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ORIGINAL ARTICLE

Developments in Special and Inclusive Learning in India

Lost in translation: The role of English as a barrier in autism support for multilingual children in Bangalore, India

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Abstract

This paper explores the role of English as a linguistic barrier in the education and therapy of children in the early years with autism in Bangalore, South India, a region marked by rich multilingualism. Despite the linguistic diversity of its population, most special education and therapeutic interventions in Bangalore are delivered primarily in English. Drawing on over a decade of field experience from practitioner journals, parental narratives and case reflections, this study uses a narrative inquiry methodology to highlight the ways in which English-only environments limit access, understanding and emotional engagement for these children. It further identifies how mothers, who are often primary caregivers, struggle to engage in therapeutic processes due to limited English proficiency, leading to decreased continuity and effectiveness of intervention at home. Findings point to the systemic exclusion that occurs when English is the default medium in inclusive education and therapy, often misinterpreting language-related confusion or distress as behavioural issues. This paper calls for a redefinition of inclusion that embraces linguistic diversity and recommends multilingual therapy models, culturally responsive teaching and the integration of regional languages in training. The paper concludes that inclusion cannot be achieved without first speaking the language of the child, both literally and metaphorically.

KEYWORDS
autism, Bangalore, inclusive education, language barriers, South India

Key Points

- English functions as a hidden barrier in autism education and therapy and multilingual context like Bangalore.
- English only intervention models can limit comprehension participation and emotional engagement for autistic children.
- Limited English proficiency among caregivers reduces their ability to participate in the process at home.
- Language related confusion is often misinterpreted as behaviour difficulty in English dominant settings.
- English education must incorporate multilingual therapy approaches and culturally responsive teaching practises.

INTRODUCTION

The city of Bangalore, in recent decades, has become one of India's linguistically and culturally diverse urban centres, due to internal migration, economic growth and the expansion of the English-medium education sector (Chowdhury & Upadhya, 2020). This rapid evolution has brought new opportunities and challenges particularly in the realm of inclusive education (Revi et al., 2016; Singal, 2019). Among the most vulnerable learners navigating these complex systems are children with autism spectrum disorder (ASD). Most of the learners come from homes where regional languages such as Kannada, Telugu, Tamil or Hindi are spoken but receive education and therapeutic services almost exclusively in English (Lal, 2021; Srikar et al., 2022).

While inclusive education in India is gaining attention under national frameworks like the Right to Education Act (2009), the Rights of Persons with Disabilities Act (2016) and the National Education Policy (2020), there remains a significant gap in both policy and practice: the question of language accessibility for children with neurodevelopmental differences. India as a country of linguistic diversity has faced many challenges in providing equitable education for all children (Seshadri, 2002). These challenges are significantly increased for students who experience difficulties with learning or live in situations of socio-economic disadvantage (Mamidi, 2017; Tsimpli et al., 2020). Autism, a developmental condition primarily affecting communication and social interaction, inherently demands individualised, consistent and meaningful engagement (Charman, 2025). When this engagement occurs in a language unfamiliar or underdeveloped for the child, the very foundation of support is compromised (Wang et al., 2019).

English is widely perceived in India as a vehicle for upward mobility and access to high-quality education and services (Bhandari & Blumenthal, 2011; Highet, 2021). As a result, many special education schools and therapy centres in Bangalore operate predominantly or entirely in English. This includes assessments, speech and occupational therapy sessions, classroom instruction and parental communication.

For many children on the autism spectrum who are still developing functional language skills in their home tongue, English becomes a double barrier; they must first overcome a communication deficit, and then do so in an unfamiliar linguistic framework. For families, particularly mothers who serve as primary caregivers and therapy partners at home, the dominance of English imposes an additional burden. Many mothers in Bangalore report feeling unprepared, anxious or excluded during therapy sessions conducted in English, especially when they must translate instructions into their child's first language or when they themselves are not fluent in English. This creates a disconnect between home and institutional learning environments, affecting the continuity of intervention and overall outcomes.

Despite these challenges, the role of language, especially the mismatch between the home language and therapy language, has received little scholarly attention in the Indian context. Much of the current discourse on inclusive education in India focuses on access, awareness and infrastructure, but less on linguistic inclusion, which is equally essential for effective learning and participation (Singal, 2019). In contrast, inclusive education models have increasingly acknowledged the importance of cultural and linguistic responsiveness. Frameworks such as Universal Design for Learning (UDL) and Communication Accessible Environments promote the use of multiple languages and communication modes to ensure equitable participation for all (Shyyan et al., 2025).

