

Collaborative Bidirectional Training in Mental Health and Deaf Culture for Deaf Leaders and Professionals

Rivo Mario Warouw Lintuuran^{1*}, Herbert Klein², Adhesatya Ningsih Moodoeto³

¹Universitas Trisakti

²European Society of Mental Health and Deaf

³Animo Psikologi

*Corresponding author, e-mail: rivo.mario@trisakti.ac.id

Abstract

Introduction: Deaf communities experience barriers to mental health care related to communication, language, and cultural differences. However, opportunities for bidirectional learning between Deaf community members and mental health professionals remain limited. This program aimed to strengthen mental health knowledge among Deaf leaders and improve mental health professionals' understanding of Deaf culture and communication. **Method:** A two-day collaborative training was conducted in Bandung involving 19 Deaf community leaders and 12 hearing mental health professionals. Activities included group-specific seminars, interactive discussions, Bahasa Isyarat Indonesia (Bisindo) demonstrations, and a joint learning session. Changes in knowledge were evaluated using customized pre- and post-tests, while participant experiences and reflections were analyzed qualitatively. The Self-Reporting Questionnaire (SRQ-20) was administered to Deaf participants as a screening instrument to describe their initial mental health context. **Results:** Mean knowledge scores increased from 65 to 70.5 among Deaf leaders, representing an 8.5% relative increase, and from 51 to 60.6 among hearing mental health professionals, representing a 19.0% relative increase. Among Deaf leaders, reported knowledge of mental health symptoms increased from 58% to 89%, while perceived ability to support Deaf peers increased from 53% to 89%. Among professionals, understanding of Deaf culture increased from 8% to 42%, and awareness of barriers to mental health services increased from 50% to 92%. SRQ-20 screening identified positive screening results for mental health problems in 79% of Deaf participants, while 32% reported suicidal ideation. These findings represent screening results among program participants and not diagnostic or population prevalence estimates. Qualitative findings highlighted four main themes: relevance of the training, the need for interactive and accessible approaches, strengthening communication competence, and the need for continued training and collaboration. **Conclusion:** The bidirectional training strengthened mental health literacy among Deaf leaders and increased awareness of Deaf culture, communication, and access barriers among mental health professionals. Continued Deaf-professional collaboration and follow-up training may support the development of culturally and linguistically responsive mental health services.

Keywords: Bahasa Isyarat Indonesia; Collaboration; Culture; Deaf; Mental health.

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Introduction

Deaf communities are widely recognized as linguistic and cultural communities in which sign language plays a central role in communication, identity, and social participation (Padden & Humphries, 1988; Young, 2018). In predominantly hearing health systems, differences in language and communication, together with limited cultural responsiveness, may create barriers to accessing appropriate mental health care (Hall et al., 2025; Terry et al., 2024).

Studies from different countries indicate substantial mental health concerns among Deaf populations. In the United Kingdom, 58% of Deaf British Sign Language users reported psychological distress and 43% reported depression (Shields et al., 2020). In the United States, 48.6% of Deaf participants were reported to experience depression or anxiety (Sanfacon et al., 2021). In Indonesia, a study involving 604 Deaf participants across several cities reported symptoms of depression and anxiety in 66.4% of participants (Lintuuran et al., 2025). These findings occur in the context of multiple factors affecting Deaf mental health, including stigma, early language barriers, bullying, exclusion, and marginalization (McRae et al., 2025).

Barriers also occur within health services. Deaf people have reported difficulties communicating with health professionals and concerns regarding the cultural responsiveness of care (Terry et al., 2024; Hall et al., 2025). Mental health professionals may have limited training in Deaf culture, sign language, and communication strategies, potentially affecting access to appropriate care. Training in Deaf culture and communication has been associated with increased awareness and confidence among health professionals working with Deaf people (Johnson et al., 2024).

