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SOCIO-PSYCHOLOGICAL PROBLEMS OF HIGH SCHOOL STUDENTS WITH HEARING PROBLEMS

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Annotation:
Childhood hearing impairment of at least an average weight of two-way affects 1 in every 750 children in Western countries. Differences in these results depend not only on hearing loss and hearing loss with hearing apparatus or cochlear implants, but also on a variety of factors, such as additional disability, IQ, parental resources and educational conditions.

Keywords: Hearing problems, high schoolstudents, psychology, social problems.

A study of the mental health of deaf children showed comparative hearing groups with rates of 0 to 77% compared to higher rates of psychiatric disease than sampled by the general population. The results of these studies show that selecting informers contributes to a change in reported propagation. Most studies are based on questionnaires for parents and teachers or only teachers. Hindley was the first to include interviews with a child and questionnaires for parents and teachers. However, the children in this study were not representative of all deaf children in society, and the prevalence rate of mental illness was much higher (50.3%). In a recent study in a deaf teen sample in the Netherlands, the prevalence rate of psychiatric disorders using a multi-informed approach was 49%. Caseness was associated with a low IQ, a method of signing and a history of more than two physical illnesses.

A number of studies reported an increase in mental illnesses related to a child's hearing impairment rate, while others found no significant difference. Our previous study confirmed that the incidence of mental illness in adults with hearing impairments was high, but the rate of increase was not consistent with hearing loss.

If we confirm these findings, our goal is to examine other social measures that may account for any growth rates in a child's representative sample, using information obtained from parents and teachers. In the upper Austrian province

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(1,38 million inhabitants), all students check their hearing during their first year of attending school. All children with hearing impairments are enrolled in a special education center for children with sensory disabilities, which supports children in general settings throughout the country, as well as providing specialized school education for hearing and visually impaired children in The City of Linz. Upper Austrian capital.

In Upper Austria, all 186 children with double hearing capacity of at least 40 dB were invited to participate from 145,000 students between the ages of 6 and 6 months and 16 years of age who attended the first to ninth grades between 2003 and 4 and 2004–5. in reading. The size of this group of children with severe and profound hearing impairements coincided with the expected spread of the population.

Kinder-DIPS is a German systematic diagnostic interview obtained from disc-R children's diagnostic interview schedule. The parent version was used to diagnose Axis I disorders under the ICD-10 and DSM-IV TR for lifetime and point dispersion in children ages 6 through 19. Kinder-DIPS is a reliable and properly structured conversation. Test-re-testing reliability for certain diseases reaches cappa coefficients from 0.49 to 1.0 (parent version). The interrater reliability for the main version varies between 96 and 100%. Kinder-DIPS assesses all childhood or adolescence anxiety disorders, panic disorders (with and without agoraphobia), agoraphobia with no history of panic disorder, simple phobia, major depression, dystimia, attentional failure-hyperactivity disorder, resistance disorder, behavior disorder. Enuresis and encorez. A parental version was used in this study. The use of our current diagnosis allowed us to examine the connection between each diagnosis and children's scores on the Strength and Challenge Questionnaire (SDQ), but this was limited to the arbitraryness of the child's life. Therefore, we also looked at lifetime exposure, as it provided information about recurring muscleallies such as depression.

SDQ is a short assessment tool that looks at positive and negative behavioral attributes of children and adolescents and creates scores for aspects of clinical relevance. It can be supplemented as self-report by parents or teachers, or by children 11 years and older. A German version was used for parents. The results were compared to sample data from Germans with hearing abilities.

The severity of hearing loss has been classified as an average (40-69 dB of hearing), heavy (70-94 dB of hearing), or in-depth (>95 dB of hearing) from

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recent auditory records (in the previous year) according to a pure tone. chegarages 500, 1000 and 2000Hz.

Non-verbal intelligence of all children was assessed using the Hamburg-Vechsler intelligence scale, 3rd TasvIr (HAWIK).

Extended structured interviews with parents and teachers were conducted for interviews with parents and teachers, including the history of the disease, family background, the child's condition at school, and the way the child communicates at school and at home. Parents and teachers were asked to assess children's ability to understand themselves with the following question: "How do you assess a child's ability to understand himself in a family?"

