



## Social competence among well-functioning adolescents with epilepsy



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### ARTICLE INFO

#### Article history:

Received 11 June 2014

Revised 20 October 2014

Accepted 8 November 2014

Available online 11 December 2014

#### Keywords:

Epilepsy  
Social competence  
Adolescence

### ABSTRACT

**Purpose:** The aims of the study were to measure the social competence of well-functioning adolescents with epilepsy and compare it with that of their healthy peers as well as to analyze the effects of epilepsy-related variables on the social competence.

**Methods:** Ninety well-functioning adolescents with epilepsy 12–19 years of age were compared with healthy controls using the Achenbach Youth Self-Report Questionnaire measures of social competence. Within the group with epilepsy, the impact of duration of epilepsy, etiology, seizure frequency, seizure type, and antiepileptic drugs (AEDs) (monotherapy or polytherapy) on the above measures was also determined.

**Results:** Twenty-five (27.8%) adolescents with epilepsy obtained Total Competence T scores in the clinical range, as opposed to only two (3.3%) of the healthy adolescents. There were statistically significant differences in the Activity and Social subscales and Total Competence T score between the group with epilepsy and the control group ( $p < 0.05$ ). Comparing T scores for epilepsy-related variables in the group with epilepsy, we found that there were statistically significant differences in all the social competence subscales regarding the seizure control and seizure types. No significant differences were obtained for other epilepsy-related variables: duration of epilepsy, onset of epilepsy, etiology, and AEDs.

**Conclusion:** Our results indicate that adolescents with epilepsy are less active in clubs, socialize less with their friends, and have a poorer school performance compared with their healthy peers. This study shows that adolescents with epilepsy are at an increased risk of having difficulties in social competence.

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### 1. Introduction

Although there is no agreement on the definition of social competence, one of the most common definitions is that it is age-appropriate social skills acquired and absence of behavioral problems [1,2]. Proposed key components of social competence in epilepsy are the following: social skills, social adjustment, and social performance [3–5]. Social skills refer to the individual abilities required to behave competently in specific social settings [3,4]. Social adjustment is defined as the absence of behavioral problems or antisocial behavior [6]. Social performance refers to an actual behavior in social interaction and the degree to which a child's responses to relevant, primarily social, situations meet socially valid criteria [4].

The term social competence, in our study, refers to a concept operationalized using Achenbach's subscales that relate to the social performance in daily situations (participation in sports, other recreational activities, group activities, and social relationships). Its competence scales are designed not only, primarily, to measure social skills but

also to measure the amount of time spent in activities with peers, number of structured activities outside of school, and number of friends, variables that can be affected by neurological factors rather than social deficits per se [7].

In addition to being confronted with challenges associated with having a chronic illness, adolescents with epilepsy face social difficulties related to having a disorder involving the central nervous system (CNS). Adult patients with epilepsy in general report higher levels of social problems and social isolation than does the general population [8]. Compared with controls, patients with epilepsy also have lower levels of education, higher unemployment and underemployment rates, a poorer socioeconomic status, lower rates of marriage, and less social competence [9,10]. In particular, those who experience poorly controlled seizures have been found to be more dissatisfied with their social relations compared with any other life domains [11]. In the available literature, adolescents are rarely observed as a separate group and more frequently as a part of adult or pediatric populations [12]. Difficulties in social functioning, an increased prevalence of poor social competence, social isolation, and peer difficulties have been reported in studies of children with epilepsy [1,2,7,13–22]. However, there have been very few studies including adolescents with epilepsy as well [23–27].

The association between epilepsy and social competence is complex, and the proposed hypothesis is that both pathophysiological (CNS

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dysfunction or lesion) and environmental factors, including family-related ones, may affect the development of social competence. This effect may be direct or mediated through epilepsy-related and/or neurocognitive factors [28]. On the other hand, these factors may also have an independent effect on the development of social competence [28]. Although not confirmed in all studies, the underlying brain dysfunction and seizure-related variables including etiology, seizure type, seizure frequency, age at onset of seizure, antiepileptic treatment, etc. have been associated with decreased social competence and development of behavioral or mental health problems [28,29]. The development of social competence is considered one of the best predictors of later behavioral, social, and academic success and emotional problems [30]. Social competence is influenced by demographic, cultural, cognitive, and behavioral factors, but, in young people with epilepsy, it may be multitietiological, influenced also by the underlying brain dysfunction and seizure-related variables [13,31].

Information about adolescents' functioning can be obtained from different informants, including parents, teachers, and adolescents themselves. Most of the published studies involving children relied on the parental or, rarely, the teacher report as the only means of assessing social competence and children's behavior. However, the few studies which included only adolescents were based on self-reports [24,26,27, 32,33].

