

Psychological Peculiarities of Examination of Children with a Diagnosis of "Logoneurosis", Complicated with Disorders of Sensory Sphere and Disorders of Perceptions

Психологічні особливості проведення обстеження дітей з діагнозом «логоневроз», ускладненого розладами відчуттів та сприйняття

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ABSTRACT

The purpose of the research is to show psychological peculiarities of examination of children with a diagnosis of "logoneurosis", complicated with disorders of sensory sphere and disorders of perceptions.

Research methods. The research methods were the method of observation and the empirical study of patients. The place of organizing the empirical stage of our research was the psychiatric hospital 1 in Kyiv. With the help of clinical, pathopsychological and anamnestic methods 86 children in the age of 3-12 years old (the average age is 8 ± 0.5 years old) with logoneurosis in anamnesis were diagnosed.

The results of the research. We proved, that adverse conditions, which facilitate logoneurosis, are: physically weakened children; age features of brain activity; accelerated development of speech (3-4 years old), when the child's communicative, cognitive and regulatory functions are developed rapidly under the influence of communication with adults; hidden mental imbalance of a child, increased reactivity as a result of not quite normal relationships with others; a conflict between the peculiarities of the environment and the degree of its awareness; lack of positive emotional contacts between adults and children; insufficient development of motility, sense of rhythm, facial expressions and articulatory movements; disorders of sensory sphere of the person and disorders of perceptions.

Conclusions. The ability of a child with logoneurosis to present speech freely depends not only on varying degrees of independence, but also on his/her readiness. So, the speech therapist should trace the features of the appearance of speech spasms depending on whether the child utters a complex or simple

phrases, individual words or sounds. On the material of retelling the texts, it is recorded in which cases speech convulsions take a place: only at the beginning of the story, at the beginning of phrases, by use of individual words or sounds. It is being investigated whether speech convulsions do not depend on the level of speech volume. For this purpose, the examinee is asked to speak quietly, loudly, in a whisper.

Key words: logoneurosis, disorders of sensory sphere, disorders of perceptions, age features of brain activity, speech convulsions, speech volume.

Introduction

Logoneurosis is a disorder of the tempo and rhythmic organization of speech, caused by a convulsive state of the muscles of the speech apparatus (the synonyms of "logoneurosis" are: Balbuties, Dysphemie, Spasmophemie, Lalonewros). The problem of logoneurosis can be considered one of the oldest in the history of the development of the theory of speech disorders (Chen, Zhou & Dong, 2020). The different understanding of its essence is determined by the level of the development of science and the positions from which the authors study this speech disorder (Edwards, Lee & Esposito, 2019).

In ancient times logoneurosis was mainly seen as a disease associated with the accumulation of moisture in the brain (Hippocrates) or an incorrect ratio of the parts of the articulation apparatus (Aristotle). Galen, Celsus, and Avicenna recognized the possibility of disturbances in the central or peripheral parts of speech apparatus during logoneurosis (Corbitt, Malone, Haas & Mann, 1996).

At the end of the 20th century scientists (Epstein, Blake & González, 2017) tried to explain logoneurosis as a consequence of the imperfection of the peripheral speech apparatus. So, for example, Santorini believed that logoneurosis occurs when there is a hole in the hard palate, through which mucus supposedly seeps into speech and makes communication difficult. Wutzer explained this by an abnormal depression in the lower jaw, in which the tip of the tongue hides during its movement; Hervé de Cheguan explained this by incorrect ratio between the length of

the speech apparatus and the oral cavity or its very tight attachment with a short frenulum (Huang, Oquendo, Friedman, Greenhill, Brodsky, Malone, Khait & Mann, 2003).

Other researchers associated logoneurosis with disorders in the functioning of speech organs: convulsive closure of the glottis (Gorbalenya, Baker & Baric, 2020); excessively fast exhalation (Choi, Chau, Tsang, Tso, Chiu, Tong, Lee, Ng, Wai, Lee, Lam, Wai, Lai & Sik, 2003); spasmodic contraction of the muscles that hold words in the oral cavity (Chan, Ng & Chan, 2003); incoherence of thinking and speech processes (К.П. Becker); imperfection of a person's will, which affects the strength of the muscles of the speech-motor mechanism (Grunebaum, Oquendo, Burke, Ellis, Echavarria, Brodsky, Malone & Mann, 2003).

