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COLLABORATION OF A PEDIATRICIAN, SPEECH THERAPIST, AND DEFECTOLOGIST IN THE EARLY DIAGNOSIS OF SPEECH AND PSYCHOMOTOR DEVELOPMENT DELAYS IN CHILDREN

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Abstract. The early identification and management of speech and psychomotor developmental delays in early childhood are critical for preventing long-term cognitive and social impairments. However, the traditional sequential diagnostic pathway often leads to significant delays in intervention. This research aims to comprehensively evaluate the clinical efficacy of a synchronous multidisciplinary team approach, specifically integrating the expertise of pediatricians, speech therapists, and defectologists in the primary diagnostic phase. Employing a prospective comparative methodology, the study monitored a cohort of preschool-aged children presenting with suspected developmental delays. The integrated literature review highlights the paradigm shift from isolated medical screening to holistic bio-psycho-pedagogical assessments, emphasizing the intense neuroplasticity of the first thousand days of life. Empirical results demonstrate that the synchronous collaborative model drastically reduces the latency period between initial suspicion and definitive diagnosis. Furthermore, the multidisciplinary approach significantly increases diagnostic accuracy, effectively differentiating between isolated speech delays, global developmental delays, and emerging autism spectrum disorders, which are frequently misclassified in isolated pediatric settings. The discussion emphasizes the unique and complementary roles of each specialist, wherein the pediatrician excludes somatic and neurological etiologies, the speech therapist assesses linguistic and phonetic constructs, and the defectologist evaluates broader cognitive and adaptive milestones. Ultimately, the study concludes that restructuring primary pediatric care to facilitate immediate interdisciplinary collaboration is an essential healthcare reform required to leverage critical windows of neurodevelopment, thereby fundamentally improving the lifelong trajectory of children with psychomotor and speech delays.

Keywords: Psychomotor development, speech delay, multidisciplinary team, pediatrics, speech therapy, defectology, early intervention, neuroplasticity, cognitive development.

BOLALARDA NUTQ VA PSIXOMOTOR RIVOJLANISH KECHIKISHINI ERTA TASHXISLASHDA PEDIATR, LOGOPED VA DEFEKTOLOG HAMKORLIGI

Annotatsiya. Ilk bolalik davrida nutq va psixomotor rivojlanish kechikishini erta aniqlash va boshqarish uzoq muddatli kognitiv va ijtimoiy nuqsonlarning oldini olishda o'ta muhimdir. Biroq, an'anaviy ketma-ket diagnostika yo'li ko'pincha aralashuvning sezilarli darajada kechikishiga olib keladi. Ushbu tadqiqot birlamchi diagnostika bosqichida pediatrlar, logopedlar

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va defektologlarning tajribasini bevosita birlashtirgan sinxron multidisiplinar jamoaviy yondashuvning klinik samaradorligini har tomonlama baholashga qaratilgan. Istiqbolli qiyosiy metodologiyadan foydalangan holda, tadqiqot rivojlanishda kechikish gumon qilingan maktabgacha yoshdagi bolalar guruhini kuzatib bordi. Kiritilgan adabiyotlar sharhi izolyatsiya qilingan tibbiy skriningdan yaxlit bio-psixo-pedagogik baholashga o'tish paradigmasini yoritib, hayotning dastlabki ming kunidagi kuchli neyroplastiklikni ta'kidlaydi. Empirik natijalar shuni ko'rsatadiki, sinxron hamkorlik modeli dastlabki gumon va yakuniy tashxis o'rtasidagi yashirin davrni keskin qisqartiradi. Bundan tashqari, multidisiplinar yondashuv diagnostika aniqligini sezilarli darajada oshiradi, izolyatsiya qilingan nutq kechikishi, global rivojlanish kechikishi va ko'pincha alohida pediatrik ko'riklarda noto'g'ri tasniflanadigan autizm spektrining erta belgilarini samarali ravishda farqlaydi. Muhokama qismi har bir mutaxassisning o'ziga xos va bir-birini to'ldiruvchi rollarini ta'kidlaydi, bunda pediatr somatik va nevrologik etiologiyalarni inkor etadi, logoped lingvistik va fonetik tuzilmalarni baholaydi, defektolog esa kengroq kognitiv va moslashuvchan bosqichlarni tekshiradi. Xulosa qilib aytganda, tadqiqot zudlik bilan fanlararo hamkorlikni ta'minlash uchun birlamchi pediatrik yordamni qayta tashkil etish neyrorivojlanishning muhim darchalaridan foydalanish uchun zarur bo'lgan muhim sog'liqni saqlash islohoti ekanligini tasdiqlaydi, bu esa psixomotor va nutqiy kechikishi bo'lgan bolalarning butun hayot traektoriyasini tubdan yaxshilaydi.

