

Taking Anamnesis and Examination of the Articulatory Apparatus with Erased Dysarthria

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Annotation: This article examines the articulatory speech apparatus in children with dysarthria and the collection of anamnestic data. Information on their analysis is also provided.

Key words: Anamnesis, dysarthria, stuttering, alalia, aphasia, rhinolalia, general speech underdevelopment.

As you know, in many many specialized preschool institutions, children with different disabilities are brought up. Of these, there are children with speech impairments.

Speech disorders include dyslalia, dysarthria, alalia, aphasia, rhinolalia, stuttering and general speech underdevelopment.

Dysarthria is a speech disorder caused by diseases of the nervous system or a disorder in the work of the vocal cords, facial and respiratory muscles. Insufficient mobility of the organs of speech leads to incorrect pronunciation and general underdevelopment of speech.

Dysarthria is often found in children with cerebral palsy - in this case, the central nervous system is affected, and the facial muscles are undeveloped. This is a severe form of the disease - the child is unable to speak. In a mild form, dysarthria is manifested by difficulties in the work of fine motor skills, fuzzy pronunciation of words.

The first deviations, signaling the presence of dysarthria, are observed in a child even in infancy: the baby is inactively sucking on the breast, you can see that it is difficult for the child to feed, he often spits up and gags. Dysarthria can be recognized a little later, at the age when the child has to babble a lot, own the simplest words. You can notice the constant tension of the lips, neck and tongue, or vice versa - the muscles are sluggish, the mouth is constantly open, drooling, the child says "in the nose." There may also be constant changes of excessive tension and muscle relaxation. The child's speech is inconsistent. It can be fast at first, then slow, and by the end of the child's phrase it is practically inaudible. Often he skips sounds and letters, up to not pronouncing a number of consonants. The voice sounds squeaky. Such children do not like to work with their fingers: tying their shoelaces or having to use scissors makes them protest. They can't draw well because they have difficulty holding a pencil / pen. Children cannot dance or sing because the disease leads to hearing impairment, they do not like exercise.

It is possible to understand what form this or that case of dysarthria belongs to after conducting appropriate research, which should be done by a specialist. Self-diagnosis can be wrong. For example, dysarthria can be confused with dyslalia, and in the case of the latter, there is no organic brain damage.

Diagnosis of dysarthria begins with appropriate studies and analyzes, such as: MRI of the brain, electromyography, electroneurography, electroencephalography, etc. Children suffering from different forms of dysarthria distort speech in different ways. To assess the complexity of the case, speech therapy diagnostics of the rate of speech, intelligibility, pronunciation, work of the muscular system, written and oral speech, etc. is necessary.

Erased dysarthria is often found among children with speech impairments.

Erased dysarthria is very common in speech therapy practice. The main complaints with erased dysarthria: slurred, inexpressive speech, poor diction, distortion and replacement of sounds in words with complex syllabic structure, etc.

Erased dysarthria is a speech pathology that manifests itself in disorders of the phonetic and prosodic components of the speech functional system and arises as a result of unexpressed microorganic brain damage (L.V. Lopatina).

Studies of children in mass kindergartens have shown that in the older and preparatory groups for school, from 40 to 60% of children have deviations in speech development. Among the most common disorders: dyslalia, rhinophonia, phonetic-phonemic underdevelopment, erased dysarthria.

In groups for children with general speech underdevelopment up to 50% of children, and in groups with phonetic-phonemic underdevelopment - up to 35% of children have erased dysarthria. Children with erased dysarthria need long-term, systematic individual speech therapy assistance. Speech therapists of specialized groups plan speech therapy work as follows: in frontal, subgroup lessons with all children, they study program material aimed at eliminating general speech underdevelopment, and in individual lessons they correct the pronunciation side of speech and prosody, i.e. elimination of symptoms of erased dysarthria.

