Oral Placement Therapy
Best Practices, Advantages, Limitations and Resources

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Introduction

About Me

WORK EXPERIENCE
14 years as an SLP
9 years of direct work with children with DS
Down Syndrome Connection of the Bay Area

EDUCATION
Undergraduate: U of Arizona 2001
Graduate: Gallaudet University 2003
Talk Tools Level 4 – Specific to Down Syndrome
There are two ways to live your life. One is as though nothing is a miracle. The other is as though everything is. - Albert Einstein

**Course Objectives**

1. Understand how strength, stability, tone and sensory systems relate to oral development
2. Identify relationship between oral development, feeding and speech development.
3. Oral Placement Therapy Explained
4. Evidenced-Based Research
5. Best Practices
6. Advantages and Limitations
7. Videos
8. Forum to address your children

**Low Muscle Tone/Hypotonia**

Low tone means there is not enough tension in the muscle when it is at rest.
- muscle has a slightly mushy or floppy feel
- lack of graded control of the muscle when it is being used
- graded control: the right amount of movement and effort is used as appropriate to the task at hand
Strength v. Tone

**Strength**

**Tone**

Tactile System

- **Hypo Sensitivity**: An under-reaction to tactile input
- **Hyper Sensitivity**: An over-reaction to tactile input
- **Mixed Sensitivity**: Any combination of hyper/hypo or normal sensitivity
- **Fluctuating Sensitivity**: Responses that change over time
- **Tactile Defensiveness**: A learned tendency to respond negatively or emotionally to tactile input

Six Structures that Compose Speech Clarity

- Tongue
- Jaw
- Abdomen
- Lips
- Velum
- Cheeks
Jaw

- The jaw is the foundation for speech clarity.
- Without adequate stability in your jaw; your lips, cheeks and tongue cannot move freely during speaking and feeding tasks (dissociation)

ACTIVITY: Chair Dissociation

Definitions

- Dissociation: The separation of movement, based on stability and adequate strength, in one or more muscle groups
- Grading: The controlled segmentation of movement through space based upon dissociation
- Fixing: An abnormal posture used to compensate for reduced stability which inhibits mobility.

Definitions

- Dysarthria: Muscle weakness characterized by reduced mobility, coordination, and precision of the oral musculature resulting in poor speech intelligibility and oral movement patterns.
- Apraxia: Inability to motor plan volitional movements for speech production in the absence of muscle weakness
- Motor Planning Disorder: Difficulty formulating the motor plan for volitional movements for speech production with or without muscle weakness.

Apraxia and Dysarthria can co-occur in children with Down syndrome
Feeding Profiles

Child A

- Eats everything family eats
- Stuffs his mouth
- Quite messy during mealtime
- Can/has choked on food
- Drinks from a straw but his tongue wraps under the straw and can often be seen protruding from his lips
- Parents often don’t think he has a feeding difficulty because he eats everything
Child A

WHY?

- This is a child that has some chewing ability but also suckles his food.
- Often chews 3x then swallows his food in large pieces because his tongue, cheek and jaw are not working properly to hold food on his molars while chewing.
- Often cannot feel what's going on in his mouth (Hypo-sensitivity).
- Has unresolved tongue protrusion and a low open jaw position which affects his speech development.
- Possible Diagnosis: Dysarthria.

Child B

WHY?

- Eats only crunchy dissolvable things (i.e., crackers/chips and prefers purees and softer foods like bananas, cheese, ground meats (chicken nuggets) etc).
- Lacks fresh food - fruits, vegetables and often meats.
- Chokes on food occasionally.

Child B

WHY?

- Eats crunchy dissolvable foods — provide him with sensory awareness when they crunch.
- Dissolvable and soft mashable foods are safest because of hyposensitivity and reduced oral skill.
- He may have the appearance of chewing but often it is a tongue mashing/suckle pattern.
- Tongue protrusion, open mouth posture and decreased speech clarity.
- Possible Diagnosis: Dysarthria.
**Child C**

- Drinks only 1 type of juice
- Eats the same limited brand-specific group of foods each day — smoothies, soft mashable, soups/porridge, purees.
- Parents pack food every time eating out.
- Diet is often nutrient depleted.
- Skin tone may show difference in color based on the foods he is eating.

