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Effectiveness of an Indian Sign Language–Adapted Psychological First Aid Intervention on the Well-Being of Deaf Adults in India

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Abstract

The deaf community in India experience chronic barriers to mental health support due to limited access to services in Indian Sign Language (ISL). Psychological First Aid (PFA) is an evidence-informed, early psychosocial intervention that emphasizes safety, empathy, and coping, yet its effectiveness with deaf populations remains insufficiently examined. The present study investigated the impact of an ISL-adapted PFA training on the well-being of deaf adults. A quasi-experimental pretest–post-test control group design was used with 102 deaf participants (experimental group = 51; control group = 51). The experimental group participated in a week-long PFA training delivered entirely in ISL, while the control group received regular training. Well-being outcomes were assessed using the Mental Health Continuum–Short Form (MHC-SF), measuring emotional, social, and psychological well-being. Results indicated statistically significant improvements in overall mental health and across all three well-being domains (social, emotional and psychological) for the experimental group, with no significant changes observed in the control group, except in social wellbeing. Thematic analysis of voluntary ISL video feedback further confirmed improvements in emotional regulation, self-efficacy, sense of belonging, and peer support. The findings suggest that culturally and linguistically adapted PFA can effectively enhance well-being among deaf adults, with important implications for inclusive mental health practice, deaf education, and community-based psychosocial interventions.

Keywords: Psychological first aid, Indian Sign Language, Well-being, Mental health, Mental Health, Adversity, deaf, Community based intervention, Hearing Impairment, Disability, Disaster, Psycho-social Intervention, Accessibility, Inclusion.

Psychological First Aid (PFA) is widely recognized as an early psychosocial response for individuals and communities affected by adversity, crisis, and trauma. International organizations including the World Health Organization (WHO), the National Child Traumatic Stress Network (NCTSN), and the International Federation of Red Cross and Red Crescent Societies (IFRC) as well as national institutions such as the National Disaster Management Authority (NDMA), the National Institute of Disaster Management (NIDM), and the National Institute of Mental Health and Neurosciences (NIMHANS) promote PFA as a humane, scalable, and non-intrusive approach that can be delivered by trained non-specialists across diverse settings (WHO, 2011; NCTSN, 2006; IFRC, 2018; NIDM, 2009; NDMA, 2023). Grounded in principles of safety, calming, connectedness, self- and collective efficacy, and hope, PFA aligns closely with consensus guidelines for mass trauma intervention and disaster mental health (Hobfoll et al., 2007). By prioritizing practical support, emotional validation, and the strengthening of natural coping and social resources, PFA is particularly relevant for populations with limited access to formal mental health services.

Despite its widespread adoption, the empirical evidence base for PFA remains mixed. Early systematic and narrative reviews highlighted a scarcity of rigorous randomized controlled trials and noted considerable variability in implementation and outcome measurement (Fox et al., 2012; Shultz & Forbes, 2013; Dieltjens et al., 2014). A comprehensive systematic review by Hermosilla et al. (2023) reported generally positive trends, including reductions in psychological distress and improvements in perceived control, emotional regulation, and social connectedness, while continuing to emphasize methodological limitations and the need for culturally and linguistically adapted evaluations, particularly in low- and middle-income contexts.

Studies consistently demonstrate improvements in knowledge, perceived competence, and helper self-efficacy among trainees, including educators, health workers, and community responders (Everly et al., 2014; Everly & Lating, 2017). These proximal outcomes are theoretically linked to downstream benefits for recipients through improved supportive interactions, social bonding, and adaptive coping.

Conceptualizing outcomes in terms of well-being provides a broader lens for evaluating the impact of PFA beyond symptom reduction. Keyes' (2005) model conceptualizes mental health as comprising emotional, social, and psychological well-being. The Mental Health Continuum–Short Form (MHC-SF) operationalizes this framework and has demonstrated robust psychometric properties across cultures, age groups, and populations (Keyes et al., 2008; Lamers et al., 2011; Franken et al., 2018; Yeo & Suárez, 2022). Given that PFA targets connectedness, agency, meaning, and hope, the MHC-SF represents a theoretically coherent and educationally relevant outcome measure for assessing its broader psychosocial impact.