Diagnostics of erased dysarthria and methods of corrective work have not yet been developed enough. In the works of G.G. Gutzman, O.V. Pravdina, L.V. Melekhova, O.A. Tokareva, I.I. Danchenko, R. I. Martynova discusses the issues of the symptomatology of dysarthric speech disorders, in which there is a "washout", "wear" of articulation. The authors note that erased dysarthria in its manifestations is very similar to complex dyslalia. In the works of L.V. Lopatina, N.V. Serebryakova, E. Ya. Sizova, E.K. Makarova and E.F. Sobotovich, the questions of diagnosis, differentiation of teaching and speech therapy work in groups of preschoolers with erased dysarthria are raised. The problems of differential diagnosis of erased dysarthria, the organization of speech therapy assistance to these children remain relevant, given the prevalence of this defect.

The erased form of dysarthria is most often diagnosed after five years. All children, whose symptoms correspond to erased dysarthria, are referred to a neurologist for consultation to clarify or confirm the diagnosis and to prescribe adequate treatment, because with erased dysarthria, the method of corrective work should be comprehensive and include:

- medical impact;
- psychological and pedagogical assistance;
- speech therapy work.

For the early detection of erased dysarthria and the correct organization of the complex effect, it is necessary to know the symptoms that characterize these disorders. The examination of the child begins with a conversation with the mother and the study of the outpatient card of the child's development. Analysis of anamnestic information shows that there are: deviations in intrauterine development (toxemia, hypertension, nephropathy, etc.); asphyxia of newborns; rapid or protracted labor. According to the mother, "the child did not cry right away, the child was brought to feed later than everyone else." In the first year of life, many were seen by a neurologist, prescribed medication and massage. The diagnosis was NEP (perinatal encephalopathy) for up to a year. The development of the child after one year, as a rule, is successful for everyone, the neuropathologist no longer observes these children, and the child is considered healthy.

When examined in a polyclinic by a speech therapist in children aged 5-6 years with erased dysarthria, the following symptoms are revealed:

General motor skills. Children with erased dysarthria are motor awkward, the range of active movements is limited, the muscles quickly get tired during functional loads. They stand unstably on any one leg, cannot jump on one leg, walk along the "bridge", etc. They imitate poorly when imitating movements: how a soldier walks, how a bird flies, how bread is cut, etc. Motor failure is especially noticeable in physical culture and music lessons, where children lag behind in the tempo, rhythm of movements, as well as during switching of movements.

Fine motor skills of the hands. Children with erased dysarthria learn self-care skills late and with difficulty: they cannot fasten a button, untie a scarf, etc. In drawing classes, they do not hold a pencil well, hands are tense. In origami classes, they have tremendous difficulties and cannot perform the simplest movements, because both spatial orientation and subtle differentiated hand movements are required. According to mothers, many children under 5-6 years old are not interested in games with a construction set, do not know how to play with small toys, do not assemble puzzles.

Children of school age in the first grade have difficulties in mastering graphic skills (some have "mirror writing"; replacement of letters "d" - "b"; vowels, word endings; poor handwriting; slow writing pace, etc.).

Features of the articulatory apparatus. In children with erased dysarthria, pathological features in the articulation apparatus are revealed.

The pareticity of the muscles of the organs of articulation is manifested in the following: the face is hypomimic, the muscles of the face are sluggish on palpation; many children do not hold the position of the closed mouth, because the lower jaw is not fixed in a raised state due to the lethargy of the chewing muscles; the lips are flaccid, their corners are lowered; during speech, the lips remain lethargic and the necessary labialization of sounds is not performed, which worsens the prosodic side of speech.

The spasticity of the muscles of the organs of articulation is manifested in the following: the face is amimic, the muscles of the face are hard and tense on palpation. The lips of such a child are constantly in a half-smile: the upper lip is pressed against the gums. During speech, the lips do not take part in the articulation of sounds.

Hyperkinesis with erased dysarthria is manifested in the form of tremors, tremors of the tongue and vocal cords. Tongue tremor manifests itself during functional tests and loads. For example, when asked to maintain a wide tongue on the lower lip at a count of 5-10, the tongue cannot maintain a state of rest, trembling and slight cyanosis appear (i.e., the tip of the tongue turns blue), and in some cases the tongue is extremely restless (waves roll over the tongue longitudinal or transverse). In this case, the child cannot keep the tongue out of the mouth.

Apraxia with erased dysarthria is revealed simultaneously in the impossibility of performing any arbitrary movements with the hands and organs of articulation. In the articulatory apparatus, apraxia manifests itself in the impossibility of performing certain movements or when switching from one movement to another.