**Why?**

- Food choices are controlled by subconscious and/or very obvious fear.
- Extremely limited skill in his jaw, tongue, and lips.
- Watches you make, place and feed him his food.
- Oral sensory profile may be characterized by tactile defensiveness and mixed sensitivity. Child is often overwhelmed by sensory system and is unable and unwilling to vary food choices.
- Possible Diagnoses: Apraxia of speech, Dysarthria and Autism Spectrum Disorder, Sensory Processing Disorder

**Child D**

- Over 3+ years old
- Drinks milk or Pediasure from a baby bottle or adapted sports bottle.
- May eat purees/baby food, but perhaps not.
- Nutrient depleted.
- Most likely a very late walker.
Child D

WHY?
• Lacks ability to move his jaw up and down in a chewing manner — has never done it before.
• May swing jaw side to side regularly at rest.
• Extremely low muscle tone and strength in entire body.
• Retains an infantile sucking pattern on his baby bottle — has large tongue thrust.
• Dangerous to give this child chewable solids.
• Extremely hypo-sensitive in his mouth
• Possible Diagnoses: Apraxia of speech. Dysarthria. Hypotonia. Hyposensitivity

Which type of feeding profile does your child have?

Oral Placement Therapy: Best Practices
AAPPSPA Position Statement

- Oral Motor Therapy is an acceptable treatment method for those individuals who present with disorders of strength and tone, oral phase feeding deficits and/or orofacial myofunctional disorders. This may include the oral phase of feeding, oral resting posture, drooling, and overall appearance of the oral-facial musculature. Oral Motor Therapy encompasses activities that target the improvement of strength, tone, dissociation and grading of the oral musculature and usually involves regulation of the oral sensory-motor system (Overland, 2010). Oral Motor Therapy for strength, tone and the oral phase of feeding has been accepted in the field without debate.

- Oral Placement Therapy, a form of Phonetic Placement Therapy, is an acceptable form of treatment. It is used when an individual may present with gross oral and feeding issues. In this method, the individual’s mouth and tongue may be manipulated with oral tools to provide tactile cues for speech sound production (Bahr & Rosenfeld-Johnson, 2010; Marshalla, 2007). Once the individual can imitate the sound(s) through traditional methods, direct work on speech sound production should be implemented.

- The combination of Oral Motor Therapy and Oral Placement Therapy may be present in an individual. If one or both are needed, then both must be addressed. A co-morbid diagnosis (e.g., low tone and an orofacial myofunctional disorder) may require the implementation of both Oral Motor and Oral Placement Therapy simultaneously.

Peer Reviewed Journals

- Non-speech Oral Movements and Oral Motor Disorders: A Narrative Review
- A Sensory Motor Approach to Feeding
- Horns, Whistles, Bite Blocks and Straws
- Early Oral-Motor Interventions for Pediatric Feeding Problems: What, When and How
- Treatment of Children with Speech Oral Placement Disorders (OPDS): A Paradigm Emerges

Components of an OPT Program and Theory

- Sensory Stimulation
- Feeding Strategies
- Standard Speech Therapy Approaches
- Oral Placement Techniques
Oral Placement Tools

Speech Therapy Approaches Used Tools

• Oral Placement Techniques/ Feeding
• Apraxia Shapes and Tubes
• PROMPT or Facial Cuing Techniques
• Kauffman Cards
• Word Flips (Super Duper)
• Moving Across Syllables
• Play-based learning

Evaluation and Therapy

• Have your child evaluated by a trained Oral Placement Therapist listed on the TalkTools website. https://talktools.com/apps/Find-a-Therapist/

• Follow a program plan developed by an Oral Placement therapist 3-5x per week, 20 min per day.