Some researchers associated logoneurosis with disorders in the course of mental processes. For example, scientists (Kimball, Hatfield, Arons, James, Taylor, Spicer, Bardossy, Oakley, Tanwar & Chisty, 2020) believed that logoneurosis arose from the fact that a person either thought quickly, so that the speech organs did not reach and therefore stumble, or, on the contrary, speech movements preceded the thinking process. And then, due to the intense desire to straighten this mismatch, the muscles of the speech apparatus enter a "convulsive state" (Lin, Chen, Chan & Hsu, 2019).

Despite everything, the problem of physical rehabilitation of patients with a diagnosis of "logoneurosis" remains poorly developed in the scientific literature, so the relevance of the research topic is beyond doubt. So, **the purpose** of our article is to show psychological peculiarities of examination of children with the diagnosis of "logoneurosis", complicated with disorders of sensory sphere and disorders of perceptions.

Methods of the research

The place of organizing the empirical stage of our research was the psychiatric hospital 1 in Kyiv. With the help of clini-

cal, pathopsychological and anamnestic methods 86 children in the age 3-12 years old (the average age is 8 ± 0.5 years old) with logoneurosis in anamnesis were examined. The research method was empirical study of patients.

The examination of children who stutter was carried out comprehensively (a speech therapist, a neurologist, a psychologist) with the involvement of other specialists: a pediatrician, a therapist, a psychiatrist, an ophthalmologist, an otolaryngologist and others.

Results and their discussion

Considering different points of view on the problem of stuttering, we can conclude that the mechanisms of logoneurosis are heterogeneous. In some cases, stuttering is *a complex neurotic disorder*, which is the result of disorganization of nervous processes in the root of the brain, impaired interaction of the cortical subcortex, a disorder of a single autoregulated rate of speech movements (voice, breathing, articulation). In other cases, *logoneurosis is a complex neurotic disorder* caused by a fixed reflex of incorrect speech, which initially arose due to speech difficulties of various origins. In the third case, *logoneurosis is a complex, mostly functional speech disorder* caused by general and linguistic dysontogenesis and disharmonious of person's development. Fourth, *logoneurosis is a mechanism of stuttering* that can be explained by organic changes in the central nervous system. Other interpretations are also possible. But in any case it is necessary to take into account the violations of physiological and psychological nature, the peculiarities of their combination and so on.

The reasons of logoneurosis are:

- *neuropathic burden of parents* (nervous, infectious and somatic diseases that weaken or disrupt the functions of the central nervous system);
- *neuropathic features of a stuttering person* (night terrors, enuresis, irritability, emotional tension);

– *constitutional predisposition* (diseases of the autonomic nervous system and increased susceptibility to higher nervous activity, its special predisposition to mental trauma);

– *hereditary burden* (stuttering developed on the basis of congenital weakness of the speech apparatus, which can be inherited as a recessive trait). The role of exogenous factors must be taken into account when the tendency to stutter is combined with adverse environmental effects;

– *brain damage in different periods of the personal development under the influence of many harmful factors*: intrauterine and birth injuries, asphyxia; postnatal factors, such as: infectious, traumatic and metabolic-trophic disorders in various diseases in the childhood.

When we tell about brain damage in different periods of the personal development, we mean disorders of sensory sphere of the person and disorders of perceptions. These disorders are relevant in our article, that's why we've to show them in detail.

Sensations and perception (in general, the sensory sphere, perception) is the initial stage, the first stage of cognitive activity, such as sensory cognition, "living contemplation" of the surrounding reality. Together with ideas, sensations and perceptions form the basis of visual-active and concrete-figurative thinking, and also serve as a source of abstract-logical thinking (Onufrieva, Chaikovska, Kobets, Pavelkiv & Melnychuk, 2020).

According to the anatomical and physiological mechanism of sensations and perceptions, depending on the analyzers, sensations and perceptions are divided into *exteroceptive* (visual, auditory, gustatory, olfactory, skin – tactile, temperature, etc.) and *proprioceptive* and *interoceptive* (from the musculoskeletal side), such as kinesthetic, and from the side of internal organs).

In childhood *feeling and perception* as a mental (conscious) act are formed as a result of individual development under the influence of learning, upbringing and using the experience of predecessors. The process of their assimilation goes from the perception of simple, the brightest signs of surrounding objects

to the perception of their complex combinations (objects and phenomena, space, time, etc.).

Children's perception is often recorded as sensuously vivid representations (*eidetism* – vivid visual representations). Sensations and perceptions *are characterized by*: sensory vivacity, extra-projection and lack of arbitrary changeability (Onufrieva & Ivashkevych, 2021).