Kalit so‘zlar: Psixomotor rivojlanish, nutq kechikishi, multidisiplinar jamoa, pediatriya, logopediya, defektologiya, erta aralashuv, neyroplastiklik, kognitiv rivojlanish.

СОТРУДНИЧЕСТВО ПЕДИАТРА, ЛОГОПЕДА И ДЕФЕКТОЛОГА В РАННЕЙ ДИАГНОСТИКЕ ЗАДЕРЖЕК РЕЧЕВОГО И ПСИХОМОТОРНОГО РАЗВИТИЯ У ДЕТЕЙ

Аннотация. Раннее выявление и коррекция задержек речевого и психомоторного развития в раннем детстве имеют решающее значение для предотвращения долгосрочных когнитивных и социальных нарушений. Однако традиционный последовательный диагностический путь часто приводит к значительным задержкам во вмешательстве. Данное исследование направлено на всестороннюю оценку клинической эффективности синхронного мультидисциплинарного командного подхода, в частности, объединяющего опыт педиатров, логопедов и дефектологов на этапе первичной диагностики. Используя проспективную сравнительную методологию, исследование отслеживало когорту детей дошкольного возраста с подозрением на задержку развития. Интегрированный обзор литературы освещает смену парадигмы от изолированного медицинского скрининга к целостной био-психо-педагогической оценке, подчеркивая интенсивную нейропластичность первых тысячи дней жизни. Эмпирические результаты показывают, что модель синхронного сотрудничества резко сокращает латентный период между первоначальным подозрением и окончательным диагнозом. Кроме того, мультидисциплинарный подход значительно повышает точность диагностики, эффективно дифференцируя изолированную задержку речи, глобальную задержку развития и формирующиеся расстройства аутистического спектра, которые часто ошибочно классифицируются в изолированных педиатрических условиях. В обсуждении подчеркивается уникальная и взаимодополняющая роль каждого специалиста, когда педиатр исключает соматические и неврологические этиологии, логопед оценивает лингвистические и фонетические конструкции, а дефектолог оценивает более широкие когнитивные и адаптивные вехи. В конечном итоге исследование приходит к выводу, что реструктуризация первичной педиатрической помощи для содействия немедленному междисциплинарному сотрудничеству является важной реформой здравоохранения, необходимой для использования критических окон нейроразвития, что фундаментально

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улучшает жизненную траекторию детей с психомоторными и речевыми задержками.

Ключевые слова: Психомоторное развитие, задержка речи, мультидисциплинарная команда, педиатрия, логопедия, дефектология, раннее вмешательство, нейропластичность, когнитивное развитие.

INTRODUCTION

The optimal psychomotor and speech development of a child during the first years of life serves as the fundamental biological and psychological scaffolding upon which all future cognitive learning, emotional regulation, and social integration are built. Modern developmental neuroscience unequivocally demonstrates that the human brain experiences its most rapid and profound period of structural synaptogenesis and functional neuroplasticity between birth and thirty-six months of age. Consequently, any disruption, delay, or deviation in acquiring critical motor or linguistic milestones during this highly sensitive window can initiate a cascading sequence of developmental deficits that become increasingly resistant to therapeutic correction as the child grows older. Despite the widespread global recognition of the absolute necessity for early intervention, the timely and accurate diagnosis of developmental delays remains a pervasive challenge within primary healthcare systems worldwide, largely due to systemic fragmentations in pediatric screening methodologies.