Taken together, these findings indicate that strengthening Deaf mental health requires capacity at both community and professional levels. Deaf community members may benefit from greater mental health literacy and skills to support peers, while mental health professionals require greater understanding of Deaf culture, language, communication, and barriers to care. However, opportunities for structured learning between Deaf community members and mental health professionals remain limited.

A bidirectional approach provides an opportunity to address this gap by recognizing Deaf leaders not only as recipients of mental health information but also as contributors of cultural and lived knowledge. Therefore, this program developed a collaborative bidirectional training model involving Deaf community leaders and hearing mental health professionals. The program aimed to: (1) strengthen mental health knowledge and perceived capacity among Deaf leaders; (2) increase hearing mental health professionals' understanding of Deaf culture, communication, and access barriers; and (3) facilitate bidirectional dialogue and collaboration between Deaf leaders and mental health professionals. These outcomes were explored through pre- and post-training assessments, joint discussions, and qualitative participant feedback.

Method

Program Design and Participants

The program used a two-day collaborative training design consisting of three sequential components: (1) group-specific learning, (2) group-specific assessment, and (3) joint dialogue and shared learning. The two participant groups received different initial content because their learning needs were distinct. Deaf leaders received mental health literacy and community-support content, whereas hearing mental health professionals received training on Deaf culture, language, communication, and access barriers. A joint session subsequently provided an opportunity for reciprocal exchange between both groups.

The training was conducted over two consecutive days at UTC Dago Hotel, Bandung, under the title *"Bridging Minds: Pelatihan Kesehatan Mental bagi Pemimpin Tuli dan Profesional Kesehatan Mental."* Participants were recruited through online invitations targeting Deaf community leaders and hearing mental health professionals in the region. A total of 19 Deaf community leaders and 12 hearing mental health professionals participated.

Training Activities

Day 1 was designed specifically for Deaf leaders and consisted of interactive seminars delivered in accessible formats. Topics included an introduction to mental health, prevention of mental health problems, recognition of common mental disorders, available mental health services in Indonesia, and strategies for supporting mental well-being within the local Deaf community.

Day 2 targeted hearing mental health professionals. Activities included seminars, interactive discussions, an introduction to Bahasa Isyarat Indonesia (Bisindo) with practical demonstrations of basic signs, and a collaborative session involving participants from Day 1 to facilitate dialogue and shared learning. Topics included Deaf mental health, culturally and linguistically appropriate communication with Deaf clients, and key cultural aspects of the Deaf community.

Resource persons included a Deaf mental health advocate from the United Kingdom, clinical psychologists from Indonesia and the United Kingdom, a psychiatrist from Indonesia, and representatives from the Bandung branch of Bisindo and Gerakan untuk Kesejahteraan Tuna Rungu Indonesia (Gerkatin). Sign language interpreters fluent in Indonesian and International Sign were available during all sessions to facilitate communication between Deaf and hearing participants.

Program Evaluation

Program evaluation used separate methods for describing participant context and assessing training-related changes. The Self-Reporting Questionnaire (SRQ-20) was administered to Deaf participants on Day 1 to provide a descriptive baseline of mental health symptoms among participants. The SRQ-20 was used as a screening instrument and not as a diagnostic instrument or a measure of training effectiveness. Therefore, screening results were interpreted as contextual information about participants rather than estimates of mental health prevalence in the wider Deaf community.

Training-related changes were assessed using customized pre- and post-tests. The knowledge assessment used true/false items and was summarized using mean scores before and after training. Perception and self-reported competency items used an agree/disagree format and were summarized as the percentage of participants endorsing each item before and after training.

Qualitative data were collected from participant discussions and feedback. Analysis involved grouping responses, identifying recurring patterns, and interpreting the main themes emerging from participants' experiences and recommendations.

Result and Discussion

Participants and Implementation

A total of 19 Deaf leaders representing Gerkatin Bandung and 12 hearing mental health professionals participated in the training. All sessions included sign language interpretation, including seminars, discussions, screening, and pre- and post-training assessments (Figure 1). The program therefore provided an accessible communication environment for both participant groups.