Teachers reported on the adoption of the child by peers: "He has experienced negative experiences, such as how often to ridicule: often/sometimes/rarely/never?" Evaluation and interviews were conducted in regional children's schools. a multi-professional team with extensive experience in working with children with hearing impairments and deaf children. The team consisted of two linguists, one psychologist and one neuropsychologist who also conducted DIPS interviews.

The study was approved by the Ethics Committee of the St. John's Hospital in Linz, Austria, and conducted in accordance with the ethical standards laid down in the 1964 Helsinki Declaration. The primary educators of 116 children have issued written notification consent.

Parental response rate was 62,4%; there was no significant difference between those participating in the study and those who refused to be native to gender, age or German; However, parents of those with deep deafness (>95dB) had a greater need to participate (ch2 = 9,67, p=0,008). 70 children with an IQ below 17 were excluded due to the heterogenity of additional disabilities. Parents of four children did not perform their appointments, so we were unable to get a clinical diagnosis, leaving 95 children with parental DIPS supplements. 57 children were educated in ordinary schools and 38 in special schools for the deaf. Fifteen children were given cochlear implants, all of which were from a deaf group.

The average age of children at the time of testing was 11 years and 1 month (SD 2y 7 months; diaphragm 6y 5 months to 16 months). The sample was evenly distributed by gender (47 women, 48 males) and nonverptional intelligence was in the normal range (average IQ 97.9, SD 15.5; Oral language was the preferred means of communication for almost all children (94,7%). Less than half (48.4%)

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of children with general education schools and hearing impairments were the main alternative sign language or sign speech to the oral language.

Our finding that lifetime rates of children with hearing impairments were 26.3% for depression and 45.3% for any diagnosis average age 11 years 1 month and 6 years to 5 months to 16 years of age. For German-speaking children with normal hearing, the closest comparable rates are 3.4% and 18%, respectively, but all this applies to children under the age of 13. The precision rate of current depression and any diagnosis was also much higher among children. the size of the differences is less, but there is a hearing impairment.

The use of "lifetime" measures allowed us to show unexpectedly high levels of depression among our participants. While parents knew their child was working in an unusual way, none of them interpreted the problems as depression. However, the characteristics of family and peer relationships associated with mental health disorder in people with hearing impairments are also factors of hearing impairment. The representation of the association does not mean a causal relationship: the likelihood that a child with mental health disorders will be ridiculed or reproached may also be appropriate.

A factor that is unique to deafness is the parent's view of a child's ability to understand by others and the peer-to-peer experience of bad acceptance. Colvin et al.6 also noted that the deeply deaf in their sample are more likely to be insulted and mocked than hearing controls, and those who "hear partially" are also more likely to ridicule.

This study shows that for the development of psychiatric problems in deaf people, the ability to perceive themselves at home and the positive experiences of deaf children both at home and at school are important, not the level of hearing loss. meet. Parents may be able to underestimate their child's difficulties in communicating with others, so their ratings can be the minimum assessment of the problems their child is experiencing. Problems with communication can also arise because a parent has problems understanding their child: for example, 22 of the children used sign language, but only 25% of parents considered themselves proficient in sign language.

Our finding of normal indicators of opposition resistance disorder may be due to relatively low levels of hearing loss in children with severe/profound hearing loss. Most children with such a diagnosis only had moderate levels of hearing and therefore are better versed in the language to argue with their parents.

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Low response rates of those with only moderate levels of deafness are a limitation of this study. Parents of those with deep deafness were more likely to agree with the survey, perhaps because they were more likely to have clinical contact with the service before, so this group is close to the spread of the international population. The findings published here certainly depend on only one conversation with parents and teachers: repeated measures may increase the rate even further.

This study confirms that there is no association between high levels of depression and depression and levels of hearing impairement. Children with hearing impairments share etiological factors with children with hearing, such as ridicule, misuse or neglect, but they may have problems understanding themselves when compared to them (25.8% versus 7.7%), which also contributes to higher rates. Therefore, we have implemented an anti-deaf anti-borne program for children in a deaf school and a training program for teachers to identify children in need of help; In addition, there is a clinical psychologist who helps individual children. In our early intervention programs for deaf children, family communication is now a priority compared to previous approaches to acquiring language skills.

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