Pathophysiological mechanisms of disorders of sensations and perceptions are *complex* (it is assumed that hallucinations are based on the inertia of the irritating process and phase states in the area of the cortical nucleus of the analyzer) (Lane, Marston & Fauci, 2016).

Sensation is a mental process of reflecting of individual characteristics of objects or phenomena in a person's consciousness when they are directly affected by senses. *Perception* is a mental process of reflecting objects or phenomena in the person's consciousness in the aggregate of their personal characteristics, under their direct influence on the sense organs. Perception is a synthesis of a complex of cash sensations with ideas. Perceptions are subjective images of objects and phenomena of the objective world, perceived earlier and which directly affect the sense organs at this time, such as traces of feelings and perceptions.

Violations of sensations and perceptions (perceptual pathology) are diverse. In childhood they are usually more elementary, visual disorders are more common than other disorders.

So, the classification of disorders of sensations and perceptions is:

- I. Hypoesthesia and anesthesia.
- II. Hyperesthesia, synaesthesia and senestopathy.
- III. Psychosensory disorders.
 1. Visual psychosensory disorders (metamorphopsia):
 - a) micropsia;
 - b) macropsia;
 - c) dysmorphopsia.

2. Intero- and proprioceptive disorders (disruption of the body scheme).

IV. Illusions (according to different analyzers).

1. Physical.

2. Physiological.

3. Mental.

V. Hallucinations.

1. By analyzers – visual, auditory, olfactory, gustatory, tactile, general sense (visceral and proprioceptive).

2. By complexity – simple (photopsias, akoasms, etc.) and complex (having meaning).

3. According to the completeness of the development – true complete and pseudo-hallucinations.

4. Regarding personality – neutral, commenting, imperative.

5. Special types – hypnagogic, extracampal etc.

Let us show syndromes with predominant disorders of sensations and perceptions. They are:

1) verbal hallucinosis syndrome;

2) visual hallucinosis syndrome;

3) tactile hallucinosis syndrome.

Hyperesthesias are a decrease in the subjective brightness and intensity of sensations and perceptions, which manifests itself in their loss of sensual concreteness, liveliness and brightness, up to the emergence of a feeling of their alienation (included in the structure of depersonalization and derealization syndromes).

Anesthesia is the exclusion of sensations and perceptions due to disturbances in the course of the projection system or damage to the cortical nucleus of the analyzer (optical, auditory, tactile and other agnosias).

Hyperesthesias are the aggravation of sensitivity to previously neutral stimuli, accompanied by hyperpathic coloring; in the field of interoception and proprioception, this manifests itself in various senestopathy (burning, pulsation, tightening, and others).

Senestopathy is a severe, unpleasant bodily sensation localized on the surface of the body or in internal organs, devoid of objectivity (as it differs from visceral hallucinations), occurring without an objective pathological process in the place of its localization. Senestopathy is a frequent symptom of mental disorders that are included in the structure of hypochondriacal delusions, depressive syndrome, Kandinsky-Clerambault syndrome, and others (Mykhalchuk, Pelekh, Kharchenko, Ivashkevych, Ed., Ivashkevych, Er., Prymachok, Hupavtseva & Zukow, 2020).

Synaesthesia is a neurological phenomenon in which stimulation in one sensory or cognitive system leads to an automatic, involuntary response in another sensory system. A person who goes through a similar experience is a synesthete. Another definition of synesthesia is a phenomenon of perception in which the irritation of one sense organ (as a result of the irradiation of a disturbance from the nervous structures of one sensory system to another) along with its specific sensations, also causes sensations corresponding to another sense organ. It should be taken into account that synesthesia has ceased to be a mental disorder. Tactile synesthesia is included in the list of symptoms and clinical signs of the ICD-10 under code R20.8 ("other and unspecified disorders of skin sensitivity").

Visual psychosensory disorders (metamorphopsia) are the distortion of the perception of surrounding objects while preserving the understanding of their meaning and essence, as well as the patient's critical attitude towards them (*dysmorphopsia* is the distortion of the shape of objects, *macropsia* is the enlargement of objects, *micropsia* is the reduction of their size). Inter- and proprioceptive psychosensory disorders (disorders of the body scheme) are manifested in the feeling of lengthening, shortening, twisting of the limbs, head, and internal organs. They are usually included in the structure of depersonalization, dysmorphophobia and hypochondriacal syndromes (Khwaja, 2012).