The two-day structure allowed each group to receive content relevant to its respective learning needs before participating in shared dialogue. This design positioned Deaf leaders as contributors of cultural and lived knowledge while providing mental health professionals with opportunities to develop greater awareness of Deaf culture and communication.



Figure 1. Training activities with participants, resource persons, and interpreters

Mental Health Screening among Deaf Leaders

The SRQ-20 was administered to Deaf leaders as a screening measure to describe the mental health context of participants at the beginning of the program. The screening identified positive screening results for mental health problems in 79% of Deaf participants, while 32% reported suicidal ideation.

These findings should not be interpreted as diagnoses or as estimates of the prevalence of mental health problems or suicidal ideation in the wider Deaf community in Bandung. Rather, they indicate that mental health concerns were present among participants who attended the training and provide important context for the need for accessible mental health information and support.

The findings are consistent with previous literature describing mental health and access concerns among Deaf populations (Fellinger et al., 2012; Shields et al., 2020; Lintuuran et al., 2025). However, because the participants were recruited for a community training and the sample was relatively small, the screening results cannot be generalized to the broader Deaf population.

Knowledge Gain

The training was associated with an increase in mean knowledge scores in both participant groups as shown in Tabel 1.

Table 1. Mean knowledge scores before and after training

	Pre-test mean	Post-test mean	Relative increase
Deaf leaders	65	70,5	+8,5%
Hearing professionals	51	60,6	+19%

Among Deaf leaders, the mean knowledge score increased from 65.0 before training to 70.5 after training, representing an 8.5% relative increase. Among hearing mental health professionals, the mean score increased from 51.0 to 60.6, representing a 19.0% relative increase. Thus, the reported 8.5% and 19.0% values represent relative changes in mean scores, rather than percentages of participants answering correctly.

The larger relative increase among hearing professionals may partly reflect their lower baseline score and the specific focus of their training on Deaf culture, language, communication, and access barriers. Because the assessment used a customized instrument and the analysis was descriptive, this difference should not be interpreted as evidence that the training had a statistically greater effect in one group than the other.

The findings nevertheless indicate that both groups demonstrated measurable changes in the assessed knowledge domain. For Deaf leaders, the training focused primarily on mental health literacy and community support, whereas for professionals it emphasized knowledge that may be less familiar within conventional mental health training, particularly Deaf culture and communication.

Changes in Perceptions and Perceived Capacity Among Deaf Leaders

Among Deaf leaders, the post-training assessment showed increased endorsement across the assessed mental health-related perceptions and self-reported capacities.

Table 2. Pre- and Post test on improvement of personal perceptions (number of participants)

Deaf leaders	Pre-test n (%)	Post-test n (%)
Know mental health symptoms	11 (58%)	17 (89%)
Understand mental health terminology in Bisindo	13 (68%)	17 (89%)
Know how to support Deaf peers with mental problems	10 (53%)	17 (89%)
Know how to prevent mental problems	10 (53%)	13 (68%)
Able to become mental health role model in Deaf community	12 (63%)	17 (89%)

Knowledge of mental health symptoms increased from 58% to 89%, while understanding of mental health terminology in Bisindo increased from 68% to 89%. The proportion reporting knowledge of how to support Deaf peers increased from 53% to 89%, and the proportion reporting ability to become a mental health role model increased from 63% to 89%. Knowledge related to prevention showed a smaller increase, from 53% to 68%.

These findings suggest that the training particularly strengthened recognition of mental health concerns and perceived capacity to support peers. The smaller change in prevention-related knowledge may indicate an area requiring more practice-oriented or repeated learning in future programs. The findings are consistent with the importance of accessible mental health education and peer-support capacity within Deaf communities (Glickman, 2008; Opoku et al., 2024).