Deviation, i.e. deviations of the tongue from the midline, also manifests itself during articulation tests, during functional loads. The deviation of the tongue is combined with the asymmetry of the lips when smiling with the smoothness of the nasolabial fold.

Hypersalivation (increased salivation) is determined only during speech. Children cannot cope with salivation, do not swallow saliva, while the pronunciation side of speech and prosody is affected.

When examining the motor function of the articulatory apparatus in children with erased dysarthria, it is noted that all articulation tests can be performed, i.e. On assignment, children perform all articulatory movements - for example, puff out their cheeks, click their tongue, smile, stretch their lips, etc. When analyzing the quality of these movements, one can note: blurredness, fuzzy articulation, weak muscle tension, arrhythmia, decreased range of motion, short duration of holding a certain posture, decreased range of motion, rapid muscle fatigue, etc. Thus,

with functional loads, the quality of articulation movements is sharp falls. This leads during speech to distortion of sounds, their mixing and deterioration in the whole of the prosodic side of speech.

Sound reproduction. At the initial acquaintance with the child, his sound pronunciation is assessed as complex dyslalia or simple dyslalia. When examining the pronunciation of sounds, the following are revealed: mixing, distortion of sounds, replacement and absence of sounds, i.e. the same options as for dyslalia. But, unlike dyslalia, speech with erased dysarthria has violations and a prosodic side. Pronunciation and prosody disorders affect speech intelligibility, intelligibility, and expressiveness. Some children go to the clinic after classes with a speech therapist. Parents ask the question why the sounds that the speech therapist delivered are not used in the child's speech.

Interdental utterance and lateral overtones are quite often noted. Children experience difficulties in pronouncing words of a complex syllable structure, simplify the filling of sounds, omitting some sounds when consonants are confluent.

Prosody. The intonation-expressive coloring of the speech of children with erased dysarthria is sharply reduced. Voice, voice modulations in height and strength suffer, speech exhalation is weakened. The timbre of speech is disturbed and sometimes a nasal tinge appears. The rate of speech is often accelerated. When reciting a poem, the child's speech is monotonous, gradually becomes less legible, the voice fades. The voice of children during speech is quiet, modulation in pitch, in the strength of the voice fails (a child cannot change the pitch of his voice by imitation, imitating the voices of animals: cows, dogs, etc.).

In some children, speech exhalation is shortened, and they speak while inhaling. In this case, speech becomes choking. Quite often, children (with good self-control) are identified, in whom, when examining speech, deviations in sound pronunciation do not appear, because they pronounce the words in a chant, i.e. by syllables, and only the violation of prosody is in the first place.

General speech development. Children with erased dysarthria can be conditionally divided into three groups.

First group. Children who have a violation of sound pronunciation and prosody. This group is very similar to children with dislalia. Often, speech therapists conduct them as dislaliks, and only in the process of speech therapy work, when there is no positive dynamics in the automation of sounds, a suspicion arises that this is an erased dysarthria. This is most often confirmed by a deep examination and after consultation with a neurologist.

These children have a good level of speech development, but many of them have difficulties in assimilating, distinguishing and reproducing prepositions. Children confuse complex prepositions, have trouble distinguishing and using platonic verbs. At the same time, they have a coherent speech, have a rich vocabulary, but may have difficulty pronouncing words with a complex syllable structure (for example, a frying pan, tablecloth, button, snowman, etc.). In addition, many children have difficulty with spatial orientation (body layout, bottom-top concepts, etc.).

Second group. These are children in whom a violation of sound pronunciation and the prosodic side of speech is combined with an unfinished process of forming phonemic hearing. In this case, children have single lexical and grammatical errors in speech. Children make mistakes in special tasks when listening to and repeating syllables and words with opposition sounds - for example, when they are asked to show the desired picture (mouse-bear, fishing rod-duck, scythe-goat, etc.).

Thus, in children, the lack of formation of the auditory and pronunciation differentiation of sounds is ascertained. Children's vocabulary lags behind the age norm. Many have difficulties in word formation, make mistakes in reconciling a noun with a numeral, etc. Defects in sound pronunciation are persistent and are regarded as complex, polymorphic disorders. This group of children with phonetic and phonemic underdevelopment (FFN and erased

dysarthria should be sent by the speech therapist of the polyclinic to the MPC (medical and pedagogical commission), to a specialized kindergarten (to the FFN group).