An extensive review of contemporary literature regarding pediatric neurodevelopment reveals a critical paradigm shift in how developmental disorders are conceptualized and diagnosed. Historically, the primary care pediatrician operated as the sole gatekeeper for developmental surveillance. While highly competent in identifying acute somatic illnesses, severe congenital anomalies, and gross neurological deficits, standard pediatric consultations are inherently time-constrained and often lack the specialized observational tools required to detect subtle, nuanced deviations in receptive language processing, pragmatic speech, or complex cognitive play [1]. Consequently, an alarming percentage of children with mild to moderate developmental delays are either dismissed as merely being "late talkers" or are placed on extended waiting lists for sequential specialist evaluations. Researchers emphasize that this traditional, linear referral model inherently squanders the most critical months of neuroplasticity, transforming preventable or entirely reversible functional delays into permanent cognitive disabilities [2].

To combat this diagnostic inertia, international developmental guidelines now strongly advocate for the establishment of cohesive multidisciplinary assessment models [3]. Within the specific context of psychomotor and speech delays, this multidisciplinary core is optimally formed by the triad of a pediatrician, a speech-language pathologist, and a special education specialist, commonly referred to as a defectologist in many educational frameworks. The pediatrician anchors the assessment in biomedical reality, systematically ruling out underlying genetic syndromes, metabolic derangements, sensory impairments such as hearing loss, and covert seizure disorders [4]. The speech therapist provides deep, granular analysis of the child's phonetic inventory, expressive vocabulary, and receptive language comprehension, distinguishing between mechanical articulation disorders and central language processing deficits [5]. Simultaneously, the defectologist evaluates the child’s broader cognitive architecture, including visual-spatial reasoning, fine motor coordination, attention span, and adaptive behavioral skills [6].

Despite the overwhelming theoretical consensus supporting interdisciplinary collaboration, empirical data quantifying the direct clinical impact of this triad operating synchronously at the primary care level remain surprisingly sparse. In many regional healthcare networks, these three professionals exist in entirely separate administrative silos—the pediatrician in the medical clinic, the speech therapist in a rehabilitation center, and the defectologist within the educational sector. This structural segregation guarantees diagnostic fragmentation, parental exhaustion, and

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prolonged latency in the initiation of targeted therapeutic interventions. Therefore, the primary objective of this comprehensive clinical research is to systematically investigate and quantify the diagnostic and therapeutic advantages of establishing a synchronized, co-located collaborative framework between pediatricians, speech therapists, and defectologists. By directly comparing this synergistic approach to the traditional sequential referral system, the study aims to scientifically validate the necessity of multidisciplinary team integration as the new standard of care for the early identification of pediatric developmental delays.

MATERIALS AND METHODS

To meticulously evaluate the diagnostic efficacy and clinical impact of the proposed multidisciplinary collaboration, a prospective, comparative, and observational clinical study was designed and conducted over a continuous twenty-four-month period. The research was strategically situated within the facilities of a regional pediatric developmental center that served a broad, socioeconomically diverse population. The entire methodological framework and all associated clinical protocols were subjected to rigorous ethical scrutiny and received formal approval from the institutional bioethics review board. Absolute adherence to international ethical standards for medical and psychological research involving vulnerable pediatric populations was strictly maintained throughout all phases of the study. Comprehensive, transparent written informed consent was systematically obtained from the parents or legal guardians of all participating children prior to their enrollment.

The clinical study population comprised two hundred and forty children, aged between eighteen and forty-two months, who presented to the primary healthcare system with parental or clinical concerns regarding delayed speech acquisition, atypical social interaction, or delayed motor milestones. To ensure the clarity and focus of the research, stringent exclusion criteria were applied. Children possessing previously diagnosed, severe chromosomal abnormalities such as Down syndrome, documented profound sensorineural hearing loss requiring cochlear implantation, or non-ambulatory cerebral palsy were explicitly excluded from this cohort, as their diagnostic pathway and multidisciplinary needs are fundamentally different from those presenting with subtle, undifferentiated developmental delays. The remaining enrolled children were subsequently divided into two demographically matched clinical cohorts utilizing a randomized allocation protocol to prevent selection bias.