Importantly, these measures represent participants' reported perceptions and knowledge rather than independently observed behavior or demonstrated clinical competence. Further evaluation would be required to determine whether these changes translate into sustained community support practices.

Changes in Perceptions and Perceived Competence Among Mental Health Professionals

Among hearing mental health professionals, changes were observed in perceived understanding of Deaf culture, communication, and access barriers as shown in Table 3.

Table 3. Pre- and Post test on improvement of personal perceptions (number of participants)

Mental health professionals	Pre-Test n (%)	Post-Test n (%)
Understand Deaf culture	1 (8%)	5 (42%)
Know the roles of Deaf culture and language in consultation	11 (92%)	12 (100%)
Know how to communicate with Deaf	0 (0%)	6 (50%)

Understand Deaf challenges in accessing mental health service	6 (50%)	11 (92%)
Understand discrimination faced by Deaf (audism, ableism, linguicism)	2 (17%)	10 (83%)

Understanding of Deaf culture increased from 8% before training to 42% after training. Reported knowledge of communicating with Deaf individuals increased from 0% to 50%. Awareness of barriers faced by Deaf people in accessing mental health services increased from 50% to 92%, while understanding of discrimination, including audism, ableism, and linguicism, increased from 17% to 83%. Recognition of the role of Deaf culture and language in consultation increased from 92% to 100%.

The findings indicate increased self-reported awareness and perceived competence, particularly regarding communication and structural barriers. They should not, however, be interpreted as evidence of demonstrated clinical communication competence or changes in actual clinical practice. Training focused on Deaf culture and communication has previously been recommended as an important component of improving health professionals' ability to provide appropriate services to Deaf people (Hall et al., 2025; Johnson et al., 2024; Qadhi, 2025).

Qualitative Findings

Thematic analysis identified four main themes across participant discussions: relevance of the training, interactive and accessible learning, communication competence, and continued training and collaboration.

First, participants described the training as relevant to their mental health and service experiences. Deaf leaders discussed difficulties recognizing emotional symptoms, managing stress, understanding previous psychological experiences, and accessing appropriate support. Participants also discussed experiences of emotional distress, sleep disturbance, and suicidal ideation. Peer support emerged as an important area of interest, although participants also raised concerns about confidentiality and gossip within the community. These experiences were discussed alongside family misunderstanding, bullying, and social marginalization.

Second, participants emphasized the importance of interactive and accessible learning approaches. Deaf participants valued clear communication, sign language interpretation, and opportunities for direct interaction. Their feedback also suggested the need for more visual materials, practical activities, and community-inclusive approaches.

Third, communication competence emerged as an important theme. Discussions highlighted the limited availability of professionals fluent in Bisindo, concerns regarding communication through interpreters, and the importance of understanding Deaf culture when providing mental health services. Hearing professionals also reported increased awareness of the communication experiences and access barriers faced by Deaf people.

Fourth, participants identified a need for continued training and collaboration. Deaf leaders expressed interest in follow-up programs, peer support, leadership development, and stronger community support systems. Mental health professionals expressed interest in continued learning about Deaf experiences, Bisindo, assessment adaptations, family interventions, and further interaction with Deaf community members.

These themes are consistent with previous literature identifying communication barriers, limited mental health literacy, professional training needs, and the importance of culturally responsive services for Deaf populations (Fellinger et al., 2012; Rannefeld et al., 2023; Terry et al., 2024; Opoku et al., 2024).

Participant Feedback and Implications for Program Development

Deaf participants described the training as relevant and beneficial and emphasized the value of collaboration between Deaf participants and mental health professionals. They recommended continued follow-up programs, interdisciplinary discussions, accessible learning materials, and stronger language support. They also highlighted the importance of sign language proficiency among professionals and the availability of qualified interpreters and captioning.

Mental health professionals reported that direct interaction with Deaf participants and the presence of interpreters expanded their understanding of Deaf experiences and barriers to care. Participants expressed interest in learning Bisindo, improving services for Deaf clients, and continuing dialogue between Deaf and hearing communities. They also suggested structured educational programs to strengthen Deaf leadership and long-term community empowerment.

