[18] Myronova, S., Buinyak, M. (2021). A study of parents' readiness to raise children with intellectual disabilities». *Pedagogika-Pedagogy.* Vol. 93, Issue 6, pp. 821-830. (in English)

[19] Rudenok, A., Didyk, N., Kovalchuk, A., Petyak, O., Antonova, Z., Khanetska, N. Psychological Support for Children with Intellectual Disorders in War Conditions. *Brain-Broad Research in Artificial Intelligence and Neuroscience,* 2022, Volume 13 (3), pp. 63-84. (in English)

УДК 376-056.264:616.315-007
DOI 10.32626/2413-2578.2025-25.147-165

KONOPLIASTA Svetlana
Doctor of Science in Pedagogy, Full Professor,
Professor of the Department of Speech-language
pathology and Speech Psychology,
Dragomanov State University of Ukraine,
Kyiv, Ukraine
https://orcid.org/0000-0001-9233-7505

BIELOVA Olena
Doctor of Science in Pedagogy, Full Professor,
Head, Professor of the Department of Speech
Therapy and Special Methods,
Kamianets-Podilskyi Ivan Ohiienko National University,
Kamianets-Podilskyi, Ukraine
https://orcid.org/0000-0001-6162-4106

MENTAL DYSONTOGENESIS IN PERSONS WITH CONGENITAL CLEFT LIP AND PALATE

Annotation. The article discusses the mental dysontogenesis of individuals with congenital cleft lip and palate. The study used the general results of the study of the main components (voluntary regulation: motor activity, mental processes and functions, emotions and behavior) of the mental development of individuals with congenital orofacial clefts of the upper lip and palate from birth to eighteen years of age in Ukraine. This allowed us to identify variants of mental dysontogenesis, to trace the interaction of speech defect and mental development.

The results of a comprehensive study of the psychospeech development of children of different age categories with congenital cleft lip and palate

proved that today it is insufficient and ineffective to consider children with congenital cleft lip and palate as a homogeneous group of children with a certain nosology, to whom standard pedagogical approaches and single-vector speech therapy techniques should be applied. Since they are a polymorphic category of personalities both clinically and in logopsychological terms and have a multivariate combination of disorders of various functional systems. It has been proven that children with disorders of the central organization of functional systems demonstrate much more complex mechanisms underlying speech activity than previously thought. These children not only develop subsystems of the functional system of speech and language, such as semiotic, programmatic, interpretative and regulatory components, but also experience profound disorders in the development of the main elements of mental functioning. This includes voluntary regulation of motor activity, cognitive processes and functions, as well as emotions and behavior. As a result, the child's cognitive abilities decrease, emotional and personal development is limited, and social adaptation becomes more difficult.

The primary defect of these children, underdevelopment or damage to the subsystems of the functional speech and language system in the absence of special corrective measures, causes a number of secondary and even tertiary deviations: underdevelopment of all structural components of speech; limited sensory, temporal, and spatial representations; underdevelopment of mnemonic processes; insufficient orientation and concentration of voluntary attention, and a decrease in the level of mental operations.

Keywords: congenital orofacial clefts, psycho-speech activity, the functional system of language and speech, the basic components of mental ontogenesis, mental dysontogenesis, types of mental development.

1. INTRODUCTION

Problem statement. Psychorechological development of children with congenital orofacial clefts (COFCs), (which are common congenital malformations of the lip, palate, or both caused by complex genetic and environmental factors). Nowadays it remains one of the most complex and insufficiently solved logo-psychological problems in Ukraine.

Out of 11 million children in Ukraine, twelve thousand are patients with congenital malformations of the maxillofacial area. Every year, 500 babies are born with congenital incompleteness of the upper lip and palate (hard and/or soft). The severity of this defect is determined not only by an external anomaly, complex morphological and functional disorders, but also by severe

speech defects, communicative discomfort, psychological and social tension, and problems of personal adaptation.

Taking this into account, children of COFCs are in the risk group not only in the field of surgical dentistry and maxillofacial surgery of children, but also is a rather complex object of scientific research in the field of defectology and, in particular, speech therapy and speech psychology.

Analysis of recent research and publications. Recent studies (N. Wantia, G. Rettingcr, 2002, etc.) show that congenital orafacial clefs of the upper lip and palate are most common among boys [18]. They are more likely to show orafacial clefs of the upper lip and palate, and among girls, only orafacial clefs of the palate or severe forms of complete orafacial clefs of the upper lip and palate are observed. L. Kharkov (1998), in his research, noted the seasonal dependence at the birth of children with this disabilities [10]. According to him, they are more often born in the winter. Although other researchers argue that the birth rate of these children increases in the spring [8].

Children with congenital orafiacial clefs of the upper lip and palate are often born prematurely, weighing less than 1,500 grams. Therefore, they have a higher risk of various infectious diseases in early childhood. As a rule, these children have concomitant birth defects. There are detected the disorders of the nervous, cardiovascular system, alkaline, and acid balance [11, 12].

