

# DIFFERENTIATING SECONDARY SPEECH DISORDERS DUE TO DELAYED MENTAL DEVELOPMENT FROM SIMILAR CONDITIONS

Rakhmatova Dilnavoz A'zamovna

Lecturer at the Faculty of Pedagogy and Psychology, Alfraganus University

Jurabayeva Barno Rasulbek qizi

Student of Defectology, Faculty of Pedagogy and Psychology, Alfraganus University

## Abstract

Secondary speech disorders resulting from delayed mental development (DMD) can resemble various speech and cognitive developmental disorders. This article analyzes the criteria for differentiating speech disorders associated with DMD from conditions such as dyslalia, alalia, dysarthria, aphasia, and general speech underdevelopment. The diagnostic process examines the interrelation between cognitive and speech abilities, as well as the phonetic-phonemic, grammatical, and lexical aspects of a child's speech. Accurate diagnosis and effective correctional strategies require the use of specialized tests and speech therapy evaluations.

**Keywords:** Delayed mental development, secondary speech disorders, dyslalia, alalia, dysarthria, aphasia, diagnostics, speech therapy evaluation, phonetics, phonemics, cognition.

## Introduction

Among primary school children, some may exhibit delayed mental development. These children often show underdeveloped intellectual functions such as logical reasoning, perception, memory, attention, and work capacity, primarily due to central nervous system disorders.

Emotional and volitional deficits are primary, whereas intellectual delay is considered secondary. Such children require specialized education conditions until they finish school, as they cannot keep up with standard curricula. Integrating them into general classrooms may negatively impact overall educational outcomes.

## Types of Delayed Mental Development:

### 1. Constitutional Form:

These children often appear younger than their age (by 1–2 years) and act like preschoolers. They lack interest in learning, have low work capacity, and display weak motivation and responsibility. They struggle significantly with reading, writing, and math. This form may be linked to the mother's thyroid dysfunction or cardiovascular diseases during pregnancy.

**2. Somatic Form:**

Caused by frequent chronic illnesses in early childhood, leading to physical and mental underdevelopment. Conditions include chronic infections, allergies, congenital heart defects, etc. These children may appear infantile, lack self-confidence, and show neurotic features.

**3. Psychogenic Form:**

Results from adverse early-life environments and improper upbringing. Cognitive deficits are often combined with traits acquired from inappropriate parenting. These children must be distinguished from those who are educationally neglected but psychologically normal.

**4. Cerebral Form:**

Caused by brain injuries, meningitis, meningoencephalitis, hydrocephalus, etc. Proper and timely diagnosis and support can enable these children to adapt and succeed in mainstream education.

**Differentiating Secondary Disorders from Intellectual Disability:**

Studies by N.P. Vaizman and others show that children with DMD fall between intellectually healthy children and those with mild intellectual disability. While mildly intellectually disabled children fail basic tasks, DMD children can often complete them with guidance.

Their verbal-logical thinking may be underdeveloped, making them appear similar to intellectually disabled peers. However, their visual-motor and figurative thinking are closer to those of their healthy peers. This indicates potential for development with special education and therapy.

When analyzing objects, DMD children identify fewer features than healthy peers but more than intellectually disabled ones. Their analysis tends to be unstructured, but with teacher support, they show notable improvement—more so than intellectually disabled children.

**Conclusion:**

Differentiating speech disorders caused by DMD from other similar conditions is essential for accurate diagnosis and effective intervention. A comprehensive approach involving speech therapists and psychologists, using specific diagnostic tools, is crucial. Early detection and individualized rehabilitation programs significantly improve outcomes.

Parental involvement is also vital—educators should provide home-based exercises and communication guidelines to ensure proper speech development.

Together, these approaches make it easier to eliminate speech impairments in children with DMD and help them adapt socially.

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