This paper seeks to fill a critical gap by exploring how the dominance of English in autism-related education and therapy services affects children from multilingual households in Bangalore. Drawing on practice-based observations, caregiver narratives and existing policy frameworks, the paper argues that English functions not just as a medium of instruction but also as a systemic barrier to meaningful inclusion. It calls for a reimagining of autism support through a culturally and linguistically inclusive lens one that respects the child's native language and supports the family's role in intervention.

LITERATURE REVIEW

ASD is fundamentally characterised by differences in social communication, language development and behavioural flexibility. Children on the autism spectrum often experience delayed speech and language acquisition, echolalia, difficulties with pragmatic language and in some cases, remain minimally verbal. These features necessitate intervention strategies that prioritise accessible, consistent and meaningful modes of communication.

Studies have emphasised that children with autism benefit most when communication strategies are tailored to their individual developmental and linguistic profiles (Tager-Flusberg et al., 2005; Prizant et al., 2006). However, these strategies presuppose a shared language between the child, caregiver and therapist, an assumption that often fails in multilingual societies where institutional language diverges from the child's home language. This language mismatch disrupts comprehension but may also reduce engagement, impair social bonding and increase anxiety for the child (Kay-Raining Bird et al., 2005).

UNESCO (2003) has often emphasised the importance of mother tongue-based education, particularly in early childhood and primary years, for both academic performance and psychosocial development. Cummins' (2000) theory of language interdependence distinguishes between Basic Interpersonal Communicative Skills (BICS) and Cognitive Academic Language Proficiency (CALP), showing that while conversational English may develop relatively quickly, academic fluency takes years and cannot substitute for foundational skills in the child's first language. This becomes especially salient in the case of children with learning and developmental disabilities, for whom expressive and receptive language difficulties are already a primary concern. If these children are placed in English-only environments, as is often the case in Bangalore's special education schools and therapy centres, they are doubly disadvantaged.

Language mismatch is not merely a pedagogical issue but a matter of equity (Ghosh, 2012). Mohanty (2010) and Skutnabb-Kangas (2002) have both argued that when children are forced to learn and function in a second or third language, their cultural identity and self-esteem may be undermined, leading to alienation and long-term disengagement from education. For children with autism, whose world is already experienced differently, linguistic alienation can aggravate the sense of isolation and behavioural distress.

English as an institutional barrier in Indian special education

In urban India, English has come to symbolise quality education, social mobility and economic opportunity (Proctor & Pandey, 2020). This perception influences not only mainstream schooling but also special education services. A majority of private special schools and therapy centres in Bangalore operate predominantly in English, often modelling themselves on Western standards or curricula, especially for autism-related interventions like Applied Behaviour Analysis (ABA), Treatment and Education of Autistic and Related Communication Handicapped Children (TEACCH) and speech-language therapy.

While these methods can be effective, their translation into an English-only therapeutic environment overlooks the linguistic realities of the children and families they serve. Many children attending these centres come from homes where regional languages such as Kannada, Telugu, Tamil or Hindi are spoken exclusively. When assessment, diagnosis and intervention are all delivered in English, the child may struggle to respond appropriately, leading to inaccurate evaluations or ineffective therapy (Patel, 2026). Parents, especially mothers who often accompany children to therapy and act as co-therapists at home, report feeling confused, excluded or pressured to learn English in order to support their child (field observations, 2024).

Moreover, institutional preferences for English often create hierarchies of accessibility. Middle-class families who can afford to invest in English-speaking tutors or schooling may adapt more easily, while lower-income or recent migrant families who may have limited English fluency find themselves alienated from the very services their children need most.

Linguistic inclusion in global contexts

While India struggles with the paradox of linguistic richness and institutional monolingualism, international frameworks have moved toward more inclusive linguistic practices (Mohanty, 2010). The Universal Design for Learning (UDL) framework encourages the use of multiple means of representation, expression and engagement. This includes accommodating different languages, dialects and modes of communication, including visual schedules, sign language and augmentative and alternative communication (AAC) systems. Tools such as Makaton (Symbols/pictures/signs/gestures and speech to enable people to communicate) and PECS (Picture Exchange Communication System) are routinely adapted into multiple languages to serve a wider range of learners.