According to scientists severe forms of oraficial clefs are often combined with other anomalies: with disorders of the head and brain, severe anomaly of the visual organ, defects of the toes (polydactyly, syndactyly), CNS lesions, genital abnormalities, the accession of various complex syndromes, gene mutations [9, 15].

Anatomical changes in the upper respiratory tract of children with congenital orafiacial clefs of the upper lip and palate cause mixed oral and nasal breathing, which is the result of the limited activity of the respiratory muscles, impaired pulmonary ventilation and gas exchange, and so on. This leads to hypoxia and a focus of infection in the nasopharynx and lungs. But in all children operated on before the age of four, external respiration is gradually normalized [16]. B. Neville (2009), S. Thomas (2011) study has found that children with congenital orafiacial clefs of the upper lip and palate had problems with the nervous system. Neuropsychiatric disorders are characterized by constant reactive states, neuroses, mental retardation and distinctive changes, behavioral disorders, and more. According to the author, one of the main reasons for the formation of these deviations is also a violation of speech development [16, 17].

After realisatiom of rhinoplasty of children with congenital orafiacial clefs of the upper lip and palate also observed disorders of the nervous system, which negatively affected the formation of speech causing combined speech disorders. At the time of examination of children with this problem, scientists proved neurological disorders in the form of minimal cerebral dysfunction, which complicated the course of early psychomotor development of children, their preverbal and verbal periods of speech development [3, 9, 12, 17].

Analysis of scientific literature proves that children with congenital orafiacial clefs of lip and palate have a severe anatomical and physiological defect which is parallel to the pathological changes in many established systems (muscular, respiratory, nervous, skeletal, cardiovascular, digestive, teeth-jawetc.), and also causes a disruption in the neuropsychological, emotional system of the child [4, 10, 12].

The study of psychological problems of development of children with congenital orafiacial clefs of the lip and palate.

2. THEORETICAL BASIS OF THE STUDY

Children with congenital orafacial clef of the upper lip and palate usually have various functional and morphological changes in the body. This in turn, also affects the development of their speech activity. The complexity and severity of this defect have not only an external feature, complex morphological and functional underdevelopment, social and psychological tension, communicative discomfort, but also the presence of congenital cleft lip and palate, which causes a number of somatic disorders that can affect the normal development of the child.

In recent years, the birth rate of children with congenital orafacial clef of the upper lip and palate has a steady tendency to increase both worldwide and in Ukraine in particular. According to medical research, forecasts for a decrease in the number of births of such children are disappointing. According to a recent study of children with congenital orafiacial clefs of the upper lip and palate disorders of speech development represent a form of complex cognitive defect that involves a selective disorder of language functions and the resulting deviations out of language functions and processes [1, 3, 7, 11, 12, 13].

The specificity of dysontogenesis is based on typical indicators: functional localization of the disorders, the time factor, which affects on pathogenic influence, age-related dynamics of cross-functional relationships, influence primary and secondary disorders:

1. General mental underdevelopment (a typical model of which is

mental retardation).

2. Delayed mental development (polymorphic group, presented the various options of infantilism, immaturity of the higher cortical functions).

3. Damaged mental development (the development of is interrupted from 2.5 to 3 years by the head injury or CNS disease).

5. The deficient mental development is an option of mental development in conditions of deep violations or scarcity disruption of analytic systems − visual, auditory, musculoskeletal.

6. Twisted mental development is a combination of hypoplasia, delayed development and damaged development with possible accelerated development of separate mental functions.

7. The disharmonious mental development, which is based on congenital or early acquired a strong disparity of the psyche, mainly the emotional-volitional sphere.

Developed a typology of disturbed development and included four main blocks: lack of development, asynchronous development, damaged development, deficient development. Inside each block, there is a separate subgroup that differs from other qualitative indicators or characteristics [12].

Studying the problems of the development and rehabilitation of children with congenital orafiacial clefs of the upper lip and palate, many researchers (both physicians and educators and psychologists) noted that speech impairment negatively affects the formation of all mental functions of these children, especially the process of personality formation. Two types of psychogenic reactions have been identified in children with complex orafiacial clefs: hyposthenic (laxity, shyness, low sociability, the propensity to list, fatigue, etc.) and hypertensive (increased irritability, mental instability, motor restlessness, etc.). The author noted in children with orafiacial clefs of the palate pathological distinctive changes in personality.

Scientists (H. Broder, 2005; J. Clark, 2003; B. Neville, 2009) found the predominance of mental illness of children with congenital oraphiacial clefs of the upper lip and palate in comparison with children without such disabilities. Moreover, neurotic disorders are more common among children of primary school age. Scientists (Konoplyasta, & Sak, 2010) noted that the inferiority of speech in rhinolalia has a negative impact on the development of all mental functions of such a child. Speech disorders as the main means of communication traumatize the child, create unfavorable living conditions in the team, and leads to a kind of personal development of children. They usually develop introversion, excessive shyness, irritability [6, 7, 16].