The need for culturally adapted psychosocial inter-

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ventions is particularly salient in the context of deaf mental health. The deaf populations consistently report higher rates of depression, anxiety, and trauma exposure compared to hearing populations (Fellinger et al., 2012). These disparities are not inherent to deafness but are largely attributable to structural and linguistic exclusion across the life course. Language deprivation arising from delayed or inaccessible communication in families and educational settings has been identified as a critical risk factor for chronic stress and adverse mental health outcomes (Steinberg et al., 1998; Barnett et al., 2011; McKee et al., 2015; Glickman & Hall, 2018). Emerging qualitative and longitudinal work further links early communication deprivation to difficulties in emotional regulation, identity formation, and adult well-being (McRae et al., 2025).

In addition to structural barriers, the deaf adults often experience internalized oppression related to audism and linguicism, which has been increasingly recognized as a psychosocial determinant of distress (Tomaszewski et al., 2025). Access to mental health care is further constrained by shortages of sign language–fluent professionals and interpreters, particularly in low-resource settings. In India, ISL-accessible mental health services remain scarce, reinforcing systemic exclusion from psychosocial care. These conditions underscore the urgent need for preventive and promotive interventions that are linguistically accessible, culturally affirming, and community based.

Against this backdrop, adapting PFA for deaf adults represents a promising yet under-researched approach. Delivering PFA in Indian Sign Language and embedding it within deaf cultural norms may support both individual coping and collective well-being through peer support, shared meaning-making, and empowerment. Evaluating PFA through a multidimensional well-being framework responds to calls in educational and community psychology to move beyond deficit-oriented models and foreground strengths, resilience, and social inclusion. The present study contributes to this emerging literature by examining the impact of an ISL-adapted PFA training on the emotional, social, and psychological well-being of deaf adults in India.

Method

Design

A quasi-experimental pretest–post-test control group design was employed to examine changes in well-being following Psychological First Aid (PFA) training.

Participants

The sample comprised 102 deaf adults aged 18 to 35 years, divided equally into an experimental group (n = 51) and a control group (n = 51). Participants were recruited through deaf organizations and community networks in two Indian regions, Telangana and Delhi, with 31 participants from Telangana and 20 from Delhi in the experimental and control groups, each. The two groups were matched on key demographic variables, including age, gender, educational attainment, and rural–urban residence, to enhance baseline comparability.

Across groups, male participants outnumbered female participants (M = 31, F= 20), and the sample included representation from both rural and urban contexts (R = 28, U = 23) as well. The education ranged from Class 10th till graduation, but the reading level were low which is why deaf participants depended heavily on ISL explanation.

The eligibility criteria required participants to self-identify as deaf, demonstrate functional fluency in Indian Sign Language (ISL), have no prior exposure to formal Psychological First Aid training, and report no severe medical or cognitive conditions that could interfere with participation. Participation was voluntary, and informed consent was obtained using ISL-based video explanations to ensure full linguistic accessibility and comprehension.

Measure

Mental Health Continuum–Short Form (MHC-SF).

Well-being was assessed using the Mental Health Continuum–Short Form (Keyes, 2005), a 14-item self-report measure capturing emotional (3 items), social (5 items), and psychological (6 items) well-being. Items are rated on a 6-point frequency scale ranging from 0 (never) to 5 (every day). The MHC-SF has demonstrated strong internal consistency (Cronbach's α typically > .80) and acceptable test–retest reliability (.65–.68) across diverse cultural contexts (Keyes et al., 2008; Lamers et al., 2011).

