TEENS’ COPING/NON-COPING WITH COMMUNICATION DIFFICULTIES IN A SPECIAL BOARDING SCHOOL SETTING

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Abstract
The paper focuses on teenagers’ with special needs communicative stress and coping. Russia has little experience in inclusive education and adolescents with special needs (health impairments: auditory, visual, speech and motor) as a rule study in special boarding schools. Similar phenomena in typically developed teenagers (12-13 yrs. old, n=100) and their peers having visual (n=30), auditory (n=30), speech (n=25) and motor (n=15) disorders are compared: communication difficulties, stress experience and coping strategies. Results show teenagers’ with special needs vulnerability and disadvantage: only part of them use resources and overcome communication difficulties successfully, while the others are not able to cope with chronic communicative stress.

Keywords: communication, difficulties, special needs, teenagers, stress, coping and non-coping behavior, a special boarding school for children with disorders.

Introduction
The issues of personal impaired communication usually belong to social psychology and developmental psychology subject fields. Western psychological tradition defines impaired communication as communication disorders (Kim & Lombardino, 2013; Bruce, Braidwood, & Newton, 2013); connection violations in “multi-personal systems” (McCormack, Harrison, McAllister, McLeod, 2011); or as risk factors’ effects (Risikofaktors) that increase children’s social maladjustment (Holtmann, Becker, Kentner-Figura, & Schmidt, 2004).

Psychological studies in Russia also do not have a clear integrative definition of impaired communication: it may be regarded as a consequence of communicative incompetence; as a result of negative subjective emotional experiences; as a merger of subjective emotional hardships and objective communication difficulties (Labunskaya, Mendzheritskya, & Breus, 2001; Samokhvalova, 2014).

Impaired communication in children is an integrated psychological process, when, due to the actual communication level, a person fails to find an effective solution to a communication task without access to additional resources, which leads to a variety of communication difficulties and determines the nature of children’s interaction (Samokhvalova, 2015). The
main feature of impaired communication is connected with one or both partners’ difficulties in the process of implementation of the goals. That is communication difficulties in personal interaction or subjectively perceived communication barriers are main attributes of impaired communication. Barriers overthrow the partners’ inner balance and weaken interpersonal relationships. Barriers also require additional partners’ efforts to overcome obstacles.

Communication difficulties are classified in four categories (Samokhvalova, 2011):

- **basic communication difficulties** are those of low empathy and contact-making; difficulties related to children’s egocentrism, absence of positive attitudes to others; inadequate self-esteem, an excessive emotional addiction to a partner;
- **content-related communication difficulties** are connected with the lack of communicative knowledge, inability to forecast and plan, control and adjust the communicative strategies;
- **instrumental communication difficulties** are manifested through a child’s inability to implement planned communication strategies in an effective way. These difficulties can be verbal, non-verbal, prosodic, extralinguistic and strategy-related;
- **reflective communication difficulties** include problems of self-reflection, self-analysis and self-growth.

**Children with special needs** are hit hardest when it comes to communication. Various interpersonal communication disorders are dangerous for them as they hinder socialization and restrict adaptive communicative abilities. According to research, children with special needs (health impairments) live under constant pressure (Aisherwood, 2010; Fourie, 2011). As early as at the pre-school they gradually realize that they are “different from others”, are often laughed at or shunned. They are always on the alert, which actualizes their compensatory defensive mechanisms. Their interpersonal communication is often characterized by vivid defensive behaviour, aimed at self-protection and impairments’ disguise (Aisherwood, 2010). That is why stress related to physiological deficiency is enhanced by interpersonal communicative situations.

Social and psychological care for children with **special health needs** in Russia aims mainly to provide them with proper education, whereas their personal realization and satisfaction in interpersonal communication is rather neglected. The parents of physically impaired children are often unable to provide them with adequate help overcome communication difficulties due to lack of either empathy or knowledge and competencies. Therefore children attempt to cope with communication problems on their own. As their abilities are limited, they perceive the world as “alien” and “hostile” (Zashhirinskaja, 2013). Situations of impaired communication accumulate negative communication experience; perhaps add an inferiority complex and loneliness; “start” destructive coping strategies and even non-coping (Kryukova, 2010), destroy psychological independence and personal emotional stability (Nartova-Bochaver, 2015). These are the reasons to investigate the teens’ with **special health needs** coping with stressful communication difficulties and provide them with personalized psychological care and counselling.