The first cohort, designated as the control group, consisted of one hundred and twenty children who navigated the traditional, sequential diagnostic pathway. In this model, the initial developmental concern was evaluated solely by the primary care pediatrician during a standard clinical encounter. Based on the pediatrician's independent clinical judgment, the child was either scheduled for a follow-up observation or provided with separate, individual referrals to a speech therapist and a defectologist located at different facilities. The second cohort, designated as the experimental collaborative group, consisted of the remaining one hundred and twenty children. These children were evaluated utilizing a novel, synchronous multidisciplinary approach. Upon presentation, the child and their parents were evaluated in a single, extended diagnostic session by a unified medical-pedagogical board comprising a senior pediatrician, a licensed pediatric speech therapist, and a certified clinical defectologist operating simultaneously within the same observational environment.

The diagnostic instruments utilized across both cohorts were standardized to ensure objective comparability. The medical evaluation included a comprehensive neurological examination and anthropometric assessments. The developmental, cognitive, and linguistic evaluations were conducted utilizing culturally validated versions of the Denver Developmental Screening Test, the MacArthur-Bates Communicative Development Inventories for expressive and receptive vocabulary, and structured play-based observational rubrics designed to assess joint attention, symbolic play, and fine motor praxis. In the collaborative group, these tools were administered interactively by the team members, allowing the speech therapist to observe the child's communication during a cognitive task administered by the defectologist, and allowing

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the pediatrician to observe subtle motor asymmetries during unstructured play.

The vast repository of clinical, psychological, and logistical data generated by the study was subjected to rigorous quantitative processing utilizing advanced biostatistical software. The primary outcome measures focused on the diagnostic latency period, defined as the precise number of weeks elapsed from the date of the initial parental complaint to the date a definitive, actionable diagnosis was established and an individualized intervention plan was initiated. Secondary outcome measures evaluated diagnostic accuracy and the specific frequency of subsequent diagnostic revisions. Continuous variables were tested for normal distribution and expressed as mathematical means accompanied by their standard deviations. The statistical significance of the differences between the sequential and collaborative groups was calculated utilizing independent sample Student's t-tests for continuous time-based data and Pearson's Chi-square tests for categorical diagnostic outcomes. A probability value of less than zero point zero five was strictly maintained as the absolute threshold for declaring statistical significance across all analytical procedures.

RESULTS

The rigorous statistical analysis of the clinical pathways and diagnostic outcomes revealed profound and highly significant advantages associated with the synchronous collaborative framework, highlighting severe structural deficiencies within the traditional sequential referral system. The most striking and immediately actionable finding pertained to the diagnostic latency period. Within the control group navigating the traditional pathway, the mean duration from the initial presentation of developmental concerns to the establishment of a comprehensive diagnosis and the commencement of targeted therapy was an alarming twenty-two weeks. This extended delay was primarily driven by logistical bottlenecks, including prolonged wait times for sequential specialist appointments, poor inter-agency communication, and the frequent requirement for parents to repeatedly transport the child to different institutions, recounting their medical history at each juncture.

Conversely, the experimental group evaluated by the synchronized multidisciplinary team experienced a dramatic reduction in diagnostic latency. The mean time to definitive diagnosis and intervention initiation in this collaborative cohort plummeted to merely three weeks. By consolidating the expertise of the pediatrician, speech therapist, and defectologist into a unified, simultaneous evaluation session, the logistical fragmentation was entirely eliminated. Parents left the initial two-hour assessment not with a stack of referrals, but with a definitive, cohesive diagnostic profile and an immediately actionable, individualized bio-psycho-pedagogical rehabilitation plan. The statistical comparison of the latency periods between the two cohorts yielded an extraordinarily high degree of significance, proving that structural collaboration mathematically accelerates the clinical response to developmental crises.

Beyond the sheer speed of the process, the integration of the three disciplines fundamentally elevated the qualitative accuracy of the diagnostic conclusions. In the sequential control group, the longitudinal follow-up revealed a high rate of initial misclassification. Approximately thirty percent of the children initially diagnosed by the solo pediatrician as simply exhibiting an "isolated expressive language delay" requiring only basic speech therapy were subsequently re-diagnosed six to eight months later by defectologists as possessing much broader neurodevelopmental disorders, including early-stage autism spectrum disorder and mild global cognitive impairment. These children had effectively lost several months of critical neuroplasticity receiving overly narrow, phonetically focused therapy when they actually required intense behavioral, pragmatic, and sensory integration interventions.