For the present study, the MHC-SF was translated and adapted into Indian Sign Language following a multistep process. Initial translation was conducted by certified deaf experts, followed by iterative refinement through a bilingual expert panel consisting of six deaf and hearing professionals with expertise in psychology, sign linguistics, and deaf education. To assess equivalence, the English and ISL versions were administered to a separate validation sample of 70 bilingual participants, yielding a high similarity index (r = .93), indicating strong cross-linguistic correspondence.

Adaptation and Delivery of Psychological First Aid

The intervention was based on established PFA frameworks (WHO, 2011; NCTSN, 2006; IFRC, 2018) and adapted to reflect the linguistic, cultural, and social realities of deaf adults in India. To allow adequate engagement and experiential learning, the training

was extended to seven days, comprising 12 modules of approximately two hours each.

Core modules addressed foundational PFA competencies, including recognizing distress, active listening, emotional stabilization, prioritization of needs, referral pathways, and self-care. Adapted modules focused on deaf-specific contexts, including deaf identity and culture, chronic adversity related to communication barriers, community-based coping strategies, peer support, and advocacy within deaf networks.

All sessions were delivered entirely in ISL. Pedagogical methods emphasized experiential and collaborative learning, including role-plays, small-group discussions, reflective exercises, and simulated helping scenarios. This approach was intended to enhance relevance, accessibility, and skill integration. The control group did not receive any PFA training during the period, and had their regular training.

Procedure

Participants were recruited through deaf community organizations, vocational training centers, and deaf-led networks in Delhi and Telangana. Recruitment materials and study information were disseminated in Indian Sign Language (ISL) to ensure linguistic accessibility. Prior to participation, informed consent was obtained individually through ISL-based video explanations, with opportunities for clarification.

At baseline, participants in both the experimental and control groups completed the pre-test assessment using the ISL-adapted Mental Health Continuum–Short Form. Assessments were administered in small, facilitated group settings to support comprehension while minimizing peer influence on responses.

Following the pre-test, the experimental group participated in a seven-day Psychological First Aid training adapted for deaf adults and delivered entirely in ISL. The control group did not receive any intervention during the study period and continued with their routine activities. Immediately after completion of the training, both groups completed the post-test assessment using the same ISL-adapted measure to allow direct comparison of change over time.

Upon completion of the post-test, participants in the experimental group were invited to provide voluntary video-recorded feedback in ISL. These recordings captured reflective narratives on participants' experiences of the training, perceived changes in well-being, and the applicability of PFA skills in personal and community contexts. Participation in the qualitative component was optional and did not affect inclusion in the quantitative analysis.

Data Analysis

Quantitative data were analyzed using paired-samples *t* tests to examine within-group differences between pre-test and post-test scores for the experimental and control groups separately. Analyses were conducted for total well-being as well as for emotional, social, and psychological well-being subscales of the MHC-SF. Effect sizes were calculated using Cohen's *d* to estimate the magnitude of observed changes, with values of 0.20, 0.50, and 0.80 interpreted as small, medium, and large effects, respectively.

Between-group differences were examined using change scores (post-test minus pre-test) to compare patterns of improvement between the experimental and control groups. Descriptive comparisons were used to contextualize findings while avoiding overstatement of causal inference, given the quasi-experimental design.

Qualitative data from ISL video feedback were transcribed into English by trained ISL interpreters and cross-checked for accuracy. Thematic analysis was conducted following a grounded, inductive approach. Transcripts were coded iteratively to identify recurring patterns related to emotional regulation, self-efficacy, social connectedness, and meaning-making. Themes were refined through constant comparison and consensus discussion among the research team, allowing integration of qualitative insights with quantitative findings to elucidate perceived mechanisms of change.

Results

Pre–Post Comparisons: Experimental and Control Groups

Participants in the experimental group demonstrated significant improvements from pre-test to post-test across overall mental health and all three well-being domains. Overall mental health increased substantially, $t(50) = -6.29$, $p < .001$, with a large effect size ($d = 0.88$). Significant gains were also observed in emotional well-being, $t(50) = -3.49$, $p = .001$, $d = 0.49$; social well-being, $t(50) = -3.92$, $p < .001$, $d = 0.55$; and psychological well-being, $t(50) = -7.18$, $p < .001$, $d = 1.00$, indicating medium to large effects across domains.