Illusions are perverted feelings and perceptions of actually existing objects and phenomena, in which the understanding of

the latter (images) always corresponds to reality and may have a different meaning. It is possible to have a critical attitude and the ability to correct (Brodsky, Oquendo, Ellis, Haas, Malone & Mann, 2001).

Types of illusions are:

A) *physical illusions* that arise as a result of the peculiarities of the physical properties of objects and things (refraction of objects at the boundary of two environments, mirages, etc.);

B) *physiological illusions* that related to the physiological features of the analyzer's functioning (for example, the feeling of movement of surrounding objects after the train stops);

C) *mental illusions* that arise as a result of an affective change in consciousness, which prevails over perceptions and changes in other mental functions, can be observed in healthy people who are in a state of anxious anticipation or overfatigue, and in patients with delirious, twilight and other changes in consciousness (de Wit, van Doremalen, Falzarano & Munster, 2016).

Depending on the disorder of activity of this or that analyzer, auditory (distorted perception of the meaning of real speech, hearing voices in noise), visual and other illusions are distinguished.

Illusions of general feeling (intero- and proprioceptive) include the feeling of compression, pressure, spasm, tension, pulsation in internal organs and other parts of the body, i.e. those diverse and unique sensations, which can be based on real irritations of the corresponding receptors (Chenguang, Zhaoqin, Fang, Yang, Jinxiu, Jing, Fuxiang, Delin, Minghui, Li, Jinli, Haixia, Yan, Jiuxin, Ling, Li, Zhixiang, Ling, Yanjie, Haixia, Feng, Kun, Yujing, Dongjing, Zheng, Yingxia & Lei, 2020).

Hallucinations (real full) are imaginary perceptions, perceptions without a real object. According to the mechanism of emergence, these are painfully changed and involuntary ideas that acquire a dominant position and an intensely sensual character, projecting into the real world and receiving their image of objective reality, i.e. all signs of perception (Hayden, Farrar & Peiris, 2014).

Visual hallucinations (animals, monsters from fairy tales) are more common in childhood and adolescence, and auditory hallucinations are simple or elementary hallucinations (ringing, noise, gunshots, calling names). *Pseudohallucinations* are incomplete hallucinations or false perceptions that do not have sensory brightness and extra-projection. They are localized above the "objective" and "subjective" space, are seen and heard by the inner sight and hearing. V.K. Kandinsky considered the characteristic feature of pseudo-hallucinations to be the absence of the nature of objective reality, as a result of which they give the impression of artificiality and alienation of consciousness, given the patient's passive attitude towards them (Lane, Marston & Fauci, 2016).

There are *visual* (silhouettes and shadows in the inner vision), auditory (voices in the head, "loud thoughts"), *general feeling* (feeling of a hole in the stomach with a feeling of done-ness) *pseudo-hallucinations*. *Special types of hallucinations* are varieties of the previously listed hallucinations and pseudo-hallucinations observed in special mental states (hypnagogic hallucinations – visual and other hallucinations that occur when falling asleep; extracampal – visual images outside the field of vision, from the side or behind).

Let us describe *Syndromes with predominant disturbance of sensations and perceptions*. *Verbal hallucinosis syndrome* is characterized mainly by auditory hallucinations such as threats, insults, irritation, dialogues with the patient (in alcoholic hallucinosis), direct appeal to the patient, imperative voices (in schizophrenia). *Auditory hallucinations* are often combined with delirium, sometimes the patient has a critical attitude towards them. *Visual hallucinosis syndrome* is characterized by the predominance in the picture of the disease of mass and moving colorful visual hallucinations that occur instead of a clear consciousness (Villar, Blanco & del Campo, 2015).

Tactile hallucinosis syndrome is characterized by the presence of abundant tactile hallucinations (insects, worms) with

clear consciousness, but often in combination with delirium. In order to detect violations of perception (feelings and perception), reports about it both by the patient himself and by his relatives and friends can be used.

However, patients are often reluctant to talk about their painful experiences or try to hide them. In such cases, the so-called objective signs of hallucinations, which are revealed during observation of the patient, are of great importance for diagnosis. These include various measures taken by the patient to protect himself/herself from the "influences" he experiences (plugging his ears during auditory hallucinations, searching for their sources, removing radio receivers from the room), then – an anxious look, horror on his/her face, attempts to hide from someone, accusing others of obscene conversations.

Visual hallucinatory readiness of a delirious person (in case of alcoholic delirium) can be detected by pressing on the eyeballs and suggesting a hallucinatory image (Lympamus symptom).

