Secondary Impairments Arising as a Result of Delayed Intellectual Development

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Abstract: This article examines the essence of secondary impairments that arise as a consequence of delayed intellectual development, as well as their causes and types. The study is intended for specialists and students working in the fields of special pedagogy and inclusive education.

Keywords: delayed intellectual development, intellectual disability, secondary impairments, correction, speech disorders, intellectual development, inclusive education, special pedagogy

Introduction

In our developing country, extensive efforts are being made to provide comprehensive care for children and to ensure their protection. As emphasized in the Constitution of the Republic of Uzbekistan and the Law “On the Rights of the Child,” all citizens of the Republic have equal rights.

Children with special educational needs have the same rights as their healthy peers. Within the framework of ongoing reforms, raising a healthy and harmoniously developed generation, capable of representing Uzbekistan on the global stage, is a priority. In particular, the social protection of orphans, children deprived of parental care, children with disabilities, and those with developmental impairments remains one of the foremost responsibilities of the state and society.

Currently, in order to avoid discrimination, the term oligophrenic is no longer used in practice. However, terms such as intellectual disability, oligophrenia, and dementia are still encountered. Intellectual disability is a collective concept that encompasses the timing of cognitive impairment, the nature of the disease experienced, the progression of pathological changes, and their severity.

Intellectual disability is widespread globally, affecting approximately 1–3% of the population. In recent years, an increase in the prevalence of intellectual disability has been observed. This is associated with congenital anomalies, disorders of the central nervous system, and maternal illnesses during pregnancy, such as measles, influenza, and toxoplasmosis.

Intellectual impairment arises as a result of damage or illness of the child’s central nervous system during the prenatal period, at birth, or within the first three years of life. If intellectual impairment develops after the age of three due to various factors, it is classified as acquired intellectual disability, known as dementia.

Dementia is progressive in nature, meaning that the impairment intensifies over time, whereas in oligophrenia, the defect does not progress. Based on etiology, oligophrenia may be congenital or acquired.

G.E.Sukhareva classified dementia-related impairments into three main categories:

weakened generalization ability;

disruption of logical thinking;

incongruity of goal-directed thinking.

On this basis, childhood dementia is divided into four groups.

Children in the first group exhibit dementia-related symptoms after the progression of the disease. A child who previously developed normally begins to lose speech abilities and fails to

understand spoken language. Motor functions decline, and frequent shouting or agitation is observed. Attitudes toward their condition vary: some children suffer from awareness of illness, while others remain indifferent.

Children in the second group experience a decline in generalization alongside reduced thinking and perception abilities. They are unable to solve arithmetic problems and often display irritability, resentment, and suspiciousness.

In the third group, in addition to the above impairments, self-regulation deteriorates significantly. These children show no interest in activities and exhibit apathy, lethargy, and emotional instability.

Children in the fourth group are unable to critically evaluate their own or others' behavior. They demonstrate poor memory, reduced attention, and an inability to think logically. Some exhibit excessive, incoherent speech and coarse behavior.

Rh incompatibility, chromosomal disorders, phenylketonuria, and similar conditions may lead to congenital oligophrenia. For example, Down syndrome results from chromosomal abnormalities in which an extra chromosome appears instead of the normal 46 chromosomes. Remarkably, individuals with Down syndrome often share similar physical characteristics regardless of nationality, including slanted eyes, flat nasal bridge, enlarged tongue, thick lips, low-set ears, and short fingers.

Maternal infections, parasitic diseases transmitted to the fetus, fetal trauma, and parental alcoholism may also cause oligophrenia. French researchers, after long-term observation of 57 children born to alcoholic parents, found that 25 died before the age of one, 5 suffered from epilepsy, 5 from hydrocephalus, 12 had intellectual disabilities, and only 10 were born healthy.

Intellectual disability may also result from severe illnesses before the age of three, such as meningitis, meningoencephalitis, and central nervous system damage. Often, intellectual disability arises not from a single cause but from the combined influence of several factors. Therefore, early diagnosis, prevention, and corrective pedagogical support are of paramount importance.

Intellectual disability manifests at three levels:

mild intellectual disability (debility);

moderate intellectual disability (imbecility);

severe intellectual disability (idiocy).

Idiocy represents the most severe form, characterized by the absence of speech and thinking abilities, requiring constant supervision and care. Cognitive perception is severely underdeveloped, attention is absent, and self-care skills are lacking.

Imbecility is a moderate form of intellectual disability. Speech and psychological functions are more developed than in idiocy, and individuals may perform basic self-care tasks. Vocabulary is limited (200-300 words), and grammatical structures are poorly developed.

Debility is the mildest form of intellectual disability. Individuals are capable of learning, performing simple tasks, and adapting relatively well to life, though abstract thinking and independent judgment remain limited.

Secondary Impairments

Delayed intellectual development significantly affects a child's cognitive activity, personality formation, and social adaptation. Over time, it leads not only to primary intellectual impairments but also to secondary disorders.

One of the most common secondary impairments is speech development disorder. Children with intellectual delays have limited vocabulary and struggle to express their thoughts clearly, resulting in communication difficulties. Insufficient speech development restricts learning opportunities and academic achievement.

Secondary impairments also affect cognitive processes, including attention instability, weak memory, and slow thinking. These children tend to rely on concrete thinking and face difficulties with abstraction, analysis, and generalization.

Social adaptation is another area of concern. Due to underdeveloped communication skills, such children often struggle to interact with peers, leading to social isolation and emotional distress.

Learning difficulties, low motivation, lack of independent learning skills, motor coordination problems, and fine motor delays further hinder educational progress and reduce self-confidence.

Despite these challenges, properly organized special education and corrective pedagogical support enable children with intellectual disabilities to develop essential life skills, vocational abilities, and social competencies. Many graduates of special schools successfully integrate into industrial, agricultural, and service sectors. Conclusion

In conclusion, secondary impairments resulting from delayed intellectual development negatively affect a child's personal, emotional, and social growth. Early identification, comprehensive pedagogical and psychological support, and close collaboration with families are crucial for prevention and reduction of these impairments.

As special educators, it is our responsibility to provide holistic support to children with intellectual disabilities, treating them with compassion, dignity, and professional competence. Through effective corrective interventions, we can help them achieve better adaptation and quality of life.

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