By contrast, Indian special education and therapy models rarely incorporate the child's home language into intervention. Teacher training programmes often lack modules on bilingual education or multilingual therapy design. As a result, the classroom and clinic become spaces of linguistic disconnect, where the child is expected to adapt to English rather than the institution adapting to the child.

Gaps in the literature and need for regional focus

Despite India's multilingual reality and the increasing prevalence of autism diagnoses, there is limited research on how language affects therapeutic efficacy and educational inclusion for autistic children. While some studies have examined inclusive education in general (Mukhopadhyay et al., 2012; Giffard-Lindsay, 2007), few focus on the intersection

of language, disability and access in urban Indian contexts. Even fewer consider the perspective of families, especially caregivers, navigating the simultaneous challenges of neurodiversity and linguistic marginalisation.

This paper seeks to fill this gap by offering a regional, practice-based perspective from Bangalore—a city emblematic of both educational aspiration and linguistic diversity (Sudha & Ravindranath, 2000). By exploring how English functions as a barrier rather than a bridge for children with autism, the study aims to reframe the conversation around inclusion to centre not only on disability but also on linguistic justice.

Methodology and practitioner narrative

This study is based on over a decade of firsthand experience working with children with specific learning disabilities and autism in Bangalore, India. The insights presented here are drawn from direct interactions with children, their families, educators and therapists in both private and semi-private educational and therapeutic settings. The children involved were primarily in the age group of 5 to 10 years, and the majority came from multilingual households where regional languages such as Kannada, Tamil, Telugu and Hindi were spoken as the primary languages at home.

My role has encompassed classroom teaching, special education coordination, individualised education plan (IEP) development and collaborative work with therapists and families. As a practitioner deeply embedded in the regional education and therapy ecosystem, I have witnessed firsthand how language barriers—particularly the dominance of English in institutional settings—have affected the access, engagement and success of children on the autism spectrum. Rather than adopting a strictly empirical research model, this paper takes a qualitative, narrative-based approach. The methodology is reflective and interpretive, aligning with traditions in educational ethnography and auto-ethnography (Ellis et al., 2011). It privileges lived experience, practitioner knowledge and parental voices, especially those often excluded from academic discourse.

The insights discussed in this paper emerge from a combination of observations and informal case narratives drawn from four inclusive education centres and three therapy clinics in Bangalore, all of which use English as the primary medium of instruction and communication. While the centres vary in terms of infrastructure and curriculum, a common thread across all of them is the use of English as the default language in teaching, assessments, speech and occupational therapy and parent communications. Children featured in the case narratives come from families where English is not the primary home language. Their parents, especially mothers, expressed varying degrees of fluency in English, ranging from limited conversational ability to complete unfamiliarity. These families often migrated from other parts of Karnataka, Tamil Nadu, Andhra Pradesh or northern India for employment or access to better educational facilities.

Methods—Sampling and data collection

Data were drawn from over 50 children and families across diverse linguistic and socio-economic backgrounds. From this broader base, three narratives were purposefully selected to illustrate recurring systemic patterns. Observations were recorded immediately post-session in a field journal, capturing descriptive accounts of interactions, behaviours and parent feedback. No structured interviews were conducted; instead, informal conversations with parents were documented through reflective memos, offering naturalistic insights into their concerns and strategies.

Data management and analysis

All data were anonymised and stored securely, using unique identifiers to ensure participant confidentiality.

A thematic narrative analysis approach was adopted, combining the strengths of both thematic and narrative analysis. First, each participant's account was read in its entirety to preserve the narrative flow, attending to the sequence of events, tone and contextual background of their experiences. This ensured that the meaning within each personal story was retained. Repeated readings of the transcripts allowed for the identification of emerging themes both within and across narratives.

Coding was inductive, guided by the participant's own words and meanings, and conducted manually. Initial codes captured salient ideas, such as parental discomfort with English, children's silence in class or negotiation between home and school languages. These codes were then reviewed to develop broader thematic categories that reflected shared experiences across participants while respecting the unique context of each story (Braun & Clarke, 2006). The analysis moved between the whole narrative and the identified themes, enabling an understanding of both the individual lived experience and common patterns, ensuring that findings were grounded in the participant's voices.