**Coping with communicative stress framework**

Stress-coping studies nowadays try to concern psychological, social, cross-cultural perspectives. Theoretical research basics are more often cognitive-behavioral (e.g. stress-coping transactional theory by Lazarus & Folkman, 1984) (Aldwin, 2007; Carver & Connor-Smith, 2010; Compas, 2004; Hobfoll, 1988; Frydenberg, 1997; Kuo, 2011; O’Brien & DeLongis, 1997; Seiffge-Krenke, 1995; Zimmer-Gembeck & Skynner, 2016; et al). The
classic definition of coping by Lazarus and Folkman (1984) describes coping as ‘the constantly hanging cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person’ (p. 141). In Russia these studies first appeared in space and military psychology “closed” research: Kitaev-Smyk, 1983; Bodrov, 2006. Then clinical, health, organizational, developmental and other research were added: Leonova, 2007; Libina, 2009; Nikolskaya and Granovskaya, 2010; Kryukova, 2004, 2010; Khazova, 2015; Sirotka, 1994, Wasserman, 2009, etc. Coping is an adaptive behavior chosen in stressful/difficult situations aimed to alter a stressor, regulate an emotional response, or avoid/tolerate a stressor. Modern state and new findings support the idea that coping provides an individual with productivity, good health, well-being due to conscious choice of ways to behave according to personal abilities and situational/contextual demands (Kryukova, 2010, 2016). Coping behavior is considered to belong to an individual as a subject (Kryukova, 2010; Khazova, 2015; Saporovskaya, 2014; eds. Zhuravlev, Kryukova, & Sergienko, 2008, etc.). Coping belongs to a human being as a subject – free, independent, self-efficient. The self-choice of coping strategies during hardships is one of the key characteristics of this behavior. Coping helps people adapt, adjust, develop and maintain well-being, resilience, and health due to its adaptive nature. We are sticking to an integrative stress-coping approach. It means that all determining coping factors – dispositional, situational, socio-cultural (ecological), and regulative – have heterochronic disjunctive influence and interaction (Kryukova, 2010, 2016; Saporovskaya, 2014; Khazova, 2015). There is no one key or dominant factor so far. Another idea being worked out is coping contextualization (Chun, Moos, & Cronkite, 2006; Moos & Holahan, 2003; Kryukova & Gushchina, 2015), that is historical, generational, etc. features, way of life, values, meanings – learned, shared, altered and transmitted – all that helps understand and interpret what is happening to a person. These ideas serve better understanding of what happens when teens, who study in special boarding schools, experience communication difficulties as acute or chronic stress connected with their special health needs.

The Present Empirical Research

The study aim relates to investigate teens’ with special health needs communication difficulties and coping/non-coping with them in a special boarding school setting. The following hypothesis has to be verified: alongside communication problems age typical in general, teenagers with health disorders have specific difficulties that differ from their so-called conditionally “healthy peers”. Another idea to confirm is: in a closed boarding school setting teenagers acquire and develop specific ways of coping with communication difficulties. Meanwhile outside a boarding school the teens often cannot cope with communicative stress generated by their special health needs. The study design includes comparison of teenagers’ with health impairments (special boarding schools’ students) and typically developed teenagers’ from secondary schools communication difficulties. Objective of the current research is teens’ coping ways in the situations of stressful communication difficulties.

Method

Sample and Procedure

Two hundred (200) teenagers aged 12-13 took part in the research (average age 12,9; SD=0,46). 100 of them were children with special needs (physically impaired) with intact intellectual faculties, without any experience of inclusive education, living in their families and attending municipal closed specialized boarding schools from the first grade. The sample
was divided into four groups, according to the impairments, sensory and other: auditory, visual, speech and motor. Group 1 – teenagers with visual impairments, namely moderate and high myopia (n=30, 18 girls and 12 boys from a specialized boarding school for sensory/visually impaired children); Group 2 – teenagers with auditory impairments, i.e. neurosensory hearing loss, Degree II and III (n=30, 11 girls and 19 boys from a specialized boarding school for children with sensory/auditory impairments); Group 3 – teenagers with speech impairments, namely uncomplicated cases of general speech underdevelopment, manifesting itself in underdeveloped phonetic and semantic aspects of speech, dysgraphia or dyslexia typical of the second and third degrees of speech development (n=25, 10 girls and 15 boys – all were students of speech and motor impairments boarding school); Group 4 – teenagers with motor impairments, namely infantile cerebral paralysis (n=15, 6 girls and 9 boys, also students of speech and motor impairments boarding school).