In stark contrast, the synchronized collaborative group demonstrated a remarkable diagnostic stability and precision. The simultaneous observation of the child’s behavior by multiple specialists drastically reduced the rate of diagnostic tunnel vision. While the speech therapist evaluated the mechanics of articulation, the defectologist simultaneously observed the child's lack of symbolic play and poor eye contact, while the pediatrician correlated these

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findings with mild muscular hypotonia. This real-time synthesis of medical, linguistic, and cognitive data allowed the collaborative team to accurately distinguish between highly overlapping phenotypes from the very first encounter. The rate of diagnostic revision in the collaborative group over the subsequent twelve-month observation period was statistically negligible at less than four percent. Furthermore, the collaborative evaluations frequently uncovered subtle, concurrent deficits that would have been missed in isolation; for example, identifying that a child's severe speech delay was intrinsically linked to an undiagnosed deficit in fine motor praxis and tactile defensive behaviors, thereby allowing for the immediate prescription of a holistic therapy plan combining logopedics with targeted defectological psychomotor stimulation.

DISCUSSION

The empirical data generated by this comprehensive clinical investigation powerfully validate the hypothesis that the complex, multifaceted nature of early childhood developmental delays cannot be accurately deciphered through the lens of a single clinical discipline. The traditional medical model, heavily reliant on the solitary pediatrician to triage complex neurodevelopmental phenotypes, is demonstrably inadequate for modern early intervention requirements. As the literature extensively emphasizes, early childhood development does not occur in isolated tracks; language acquisition, cognitive reasoning, and motor execution are deeply intertwined neurological processes [7]. Therefore, attempting to diagnose a failure in this complex system using sequentially isolated specialists inevitably leads to diagnostic blind spots, misinterpretation of symptoms, and the tragic loss of the optimal biological window for therapeutic correction [8].

The profound reduction in diagnostic latency achieved by the collaborative triad is not merely an administrative victory; it is a critical neurological triumph. During the period between eighteen and thirty-six months of age, the brain is undergoing massive synaptic pruning and the myelination of major linguistic and cognitive tracts [9]. Every week that a child spends waiting for a sequential specialist appointment is a week where maladaptive neurological pathways are solidifying. The ability of the multidisciplinary team to compress a five-month diagnostic odyssey into a three-week definitive action plan ensures that therapeutic intervention intersects with the peak period of the child's central nervous system plasticity. This rapid initiation of therapy fundamentally alters the trajectory of the disorder, frequently allowing the child to achieve mainstream educational integration by school age, an outcome that becomes statistically less probable with every passing month of delayed treatment [10].

The unique synergy of the pediatrician, speech therapist, and defectologist represents a perfect bio-psycho-pedagogical equilibrium. The pediatrician’s foundational role is indispensable in establishing the biological baseline. Before any behavioral or speech intervention can succeed, the pediatrician must ensure that the child's thyroid function is normal, that hidden epileptiform discharges are not arresting cognitive development, and that basic nutritional and metabolic parameters are optimized [11]. However, medical clearance is only the first step. The speech therapist provides the highly specialized analysis of the linguistic architecture, identifying whether the breakdown is occurring in phonological processing, motor planning of the articulators, or semantic comprehension [12].

Crucially, the integration of the defectologist bridges the gap between pure medical science and functional pedagogy. A child may possess the anatomical capacity for speech, but lack the fundamental cognitive prerequisites for communication, such as shared joint attention, object permanence, and the desire for social reciprocation. The defectologist excels at identifying these foundational cognitive and adaptive deficits [13]. The study clearly demonstrated that when the speech therapist and defectologist observe the child simultaneously, they effectively prevent the common diagnostic error of mistaking a pervasive developmental disorder for a simple speech delay. For example, a child failing to speak because of autism spectrum disorder presents very differently to a defectologist analyzing their play patterns than a child failing to speak due to

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childhood apraxia of speech, even though the primary parental complaint—lack of talking—is identical.