Third group. These are children in whom a persistent polymorphic disorder of sound pronunciation and a lack of the prosodic side of speech is combined with an underdevelopment of phonemic hearing. As a result, during the examination, a poor vocabulary, pronounced errors in grammatical structure, the impossibility of a coherent statement, significant difficulties in mastering words of various syllable structures are noted.

All children in this group demonstrate an unformed auditory and pronunciation differentiation. Disregard of prepositions in speech is indicative. These children with erased dysarthria and general speech underdevelopment (OHP) should be sent to the IPC (in specialized kindergarten groups) in the OHP groups.

Speech therapy examination should be comprehensive, complex and dynamic. The complexity, integrity and dynamism of the survey are ensured by the fact that all aspects and components of speech are examined: sound pronunciation, phonemic hearing, vocabulary, grammatical structure. Reading and writing are examined in school-age children. In this article, we will consider the collection of anamnesis and examination of the state of the articulatory apparatus of children.

The examination requires a detailed analysis of pathological signs. When examining speech development, it is necessary to take into account the child's age, the degree of maturity of the body, the state of the internal organs, the state of the nervous system.

The conditions in which the research is carried out also matter. Children should be calm and communicative. The research is carried out in a playful way with the use of bright toys. It is important to establish full psychological contact with children of school age.

The word "anamnesis" comes from the Greek anamnesis - memory. Anamnesis consists of two parts: a life history and a medical history. The life history describes the history of the child's development from the moment of birth to the moment of the study. At the same time, it is important to find out how the childbirth proceeded, whether there was jaundice in the first days after birth, what diseases the child suffered at an early age (infections, intoxication, craniocerebral trauma, etc.) and how these diseases affected his neuropsychic development.

Heavy and prolonged childbirth (or fast, rapid), various surgical obstetric interventions during childbirth can cause damage to the nervous system of the newborn or disruption of the processes of neuropsychic development of the child.

It is very important to find out the features of the psychophysical development of a child at an early age. It should be clarified when the child began to hold the head. Crawl, sit. Put on legs, stand on your own, walk. We especially find out when humming, babbling, the first words, the first sentence appeared, as well as when phrasal speech appeared. If early development was delayed, you should find out whether the parents went to the doctor, how the treatment was carried out, what effect was observed during the treatment. It is also necessary to find out how the child's physical and mental development took place in preschool and school age.

The life history should contain a description of the sanitary-hygienic and social conditions in which the child was before the examination, since it is these factors that can have a significant impact on the formation of the child's neuropsychic structure. One of the unfavorable social and living conditions is the alcoholism of the parents.

Of particular importance when collecting anamnesis are information about immediate and distant relatives, as well as data on certain diseases or anomalies in the mother's or father's line. The collection of these data is of great importance due to the increased proportion of hereditary diseases in recent decades. According to the WHO, 3% of newborns suffer from hereditary pathology to one degree or another. Currently, about two thousand genetically

determined diseases are known. Studying the pedigree helps to find out the nature of the disease, gives an idea of the type of inherited disease, and facilitates the diagnosis.

The family history is important to reflect the health status of the mother. Describe the hazards that could have affected her during pregnancy. Many diseases of the mother (diseases of the heart, lungs, endocrine system, etc.) can complicate the course of pregnancy and lead to damage to the fetus. So, if the mother has congenital heart defects with symptoms of circulatory disorders, the fetus may develop congenital malformations of the brain.

The medical history is devoted to the presentation of the development of the present disease from the appearance of its first signs to the moment of examination. At the same time, it is important to find out how and when the first signs of the disease appeared, in what order and when the subsequent signs were revealed, aka the child behaved, what changes were found in his condition. The presence of general infectious signs of the disease is revealed (fever, cough, runny nose, inflammatory changes in blood and blood tests, etc.); a history of epidemiological data is recorded (the presence of a similar infectious disease in the family, in kindergarten, at school). Anamnestic information is collected from children, parents, relatives or caregivers.