Four control groups included 100 conditionally “healthy” teenagers aged 12-13, living with their families and attending municipal comprehensive schools without any experience of inclusive education (n1=30, 18 girls and 12 boys; n2=30, 11 girls and 19 boys; n3=25, 10 girls and 15 boys; n4=15, 6 girls and 9 boys).

A comparative study of communication problems in physically impaired and conditionally “healthy” teenagers has been done. At first each group of physically impaired children was compared to a control group consisting of typically developing peers (Mann-Whitney U-test). The experimental and control groups were similar in number of respondents, gender and age. Then four groups of physically impaired children were cross-compared to each other to identify specific communication difficulties in physically impaired teenagers (Kruskal-Wallis test).

Empirical data were processed with SPSS V.19.0 package. The differences between group profiles of separate communication variables were identified with Mann-Whitney U-test, Kruskal-Wallis test. Teenagers’ statements about their ways of coping with communication difficulties were content-analysed by Fisher angular transformation (φ*).

Measures

Experts’ evaluation of children’s communicative behaviour (summarizing independent evaluations’ method) was used to identify the objective component of impaired communication. It enabled recording the level of teenagers’ communicative skills and identifying their actual communication difficulties (Samokhvalova, 2011). Among the experts there were adults – specialized and comprehensive school psychologists, teachers, and social counselors, who knew children well and had a chance of meeting them on a daily basis. In each series of research, the opinions of four experts were taken into account.

Experts were performing standard observations of teenagers’ communicative manifestations in potentially difficult communicative situations, giving and registered each participant’s points in accordance with certain criteria. Observations were also carried out in various situational contexts:

1. Communication with peers: situations of interpersonal peers’ conflicts; meeting new people; peers’ aggression; opposing the opinion of the majority; standing up for one’s opinion; persuading peers, asking classmates for help.

2. Communication with adults: situations of dealing with teachers’ or school administration’s comments, asking adults (teachers, psychologists) for help; situations of having to prove their opinion to adults; or admitting one’s fault.
The chart included 16 basic items describing teenagers’ communicative development, each of which was assessed by Likert scale from 1 to 5. The items were as follows:

- **basic items**: rapport, emotional generosity, readiness to help and to accept help, empathy, peacefulness;
- **content-related items**: ability to plan interaction, communication adequacy, initiative, self-control in communication;
- **instrumental items**: ability to cooperate, to resolve a conflict, persuasive abilities, ability to use communicative devices;
- **reflexive items**: ability to analyse communication outcomes, ability to accept and correct communication errors.

At the final research stage after observing teenagers in different contexts of everyday school life and extracurricular activities each expert recorded total points for each criterion of a teenager’s communicative behaviour. All experts’ points were processed; empirical data were verified for coherence and consistency. The final data were used to make an individual profile of communicative behaviour and actual communication difficulties. The low and extremely low values for a particular item signified certain communication difficulties.

The incomplete sentences as a method based on the principles of projective research and content analysis (Holaday, Smith, & Sherry, 2000) was used to identify the ways of teens’ coping/non-coping with communication difficulties (causing distress) in situations of interpersonal interaction with peers and adults. The teenagers were asked to complete several sentences with their own ideas, reflecting their feelings, thoughts, or actions:

1. Communication for me is...;
2. Sometimes I have difficulties in interaction, such as...;
3. I find it hardest to communicate with ...;
4. When I feel it’s hard to interact with classmates I...;
5. When I feel it’s hard to interact with teachers I...;
6. When I feel it’s hard to interact with guys from another school I...;
7. When I feel it’s hard to communicate with adult strangers I...;
8. It helps me cope with difficulties: that is ...;
9. It hinders me cope with difficulties: that is ...;
10. To get rid of any communication problems, I would like to learn... .