Themes were refined through reflective comparison across cases, consistent with narrative research (Clandinin & Connelly, 2000).

The findings are based on three main sources:

Participant observation

As an educator and learning support specialist, I observed children in classroom environments and therapy sessions. These observations were unstructured but detailed, often documented in reflection journals immediately following the sessions. They focused particularly on child engagement, response to instructions, emotional regulation and communication challenges in English-dominated settings.

Informal parent interviews and conversations

A key feature of my practice has been regular communication with parents, many of whom shared their frustrations, anxieties and coping strategies related to navigating English-language therapy and schooling. These conversations were not formal interviews, but organically took place during parent meetings, post-therapy debriefs and home visits.

Narrative case studies

With names and details anonymised, I present three case studies that illustrate the impact of language mismatch on children's therapeutic and academic progress. These were selected because they represent recurring patterns seen across multiple families and reflect different linguistic and socio-economic backgrounds.

Ethical considerations

All examples and narratives presented in this paper have been anonymised to protect the identities of the children and families involved. While this research is based on practice rather than formal institutional research, every effort has been made to maintain ethical integrity, confidentiality and respect for the lived experiences of the individuals represented. This approach aligns with ethical standards in narrative and action research, where ongoing practitioner relationships serve as the basis for ethical trust and participation (Pinnegar & Daynes, 2007). Consent for sharing de-identified anecdotes in professional and academic settings has been obtained where applicable.

As a practitioner-researcher working within the community, ethical principles were guided by the British Educational Research Association (BERA, 2018) guidelines for practitioner research. While a formal institutional review board (IRB) approval was not sought, ethical protocols included:

- Verbal informed consent from parents for observations and conversations,
- Anonymity and de-identification of all participant details,
- A commitment to non-harmful, respectful engagement within familiar school/therapy contexts.

Narrative as a method

This paper adopts narrative inquiry as a method of knowledge making. In the context of inclusive education in India, where empirical data on linguistic barriers is sparse, practitioner narratives offer valuable insights into the how and why of systemic exclusion. Clandinin and Connelly (2000) argue that narrative inquiry allows researchers and practitioners to make meaning from experience in ways that are holistic, context-rich and responsive to complex realities, particularly in education and disability studies.

The narrative method allows me to explore the following:

- How a child's silence in therapy might be misread as cognitive delay when it is actually a language barrier?
- How a mother's discomfort with English-language therapy instruction leads to fragmented home support?
- How institutional insistence on English acts as a form of gatekeeping, privileging children and families already familiar with the language?

While narrative-based research offers depth, it also carries certain limitations. The insights are context-specific and may not be generalisable to all parts of India or even all settings in Bangalore. There is no standardised data set, and the analysis is interpretive. However, given the paper's aim to surface an underexplored issue in inclusive education, the narrative method is both appropriate and necessary.

FINDINGS

The findings collectively demonstrate how the dominance of English as the medium of instruction and therapy contributes to a systemic exclusion of children with autism who come from non-English-speaking households.

Language delay complicated by English-only centres

Children with autism often experience delays in expressive and receptive language skills. When therapy and classroom instruction are conducted entirely in English, a language the child may have no exposure to at home, the existing communication delay is worsened. In several instances, children who were initially labelled as 'non-verbal' or 'non-compliant' showed clear signs of verbal or symbolic communication when engaged in their home language.

Case example of Ravi (aged 10)

Ravi, whose family spoke only Telugu at home, was enrolled in an English-medium special school. Teachers noted that he did not respond to questions, showed no eye contact and did not follow instructions. It was only during an informal classroom activity led by a visiting volunteer who spoke Telugu that Ravi smiled, nodded and responded to simple verbal cues. Later, with parental support, the team discovered that Ravi used a few functional words in Telugu but had no understanding of the English commands he encountered daily in school. His IEP had to be modified to include bilingual strategies, and once this was done, significant improvement was noted. This pattern, where children are prematurely diagnosed with 'severe' or 'low-functioning' autism based on their non-response in English, was observed repeatedly. The misunderstanding often stemmed from an institutional inability to distinguish between a communication delay and a language barrier.