Various *physiological methods* are widely used to study the functions of the analyzers (determination of perception threshold, functions of adaptation).

So, ***adverse conditions***, which facilitate logoneurosis, are:

- *physically weakened children*;
- *age features of brain activity*; large hemispheres of the brain are mainly formed by the 5th year of life, by the same age functional asymmetry is formed in the brain. Language function is ontogenetically the most differentiated, especially fragile. Moreover, its slower maturation in a case of boys compared with girls caused greater instability of their nervous system;

- *accelerated development of speech* (3-4 years old), when the child's communicative, cognitive and regulatory functions are developed rapidly under the influence of communication with adults. Many children during this period are characterized by a repetition of syllables and words (iterations), which has a physiological nature;

– *hidden mental imbalance of a child*, increased reactivity as a result of not quite normal relationships with others;

– *a conflict between the peculiarities of the environment* and the degree of its awareness;

– *lack of positive emotional contacts between adults and children*. There is emotional tension, which is often externally accompanied by stuttering;

– *insufficient development of motility, sense of rhythm, facial expressions and articulatory movements*;

– *disorders of sensory sphere of the person and disorders of perceptions*.

There are anatomical and physiological causes of logoneurosis. They are: physical diseases with encephalitic consequences; injuries – such as intrauterine, natural, often with asphyxia, concussion; organic disorders of the brain, which can damage the mechanisms of the subcortex, regulatory movements; exhaustion or fatigue of the nervous system as a result of intoxication and other diseases that weaken the central speech apparatus: measles, typhoid, rickets, worms, especially whooping cough, diseases of internal secretion, metabolism; diseases of the nose, pharynx and larynx; imperfection of the sound apparatus in cases of dyslalia, dysarthria and speech delay.

We distinguish mental and social causes of logoneurosis: short-term, one-time mental trauma (fear, stress); long-term (longitudinal) mental trauma, which means improper upbringing in the family: spoilage, imperative upbringing, unequal upbringing, upbringing of “the exemplary” child; chronic conflict experiences, long-term negative emotions in the form of persistent mental stress or unresolved, constantly fixed conflict situations and situations of cognitive dissonance (internal conflict); acute severe mental trauma, strong, sudden shocks that cause acute reactions of affect: a state of horror, excessive joy; incorrect speech formation in childhood: speech on the breath, rapid speech, speech disorders, rapid nervous speech of parents; overloading young children with language material; age-inappropri-

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ate complication of language material and thinking (abstract concepts, complex phrase construction); polyglossia: simultaneous mastery of different languages at the early age, which can cause stuttering, usually in any one language; imitating another stuttering person.

There are two forms of such mental induction: passive one – the child involuntarily begins to stutter; the active form – a child copies the language and stutters; retraining of left-handedness. Constant reminders, requirements can disrupt the higher nervous activity of the child and bring him/her to a neurotic and psychopathic state with the onset of stuttering; wrong attitude to the child from the side of a teacher: excessive severity, inability to adjust the student to a positive perception of themselves. All these may also be a trigger for the emergence of logoneurosis.

The speech therapist should be primarily interested in when stuttering occurs, the first signs of it. How outwardly was it expressed? What are the possible reasons for it? As it developed, what features of the manifestations attracted the attention of parents: whether there are concomitant motor disorders (convulsions, tapping, shaking his head, etc.) or speech defects (extra words, sounds, pronunciation of certain sounds and words on the breath, etc.)? How does the child manifest himself/herself and whether it depends on the situation or the people around the child, on the different types of activities? How does a child speak alone (for example, with his/her toys)? What are the periods of deterioration and improvement of the language? How does the child relate to his/her language deficiency (notices, does not notice, is indifferent, worried, ashamed, hides, afraid to speak, etc.)? Did the parents ask for help: where, when, what was recommended, what were the results?

After clarifying the information about the child, describing the history of the peculiarities of the development of stuttering processes, the examination of non-speech processes that directly affect the child's speech activity, is carried out. The speech therapist organized a research of the child's sociability, motor

skills, impressive and expressive speech, abilities to play, educational, industrial activities, personal characteristics of children. A distinction is made between primary (during the first month of the child's stay in the language environment of a preschool institution or in the first two weeks of staying in a sanatorium for children who stutter, at the school speech therapy center), and providing a dynamic study of persons who stutter in the process of corrective and educational activities.