Most studies have noted pathological manifestations of a mental nature in this category of children [1, 2, 4, 5]. They noted low mood, frequent

emotional outbursts, and angry reactions, demonstrative rudeness, loss of subtlety of feelings, emotional depression, loss of social contacts and maladaptation of behavior of patients with congenital orafacial clefs of the upper lip and palate.

To identify possible relationships between the level of mental development of children with oraficial clefs of the upper lip and palate and the nature of the defect, the state of comorbidities, the nature and timing of medical care, etc., a team of scientists on the basis of the Ukrainian Center for special maps of observation of such children were developed. It was supposed to identify the presence or absence of some psychogenic reactions, distinctive features, the level of their adaptation in the team, the attitude of others and family members, and so on. It was found that a significant percentage of children had a closed, often depressed mood. They were shy, lethargic, slow, and irritable. There was also persistent indecision, extremely strong attachment to parents, psychological dependence on adults. This proves the presence of a direct negative impact of congenital facial defects on the mental development of the child.

Analysis of research by native and foreign scientists indicates the contradiction of the results of the study of people with this defect: on the one hand, they are characterized by depressive, anxious states, on the other – a high level of extraversion and low personal anxiety. The scientists themselves point to the discrepancy between testing data and actual observation. The general problems of patients with congenital orafacial clefs of the upper lip and palate are subjective difficulties of social acceptance, high appreciation of the influence of parents on their own opinions.

3. RESEARCH METHODOLOGY

Children of all ages (from birth to 18 years old), regardless of their state of psychophysical and intellectual development, made up the contingent of examined children with congenital incompleteness of the lip and palate. In general, there are 522 people with various types of congenital non-junctions.

The majority of children surveyed were children from birth to seven years old, with the predominance of the age category from 1 to 3 years. This is logical, since the surgical restoration of the lip and hard/soft palate in Ukraine today is carried out mainly before the age of two.

The study of the psychopathological activity of children with congenital orofacialclefts goes beyond the limits of exclusively speech therapy searches. The analysis of modern approaches to the organization and provision of psychological, pedagogical and correctional assistance to children with

COFCs allows us to assert that today in this problem there are not realized reserves of a complex multi-stage impact on the development of such a child. The weakest link in this chain is the psychological adaptation of children with COFCs and targeted psychological assistance to families who raise such a child.

Taking this into account, the scientific field of the experimental study included the mental development of a child with COFCs of different ages. In this case, we started from the so-called control factors or parameters that determine the nature of the mental development of any child in General, and in particular a child with COFCs.

The basis of analytical and diagnostic work on the study of the mental development of children with COFCs is a three-component model of analysis of mental development and its basic components (S. Konopliasta, 2016) [13], as the most appropriate in our opinion in the context of an interdisciplinary integrated approach. In general, the system of basic components of mental activity is divided into three relatively independent structures: 1) arbitrariness of regulation of sensorimotor activity; 2) arbitrariness of regulation of mental processes and functions; 3) basic effective regulation. These basic components of development are the main structural formations that are formed in the process of mental development of the child, and the state of their formation indicates that they belong to a particular typological group of mental dysontogenesis.

Taking this into account, the corresponding content of psychological research was developed (based on the methodological and methodological approaches of modern developmental psychology), taking into account age indicators and the structure of the defect.

4. RESULTS AND DISCUSSION

According to the data of the family social passport, the heterogeneity of the social status of children with COFCs was revealed. Of the total number of children examined, only 56% have a full-fledged family, 32% of children live in single-parent families, 12% of children are orphans and semi – orphans who came to the clinic from a baby Home or were supported by guardians in families.

It was found that 48.5% of the surveyed did not undergo speech therapy at all, and in 89% of cases, there was no primary psychological and speech therapy consultation with families where the child was under one year old.

Data on the sequence and features of early motor and psychoemotional development, which were considered as the main prerequisites for the

formation of basic levels of voluntary and affective regulation in the first years of life, showed a violation of the process of forming the psychological base of speech of children with COFCs.

The arbitrariness of mental activity as the implementation of a regulatory factor of development is in the first place in the process of heterochronous formation of all mental spheres of the child, in particular, cognitive activity and the emotional-volitional sphere. The analysis of motor activity as the basis for the "deployment" of mental development in general, which "pulls" at an early age and the cognitive and emotional spheres showed significant pace and content lag in the formation of the so-called cross-cutting basic components of mental development in 49% of the examined children with COFCs. This means that at an early age in half of children with COFCs sensorimotor activity is untimely "included" in the hierarchical structure of voluntary activity, slowing down in the future the regulation of mental processes, their own emotions and, as a result, behaviour in general.

The obtained generalized data of early development indicate the features of mental ontogenesis of a child with COFCs, which often border on various variants of mental dysontogenesis.

