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CLINICAL CHARACTERISTICS OF STUDENTS IN AUXILIARY SCHOOLS (OLIGOPHRENIA)

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КЛИНИЧЕСКАЯ ХАРАКТЕРИСТИКА УЧАЩИХСЯ ВСПОМОГАТЕЛЬНЫХ ШКОЛ (ОЛИГОФРЕНИЯ)

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Abstract. This article discusses the clinical characteristics of students in auxiliary schools—children diagnosed with oligophrenia. A particularly characteristic sign of oligophrenia is a disturbance in the mobility of nervous processes. Specifically, this leads to the formed neural connections becoming inert and the formation of new connections becoming difficult. In children with oligophrenia, the strength of nervous processes is generally reduced, especially active internal inhibition. The primary pedagogical task in relation to this group of children is organizing and managing their attention. Observations of such children show that, in the process of learning, and with an appropriate pedagogical approach, they can develop complex forms of cortical inhibition.

Аннотация. Представлена клиническая характеристика учащихся вспомогательной школы. Это – дети олигофрены. Особенно характерным признаком для олигофрении является нарушение подвижности нервных процессов, в частности, это приводит к тому, что возникшие связи становятся у них инертными, а выработка новых связей затрудняется. У детей – олигофренов обычно снижена сила нервных процессов, причём особенно ослаблено активное, внутреннее торможение. Основной педагогической задачей в отношении данной группы детей является организация их внимания. Наблюдения за такими детьми показывают, что в процессе обучения при правильном педагогическом подходе у них могут развиваться сложные формы коркового торможения.

Keywords: children with oligophrenia, dysfunction, inhibition, nervous processes.

Ключевые слова: дети – олигофрены, нарушение, торможение, нервные процессы.

The majority of children enrolled in auxiliary schools are children with oligophrenia. Oligophrenia should be understood as a type of underdevelopment of cognitive activity that results from organic damage to the central nervous system at various stages of fetal development or during the earliest periods of a child's life. Oligophrenia is fundamentally based on diffuse damage, primarily to the cerebral cortex. This diffuse damage to the cerebral cortex is what gives rise to pathological disorders in higher nervous activity. Children with oligophrenia generally exhibit weakened nervous processes, particularly a marked reduction in active internal inhibition. In some forms of oligophrenia, there is a significant imbalance between excitatory and inhibitory nervous processes: in some children, excitation dominates, while in others, excitation is weakened and passive external inhibition prevails [2].

However, the most characteristic feature of oligophrenia is the impaired mobility of nervous processes. This, in particular, leads to the established neural connections becoming inert, and the

formation of new connections being greatly hindered. All these neurodynamic characteristics lead to the well-known defect in abstraction and generalization and significantly hinder the formation of complex types of mental activity. This represents the primary obstacle to educating such children in mainstream schools. Clinically, oligophrenia is classified into three groups based on the severity of the defect: idiots, imbeciles, and morons (also known as “debils”).

Children with the most profound level of intellectual disability (idiots) are typically placed in social welfare institutions, as they are incapable of independent living.

Idiocy is marked by severe physical developmental impairments, which include general dysplasia, cranial deformities, and dwarfism. It is common for individuals with idiocy to have a drooping lower jaw with an open mouth from which saliva continuously flows. Their motor skills are extremely underdeveloped. They have poor coordination, and many of them show significant difficulties with standing and walking. They are unable to dress themselves and often need to be fed by others. Idiots often exhibit stereotypical rhythmic movements such as body rocking, clapping hands, head shaking, and sucking their own fingers and toes. Their behavior is severely disorganized. Some are completely helpless, remaining seated or lying down, while others are motorically restless—running, jumping, somersaulting, or biting. Elementary sexual arousal is common in such individuals, and many engage in masturbation. Some display a tendency toward sudden affective outbursts [1].

Children with idiocy only respond to strong stimuli, usually those directly tied to basic instincts. Their attention can be attracted, though only briefly, by food, bright lights, or shiny colorful objects. In severe cases, speech development is almost entirely absent—such children only produce isolated, inarticulate sounds. In other cases, they may be capable of uttering individual words or phrases, the meaning of which they do not understand. Even in such cases, their speech is impaired, often presenting with complex forms of speech disturbance (dyslalia).

Due to these characteristics, the education and upbringing of this group of children is extremely difficult. However, under conditions of institutional treatment and with ongoing individual pedagogical work, it is sometimes possible to instill basic skills in many of these deeply intellectually disabled children, such as cleanliness habits and elementary self-care abilities. This group of children is not suitable for formal schooling.

At a somewhat higher level of intellectual development are the so-called imbeciles. In imbecility, although the condition is less severe than idiocy, there are still significant physical developmental disorders. These children often exhibit dysplasia and frequently have cranial structure abnormalities. Compared to idiots, the underdevelopment of motor skills in imbeciles is less severe, yet still quite pronounced. Their coordination of movement is insufficient. Their motor functions are characterized by sluggishness and stiffness, and at the same time, they often display superfluous or unnecessary movements. Despite these difficulties, imbeciles can, with effort, learn to care for themselves: they can dress, wash, and make their own bed [5].