To study speech of children speech therapist used different pictures, books with poems, fairy tales, which are used, toys, which were selected (dolls, cars, animal figurines, building material).

The specific tasks of the speech examination are to determine:

- a place of occurrence and a form of speech spasms;
- the frequency of their findings and those peculiarities to be stored, speech capabilities;
- concomitant speech disorders, in particular, movement disorders;
- the attitude of the person who stutters towards his/her speech defect;
- the presence of psychological peculiarities.

The place of occurrence of convulsions (respiratory, vocal, articulation, mixed ones) and their forms (clonic, tonic, mixed ones) are determined aurally or visually. The frequency of convulsions of a person who stutters is of a particular interest to a speech therapist. It allows the doctor to judge about those parts of the language that should be preserved, and therefore, it will directly depend on how correctly and successfully the first language lessons with the child will begin. The study of the level of fluency begins with the identification of the dependence of paroxysms of logoneurosis on different degrees of its linguistic independence. In a conversation with the patient, the speech therapist asks about his/her parents, friends, interests, etc. Thus, the peculiarities of the child's speech behavior and speech

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convulsions are revealed. The child is invited to write a story or to describe the content of the picture, retell a familiar fairy tale; speech therapist reads a story and offers to retell it, etc. Then a speech therapist tests the state of reflected and connected language by repeating or co-pronouncing simple and complex phrases.

Conclusions

The ability of a child with logoneurosis to present speech freely depends not only on varying degrees of independence, but also on his/her readiness. So, the speech therapist should trace the features of the appearance of speech spasms depending on whether the child utters a complex or simple phrases, individual words or sounds. On the material of retelling the texts, it is recorded in which cases speech convulsions take place: only at the beginning of the story, at the beginning of phrases, by use of individual words or sounds. It is being investigated whether speech convulsions do not depend on the level of speech volume. For this purpose, the examinee is asked to speak quietly, loudly, in a whisper.

The influence of different degrees of rhythmicity on the speech of a person who stutters can be tested in such a way: a child with a diagnosis of "logoneurosis" tells about details which are drawn on the pictures, conveys the meaning of a fairy tale, which is rhythmic prose, and recites a poem. All these techniques will be studied in detail in further our articles.

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Харченко Євген, Комарніцька Людмила. Психологічні особливості проведення обстеження дітей з діагнозом «логоневроз», ускладненого розладами відчуттів та сприйняття.

Мета дослідження – дослідити психологічні особливості обстеження дітей з діагнозом «логоневроз», ускладненого розладами відчуттів та сприйняття.

Методи дослідження. Методами дослідження були метод спостереження та метод емпіричного дослідження хворих. Місцем організації емпіричного етапу нашого дослідження стала психіатрична лікарня № 1 м. Києва. За допомогою клініко-патопсихологічних та анамнестичних методів було обстежено 86 дітей віком 3-12 років (середній вік $8 \pm 0,5$ року) з логоневрозом в анамнезі.

Результати дослідження. Доведено, до несприятливих умов, які призводять до логоневрозу, відносяться: фізична ослабленість дітей; вікові особливості діяльності мозку; прискорений розвиток мовлення (3-4

роки), коли його комунікативна, пізнавальна і регулююча функції швидко розвиваються під впливом спілкування з дорослими; прихована психічна неврівноваженість дитини, підвищена реактивність у результаті не зовсім нормальних відносин з оточуючими; конфлікт між особливостями середовища і ступенем його усвідомлення; недостатність позитивних емоційних контактів між дорослими і дитиною; недостатній розвиток моторики, відчуття ритму, міміко-артикуляторних рухів; розлади відчуттів та сприйняття.

Висновки. Показано, що здатність дитини з логоневрозом до вільної презентації мовлення залежить не тільки від різного ступеня її самостійності, але й від її підготовленості до усного мовлення. Так, логопеду потрібно простежити за особливостями появи мовленнєвих судом залежно від того, чи вимовляє дитина складну або просту фразу, окремі слова або звуки. На матеріалі переказу тексту логопедом фіксується, в яких випадках виникають мовленнєві судоми: тільки на початку розповіді, на початку фраз, в окремих словах або звуках. Також має з'ясуватися, чи не залежать мовленнєві судоми від рівня гучності мови. З цією метою пропонується респондентові говорити тихо, голосно, пошепки.

Ключові слова: логоневроз, розлади відчуттів, розлади сприйняття, вікові особливості мозкової діяльності, мовленнєві судоми, гучність мовлення.

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