Parent disempowerment and emotional toll

In the Indian context, mothers often serve as the primary caregivers and are expected to actively support their child's learning and therapy at home. However, when therapy sessions are conducted in English using clinical jargon, behaviour charts and task instructions unfamiliar to the caregiver, mothers report feeling helpless, ashamed or excluded from the process.

Case example 'Ruksana' (mother of a 7-year-old boy with autism)

Ruksana attended every speech therapy session with her son but rarely spoke during meetings. In a later conversation, she shared (in Urdu/Hindi) that she did not understand most of what the therapist said and often pretended to nod along to avoid embarrassment. She could not translate the instructions at home and eventually gave up trying. 'I feel like a bad mother', she said, 'because I cannot speak English. But how can I help him when I don't understand?'

Due to social pressures, many mothers blame themselves or are blamed by their extended family for 'not preparing the child' which compounds this emotional burden adequately, when in fact the system fails to meet them where they are linguistically. In some therapy centres, there is even subtle encouragement for mothers to enrol in spoken English classes, placing the burden of change entirely on the family rather than adapting services to fit their needs.

Misinterpretation of child behaviour

A recurring observation across different schools and clinics is the misreading of child behaviour when the child fails to respond or comply in English. Non-responsiveness is often interpreted as a behavioural issue, defiance or lower cognitive ability. In reality, many of these behaviours are expressions of frustration or confusion arising from language disconnect.

Case example—'Ananya' (aged 6)

Ananya, a Tamil-speaking child, often had meltdowns during classroom activities involving verbal instructions. Teachers believed she was 'intolerant of structure' and prone to emotional dysregulation. However, a trial session with visual schedules and simple Tamil instructions showed a marked reduction in stress behaviours. The child's so-called meltdowns were responses to linguistic confusion, not defiance or sensory overload. With modified language input, her behaviour improved and she began to participate more confidently. Behavioural assessments in English-only environments had misinterpreted her abilities and needs, leading to inappropriate placement, misguided interventions and over-reliance on medication.

Cultural and emotional disconnect

Language is deeply tied to culture, identity and emotional expression. When therapy is conducted exclusively in English, many children with autism lose opportunities to connect emotionally with their caregivers, rituals and home environment. The school or clinic becomes a disjointed world, where their mother tongue is irrelevant and the words they understand at home have no power or meaning.

Case example—'Manoj' (aged 11)

Manoj's father, a Kannada speaker, expressed sadness that his son 'does not laugh anymore'. At home, Manoj enjoyed listening to Kannada lullabies and stories, but at school and therapy, everything was conducted in English. The therapists used praise words like 'good job' or 'well done', to which he did not respond. One teacher decided to introduce Kannada praise words such as 'chennagide' (well done) and 'sari' (okay), and Manoj immediately began smiling and showing signs of recognition. His behaviour changed dramatically with just the inclusion of two familiar words.

Across the findings, a clear pattern emerged that the institutional prioritisation of English over regional languages in special education settings in Bangalore systematically excludes children with autism from effective learning and therapy. The issue is not simply that English is used but that it is used exclusively, often at the cost of child comprehension, family involvement and cultural identity.

This exclusion is subtle and often goes unnoticed because English is seen as 'neutral' or 'standard'. Yet, it functions as a gatekeeping mechanism, determining which children receive effective services and which families feel empowered to participate. Those with prior access to English due to class, location or education can navigate the system. Others feel left behind.

DISCUSSION

The findings presented in this paper challenge the prevailing assumptions within special education and autism therapy in urban India, particularly the assumption that English-medium instruction is inherently inclusive or effective. In Bangalore, where children from Kannada, Tamil, Telugu and Hindi-speaking homes enter institutions that operate entirely in English, the concept of inclusion remains incomplete and conditional. Children are included only to the extent that they can function in English, and parents are empowered only if they are English-speaking parents. Thus, inclusion becomes a linguistic filter (Kumar, 2004). For children with autism who already navigate the world differently, linguistic alignment between home and school is essential, not optional. The data in this study show that when children receive input in a familiar language, their behavioural responses, emotional engagement and learning capacity improve. When this is absent, communication delay is misread as cognitive deficit, and behaviour is interpreted through a deficit lens rather than a contextual one.

This linguistic exclusion must be understood as both a classed and empowering phenomenon. The dominance of English in Indian education is historically tied to colonial legacies and modern economic aspirations. English acts as a marker of modernity and social mobility (Proctor & Pandey, 2020), and its use in autism therapy is often justified as preparation for mainstream schools and global futures. Yet, this future-oriented rationale ignores the present realities of children who cannot yet access the language.