Achenbach et al. suggested that it is essential to include different informants [34]. Achenbach found that informants who played similar roles (e.g., mothers and fathers) tended to show higher levels of agreement in their ratings of the emotional and behavioral problems of children and adolescents than did informants who played different roles (e.g., teachers and peers) [35]. This finding may apply to cross-informant ratings of social competence as well. However, studies examining social competence have found conflicting results. Some authors reported that teachers and adolescents did not differ in their ratings of social competence, whereas parents had higher ratings compared with adolescents [32,36]. Other authors have reported that self-rating social competence does not correspond with that of other sources of information and that teacher reports of social competence correspond more with those of parents than with those of peers. [37,38]. Finnish children and adolescents described themselves as having considerably more behavioral problem than their parents did [39]. A meta-analysis of social competence in children with chronic illness found evidence that parent reports were the most widely used, and parents reported the highest levels of impairment, followed by self-reports and teacher and peer reports. The authors also concluded that parent reports may be most accurate for younger children whose social interactions are closely monitored by parents in contrast to adolescents [40]. The self-reporting instead of peer or parent reporting may be more acceptable for adolescents. It is possible that as they grow older, adolescents increasingly keep their feelings, opinions, and even social relations to themselves. Self-perceived social competence, therefore, may provide more reliable information about direct peer relation and friendship quality, which may be obscure to the parents.

The aims of the present study were to measure the social competence of well-functioning adolescents with epilepsy using the Achenbach Youth Self-Report Questionnaire (YSR) [41], a standardized quantitative measure of social competence in adolescents and compare it with that of their healthy peers and to analyze the effects of epilepsy-related variables on social competence.

## 2. Methods

### 2.1. Definitions

Adolescents were defined as youth from 12 to 19 years of age.

The diagnosis of epilepsy was defined as a history of at least two unprovoked epileptic seizures. In order to take part in the study, an adolescent should have had at least one epileptic seizure during the

previous five years (active epilepsy) and been taking antiepileptic drugs (AEDs) for at least 6 months. Well-functioning adolescents with epilepsy were those who, at inclusion in the study, had no neurological impairment, such as cerebral palsy, mental retardation, and epileptic encephalopathy, had normal psychomotor development, and attended regular school. Exclusion criteria were an additional neurological impairment and mental retardation. The classification of epileptic seizures and syndromes was based on the clinical semiology and electroencephalographic (EEG) findings according to the International League Against Epilepsy guidelines (Commission on Classification 1989) and the newly proposed Terminology and Concepts [42,43].

The patients were categorized by etiology into three groups: idiopathic or genetic, symptomatic or newly-termed structural/metabolic, and cryptogenic or unknown. Idiopathic epilepsies are characterized by their age-related onset, clinical and EEG characteristics, and a presumed genetic etiology. "Cryptogenic" refers to epilepsy in which there is no identifiable underlying etiology, clearly focal seizures or a lateralized EEG finding, and the form of epilepsy is not one of the specific idiopathic syndromes. Symptomatic or structural/metabolic etiology refers to a brain lesion associated with an increased risk of epilepsy confirmed on magnetic resonance imaging (MRI).

Classification of seizure control was based on the type and number of seizures experienced in the past 12 months:

- good control: no seizures during the past 12 months
- partial control–low seizure frequency: 1–20 focal or 1–4 dyscognitive (replaced the term complex partial) or 1 generalized tonic–clonic (GTC) or 1–20 absence or 1–20 myoclonic seizures
- poor control–high seizure frequency: >20 focal or >4 dyscognitive or >1 GTC or >20 absence or >20 myoclonic seizures [44].

The study was carried out at the Department of Child Neurology of the Clinic for Neurology, Clinical Center of Vojvodina in Novi Sad, Serbia.

### 2.2. Subjects

The study was cross-sectional. Study subjects were a total of 90 adolescents 12–19 years of age with the diagnosis of epilepsy who were admitted as inpatients or outpatients at the Department of Child Neurology of the Clinic for Neurology over a period of one year.

The data were collected from medical records and clinical examinations. Detailed histories were obtained from all patients and their parents. Each patient underwent EEG with a 16-channel recorder using the 10–20 system, routinely including 5 min of hyperventilation and photic stimulation, and sleep record when needed. Computed tomography (CT) and/or MRI (mostly) were performed in all patients with focal seizures and in all patients in whom a structural lesion was suspected. A detailed analysis of epilepsies and epileptic syndromes was made in all patients. We collected the following clinical information: demographic data, age at onset and duration of epilepsy, seizure type, etiology, seizure frequency, and AED treatment (monotherapy or polytherapy, new or conventional AEDs).

The control group consisted of 60 healthy adolescents randomly selected, recruited from local schools, with no history of psychiatric or neurological disorders, and matched for age and gender.

Intellectual ability was tested at the age of 6.5–7.5 years, before school enrollment (IQ > 80), and all participants attended regular primary or secondary schools. In general, children and adolescents with low IQ attend special education schools in Serbia.

### 2.3. Procedures

Both participants and their parents (if the participants were younger than 18 years) gave an informed consent for participating in the study following the explanation of the purpose of the study. Social competence was assessed in both groups using the Youth Self-Report

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