Generalizing results on the state of formation of voluntary regulation of motor activity indicate a slow pace of development of psychomotorics, which we consider as consciously controlled motor actions, in 77% of children under 3 years of age, half of whom the level of formation of General, small movements and their coordination corresponded to indicators of low and extremely low levels. For 36% of children, simple tests for dynamic praxis were not available at all. The rate of lagging behind the norm for 1 – 4 months of speech-motor activity, which in turn inhibits the manifestations of early forms of speech communication, was recorded.

Most babies with COFCs in the first months of life had a deficit of emotional information that the baby "addresses" to an adult. One of the reasons for this is the lack of emotional sensitivity of the mother, who during this period of child development is emotionally devastated, with a predominance of negative experiences about the birth of a child with cleft lip and palate, fears for its future.

The obtained data on certain features of the development of sensory functions and play activity of a child with COFCs, which lay the foundations of the entire cognitive sphere, is disturbing. We are talking primarily about the pace lag in a third of children's auditory, visual concentration, tactile-visual perception, sensorimotor experience, and sensory experience in general. This is more clearly manifested in orphans and children who live in single-parent families. Undoubtedly, in addition to the initial poor physical

health and psychosomatic state, we are talking about the absence or insufficiency of emotional and physical interaction of the mother-child dyad, about the insufficient use of opportunities to stimulate the development of a child at an early age.

The study also examined the psychological climate in the family after the birth of a child with a COFCs. A retrospective assessment of the emotional state of parents, especially mothers during this period indicates that most parents remember the birth of a child with a congenital facial defect as a complete psychological shock, "skip" this event through the prism of feelings of guilt before the child or despair, frustration, desire to withdraw into themselves. The study found that 88% of parents in the first six months after the birth of a child with COFCs were in a depressed state or in a state of psycho-emotional stress. The dependence of the psychological state of parents on the presence/ absence of early psychological family rehabilitation was revealed.

Also, the second line of development was formed with a lag in terms of time - mastering spatial representations, since almost 50% of the surveyed children had a lag in terms of mastering the vertical plane, which hindered the assimilation of the "integral" space.

For half of the children with COFCs, the first year of life was characterized by a peculiar formation of the affective regulation line. In the future, this made it difficult to form cognitive activity and affective-emotional sphere, "sprouting" into the personal sphere. 95% of children with COFCs up to one year (in particular, all orphaned children) were in a so-called state of emotional deprivation, experiencing a deficit of positive emotions. Moreover, due to the presence of a defect, frequent hospitalization, a decrease in the emotional background in the family, insufficient awareness by parents of the need for purposeful development of the cognitive sphere, most children experienced a lack of joint activities with adults or joint game actions, which hinders the formation of the psychophysiological basis of the basic structures of the functional system of language and speech, and communicative behavior in General. At the same time, the phenomenon of "snowball" was observed – with age in many children with COFCs, these features did not disappear independently, but layered, mutually burdening each other, slowing the overall pace and worsening the quality of mental development of such a child.

It is proved that the lack of adequate correctional and developmental work from an early age makes it difficult to form and function the basic components of mental development in the future.

The generalized results show that children with COFCs 3-4 years lag in

the rate of psychophysical development compared to the standard with an average of 41%, and the rate and quality of speech development disorders were recorded 82% of children of the same age category. Somewhat higher were the indicators of formation of voluntary regulation of motor activity within children aged 5-6 years, which were manifested mainly by the average level of its formation (according to the results of neuropsychological tests for dynamic praxis, posture praxis, reciprocal coordination of movements, kinetic melody, etc.). This, in turn, showed the relative formation of voluntary regulation of motor activity 49% of postoperative children aged 5-6 years (taking into account the data that this sphere is considered to be finally formed only at 8 years). The other children's quality indicators differed by more than 40% from the standard ones. The same trend was observed in the results of the formation of movements of facial muscles, articulatory motor skills and kinetics.

The generalized results indicate a negative impact of insufficient regulation of the so-called lower motor functions (general, fine and articulatory motor skills) 89% of children with pre-school age COFCs on the state of higher-level movements-speech-motor 78% of preschoolers. The data obtained indicate that the rate of immaturity or partial non-formation of the regulatory component of motor activity is associated mainly with psychosomatic and neurological symptoms with 78% of children of early and preschool age with COFCs.

The results of the formation of an arbitrary regulation of the motor sphere, taking into account the linguopathological symptoms, correlate with data on the level of development of the components of the functional system of language and speech in various clinical and logopedic groups.

The results of the study of the second component (arbitrariness of mental processes and functions) were higher than the results of arbitrariness of motor activity (especially speech-motor) with 41% of the total number of subjects. This means that, despite the violation of the phonological system at the expressive and impressive levels, the level of voluntary regulation of mental processes corresponded to the indicators of high and medium levels, probably due to sufficient speech mediation and potentially preserved cognitive resources.