Despite the overwhelming clinical superiority of the collaborative model demonstrated in this study, the widespread systemic implementation of this approach faces significant logistical and economic barriers. Restructuring primary care clinics to physically co-locate medical and pedagogical professionals requires a paradigm shift in healthcare funding and administrative organization [14]. Furthermore, executing a joint, simultaneous evaluation demands significant time and careful scheduling, which directly conflicts with the high-volume, brief-encounter model prevalent in many modern healthcare systems. However, the long-term health economics literature strongly argues that the initial investment required to establish these interdisciplinary diagnostic teams is exponentially offset by the massive reduction in the long-term costs of special education, chronic psychiatric care, and lost economic productivity associated with unmanaged developmental disabilities [15].

CONCLUSION

The comprehensive clinical and psychological investigation into the diagnostic methodologies for early childhood developmental delays unequivocally demonstrates that the collaborative, synchronous integration of a pediatrician, a speech therapist, and a defectologist constitutes the absolute gold standard of care. The research definitively proves that abandoning the traditional, fragmented sequential referral system in favor of unified multidisciplinary team evaluations drastically reduces diagnostic latency, thereby ensuring that therapeutic interventions are initiated during the critical, biologically fleeting windows of maximum neuroplasticity. Furthermore, the real-time synthesis of biomedical, linguistic, and cognitive expertise exponentially increases diagnostic accuracy, effectively eliminating the frequent and damaging misclassifications of complex neurodevelopmental disorders that occur in isolated clinical settings. The paramount conclusion of this research is that the early diagnosis of psychomotor and speech delays is not a singular medical event, but a complex bio-psycho-pedagogical process. To safeguard the developmental future of vulnerable children, national healthcare and educational systems must urgently dismantle their administrative silos and mandate the creation of integrated, collaborative primary care diagnostic centers, recognizing that early, accurate, and holistic intervention is the most profound determinant of a child's lifelong cognitive and social trajectory.

References

1. Glascoe, F. P. (2000). Early detection of developmental and behavioral problems. Pediatrics in Review, 21(8), 272-280.
2. Shevell, M., Ashwal, S., Donley, D., Flint, J., Gingold, M., Hirtz, D., ... & Quality Standards Subcommittee of the American Academy of Neurology. (2003). Practice parameter: evaluation of the child with global developmental delay. Neurology, 60(3), 367-380.
3. Guralnick, M. J. (2001). A developmental systems model for early intervention. Infants & Young Children, 14(2), 1-18.
4. Council on Children With Disabilities. (2006). Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. Pediatrics, 118(1), 405-420.
5. Law, J., Boyle, J., Harris, F., Harkness, A., & Nye, C. (2000). Prevalence and natural history of primary speech and language delay: findings from a systematic review of the literature. International Journal of Language & Communication Disorders, 35(2), 165-188.
6. Vygotsky, L. S. (1993). The collected works of LS Vygotsky: Volume 2: The fundamentals of defectology (abnormal psychology and learning disabilities). Springer Science & Business Media.
7. Diamond, A. (2000). Close interrelation of motor development and cognitive development and of the cerebellum and prefrontal cortex. Child Development, 71(1), 44-56.

pISSN:2349-5707 Volume:13,Issue 6, June -2026 eISSN:2349-5715

8. Majnemer, A. (1998). Benefits of early intervention for children with developmental disabilities. Seminars in Pediatric Neurology, 5(1), 62-69.
9. Shonkoff, J. P., & Phillips, D. A. (Eds.). (2000). From neurons to neighborhoods: The science of early childhood development. National Academies Press.
10. Ramey, C. T., & Ramey, S. L. (1998). Early intervention and early experience. American Psychologist, 53(2), 109-120.
11. Moeschler, J. B., & Shevell, M. (2014). Comprehensive evaluation of the child with intellectual disability or global developmental delays. Pediatrics, 134(3), e903-e918.
12. Bishop, D. V., Snowling, M. J., Thompson, P. A., Greenhalgh, T., & CATALISE consortium. (2016). CATALISE: A multinational and multidisciplinary Delphi consensus study. Identifying language impairments in children. PLOS One, 11(7), e0158753.
13. Lubovsky, V. I. (1993). Psychological diagnostics of abnormal development. Defektologiya, 1(1), 5-10.
14. Bruder, M. B. (2010). Early childhood intervention: A promise to children and families for their future. Exceptional Children, 76(3), 339-355.
15. Heckman, J. J. (2006). Skill formation and the economics of investing in disadvantaged children. Science, 312(5782), 1900-1902.