Content-analysis of empirical data obtained differentiated four categories: teens’ emotional response/attitude towards communication process (1-3); coping-strategies (4-7); coping-resources (8-9); desired ways of communicative actualization (10).

**Results**

The results showed that health impaired teenagers from special closed boarding schools experienced various communication difficulties with peers and adults significantly more often than their typically developed mates from secondary schools (Table 1).
### Table 1. Differences in teens’ communication difficulties (H-by Kruskal-Wallis test)

<table>
<thead>
<tr>
<th>Communication difficulties</th>
<th>Teens with visual impairments n=30</th>
<th>Teens with auditory impairments n=30</th>
<th>Teens with speech impairments n=25</th>
<th>Teens with motor impairments n=15</th>
<th>Typically developed teens n=100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulties in making a contact</td>
<td></td>
<td>H=27.26; p=0.004</td>
<td></td>
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<td>Low emotional responsiveness</td>
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<tr>
<td>Low empathy</td>
<td></td>
<td>H=22.94; p=0.001</td>
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<tr>
<td>Unwillingness to receive help from strangers</td>
<td></td>
<td>H=36.89; p=0.001</td>
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<td>Unavailability to help others</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>H=11.12; p=0.003</td>
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<tr>
<td>Egocentrism, egotism, unwillingness to concede</td>
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<tr>
<td>Difficulties of work cooperation</td>
<td></td>
<td>H=14.36; p=0.003</td>
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<tr>
<td>Negativism, protest behavior</td>
<td></td>
<td>H=25.16; p=0.002</td>
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<tr>
<td>Hostility towards partners</td>
<td></td>
<td>H=12.76; p=0.001</td>
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<td>Difficulties in communication planning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>H=22.16; p=0.002</td>
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<tr>
<td>Difficulties of restructuring communication programs</td>
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<tr>
<td>Low communicative initiative</td>
<td></td>
<td>H=6.80; p=0.03</td>
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<td>Low self-control in communication</td>
<td></td>
<td>H=20.03; p=0.002</td>
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<tr>
<td>Inadequate communicative skills</td>
<td></td>
<td>H=30.14; p=0.001</td>
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<tr>
<td>Poor communicative skills</td>
<td></td>
<td></td>
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<td></td>
<td>H=26.47; p=0.003</td>
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<tr>
<td>Difficulties to verbalize one’s own point of view and feelings</td>
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<tr>
<td>Difficulties in persuading a partner</td>
<td></td>
<td>H=11.59; p=0.003</td>
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<tr>
<td>Aggressive communication</td>
<td></td>
<td>H=20.57; p=0.002</td>
<td></td>
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<tr>
<td>Reflexive difficulties (low self-analysis)</td>
<td></td>
<td>H=16.66; p=0.001</td>
<td></td>
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<tr>
<td>Not admitting one’s own communication errors</td>
<td></td>
<td>H=23.54; p=0.003</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Unwillingness to correct errors and drawbacks</td>
<td></td>
<td>H=12.29; p=0.002</td>
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</tbody>
</table>
Consequently, the former observations have found support in the study and cleared up the following: teenagers with health impairments had much more various difficulties in communication ($p \leq 0.003$), which were more vividly expressed and differentiated. It is worth mentioning that both physically impaired children and their typically developing peers experienced *similar communication difficulties* – aggression, intolerance, the inability to admit wrongdoing, and to make concessions, difficulties in empathy, self-control, self-analysis and self-expression. The same difficulties have been revealed in a more representative sample ($n=540$) (Samokhvalova, 2015), which enabled the authors to argue that these communication difficulties were typical of the age group in general, determined by the continual genetic developmental laws (Sergienko, 2012) and could be overcome by solving typical age-related key communicative problems. At the same time teenagers with health impairments had individual specific difficulties related to the nature of their impairments, conditions of life, daily activities, and social network’s features.

Coping/non-coping strategies in teens with special health needs are given in Table 2.