The remaining children (59%) showed mostly low and extremely low levels of voluntary regulation of mental processes. These children had low indicators of formation of all components of the functional system of language and speech. We are talking about the lack of purposeful activity, the ability to focus on a specific task and the content of the implementation program against the background of inertia or rigidity of the behavior of

these children. These children were characterized by a decrease in performance and motivation against the background of rapid fatigue and loss of interest in the result. Special difficulties were felt when it was necessary to pronounce a sequence of actions, program or analyze their own activities.

In a peculiar way, with significant differences from the norm, the affective-emotional and personal sphere of a child with COFCs also develops. It is characterized by a gradual complication with age, secondary and tertiary layers of problems of a psycho-emotional nature, provided that there is no necessary, timely psychocorrection work with the child and the family that brings him up.

Insufficient or lack of psychological assistance, starting from an early age, more destructively affects the mental development of the child than the primary anatomical defect of the facial area and the consequences associated with it. Moreover, it is diagnosed that a primary defect, underdevelopment or damage to subsystems of the functional system of language and speech in the absence of special corrective means causes a number of secondary and even tertiary deviations: underdevelopment of all structural components of speech; limited sensory, temporal, spatial representations; underdevelopment of mnestic processes; insufficient orientation and concentration of arbitrary attention, a decrease in the level of generalizations; insufficient ability to plan their activities; build conclusions, establish cause-and-effect relationships, etc.

We have proved that children with COFCs have a picture of insufficient formation of the cognitive sphere, despite the fact that their overall cognitive resource is initially preserved and remains quite high. However, more significant are the conclusions that children with COFCs experience difficulties not only of a cognitive nature, but also of a communicative nature, which makes speech disorders in COFCs personally significant.

It is indisputably proved that episodic psychological assistance does not solve the problems of harmonious mental development of this category of people with COFCs in order to ensure a high level of life achievements.

It is established that the formation of the personality of adolescents with COFCs develops mainly according to the deficit type of mental development (a steady decrease in self-esteem, lack of differentiation of emotional reactions, low level of communication, lack of desire to actively communicate, subdepressive mood background, etc.), which, of course, provokes dysontogenesis of the cognitive and emotional-volitional sphere.

The analysis of the results indicates the phenomenon of persistent

deficits (unformation) of some mental functions, which makes it difficult to form and develop the speech of children with COFCs. Even without clinical diagnoses of violations of Central Genesis, some children with COFCs are the so-called "lower-normative type of development", which latercan form a risk group for subsequent pathological development. Violations of the voluntary regulation of mental processes and insufficient formation of the need for communication in some children with COFCs calls into question their readiness to study in secondary schools and leads to disappointing predictions about future success and school adaptation.

It is revealed that the psychological development of children with COFCs is based on the same basic laws as the mental development of a child in the norm. The fundamental laws of language and speech development have no fundamental differences between them. However, the main feature of the speech of dysontogenesis children with COFCs is asynchronous, disharmonically development. This became evident when comparing the levels of formation of various components of the functional system of tongue and speech (FSTS) − selective, partial mismatch, unformed individual components or subsystems of the FSTS. In our opinion, the state of speech underdevelopment is one of the forms of psychorechological dysontogenesis, a feature of which is the lack of communication and speech skills.

The results of the study of the basic components of children's mental development were interpreted taking into account the definition of their state: preserved (P), secondarily delayed (SD) or primary impaired (PI). We also took into account the qualitative features of the formation of structural components of mental microgenesis-level systems of regulation (R), cognition (C) and affective-emotional (AE) sphere – as end-to-end mental processes (Table 1).

Table 1

Matrix for determining the options for mental development of children with congenital orofacial clefts

<table>
<tr><td rowspan="5">State of basic components of mental development</td><td rowspan="2">Preserved</td><td colspan="3">End-to-end mental processes</td></tr>
<tr><td>Regulatory</td><td>Regulatory</td><td>Regulatory</td></tr>
<tr><td>N
R</td><td>N R
DH</td><td rowspan="2">N</td></tr>
<tr><td rowspan="2">Secondarily delayed</td><td>DH</td><td rowspan="2">DF</td></tr>
<tr><td>DF</td><td>R DH
DF</td></tr>
<tr><td>Primary impaired</td><td>T</td><td>T</td><td>T</td></tr>
</table>

It was found that the presence of persistent violations of the functional system of language and speech against the background of general psychosomatic weakness secondarily provokes disorders of mental development of the type of disharmonious, delayed or deficient in 65% of children with COFCs. At the same time, there is a gradual complication of the nature of mental development disorders depending on age, the period of logopsychological influence, family relationships, and the social environment.

System-dynamic analysis of dysontogenesis, comparison and generalization of data from the logopsychological diagnostic unit, provided the basis for the first time in logopsychology to offer a typology of variants of mental development of children with COFCs-normative (N) and variants of mental dysontogenesis: disharmonic (DH), delayed (D), deficient (DF), total (T) (Table 2).