However, it must be remembered that children do not always assess their condition correctly and may miss important information; in addition, they are easily suggested and may miss important information on a persistent question; in addition, they are easily suggestible and can give an answer to an insistent question depending on the tone of the questioner.

Then there is a study of the neurological status - the functional state of the nervous system at the time of examination.

After collecting the anamnesis, the speech therapist examines the state of the articulatory apparatus. The speech therapist receives data on the structure of the organs of articulation based on an examination of the oral cavity. Attention is drawn to the lips (thin, thick, sagging lips); teeth (even, crooked, extra, teeth outside the dentition); tongue (thin, thick, sedentary, long); sky (gothic, low, normal); small tongue (absence, shortened, bifurcated).

An examination of the dynamic organization of movements of the articulatory apparatus is carried out. The child is invited to complete the following tasks.

1. On the dynamic organization of movements of the tip of the tongue outside the mouth:

- pull the tongue to the chin, then to the nose;
- pull the tongue to the chin, then to the upper lip;
- pull the tongue to the chin, then move the tip of the tongue along the upper lip (imitation of licking lips);

1.1. Study of the motor function of the lips. The child is invited to complete the following tasks:

- to stretch the lips into a "tube";
- reproduce the "proboscis";
- smile broadly;
- "round" lips;
- to reproduce the "grin" with a closed mouth;
- to reproduce the "grin" with an open mouth;
- reproduce the pattern of lips for all vowel sounds.

Tasks are performed according to the model, then according to verbal instructions

2. Study of the motor function of the jaw. The child is invited to complete the following tasks:

- open your mouth, as when pronouncing the sound (a);
- open your mouth to the floor;
- make a movement of the lower jaw to the right;
- make a movement with the lower jaw to the left;
- move the lower jaw in front.

Exercises are performed according to the model, then according to verbal instructions.

2.1. Study of the motor function of the tongue. The child is invited to complete the following tasks:

- put a wide tongue on the lower lip;
- press the tip of the tongue to the upper lip;
- pull the tip of the tongue to the chin;
- Reach the tips of the tongue to the upper incisors;
- touch the tips of the tongue to the left corner of the mouth;
- bend the middle part of the back of the tongue;
- bend the back of the back of the tongue.

Study of the motor function of the soft palate:

- sing vowel (a);
- pronounce a vowel (and on a solid attack (a and a);
- pronounce the vowel (a) on a soft attack (aaa);
- pronounce the vowel (a) in a delayed expiratory phase (aspirated).

Evaluated:

- the ability to make movements with the tongue to the right and to the left (imitation of the movement of a pendulum).
- on the dynamic organization of movements of the tip of the tongue inside the mouth. Starting position - mouth wide open.
- touch the tip of your tongue to the lower incisors, then to the upper ones;
- touch the tip of the tongue to the lower incisors, then to the alveoli;

Touch the tip of your tongue to the lower incisors, then to the right and left cheeks.

3. On the dynamic organization of the movement of the tongue and jaw:

- fix the tip of the tongue at the lower incisors and open the mouth wide;
- fix the tip of the tongue at the lower incisors in a wide yawn;
- touch the tip of your tongue to the upper gums and open your mouth wide;

- touch the tip of your tongue to the alveoli, open your mouth wide and yawn.
4. On the dynamic organization of movements of the tongue and lips:
- to fix the tip of the tongue at the lower incisors, while the lips take various articulatory poses: they are rounded, as with (a), stretched, as with (and), stretched and rounded, as with (s), (e), extended with a "tube", as with (o), "proboscis";
 - fix the tip of the tongue at the upper incisors, while the lips take the listed articulation poses;
- 4.1. Study of the motor function of the tongue. The child is invited to complete the following tasks:
- put a wide tongue on the lower lip;
 - press the tip of the tongue to the upper lip;
 - pull the tip of the tongue to the chin;
 - Reach the tip of the tongue to the upper incisors;
 - touch the tip of the tongue to the right corner of the mouth;
 - bend the middle part of the back of the tongue;
 - bend the back of the bruised tongue.

In each speech therapy work, the speech therapist should pay particular attention to the fact that children with dysarthria were engaged in a game form during correctional work. Because a child in a playful way relaxes and opens up well. And this helps with speech therapy.

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