Fine, differentiated hand movements are particularly impaired in this group. Their hands are limp and weak, and their movements are clumsy. The fingers lack flexibility and strength. Imbeciles exhibit an underdevelopment of the specifically human ability to use the hand skillfully. However, in milder cases of imbecility, these children can study in special classes of auxiliary schools and, with appropriate corrective educational support, can be trained to perform basic forms of labor.

At the beginning of their schooling, their behavioral inadequacies become very apparent in the classroom. They do not understand that they are in a learning environment: they stand up, walk around the room, do not respond to the teacher’s instructions, laugh without reason, and eat during lessons. Over time, through the learning process, these children gradually acquire the skills necessary for appropriate school behavior. This is facilitated by their tendency to imitate others — a

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characteristic trait of this group. It should also be noted that the behavior of imbeciles reflects their emotional peculiarities: some are good-natured and friendly, while others are stubborn, irritable, and prone to sudden emotional outbursts.

Imbeciles acquire speech with significant delay. Their speech is often characterized by unclear pronunciation and a limited vocabulary. It is common to find children who can pronounce many words and phrases without understanding their meaning. Due to their severely underdeveloped ability to abstract and generalize, educating imbeciles according to the standard auxiliary school curriculum is very difficult. As a result, this group of children is taught using a specialized program with different timelines for mastering educational material.

It is very important to note the following fact: quite often, a child who was initially classified as an imbecile at the time of school enrollment may show significant progress in intellectual development over the course of their education. In some cases, this progress is so substantial that it becomes possible to transfer the child to a regular class within the auxiliary school.

Children with mild intellectual disability, known as “morons” (or “debiles”), differ significantly from the two previously described forms of profound oligophrenia. They represent the majority of students in auxiliary schools.

Moronism is also caused by previously sustained organic damage to the central nervous system. This group of children typically shows only mild physical abnormalities, such as short stature or asymmetries in skull structure. In many cases of mild intellectual disability, no significant deviations in physical development are observed [4].

Severe motor impairments are seen only in certain forms of moronism. In most cases, these children experience coordination issues primarily during more complex motor activities, especially involving the hands.

Motor skill deficits become particularly noticeable in tasks that require children to coordinate their movements based on verbal instructions (e.g., rhythm or labor lessons). These motor issues are relatively easy to correct with appropriate pedagogical techniques. Typically, by the time they complete auxiliary school, most of these children are well-prepared for employment and independent work.

A detailed description of the psychological characteristics of this category of children and their development under educational influence is provided in the clinical profiles of individual child groups.

Children with mild intellectual disability, in turn, can be divided into more or less homogeneous groups based on the qualitative characteristics of their cognitive impairment. These groups are described in more detail below.

Forms of Oligophrenia. A quantitative assessment of the depth of the intellectual defect alone does not provide a full understanding of the diversity among students, nor does it help solve the pedagogical challenges faced by auxiliary schools. When organizing educational work, it is important for teachers to know not only the severity of the defect but also its qualitative uniqueness.

Below is a description of the main forms of oligophrenia encountered in the context of auxiliary school education.

Oliophrenic children with underdeveloped abstraction and generalization abilities but relatively preserved elementary forms of activity. This form includes children whose underdevelopment of higher cognitive functions is not accompanied by severe damage to a specific sensory analyzer (like vision or hearing), nor by significant changes in the emotional or volitional sphere.

A distinguishing feature of these oligophrenic children is their ability to engage in stable, purposeful activity when given tasks appropriate to their capabilities. The defects in higher nervous

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activity in this form of oligophrenia are characterized by impaired mobility of nervous processes but are not accompanied by an imbalance between excitatory and inhibitory functions.

The individuals with this type of defect demonstrate relatively preserved emotional and volitional spheres. They have an elementary understanding of the situation—they rejoice in their successes. They are attached to their relatives and peers. Under organizing pedagogical influence, these children comparatively easily master the rules of school life. Over the course of their development, they develop a proper attitude toward the evaluation given by the teacher, and later, elements of critical reflection on their work.

In children, whom we classify into the first group, no gross motor disorders are observed. Similarly, there are no severe speech defects.

The leading symptom of any oligophrenia is underdevelopment of the most complex forms of mental activity, primarily the insufficient ability for abstraction and generalization. In the course of learning activities, this manifests in the children's difficulty when solving tasks that require establishing complex connections and relationships. They have trouble understanding the meaning of stories they read and struggle to master even the most elementary grammatical rules [6].

In some cases of oligophrenia, the qualitative peculiarity of the defect structure is determined by the predominant impairment of all types of activities that require complex forms of generalization and abstraction, with relative preservation of direct forms of activity. Many individuals with debility can be sufficiently purposeful and capable in more elementary types of activities. However, as soon as more complex tasks are presented to them, such as solving an arithmetic problem, understanding a story, or establishing the sequence of events, their insufficiency becomes evident.