Table 2

Types of children's mental development with COFCs

Type of mental development	**Characteristic features**	**Methods**	**Quantity of children**
Normative (N)	The formation of components of mental microgenesis corresponds to the normative indicators	R/P+C/P+AE/P	34 (32%)
Disharmonic (DH)	Cognitive, emotional-volitional, and personal immaturity	R/P+C/P+AE/SD	30 (28%)
Delayed (D)	Delay in the rate of development of the basic components of mental microgenesis	R/SD+C/D+AE/SD	21 (20%)
Deficient (DF)	Narrowing of the cognitive resource, intellectual unevenness against the background of lack of analytical systems and mental activity	R/SD+C/SD+AE/SD	18 (17%)
Total (T)	Primary violation of the basic components of mental microgenesis	R/PI+C/PI+AE/PI	3 (3%)

Extrapolation of the results of speech and mental development allowed us to generalize the conclusions about the features of psychorechological development of children and adolescents with COFCs. It was found that the presence of persistent violations of the functional system of language and

speech against the background of General psychosomatic weakness is secondary to a violation of mental development by the type of disharmonic, delayed or deficient in 65% of children with COFCs. At the same time, there is a gradual complication of the nature of mental development disorders depending on age, the period of logopsychological influence, relationships in the family, and the social environment.

5. CONCLUSIONS AND PROSPECTS FOR FURTHER RESEARCH

Thus, the inclusion of psychological methods for studying the basic components of mental development (voluntary regulation: motor activity, mental processes and functions, emotions and behavior) allowed us to determine the variants of mental dysontogenesis, to trace the mutual influence of speech defects and mental development of children, adolescents and young men with COFCs.

As a result of intersystem multi-factor analysis of aggregated data for diagnostics of speech and mental development of people with COFCs., the regularities, interdependence and interdependence of the formation of the functional system of language and speech and the basic components of the mental development of children with COFCs from birth to adulthood are revealed.

Proved beyond a reasonable doubt that the children of COFCs. have much more complex mechanisms responsible for speech activities than has traditionally been considered for many years. These children not only develop mechanisms of generation and formation of subsystems of the functional system of language and speech (semiotic, programming and interpretation of speech acts, regulatory) but also suffer from deep processes of formation of basic components of mental development (arbitrary regulation: motor activity, mental processes and functions, emotions and behavior), which narrows the child's cognitive resource, constrains emotional and personal development, complicates the process of social adaptation.

The results of a comprehensive study of the psycho-speech development of children of different age categories with COFCs proved that today it is not enough and ineffective to consider children with COFCs as a homogeneous group of children with a certain nosology, to which standard pedagogical approaches and single-vector speech therapy techniques should be applied. Since they are a polymorphic category of individuals both in clinical and logo-psychological terms and have a multi-variant combination of disorders of different functional systems.

The Ukrainian system of social adaptation and rehabilitation of children with disabilities in Ukraine is undergoing qualitative changes, it has reached a stage of its practical development and implementation that requires significant efforts from its representatives in search of a theoretical and methodological basis for their activities, the creation of appropriate scientific and methodological support for the proper rehabilitation process, the search for new organizational forms and methods of assistance to children with developmental disabilities.

REFERENCES (TRANSLATED AND TRANSLITERATED)

[1] Bielova, O. (2021). The state of development of components of speech readiness of older preschool children with speech disorders. SPECIAL EDUCATION.Vol 1, No 42, P.137–189. https://www.journals.vu.lt/special-education/article/view/25427 (in Ukrainian).

[2] Bielova, O. (2024). Intellectual functionality of speech children of older preschool age with logopathology. CHILD`S HEALTH, 19(3), P. 140–146. https://doi.org/10.22141/2224-0551.19.3.2024.1692 (in Ukrainian).

[3] Bielova, O., & Konopliasta, S. (2023). Functionality of oral and articulatory praxis in older preschool children with logopathology. CHILD`S HEALTH, 18(6), P.410–416. https://doi.org/10.22141/2224-0551.18.6.2023.1627 (in Ukrainian).

[4] Bielova, O. (2023a). Neuromotor functionality of speech readiness for school in older preschool children with logopathology. Life Span and Disability XXIV. vol.26, issue 2. P. 165-196. (www.lifespanjournal.it (in Ukrainian).

[5] Bielova, O. (2023b). Speech of Six-year-old Children with Logopathology: Features and State of Development. PSYCHOLINGUISTICS, 34(1), P. 50-84. https://psycholing-journal.com/index.php/journal/article/view/1329 (in Ukrainian).

[6] Broder, H.L., Richman, L.C, Matheson, P.B. (2005). Learning disability, school achievement, and grade retention among children in cleft lip and palate patients. Cleft Palate Craniofac J. 42(3), P.55–61.

[7] Clark, J. D. Mossey, P.A, Sharp, L, Little, J. (2003). Socioeconomic status and orofacial clefts in Scotland, 1989 to 1998. Cleft Palate Craniofac J.,40(5), P.481–485.