In contrast, the control group showed no significant changes in overall mental health or in emotional and psychological well-being (all $ps > .05$). A modest but statistically significant increase was observed in social well-being, $t(50) = -2.85$, $p = .006$, with a medium effect size ($d = 0.40$). Taken together, these findings indicate that consistent and robust improvements in well-being were evident only among participants who received the ISL-adapted PFA training.

Table 1 presents pre- and post-test means, test statistics, and effect sizes for overall mental health and the three dimensions of well-being—emotional, social, and psychological—assessed using the Mental Health Continuum–Short Form (MHC-SF; Keyes, 2005).

Subgroup Analyses: Gender and Rural–Urban Differences

To examine whether intervention-related changes varied across participant characteristics, indepen-

dent-samples *t* tests were conducted on pre–post change scores within the experimental group.

Gender Differences

No significant gender differences were observed in improvements across overall mental health, $t(49) = 0.18$, $p = .855$, emotional well-being, $t(49) = -0.16$, $p = .874$, social well-being, $t(49) = -0.26$, $p = .796$, or psychological well-being, $t(49) = 0.79$, $p = .435$. These results suggest that the ISL-adapted PFA intervention was comparably effective for male and female participants.

Rural–Urban Differences

Residential context was associated with differential patterns of improvement. Rural participants demonstrated significantly greater gains than urban participants in overall mental health, $t(49) = 2.06$, $p = .044$, and psychological well-being, $t(49) = 2.08$, $p = .043$. Differences in emotional well-being, $t(49) = 1.02$, $p = .311$, and social well-being, $t(49) = 1.57$, $p = .123$, were not statistically significant. These findings indicate that while the intervention supported well-being across residential contexts, gains were more pronounced among rural Deaf adults in select domains.

Table 1. Comparison of Experimental and Control Groups on Pre–Post Outcomes (N = 51 each)

Variable	Group	Pre-Test M (SD)	Post-Test M (SD)	*t*(50)	*p*	Cohen's *d*
Mental Health (MHC-SF total)	Experimental	41.63 (13.33)	51.33 (13.28)	–6.29	< .001	0.88 (large)
	Control	38.41 (13.12)	38.82 (13.24)	–0.89	.377	0.13 (ns)
Emotional Well-being	Experimental	9.78 (3.57)	11.39 (2.89)	–3.49	.001	0.49 (medium)
	Control	8.43 (3.59)	8.06 (3.60)	1.03	.308	0.14 (ns)
Social Well-being	Experimental	14.37 (5.28)	17.37 (5.44)	–3.92	< .001	0.55 (medium)
	Control	12.29 (6.03)	13.27 (5.75)	–2.85	.006	0.40 (medium)
Psychological Well-being	Experimental	17.47 (6.80)	22.57 (6.23)	–7.18	< .001	1.00 (large)
	Control	17.69 (6.21)	17.49 (5.98)	0.52	.604	0.07 (ns)

Qualitative Findings: Reflections in ISL

The ISL video reflections, optionally shared by the experimental-group participants (28 from Telangana and 11 from Delhi) were translated in English, and thematically analyzed to understand how the training influenced wellbeing. The open-ended ISL feedback converged on five well-being–enhancing processes that align with the MHC-SF domains and further confirm the quantitative gains.

