learners. Tools such as sign language video dictionaries, captioned and interactive e-content, learning management systems, and multimedia-based textbooks support visual learning. AI-powered tools including automatic captioning, speech-to-text applications, sign language avatars, and adaptive learning platforms can personalize instruction and improve access to classroom communication.

Digital tools also support teachers by enabling easy modification of content, creation of visual assessments, and integration of bilingual resources. When used thoughtfully, technology strengthens inclusive practices and bridges gaps between curriculum goals and learner access.

Future Directions

Future curriculum development for deaf learners should emphasize: - Greater integration of Indian Sign Language (ISL) across subjects and grade levels

- Teacher training in bilingual and technology-supported pedagogy
- Development of AI-assisted sign language learning resources and assessment tools
- Collaborative curriculum design involving deaf educators and the deaf community
- Research-based evaluation of digital and adaptive learning models

These directions will enhance the relevance, effectiveness, and inclusivity of education for deaf and hard-of-hearing learners.

Conclusion

Curriculum and text adaptation are fundamental to achieving equity, literacy, and inclusion in deaf education. By addressing language, knowledge, presentation, illustration, and assessment, adapted curricula transform textbooks and learning materials into accessible and empowering tools. Alignment with appropriate communication methods, supported by digital and AI-based innovations, ensures that deaf learners can achieve academic success while developing strong linguistic and cognitive foundations.

References

Ministry of Social Justice and Empowerment. (2016). Rights of Persons with Disabilities Act, Government of India.

Ministry of Education. (2020). National Education Policy 2020, Government of India.

NIOS. (2025). Indian Sign Language as a Subject at Secondary and Senior Secondary Level.

Rehabilitation Council of India (RCI). (2025). Deaf, Deafness and Communication Options (DISLI – T1).

JOURNAL OF INDIAN SIGN LANGUAGE (JISL)

About the Journal

The Journal of Indian Sign Language (JISL) is a peer-reviewed academic journal published in English language starting from July-2026 onwards by the Indian Sign Language Research and Training Centre (ISLRTC), an autonomous National Institute under the Department of Empowerment of Persons with Disabilities (DEPwD), Ministry of Social Justice and Empowerment, Government of India. The journal aims to promote research, innovation, and scholarly discourse in the fields of Indian Sign Language (ISL), Deaf Education, Sign Language Interpretation, Accessibility, Inclusive Education, Disability Studies, Assistive Technology, Linguistics, and related interdisciplinary areas.

Aim and Scope

The journal provides a platform for researchers, academicians, professionals, practitioners, students, and policymakers to disseminate original research findings, review articles, case studies, field reports, and best practices that contribute to the advancement of knowledge and services for Deaf and Hard of Hearing persons. The journal welcomes contributions related to Indian Sign Language, Deaf Studies, accessibility, communication, rehabilitation, inclusive practices, assistive technologies, policy development, and emerging innovations in the disability sector.

Why Publish with Us?

JISL offers a dedicated national platform for publication and dissemination of scholarly work related to Indian Sign Language and Deaf Studies. The journal encourages evidence-based research, promotes innovation and professional excellence, and supports the development of accessible and inclusive educational and communication practices. Publication in JISL provides authors with an opportunity to contribute to the growth of knowledge, research, policy development, and best practices in the field of disability and accessibility.

Submission Procedure

Authors are invited to submit original and unpublished manuscripts for consideration. Manuscripts should not have been published elsewhere or be under consideration by any other journal. All submissions should be sent electronically to abhishek.aks@islrtc.nic.in with a copy to islrtcnewdelhi@gmail.com. The manuscript should be accompanied by a declaration stating that the work is original and has not been submitted elsewhere for publication.

Review Procedure

All manuscripts received by the journal undergo an initial editorial screening to assess their relevance, originality, and conformity with the scope of the journal. Suitable manuscripts are then subjected to a double-blind peer review process by experts in the concerned field. Based on the reviewers' recommendations, the Editorial Board may accept, reject, or request revisions to the manuscript. The decision of the Editorial Board shall be final.

Citation and Referencing Style

Authors are required to follow the latest edition of the APA (American Psychological Association) Style for citations and references. In-text citations should follow formats such as (Kumar, 2025), (Kumar & Singh, 2025), and (Kumar et al., 2025), as applicable. All references cited in the manuscript should be listed alphabetically at the end of the paper with complete bibliographic details.

INSTRUCTIONS TO AUTHORS

The Journal of Indian Sign Language (JISL) invites original and unpublished manuscripts related to Indian Sign Language (ISL), Deaf Education, Sign Language Interpretation, Accessibility, Inclusive Education, Disability Studies, Assistive Technology, Linguistics, and other related interdisciplinary areas. Manuscripts submitted for publication must not have been published previously nor be under consideration for publication elsewhere.

The journal accepts Original Research Articles, Review Articles, Case Studies, Short Communications, Field Reports, Technical Notes, and Book Reviews. Manuscripts should be written in clear and concise English and submitted in MS Word format. The recommended length is 3,000–8,000 words for research articles and review papers. All submissions should include a title, author details, abstract (150–250 words), 4–6 keywords, main text, acknowledgements (if any), references, tables, and figures.

Authors are required to follow the latest edition of the APA (American Psychological Association) referencing style. All references cited in the text must appear in the reference list and vice versa. The responsibility for accuracy of facts, data, opinions, and references rests solely with the author(s).

All manuscripts will undergo an initial editorial screening followed by a double-blind peer review process. Based on reviewers' comments, the Editorial Board may accept, reject, or request revision of the manuscript. The decision of the Editorial Board shall be final.

Authors should ensure that the manuscript is free from plagiarism and complies with accepted standards of research ethics. Where applicable, studies involving human participants should indicate that appropriate ethical procedures and informed consent requirements were followed.

Manuscripts may be submitted electronically to abhishek.aks@islrtc.nic.in with a copy to islrtcnewdelhi@gmail.com. A declaration stating that the manuscript is original, unpublished, and not under consideration elsewhere should accompany the submission.

The Journal of Indian Sign Language reserves the right to make editorial modifications to accepted manuscripts for clarity, style, and formatting without altering the substance of the work.

For all correspondence regarding submissions and publication matters, authors may contact the Editorial Office at abhishek.aks@islrtc.nic.in or islrtcnewdelhi@gmail.com.

INDIAN SIGN LANGUAGE RESEARCH AND TRAINING CENTRE

(An Autonomous body under the Department of Empowerment of Persons with Disabilities (Divyangjan),
Ministry of Social Justice & Empowerment, Govt. of India
registered under Societies Registration Act XXI of 1860, Registration Number S/1440/2016)
Module No. 403-406, 4th Floor, NSIC Business Park, Okhla Industrial Estate, New Delhi - 110020
Telephone No: 26327558/50, Email: islrtcnewdelhi@gmail.com, Web: www.islrtc.nic.in

