



Sense of coherence, social networks, and mental health among children with a cochlear implant



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ABSTRACT

Objective: The aim of this study was to explore the personal and social resources of children with a cochlear implant from a child's perspective.

Method: This descriptive cross-sectional study included 19 children with cochlear implants, aged 9–12 years. Data was collected, using the children's sense of coherence (CSOC) scale, the Network map, and the strengths and difficulties questionnaire (SDQ). The data was analyzed using descriptive and correlation statistics.

Results: Most children had a strong sense of coherence. School life was an important arena for their social network. The mental health was comparable to normal hearing children. Still, some of the children with implants had low SOC and poor mental health. High SOC and closeness of the social network, especially in school, were associated with good mental health.

Conclusion: This study shows that Swedish school-aged children with cochlear implants as a group have access to personal and social resources as strong sense of coherence and social networks. Still, there are individual children with psychosocial problems who need support and treatment.

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1. Introduction

Since CI was introduced as a treatment, few studies have focused on children's social and emotional function and health-related quality of life, especially from the children's own perspective [1–3]. Previous research has found that children with deafness are more vulnerable to compromised psychological wellbeing compared to hearing peers in terms of mental health and psychological problems [4–7]. This concerns aspects such as low self-esteem, poor social–emotional adjustment, and family stress [1,8–10]. These aspects are not solely related to the degree of hearing loss and auditory performance; factors such as additional disabilities, intelligence quotient (IQ), parental resources, educational circumstances, and the social background of the family are also relevant [7,11,12].

One aspect that may be of importance for these children's psychological wellbeing is their sense of coherence (SOC). The sense of coherence construct is a global orientation reflecting the extent to which an individual has an enduring, though dynamic,

feeling of confidence that “(a) the stimuli deriving from his or her internal and external environments are structured, predictable, and explicable; (b) the resources are available to him or her to meet the demands posed by these stimuli; and (c) these demands are challenges worthy of investment and engagement” [13] (p. 19). In order to resolve, or deal with, various demands and conflicts, the individual uses several components of the SOC construct: (a) sense of comprehensibility; (b) sense of manageability; and (c) sense of meaningfulness. These components make the individual believe in life and in his or her own abilities, with a sense of being able to master even unexpected events in life [14]. Sense of coherence is therefore a personal resource that is assumed to hold unique importance for understanding individuals' coping with stressors [15]. If there are many internal and external resources available during childhood and adolescence, such as physical factors, social support, economic opportunities, and cultural stability, a strong SOC probably will develop [16]. Children with a low SOC are more likely to perceive stressful situations as threatening and less likely to appraise them as manageable [17].

A large part of socialization takes place within social networks. In this socialization process, people adopt the values, norms, and rules for fellowship of their communities [18]. Social networks are also important for reducing the negative effects produced by

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stressful situations on children's mental wellbeing [19], and are an important factor in many areas in mental health development [20]. Social networks may be defined as the interpersonal environments that are constituted by individuals and their social relationships, unlike social support which may be defined as the material, instrumental, and socio-emotional resources transferred within these interpersonal environments [21].

Network characteristics have been found to be related to psychological adjustment in direct and indirect ways. For instance, social ties may have negative as well as positive effects on mental health. Negative social interaction, particularly involving close family and friends, may decrease perceived support and increase psychological distress [18,22]. In general, people with larger networks are better able to cope with social stressors [23].

In recent decades, a new paradigm in childhood research has emerged. It focuses on the children's own activities and perspectives, their perceptions of time and space, and the way they perceive their life circumstances [24]. It is important to be aware of the difference between the terms "a child perspective" and "the child's perspective" [25]. The child's perspective is characterized by the child's insider experiences, perceptions, and actions, based on what he or she perceives as important [26]. The United Nations Convention on the Rights of the Child has strengthened the child's role within both the family and the society, and states that a child has the right to be listened to and have its views respected [26,27]. Therefore, a prerequisite for a child's perspective to be properly understood is for the adults to listen to the children and capture and learn how children perceive and understand a situation from their own perspectives [28]. In this study the children's own perspective is emphasized. Thus, it investigates how children with a cochlear implant, perceive their personal and social resources, and how these resources are related to each other.

2. Aim of the study

The aim of this study was to explore the personal and social resources of children with cochlear implants and how these are related.

The research questions were:

- How do children with a cochlear implant rate their SOC?
- How do children with a cochlear implant draw their social network?
- How do children with a cochlear implant describe their mental health?
- What is the relationship between children's SOC, their social networks and mental health?

3. Subjects and methods

This is a descriptive cross-sectional study based on data collected from children with CI.

3.1. Participants

The children were treated in the Cochlear Implant Clinic at a Swedish University Hospital. They lived in central and northern Sweden, and were subset of a project previously reported by Anmyr et al. [29,30]. Those eligible for the study were 9 or 12 years old and had a cochlear implant. They comprised all children with such implants in these age groups in the region ($n = 37$). The exclusion criteria were: multiple impairments ($n = 4$), children from non-Swedish speaking families ($n = 2$), and children not using a cochlear implant ($n = 5$). Of the 21 families who agreed to

participate, one dropped out due to difficulties scheduling a meeting, and one child did not fill in all the forms. Consequently, the final study population consisted of 19 children (14 girls and 5 boys), a response rate of 73%.

Demographic and hearing-related data was collected through a questionnaire completed by parents and through the children's medical records (Table 1). All children had parents with normal hearing. Two of the children lived in single-parent families.

The children had bilateral profound hearing loss except for two children with severe and one child with moderate hearing loss in the best ear. The mean average age at the first-time hearing experience with a cochlear implant was 4.6 years (S.D. 2.1). At inclusion to this study, the average experience of using a cochlear implant was 6.2 years (S.D. 2.6). Of the total group, 37% had two implants.

Their average speech intelligibility rating (SIR) (Nottingham Early Assessment Package) [31] was 4.8 (S.D. 1.3). Two children had not carried out the tests because their speech and language development was normal. Receptive vocabularies, measured by the Peabody Picture Vocabulary Test, 3rd edition (PPVT III) [32], were delayed for 6 of 8 children. Eleven children had undergone other types of language assessment or had not been tested at all.

3.2. Instruments

Three socio-emotional self-report measures were utilized in this study: the children's sense of coherence scale (CSOC), the

Table 1
Demographic and hearing-related data.

	Total (9 and 12 years) $n = 19$
Gender	
Girls	14
Boys	5
Etiology of hearing impairment	
Unknown	14
Hereditary	2
Other (cmv, meningitis, sudden deafness)	3
Grading of hearing impairment^a	
Moderate	1
Severe	2
Profound	16
Age at fitting	
0–2 yrs	5
3–4 yrs	7
5–6 yrs	4
7–10 yrs	3
Type of school	
Mainstream	8
Special unit	6
Deaf school	5
Preferred language	
Oral	4
Sign	2
Total communication	13
Speech intelligibility rating	
Understandable speech	11
Grade of parental education^b	
Upper secondary school	12
University	7
Family status	
Parents married/living together	14

^a Mild 20–39 dB, moderate 41–69 dB, severe 70–94 dB, profound >95 dB (pure tone average, PTA: 500, 1000, 2000, 4000 Hz).

^b The highest grade attained among the parental couple.

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