[8] Gubina, L., Krasnikova, O. (2000). Situational analysis of the frequency of congenital pathology of the MND and probable risk facts. Pediatric Dentistry, (1–2), P. 65–68.

[9] Hoover, Lance R. (2000). Rhinolalia: an underappreciated sign of pneumomediastinum. The Annals of Thoracic Surgery. 69(2). P. 615-616. https://doi.org/10.1016/S0003-4975(99)01114-5

[10] Kharkov, L., Nosco, S. (1998). Assessment of the mental development of children with a twisted non-fusion of the upper lip and palate, depending on the age and timing of their surgical rehabilitation. News of Dentistry, (3), P. 35–38.

[11] Konopliasta, S., (2008a). Rozvytok ditei z vrodzhenymy vadamy rozvytku hub ta pidnebinnia [Development of children with congenital malformations of the lips and palate]. Theory and practice: Monograph. Kyiv: NPU named after MP Drahomanov. (in Ukrainian).

[12] Konopliasta, S., (2008b). Zakonomirnosti psykhichnoho rozvytku dytyny pry normalnomu ta vrodzhenomu nepravylnomu zroshchenni hub i pidnebinnia [Patterns of mental development of the child in normal and congenital malunion of the lips and palate]. Scientific journal of NPU named after MP Drahomanov. Kyiv: MP Drahomanov National Pedagogical University. (9), P. 163 –167. (in Ukrainian).

[13] Konopliasta, S., (2015). Rynolaliia vid A do Ya [Rhinolalia from A to Z]: Monograph. Kyiv: Book-plus. (in Ukrainian).

[14] Konopliasta, S., Sak, T., (2010). Lohopsykholohiia [Logopsychology]. Kyiv: Knowledge. (in Ukrainian).

[15] Kuijpcrs–Jagtman, A., Ling, R.E. Jr. (2000). The influence of surgery and orthopaedic treatment on maxillofacial growth and maxillary arch development in patients treated for orofacial clefts. Cleft Palate Craniofacial, (37), P. 527–531.

[16] *Neville, B., Damm, D., Allen, C., et al. (2009). Oral & Maxillofacial Pathology. Second edition Philadelphia, PA: Elsevier. P.515–21*

[17] Thomas. S., Nair. P., Kumar, A., Hegde, K., Singh. V. (2011). A young boy with a maxillary swelling and closed rhinolalia. BMJ Case Rep. bcr0820103234. doi: 10.1136/bcr.08.2010.3234.

[18] Wantia, N., Rettingcr, G. (2002). The current understanding of cleft lip malformations. Facial plastic surgery, (18), P. 147–151.

The material was submitted to the editorial board on 24.04.2025.

Author`s contribution:
Konopliasta S. – 50%, Bielova O. – 50%

КОНОПЛЯСТА Світлана
доктор педагогічних наук, професор,
професор кафедри логопедії та логопсихології,
Український державний університет імені Михайла Драгоманова,
м. Київ, Україна
https://orcid.org/0000-0001-9233-7505

БЄЛОВА Олена
доктор педагогічних наук, професор,
завідувач, професор кафедри логопедії
та спеціальних методик,
Кам'янець-Подільський національний університет імені Івана Огієнка,
м. Кам'янець-Подільський, Україна
http://orcid.org/ 0000-0001-6162-4106

ПСИХІЧНИЙ ДИЗОНТОГЕНЕЗ У ОСІБ З ВРОДЖЕНИМ НЕЗРОЩЕННЯМ ГУБИ ТА ПІДНЕБІННЯ

Анотація. У статті розглянуто психічний дизонтогенез осіб з вродженою розщелиною губи та піднебіння. У дослідженні використано загальні результати вивчення основних компонентів (довільна регуляція: рухова активність, психічні процеси та функції, емоції та поведінка) психічного розвитку осіб з вродженими орофаціальними щілинами верхньої губи та піднебіння від народження до вісімнадцяти років в Україні. Це дозволило виявити варіанти психічного дизонтогенезу, простежити взаємодію мовленнєвого дефекту та психічного розвитку.

Результати комплексного дослідження психомовленнєвого розвитку дітей різних вікових категорій з вродженою розщелиною губи та піднебіння довели, що сьогодні недостатньо та неефективно розглядати дітей з вродженою розщелиною губи та піднебіння як однорідну групу дітей з певною нозологією, до яких слід застосовувати стандартні педагогічні підходи та одновекторні логопедичні методики. Оскільки вони є поліморфною категорією особистостей як у клінічному, так і в логопсихологічному плані та мають багатоваріантне поєднання порушень різних функціональних систем. Доведено, що діти з порушеннями центральної організації функціональних систем демонструють значно складніші механізми, що лежать в основі мовленнєвої діяльності, ніж вважалося раніше. Ці діти не лише мають порушення функціональної системи мови та мовлення, такі як

семіотичний, програмний, інтерпретаційний та регуляторний компонентів, але й відчувають глибокі порушення в розвитку основних елементів психічного функціонування. Це включає довільну регуляцію рухової активності, когнітивні процеси та функції, а також емоції та поведінку. В результаті когнітивні здібності дитини знижуються, емоційний та особистісний розвиток обмежується, а соціальна адаптація стає складнішою.