These recommendations suggest that a single training event may be most appropriately viewed as an initial step in developing sustained Deaf-professional collaboration rather than as a complete training intervention. Continued engagement may provide opportunities to reinforce knowledge, develop communication skills, and translate learning into community and clinical practice.

Overall Discussion

These recommendations suggest that a single training event may be most appropriately viewed as an initial step in developing sustained Deaf–professional collaboration rather than as a complete training intervention. Continued engagement may provide opportunities to reinforce knowledge, develop communication skills, and translate learning into community and clinical practice. The central finding of this program was that a bidirectional training model was associated with changes in both participant groups, although the areas of change differed according to their respective learning needs. Deaf leaders showed increased mental health knowledge and perceived capacity to recognize and support mental health concerns within their community. Hearing mental health professionals showed increased self-reported awareness of Deaf culture, communication, discrimination, and barriers to accessing mental health services.

The different patterns of change support the rationale for separating group-specific learning before bringing both groups together. Deaf leaders entered the program with a higher mean knowledge score than professionals but demonstrated gains in mental health-related knowledge and perceived peer-support capacity. Professionals had a lower baseline knowledge score and received more specific content related to Deaf culture and communication, areas in which the post-training assessment showed marked changes.

The program also illustrates the potential value of positioning Deaf leaders as active contributors to mental health education. Rather than treating Deaf people solely as recipients of professional knowledge, the bidirectional model creates space for Deaf participants to contribute knowledge about language, culture, communication, and lived experience. This approach is consistent with recommendations for greater collaboration with Deaf communities in addressing barriers to health care ([Rannefeld et al., 2023](#)).

The SRQ-20 findings provide additional context for the program. The high proportion of positive screening results among participants indicates that mental health concerns were present within the group attending the training. However, these findings cannot establish the prevalence of mental health problems in the wider Deaf community and should not be interpreted as evidence of diagnostic status. The results instead reinforce the relevance of ensuring that mental health information and services are accessible and culturally and linguistically responsive.

Several limitations should be considered. The number of participants was relatively small, participants were recruited for a community training rather than through population-based sampling, and the evaluation used customized pre- and post-tests. The perception and competency measures were self-reported and therefore do not demonstrate changes in actual clinical behaviour or communication performance. In addition, the program did not include long-term follow-up, so the sustainability of observed changes remains unknown. These limitations indicate the need for larger studies using validated outcome measures and longitudinal follow-up.

Conclusion

This two-day bidirectional training demonstrated changes in mental health knowledge among Deaf leaders and hearing mental health professionals, as well as increased self-reported awareness of Deaf culture, communication, and barriers to mental health services. The SRQ-20 screening also identified mental health concerns among participating Deaf leaders, providing important contextual information for the program but not an estimate of community prevalence or a diagnostic assessment.

The program provides an initial model for reciprocal learning in which Deaf leaders contribute cultural and lived knowledge while mental health professionals contribute clinical knowledge. Sustaining this approach will require follow-up training, continued Deaf–professional dialogue, and accessible learning resources. Further research using larger samples, validated outcome measures, and longitudinal follow-up is needed to determine whether training gains are maintained and translated into community and clinical practice.

Author Declarations

Author Contributions

All authors contributed equally to the conceptualization, program design, data collection, data analysis, manuscript preparation, and critical revision of the manuscript. All authors reviewed and approved the final version of the manuscript. First author served as the corresponding author.

Conflict of Interest

The authors declare that there are no conflicts of interest related to the implementation of the activity or the preparation and publication of this article.

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AI Use

In the preparation of this manuscript, artificial intelligence (AI) was used in a limited capacity as a language aid to improve clarity and readability. The authors take full responsibility for the content, analysis, interpretation, and final decisions presented in the manuscript.

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