**Table 2.** Teenagers’ coping strategies in difficult communicative situations

<table>
<thead>
<tr>
<th>Coping-strategies</th>
<th>Frequency of references (%)</th>
<th>Fischer criterion $\phi^*$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coping with communication difficulties</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acts of mobbing</td>
<td>6</td>
<td>33</td>
</tr>
<tr>
<td>Distancing, ignoring a problem</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>Social support</td>
<td>10</td>
<td>29</td>
</tr>
<tr>
<td>Manipulations</td>
<td>23</td>
<td>5</td>
</tr>
<tr>
<td>Aggressive actions</td>
<td>37</td>
<td>14</td>
</tr>
<tr>
<td>Emotion venting</td>
<td>19</td>
<td>9</td>
</tr>
<tr>
<td>Seeking for problem-solving</td>
<td>15</td>
<td>7</td>
</tr>
<tr>
<td>Faith in healing, a miracle</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td><strong>Non-coping with communication difficulties</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-blame, self-hate</td>
<td>13</td>
<td>-</td>
</tr>
<tr>
<td>Fear, panic, despair</td>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td>Withdrawal to illness</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Suicidal thoughts, feelings, intentions</td>
<td>8</td>
<td>-</td>
</tr>
<tr>
<td>Doing nothing, apathy, indifference</td>
<td>7</td>
<td>-</td>
</tr>
</tbody>
</table>

Note: * – $p \leq 0.05$; ** – $p \leq 0.01$; *** – $p \leq 0.001$

The content analysis of incomplete sentences test showed that physically disordered teenagers demonstrated a higher degree of emotional experience related to an impaired communicative situation ($p \leq 0.002$); in comparison to respondents from control groups, they were more often inclined to perceive interaction as a problem-fraught stressful process that required overcoming efforts. The teenagers were anxious when they found themselves interacting in an unfamiliar situation with people whom they hardly knew and understood; they were excited, shy and afraid to express their opinions; they thought up of feeble excuses and discriminated partners.

The study findings allowed to identify *prevailing coping strategies* in each group. Thus, having communication difficulties physically impaired teenagers were more likely to use
manipulative strategies ("I make them feel sorry for me", "I try to find the partner’s pressure points", "I hide my feelings", "I pretend to be unwell", "I pretend that I misunderstand the partner"); resort to defensive aggression ("I am cheeky", "I humiliate people", "I swear", "I fight", "I do harm"); emotional burst out ("I cry and scream", "I fall on the floor", "I weep"). Some teenagers were ready to realize the emerging communication difficulties and look for ways to cope with them ("I try to find causes of the difficulties", "I think how not to let the situation develop into a conflict", "I try to decide what to do") or day-dreaming/hope for the miracle ("I hope that soon I will communicate better than anyone else", "I dream that I won’t be ill any longer", "I will become like everyone, and all problems will go away", "I imagine myself to be an actress").

It is worth mentioning that by meeting people in the familiar environment of their specialized boarding schools children with special health needs were usually able to cope with communication problems. However, talking to “alien” adults and peers from other schools they prefer the strategy of self-accusation ("It is always my fault", "I hate myself", “Nobody will want to talk to somebody like me"), feel despair and fear ("I fear they will laugh at me”, “I want to hide”, “I silently scream with horror”); apathy ("I don’t want anything”, “I don’t want to see anybody”), escape into illnesses (“I have a headache/stomach ache”, “I run to the toilets”, “I feel anxious and have a fever”), have suicidal thoughts (“I don’t want to live”, “I wish I hadn’t been born like that”, “I dream of peace and death”).

Teenagers with physical impairments named the following coping resources in case of communication difficulties: smartness, optimism, slyness, strong will, persistence, politeness and good manners, patience, ability to listen to a partner, charm, attractiveness, strength. The following traits were called as obstacles for effective coping: laziness, low self-esteem, pessimism, intolerance, irritation, excessive sensitiveness, lack of desire to communicate, impatience, egotism.

The majority of teenagers were eager to self-improve communication (92%). Visually impaired teenagers dreamt of becoming brave, fearless, easy-going, proactive (φ*=5.35; p=0.001); teenagers with auditory impairments – wanted to speak fluent, correct, fine and expressive (φ*=5.10; p=0.001). Children with speech impairments wanted to be more persuasive and get rid of the fear of being misunderstood by partners (φ*=1.99; p=0.01). Teenagers with motor impairments wanted to be able to talk to unfamiliar people easily and be liked by them (φ*=1.76; p=0.04). Therefore, teenagers with special health needs most evidently realized verbal communication difficulties, difficulties of effective cooperation and mutual understanding, self-expression in interaction. Motivation for self-perfection in interaction was also obvious.