From the perspective of disability studies, this English-only model replicates what Campbell (2009) terms 'normative ableism': the expectation that children with disabilities must conform to dominant social norms in order to be included. In this case, the norm is not only neurotypical behaviour but also fluency in English. Children who do not fit this mould are seen as lacking, rather than the system being seen as inflexible. This structural ableism is compounded by linguistic hegemony, where institutional norms prioritise English at the expense of regional languages. Cummins' (2000) theory of empowerment and transformative pedagogy further helps explain the marginalisation of non-English-speaking families. When parents are unable to understand or participate in their child's learning due to language barriers, they are denied a role in co-constructing knowledge and support systems. Cummins argues that power relations in education are mediated through language, and in this context, language becomes exclusion.

India's Right to Education Act (2009), Sarva Shiksha Abhiyan (2011) and the National Education Policy (2020 emphasise inclusive and equitable education (NCERT, 2005; NIEPID, 2019). However, these policies have not yet translated into linguistically inclusive practices in special education (Rao, 2003). The assumption that English is a 'neutral' or 'standard' medium continues to erase the cultural and communicative needs of children with disabilities.

The idea that children must first learn English in order to access learning or therapy is fundamentally flawed. Instead, language itself must be accessible: the medium must meet the child, not the other way around. UNESCO's principle of 'education in the mother tongue' for early learning is supported by better cognitive, linguistic and emotional development when instruction begins in the child's first language.

For children with autism, language is not just a vehicle for content but a lifeline for expression, regulation and connection. When therapy is delivered in an unfamiliar language, it loses its therapeutic potential. As seen in the cases in this study, even small shifts like using familiar praise words or switching to bilingual instructions can transform the child's engagement and confidence. Therefore, linguistic inclusion must be recognised as a core component of inclusive education.

CONCLUSION

To address the exclusionary impact of English dominance in special education, a culturally sustaining model of inclusion is needed. Paris (2012) proposes this model as a response to cultural erasure in education systems, suggesting that schools must not only acknowledge cultural and linguistic diversity but actively sustain it. Applied to autism education in Bangalore, this means:

- Offering speech and language therapy in regional languages.
- Training special educators and therapists in bilingual communication strategies.
- Developing and distributing AAC tools and visual aids in Kannada, Tamil, Telugu and Hindi.
- Encouraging family participation by conducting parent workshops and feedback sessions in home languages.
- Embedding culturally familiar content and language into curricula and behavioural interventions.

Importantly, this shift does not mean abandoning English. It means integrating it as part of a multilingual ecology, where English is one tool among many, not the sole gatekeeper to access. By examining this issue through a regional lens, this study contributes to the broader discourse on inclusive education by highlighting the intersection of language, disability and access in a Global South context. The findings have significant implications for teacher training, therapy design, curriculum adaptation and policy implementation not only in Bangalore but also in other multilingual settings across India.

LIMITATIONS

The findings are drawn from a specific regional and cultural setting, which may limit their direct relevance to other contexts without adaptation. The participant sample was relatively small and context-specific, and while the insights are valuable for informing policy and practice in similar multilingual urban environments, caution is needed in generalising them to rural or non-Indian contexts. Further research is needed across a wider range of linguistic and socio-economic settings.

ADDRESSING THE STUDY'S AIMS

This research aimed to examine how the English language is a barrier to therapy and schooling for autistic children from multilingual backgrounds in Bangalore, and to identify culturally responsive interventions. The findings address this aim by offering both theoretical framing and concrete, contextually relevant recommendations that can inform teacher training, therapy design, curriculum adaptation and policy implementation not only in Bangalore but also in other linguistically diverse regions.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ETHICS STATEMENT

The research reported in this paper was conducted in accordance with ethical standards for educational research. The study draws upon practitioner observations and anonymised educational experiences with children with autism in Bangalore, India. All identifying information has been removed to ensure confidentiality and privacy. Informed consent for educational participation and documentation of learning processes was obtained from parents or legal guardians as part of the institution's standard practice. The study did not involve experimental procedures or interventions beyond routine educational activities. The dignity, safety, and well-being of the children and families were prioritised throughout the research process.

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