

THE PECULIARITIES OF THE SPEECH COMPREHENSION PROCESS IN CHILDREN WITH DYSARTHRIA

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Abstract

This article analyzes the specifics of the development of speech understanding in dysarthric children, the course of speech in pseudobulbar dysarthria, the movements of the muscles of the articulatory speech apparatus and their characteristics.

Keywords: Dysarthria, hyperkinesis, muscle movement, pseudobulbar, medulla oblongata, choreiform, speech motorics, speech breathing, brain injury.

Introduction

One of the speech defects is dysarthria. Initially, dysarthria was studied by neuropathologists in the context of brain injuries in adult patients. In the first classification of speech disorders (A. Kussmaul, 1879), all articulation disorders were divided into a separate group and named with the term "dysarthria". Kussmaul considers dysarthria to be the result of articulation disorders. He argues that the articulation of sounds, their correct pronunciation, is associated with the absence of damage to the motor nuclei in the medulla oblongata.

The development of speech comprehension in dysarthric children is peculiar. This is manifested in insufficient understanding of polysemantic words, difficulties in distinguishing the meaning of synonyms, antonyms, adjectives and adverbs.

Comprehensive development of oral speech in dysarthric children is an important condition for the successful mastering of program materials in basic subjects. Poor vocabulary leads to a lack of understanding of individual grammatical forms and phrases, difficulties in understanding educational texts, arithmetic problems, and works of art.

Studies have shown that in most cases, impaired pronunciation of sounds is associated with pseudobulbar dysarthria. Pseudobulbar dysarthria is caused by damage to the cortical-nuclear pathways that go from the cerebral cortex to the nuclei of the trunk nerves.

Pseudobulbar dysarthria is characterized by an increase or decrease in muscle tone in the articulatory speech apparatus. Examination of the mobility of the articulatory speech apparatus allowed us to distinguish several groups of children. In the first group, salivation, a decrease in the speed, volume and amplitude of movements of the muscles of the lips and tongue, a decrease in the strength of the voice, speech breathing and exhalation were observed. The weakening of the innervation of the cranial nerves was different, often the movement of the tongue to the side, the lifting of the tip of the tongue to the upper lip were weakened. Breathing during speech was difficult in children, which reduced the smoothness of speech breathing and caused involuntary pauses in speech.

During speech, the voice in children was low, with poor modulation. In non-speech situations - in affective reactions, children screamed acoustically better, the voice was clean and sonorous.

The movements of the muscles of the articulatory speech apparatus had the following characteristics:

1. The onset of movement and the transition to another movement usually occur smoothly.
2. The onset of movement causes subtle synkinesias in the head and limbs.
3. Movements may not occur completely in voluntary attempts, but occur in conditioned reflex acts.
4. The volume of movements is incomplete, the amplitude is always reduced, the movements are asymmetrical.
5. Passive movements are easy.
6. When the movements are repeated, salivation increases suddenly.

When the children's performance of phonetic tasks was checked, they could not complete most of the tasks. Children were observed to be slow in pronouncing almost all sounds. Many errors were detected in the differentiation of sounds.

Children of this group have difficulty in speech communication, almost all of them quickly get tired of the load, their speech activity is not always manifested. The children's speech communication is minimal, they rarely ask questions, especially those of a cognitive and learning nature.

Traces of speech reactions quickly disappear, they need to be explained the material again and again, their vocabulary is not extensive on all topics, mainly limited to the everyday conditions of the drill.

Children belonging to the second group of pseudobulbar dysarthria have paralysis mainly of the muscles of the articulatory apparatus. In these children, along with disorders in the prelingual sounds, there are also defects in the production of labial sounds, which require sufficient force, especially labial sounds (p, b, m), as well as vowel sounds, especially those that require sufficient elevation of the tongue (i, u). Due to paralysis of the soft palate, a sudden limitation of movements was detected, so the child pronounced all sounds in a nasal tone. Speech was slow, low, poorly formed.

Although hyperkinesia in speech motor skills does not always occur as intensively as in general motor skills, the nature of hyperkinesia is the same. The degree of manifestation of hyperkinesia in the speech apparatus depends not only on the emotional load, but also on the duration of speech communication. The following types of hyperkinesia are distinguished in speech muscles. Choreiform, athetoid choreoathetoid. In athetoid hyperkinesia, the speech process is severely impaired, children's speech cannot be understood without special listening and repeated questions. In choreiform hyperkinesia, children were able to perform all tasks in which the mobility of the muscles of the speech apparatus was determined. The intensity of hyperkinesia did not significantly affect the ability to perform movements. Naturally, the quality of execution was impaired, but the amplitude and volume of movements were preserved in full. In pure choreiform hyperkinesia, children were able to form all articulatory states and differential articulatory signs of sounds, so we did not observe cases of letter substitution and omission in them. Athetoid hyperkinesia always occurred in head tilts, jaw, tongue, and lip movements. Involuntary movements of the suboccipital and orbicularis oculi muscles were observed in the upper mimic muscles, eyebrows were raised and slightly moved, and surprise was observed as if experiencing pain. Hyperkinesia increased in voluntary speech manifestations, which is secondary to the nature of the movement of the muscles of the speech apparatus, which has the following features.

1. The speed of movements depends on the nature of hyperkinesia, in athetoid hyperkinesia the latent period of speech onset increases to some extent, while in choreic it is at the normal level.
2. In athetoid hyperkinesia, it is impossible to perform a number of movements, but the student always tries to perform the movements better, even for a long time. There are no movements to raise the tip of the tongue to the upper lip. In choreiform hyperkinesia, movements are somewhat more difficult, but they can be performed.
3. Hyperkinesia is observed when performing articulatory movements.
4. In choreiform hyperkinesia, the amplitude of movements is not constant, in athetoid hyperkinesia the amplitude is incomplete.
5. The fixation of movements is very limited. The main reason for the occurrence of sound pronunciation disorders in the hyperkinetic form of cerebral palsy is disorders in the tone of the speech muscles.

The next feature of the pronunciation of sounds is a violation of emotional-motor innervation, which is manifested in disorders in the prosodic side of speech. In this case, not only articulation, but also the tempo, rhythm, the ability to speak quickly or slowly, and the melodiousness of speech are disturbed. The emotional tone of speech disappears, speech becomes monotonous, monotonous, and monotonous. During expressive speech, its constant stopping occurs.

In conclusion, it can be said that in these children the voice becomes hoarse, quivering in choreic hyperkinesia, and compressed and muffled in athetoid hyperkinesia. The tempo of

speech is slightly preserved in choreic hyperkinesis, and very slow in athetoid hyperkinesis. In athetoid hyperkinesis, the voice does not become hoarse due to the lack of melodiousness of speech.

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