Teenagers whose physical status was so called “normal”, preferred the following strategies in situations of impaired communication: mobbing (“I boycott them”, “I set other people against them”, “I play petty jokes on them”, “I humiliate them”), conscious escape from traumatizing feelings, keeping distance (“I get closed”, “I stop hearing them”, “I don’t care”), seek social help (“I ask for friends’ advice”, “I complain on life”, “I have fun with friends”). Almost in all communication situations teenagers were able to cope with arising difficulties and find an adequate way out. The respondents from this group named intelligence, sense of humour, assertiveness, and self-expression as coping resources. The obstacles, named by this group, had been: shyness, modesty, indifference, intolerance, inability to speak well, inability to support their point of view. The motivation for communication self-perfection was not very clearly expressed (54%). Teenagers would like to become more independent, free, tolerant, self-confident and decisive in interpersonal communication.
Discussion

Children with special health needs (physically impaired) often become agents of impaired communication and experience negative emotions related to the understanding of their special health needs, inner barriers, and shyness. More than often they create communication difficulties for partners by demonstrating excessively high expectations, aggression, hostility, jealousy, unwillingness to accept and correct wrongdoing, inability to defend their point of view in an effective way, lack of desire to cooperate and reach an agreement with partners. These tendencies are manifested in interaction of physically impaired teenagers with their so called “healthy” peers especially well.

Impaired communication in children with various impairments (sensory – visual, auditory, speech and motor) is characterized by specific features, related to the nature of the impairment, psycho-physiological status of a teenager and his/her actual communication experience.

Alongside with those, there are communication difficulties, typical for all physically impaired teenagers: they often demonstrate “comprehension barriers” in communication; communicative situations often cause shame, awkwardness; some children demonstrate despotism in communication, capriciousness, an intention to usurp adults’ attention.

The obtained empirical data enable us to claim that ways of coping differ in two groups. Physically impaired teenagers use mainly manipulative or aggressive strategies, are prone to emotional bursts out, day-dream, but choose problem-oriented coping as well. In impaired communication situations typically developed teenagers resort to mobbing strategies, keep distance, seek social help. Physically impaired teenagers mobilize all mental resources (intellectual, emotional, related to willpower, communication, related to body language), whereas typically developed teens use only intellectual and motivational resources when they face communication difficulties.

At the same time it should be noted that teenagers with special needs more often show mental resources’ loss, related to the perception of a social situation as overwhelming, desperate, uncontrollable (Khazova, 2015); teenagers are scared, desperate, panicking, inclined to self-accusation, depression, apathy; they withdraw into illness or have suicidal thoughts, i.e. non-coping strategies could prevail (according to Frydenberg, 1997).

In the familiar specialized boarding schools’ environment, physically impaired children are usually able to cope with communication problems. However, in other social circumstances they could feel lost, cannot cope with stress, develop social fears and block mental resources. Therefore, the deprivational environment of a closed educational institution is, on the one hand, a development factor, as it helps to form specific though stereotypical coping strategies and skills, develop an individual coping-resources system (a child receives social support, understands that s/he is not alone, learns to overcome difficulties in communication on equal terms). On the other hand, it is a risk factor which “limits freedom and the environment in which a child lives, develops and is brought up; having a negative impact on development” (Petermann et al., 2000, p. 37). The risk is that in deprivational setting a child’s adaptation potential decreases, s/he becomes vulnerable to a changing social context; unable to effectively cope with life difficulties for which s/he is not ready; adapt stereotypical communicative programs to new communication situations.
Conclusions

The findings show that teenagers with special health needs (physically impaired) often find themselves under stress — the “triple pressure load”: first, they are oversensitive to own physical special needs, feeling “different”, “unlike others”. Second, they experience communication problems typical of their age and related to an acute need in autonomy and independence. Third, they have individual specific difficulties related to the nature of the impairment, life conditions, daily activities and social networks’ characteristics. All these factors add to frustration, despair and feeling helpless to change a hard situation. Could teenagers aged 12-13 cope with these difficulties on their own, without harm to their physical and mental health state? The answer is obvious — no, they could not. Differences in coping patterns and preferences among physically impaired teenagers and their peers have been confirmed, and they are understandable to some extent. But at the same time they are being reproduced by a multifactor life style system of teens’ with special health needs in a boarding school. These issues clearly represent gaps in the existing data on coping and adaptation and require additional research.