Here is an example: 1. Tonya Lvovna, a student in the first grade of a special school. She is the child of the second pregnancy. When her mother fell during the seventh month of pregnancy, she did not feel the movement of the fetus for some time. In early childhood, Tonya developed with a delay. From the age of three to four, she was in a kindergarten, where nighttime and daytime bedwetting were noted. From four to seven years old, she was raised in a preschool, where her intellectual underdevelopment was identified. She played poorly with other children and showed no interest in anything. At the age of eight, she entered school, where she failed to acquire any school skills during the first year. From that same year, she has been attending a special school. According to the pedagogical characteristic, it is evident that when Tonya entered the special school, she had no school skills or knowledge. During her studies, she had difficulty memorizing letters, confused optically similar ones, like "н" and "п", "м" and "н", and was unable to use concrete material in arithmetic. During lessons, she was lethargic, passive, and easily distracted. Gradually, Tonya mastered the program material for the first year of school and was sufficiently active during lessons in writing, reading, arithmetic, and singing. Completely different behavior was observed during lessons in speech development. Here, she was lethargic, inattentive, had a limited vocabulary, and understood the meaning of the text worse than the other children [3].

In terms of physical development, the girl lags behind her age; there are no abnormalities in the internal organs. An examination of the nervous system reveals mild, scattered residual organic symptoms. Psychological state: The girl is infantile, direct, and straightforward. In play, she is purposeful, lively, active, and interested. When approaching a toy cupboard, she picks her favorite toys, dresses the doll, prepares food for it, and when seeing a primer, she immediately starts teaching the doll how to read. In play, she demonstrates sufficient development of motor skills and the ability to use her observations in everyday life and at school. For example, upon seeing a bucket, she said she needed to gather water and put it on the stove to heat. The girl differentiates and uses all types of kitchenware. She has mastered counting, reading, and writing according to the

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curriculum of the first grade of a special school and copes quite well with tasks requiring combination. She correctly assembled a pyramid. When assembling cubes according to pictures, she firmly remembers individual parts, their arrangement, does not get confused with the usual material, and accurately places each part [6].

Purposeful activity is accessible to her in the presence of a concrete situation. In this type of activity, she is lively and productive, but as soon as the girl is asked to describe a sequential picture, or to establish a connection between pictures that represent a sequence of events, she immediately shows her incapacity. She becomes lethargic, passive, quickly tires, loses interest, and cannot cope with the task at hand. For example, the girl was shown two pictures: the first showed a cat looking at a fish, and the second depicted the cat and the bones of the fish. Tonya was supposed to arrange these pictures in the correct order and establish a meaningful connection between them. She persistently placed the picture where the cat had already eaten the fish first, and then the one where the cat was looking at the fish. The established connections are extremely inert. The girl has difficulty forming new connections and does not know how to use new impressions. For instance, she was shown a picture of a cat and asked to describe it. Tonya repeated the same thing she had said when shown the first picture. Then, when shown a picture of the cat washing itself, she repeated the same thing again, just as she did with the first picture. Instead of highlighting what is new in the subsequent pictures, she relied on the old connection she had established and did not use the new impressions [7].

Her mental inertia was even more clearly revealed in the following observation. Three weeks after a conversation with her about the cat, she was asked if she had seen a dog and what she knew about it. The girl's answer was astonishingly absurd: she said that the dog ate fish. When asked again, she explained that she had reproduced the old connection from the conversation about the cat, which confirms the inertia of the old connections she had formed [8].

In this case, we can speak of oligophrenia resulting from an intrauterine injury. With a relatively minor developmental delay in the early stages, intellectual insufficiency becomes more pronounced during the preschool age. This is understandable because the peculiarity of this group of oligophrenics lies in the underdevelopment of complex forms of thinking, which become much more significant during the preschool years. In school age, the structure of the defect becomes even more evident.

This clinical observation convinces us that the structure of intellectual insufficiency in these children is determined by their great difficulty in forming complex abstract connections. In the speech of these oligophrenics, elements that are closely tied to direct impressions and visual images predominate. The level of closure activity in the cerebral cortex allows the child, during their development, to reflect on the surrounding reality to varying depths. The level of reflection of the surrounding reality in our case is determined by the fact that these children can mainly establish only concrete connections, and any activity that involves abstraction and generalization encounters significant difficulties.

The characteristics of these oligophrenics, namely their difficulties in forming more complex connections, can be overcome through the process of teaching and upbringing. For education to promote the development of such a child — an oligophrenic — it is essential for the educator to understand the qualitative peculiarity of the structure of their defect. Determining the structure of the defect is of great importance for the proper organization of corrective and educational activities in each individual case. In particular, in the case we presented, a significant focus should be on developing the child’s speech and thinking. It is necessary to work with these children on clarifying the meaning of words, diverting them from old, rigid connections, and stimulating the formation of new ones, teaching them to use new impressions.

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