Первинний дефект цих дітей, недорозвинення або пошкодження підсистем функціональної системи мови та мовлення за відсутності спеціальних коригувальних засобів спричиняє низку вторинних і навіть третинних відхилень: недорозвинення всіх структурних компонентів мовлення; обмеженість сенсорну, часову, просторову; недорозвинення мнемонічних процесів; недостатню орієнтацію та концентрацію довільної уваги, зниження рівня розумових операцій.

Ключові слова: вроджені орофаціальні щілини, психомовленнєва діяльність, функціональна система мови та мовлення, основні компоненти психічного онтогенезу, психічний дизонтогенез, типи психічного розвитку.

СПИСОК ВИКОРИСТАНИХ ДЖЕРЕЛ

[1] O. Bielova, «The state of development of components of speech readiness of older preschool children with speech disorders» *SPECIAL EDUCATION*. Vol 1. 2021. No 42. P.137–189. https://www.journals.vu.lt/special-education/article/view/25427

[2] O. Bielova, «Intellectual functionality of speech children of older preschool age with logopathology» *CHILD`S HEALTH*. 2024. 19(3). P. 140–146. https://doi.org/10.22141/2224-0551.19.3.2024.1692

[3] O. Bielova, S. Konopliasta, «Functionality of oral and articulatory praxis in older preschool children with logopathology». *CHILD`S HEALTH*. 2023. 18(6). P.410–416. https://doi.org/10.22141/2224-0551.18.6.2023.1627

[4] O. Bielova, «Neuromotor functionality of speech readiness for school in older preschool children with logopathology» *Life Span and Disability XXIV*. vol.26, issue 2. P. 165-196. www.lifespanjournal.it

[5] O. Bielova, «Speech of Six-year-old Children with Logopathology: Features and State of Development». *PSYCHOLINGUISTICS*. 2023. 34(1). P. 50-84. https://psycholing-journal.com/index.php/journal/article/view/1329

[6] H. L. Broder, L.C. Richman, P.B. Matheson, «Learning

disability, school achievement, and grade retention among children in cleft lip and palate patients». *Cleft Palate Craniofac J.* 2005. 42(3). P. 55–61.

[7] J. D. Clark, P.A., Mossey, L. Sharp, J. Little, «Socioeconomic status and orofacial clefts in Scotland, 1989 to 1998» *Cleft Palate Craniofac J.* 2003. 40(5). P.81–485.

[8] L.Gubina, O. Krasnikova, «Situational analysis of the frequency of congenital pathology of the MND and probable risk facts». *Pediatric Dentistry*. 2000 (1–2). P.65–68.

[9] R. Lance Hoover, «Rhinolalia: an underappreciated sign of pneumomediastinum». *The Annals of Thoracic Surgery.* 2000. 69(2). P. 615-616. https://doi.org/10.1016/S0003-4975(99)01114-5

[10] L. Kharkov, S. Nosco, «Assessment of the mental development of children with a twisted non-fusion of the upper lip and palate, depending on the age and timing of their surgical rehabilitation». *News of Dentistry*, 1998 (3). P.35–38.

[11] С.Ю. Конопляста, «Розвиток дітей із вродженими незрощеннями губи та піднебіння». Теорія та практика: монографія. НПУ імені МП Драгоманова. 2008. 208с.

[12] С.Ю. Конопляста, «Закономірності психічного розвитку дитини в нормі та при вроджених незрощеннях губи та піднебіння». *Науковий часопис НПУ імені МП Драгоманова*. Серія. 2008.19. Р.163-167.

[13] С.Ю. Конопляста, «Ринолалія від А до Я»: монографія. Київ: Книгаплюс. 2015. 310с

[14] С.Ю. Конопляста, Т.В. Сак, «Логопсихологія». Київ: Знання. 2010. 204с.

[15] A.Kuijpcrs–Jagtman, R.E.Ling, «The influence of surgery and orthopaedic treatment on maxillofacial growth and maxillary arch development in patients treated for orofacial clefts». *Cleft Palate Craniofacial*, 2000. (37). P. 527–531.

[16] *B.Neville, D.Damm, C. Allen, et al. «Oral & Maxillofacial Pathology». Second edition Philadelphia, PA: Elsevier. 2009. P.515–21.*

[17] S.Thomas. P.Nair, A.Kumar, K.Hegde, V. Singh, «A young boy with a maxillary swelling and closed rhinolalia». *BMJ Case Rep*.2011. bcr0820103234. doi: 10.1136/bcr.08.2010.3234.

[18] N.Wantia, G.Rettingcr, «The current understanding of cleft lip malformations». *Facial plastic surgery*, 2002. (18). P. 147–151.