It seems essential to draw attention of professional educational community to communication problems in physically impaired children. It is necessary to study their specific difficulties, identify them in proper time, and suggest programs of personalized assistance. One of the most urgent tasks of psychological support for teens with special health needs is to train and enhance their productive and effective coping skills to overcome communication difficulties, teach them self-regulation, reflection, relaxation, and meditation.

This type of programs could take into account the nature and quality of special needs and disorders, as well as the character of communication difficulties in children with various impairments; provide psychological and counselling services to teenagers and their families, to facilitate interpersonal communication to become more optimal. Besides it is obvious that Russian educational system must allow and admit more intensive inclusive education for teenagers with special health needs, creating a more open, available, democratic social setting for development of mature and happy young personalities. Finally, as mentioned above, long-term investigation should focus on coping with communication difficulties research in the future.

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References


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Summary

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The paper focuses on teenagers’ with special needs communicative stress and coping. Russia has little experience in inclusive education, so adolescents with health impairments (auditory, visual, speech and motor) study in special boarding schools. Similar phenomena in typically developed teenagers (12-13 yrs old, n = 100) and their peers with visual (n = 30), auditory (n = 30), speech (n = 25) and motor (n = 15) impairments are compared: communication difficulties, stress experience and coping strategies.
Physically impaired children often become agents of impaired communication and experience negative emotions related to the understanding of their impairment, inner barriers, and shyness. More than often, these children create communication difficulties for partners by demonstrating excessively high expectations, aggression, hostility, jealousy, unwillingness to accept and correct wrongdoing, the inability to defend their point of view in an effective way, lack of desire to cooperate and reach an agreement with partners. These tendencies are manifested in interaction of physically impaired teenagers with their so called “healthy” peers especially well.

Impaired communication in children with various impairments (visual, auditory, speech and motor impairments) is characterized by specific features, related to the nature of the impairment, psycho-physiological status of a teenager and the accumulated communication experience. Alongside with those, there are communication difficulties, typical for all physically impaired teenagers: they often demonstrate “comprehension barriers” in communication; communicative situations often cause shame, awkwardness; some children demonstrate despotism in communication, capriciousness, and desire to usurp adults’ attention.

The obtained empirical data enable us to claim that ways of coping differ between the two groups. Physically impaired teenagers mainly use manipulative or aggressive strategies, are prone to emotional burst out, tend to fantasize, but consider problem-oriented coping as well. In situations with impaired communication, typically developed teenagers resort to mobbing strategies, keep distance, seek social help. Physically impaired teenagers mobilize all the mental resources (intellectual, emotional, related to willpower, communication, related to body language), whereas typically developed teens use only intellectual and motivational resources when they face communication difficulties. At the same time, it should be noted that physically impaired teenagers more often than not show mental resources’ loss, related to the perception of the social situation as overwhelming, desperate, uncontrollable. In such situations teenagers are scared, desperate, panicking inclined to self-accusation, depression, apathy; they withdraw into illness or have suicidal thoughts, i.e. non-coping strategies prevail.

Differences in coping patterns and preferences among physically impaired teenagers and their peers have been confirmed, and they are understandable to some extent. But at the same time they are being reproduced by a multifactor system of the health impaired teens’ life style in a boarding school. These issues clearly represent gaps in the existing data on coping and adaptation and they demand additional research attention.

It seems essential to draw attention of the professional psychological community to communication problems in physically impaired children. It is necessary to study their specific difficulties, identify them in proper time, and design programs of personalized assistance. One of the most urgent tasks of psychological support for physically impaired teens is to train and enhance their effective and productive coping skills, teach them self-regulation, mindfulness, reflection and meditation to overcome communication difficulties.

Such programmes could take into account the nature and quality of a disease as well as the character of communication difficulties in children with various impairments; provide psychological and counseling services to teenagers and their families, which facilitate interpersonal communication, transform it into more optimal. Besides it is obvious that Russian educational system must allow and admit more intensive inclusive education for health impaired teenagers, creating a more open and available social setting for development of mature and happy personalities. Finally, as indicated in this article, long-term investigation should focus on coping with communication difficulties research in the future.

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