• Update your program plan regularly with an Oral Placement therapist (local or traveling TT therapist - found on TT website).
Advantages of an OPT Program Therapy Approaches Used Tools

- Addresses strength, stability and sensory-motor differences as part of therapy
- Facilitates typical progression of oral development
- Works in hierarchies to ensure oral skills are continuing to develop and articulation goals are being met.
- Facilitates typical progression of oral development
- Individualized program per each child
- More normalized feeding and speech patterns
- Greater independence and inclusion rates

Limitations of an OPT Program Therapy Approaches Used Tools

- Programs can be extensive and confusing to follow on your own
- Programs require years of consistent work 3-5x per week.
- Private therapy can be expensive if it isn’t covered by insurance.
- Children aren’t always agreeable to therapeutic strategies.
- Each child requires their own tools - which can be expensive (Avg: $150.00)
Research

Peer Reviewed Journals

- Nonspeech Oral Movements and Oral Motor Disorders: A Narrative Review
- A Sensory Motor Approach to Feeding
- Horns, Whistles, Bite Blocks and Straws
- Early Oral-Motor Interventions for Pediatric Feeding Problems: What, When and How
- Treatment of Children with Speech Oral Placement Disorders (OPDS): A Paradigm Emerges

Presentations and Posters (ASHA)

- OPT vs Non Speech Oral Motor Exercises (NSOME) - Understanding the Debate
- A Modern Look at Van Riper’s Phonetic Placement Approach
- Using Tactile Techniques to Improve Speech Clarity in Children with Childhood Apraxia of Speech
- Diet Shaping for Self-Limited Diets In Children With A Diagnosis of Autism Spectrum Disorder

www.talktools.com
19 y/o - Post jaw work and lip rounding - Video

23 y/o - Post tongue work - Video

Generalizing /t, d, n, l/ - Video
Practicing Profanity... Because WE CAN!

24 years old - /sh/ and /t/ Video

Rachel
Will

Cheek Pulls - Video

Cheek Activation on Straw #4 - Video
Testimonials

Andre

“Our not quite 2 year old son Andre worked with a feeding therapist from our HMO. As a mother I saw that some of the therapies were further exacerbating his already forming bad habits. When we started the Talk Tools program Andre was eating only pureed foods and drinking only from a bottle.

After 11 weeks, he was chewing soft solids and moving his tongue from side to side. He is drinking from a straw and is starting to blow bubbles. What a difference the right program makes!”

Bella

“Bella started Oral Placement Therapy (Talk Tools) with Heather when she was 8 months old. She is now almost 5 years old and I am SO happy with her speech as well as eating, drinking, tongue retraction and general oral management. She basically has no tongue protrusion because her jaw has become very strong and stable with Talk Tools therapy. Her speech is prolific and very intelligible. Her teachers at her typical preschool have no trouble understanding her, which is huge. She also drinks from an open cup or with a straw and eats a very large variety of foods all with proper utensil usage. What I am most impressed with is her speech. Most of the words she says sound completely typical and she comes up with the cutest phrases all on her own. Two of my recent favorites are “try again honey” and “come on dude”. Overall I am extremely happy with what Talk Tools, and Heather specifically, have done for my daughter’s ability to speak clearly and to fit in completely in her inclusive school environment as well as in our family!”
Elliott

"Oral Placement therapy has helped Elliott improve his articulation by helping him gain control of the different parts of his mouth. He is now able to move his lips and tongue well when he is working on his sounds. This past year we have finally conquered /sh, ch, dj/ and we are transferring them into conversation. We feel the Talk Tools program has helped Elliott improve his articulation, and this has improved his self confidence in social interactions with others."

References

- TalkTools (www.talktools.com)
- A Three - Part Treatment Plan for Oral Placement Therapy, 2014

Michael

My 16 year old son has Down syndrome and a very limited intelligible vocabulary of an 18 month old. Over the years I have wondered why his intelligibility never improves and often seems to get worse as he tries to say more and more. At age 14 I started Michael on the Talk Tools oral placement therapy program. Heather explained to me that Michael has jaw weakness which inhibits his entire mouth from moving correctly during speech. She recommended I work with my son 5 times a week. She taught me how to do therapy at home. It was hard at first to get into a routine, but gradually we were making progress. Family and friends noticed a difference in the first month. They could understand him better, without me translating! In the second month he said "I love you mom" and it was clear!!! I was jumping up and down clapping and laughing. Now he's saying words like "basketball" and "tuna sandwich" (a new one!) Oral Placement Therapy has changed our lives for the better! My school speech therapist also started incorporating jaw activities into his sessions 3 or 4 per day and it's made so much difference. It has helped with behavior issues and independence. Michael really wants to lead an independent life. It is happening for us, before our very eyes and we are SO happy!
See you at NDSC!!

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