1. **Emotional well-being (calming, regulation, hope).**
   Participants described moving from "feeling caged/bored/angry" to feeling calmer and more in control after learning breathing, grounding, and emotion-regulation strategies. Several noted "reflecting on self," "naming feelings," and "breaking the chain of anger/negativity," reporting greater peace and optimism.
2. **Psychological well-being (autonomy, purpose, self-acceptance).**
   Many reported increased self-efficacy ("I can overcome barriers," "I can find solutions"), renewed purpose ("I can help others now"), and insight ("I didn't know how to identify my own emotions before"). Learners linked skills practice to personal growth—describing greater confidence, willingness to face fears, and acceptance of past mistakes while "trying to be better."
3. **Social well-being (belonging, contribution, social trust).**
   A consistent theme was strengthened connectedness: "build more connections," "support each other," "create a supportive community," and "listen without interrupting." Participants emphasized reciprocity ("support others and pass it forward"), confidentiality, and trust—highlighting that ISL-mediated group norms (respect, no interruptions, shared rules) enabled genuine inclusion and mutual aid.

Additionally, participants repeatedly contrasted exclusion in spoken-language settings with full access in ISL sessions, describing pride in signing, validation of deaf experiences, and relief at finally being "under-

stood completely." This affirmation appeared to underpin both emotional settling and social engagement, with several resolving to advocate for accessibility beyond the training.

Discussion

The present study examined the impact of an adapted Psychological First Aid (PFA) training on the well-being of deaf adults in India. Findings indicate that participation in the adapted PFA program was associated with significant improvements in emotional, social, and psychological well-being, as well as overall mental health, as measured by the Mental Health Continuum–Short Form (MHC-SF). These quantitative gains were supported by qualitative accounts describing enhanced emotional regulation, strengthened social connectedness, and increased self-efficacy. Together, the findings suggest that when PFA is delivered in a linguistically and culturally accessible manner, it can function as a promotive psychosocial intervention for deaf adults. This pattern is theoretically consistent with PFA's emphasis on restoring agency, fostering meaning, and strengthening perceived coping capacity (Hobfoll et al., 2007; Everly & Lating, 2017). While prior research on PFA has largely focused on symptom reduction or helper competence (Dieltjens et al., 2014; Shultz & Forbes, 2013), the present study extends the literature by demonstrating gains in positive mental health outcomes among a marginalized population.

Qualitative findings underscored that full access in ISL and affirmation of deaf identity were central to participants' engagement and perceived benefit. Prior research has shown that communication barriers and language deprivation are key determinants of poor mental health among deaf adults (Fellinger et al., 2012; McKee et al., 2015). By contrast, the present intervention created an environment characterized by shared language, respect, and mutual understanding, which participants linked to emotional settling, trust, and willingness to participate. These findings support emerging evidence that accessible communication and community affirmation act as protective factors for deaf mental health (McRae et al., 2025; Crowe, 2022).

Implications for Education and Community Mental Health

The findings have important implications for educational and community psychology. PFA training, when adapted for deaf adults, appears to function not only as a crisis-response tool but also as a life-skills and well-being intervention that strengthens emotional awareness, interpersonal competence, and collective responsibility. Integrating ISL-based PFA into deaf education, vocational training, and community mental health initiatives could contribute to preventive mental health promotion and peer-led support systems, particularly in low-resource settings.

Limitations

While the study provides strong evidence for the effectiveness of ISL-based Psychological First Aid (PFA) training, several limitations must be acknowledged. First, the quasi-experimental design limits causal inference, as random assignment was not feasible due to institutional and logistical constraints. Second, the sample size is small, and may not fully capture the heterogeneity of India's deaf population, particularly with respect to regional language variations and educational backgrounds. Third, well-being outcomes were self-reported, which may be influenced by social desirability or recall bias.

Future research should employ longitudinal and mixed-method designs to examine the sustained effects of PFA training over time and across diverse deaf communities. Integrating physiological or behavioral indicators of well-being could further validate findings.

Conclusion

In sum, this study provides evidence that a linguistically and culturally adapted PFA intervention can meaningfully enhance emotional, social, and psychological well-being among deaf adults. By centering accessibility, community, and strengths, adapted PFA offers a promising pathway for inclusive mental health promotion and underscores the necessity of tailoring evidence-based interventions to the lived realities of marginalized populations.

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