

Special Web Forum on Oral Motor Treatment

From the ASHA Member Forums

<http://forums.asha.org/discussion?128@@.ef3740f>

September 23, 2003

Sponsored by Special Interest Divisions 1 (Language Learning and Education), 2 (Neurophysiology and Neurogenic Speech and Language Disorders), 4 (Fluency and Fluency Disorders), 5 (Speech Science and Orofacial Disorders), 13 (Swallowing and Swallowing Disorder), and 16 (School-Based Issues).

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topic created 11 Sep 2003 by **SYSOP**

NOTE: This discussion is now a read-only archive. Members who wish to continue this discussion among themselves are encouraged to start appropriate topics in the [Speech-Language Pathology Discussion area](#) here on the Member forums.

Straws and whistles, bite-blocks, nuk brushes, sensory and motor stimulation -- the list of oral motor treatments goes on. Do they work? How do they work? When do they work? How do you know if they worked for a specific client? A panel of experts helped members explore these questions on a Web forum held September 23, 8-10 pm, ET. The event was sponsored by Special Interest Divisions 1 (Language Learning and Education), 2 (Neurophysiology and Neurogenic Speech and Language Disorders), 4 (Fluency and Fluency Disorders), 5 (Speech Science and Orofacial Disorders), 13 (Swallowing and Swallowing Disorder), and 16 (School-Based Issues).

DISCLAIMER: All comments are the opinions of the individuals who took part in this Web forum and do not necessarily reflect the official opinion of the association, nor does a mention of a commercial product here imply a recommendation for such a product by the association.

The Expert Panel [sysop](#) - 11:36am Sep 16, 2003 EST (#1) [{Bookmark}](#)

Joining us in the ASHA Member Forums for this event will be the following special guests:

Debra Beckman, MS, CCC-SLP
Beckman & Associates, Inc.
Developmental Therapy Clinic
Winter Park, FL

Heather M. Clark, Ph.D. CCC/SLP
Associate Professor, Department of Language, Reading, & Exceptionalities, Appalachian State University
Boone, NC

Karen Forrest, Ph.D.
Professor, Department of Speech and Hearing Sciences, Indiana University
Bloomington, IN

John E. Riski, Ph.D., CCC-S, FASHA
Director, Speech Pathology Laboratory
Clinical Director, Center for Craniofacial Disorders
Atlanta, GA

JoAnne Robbins, Ph.D.

Professor, Department of Medicine, University of Wisconsin
and

Associate Director for Research, Geriatric Research, Education and Clinical Center
(GRECC)

Wm S Middleton VA Hospital
Madison, WI

Recommended Reading [sysop](#) - 11:46am Sep 16, 2003 EST (#2) [{Bookmark}](#)

In anticipation of this event next week, the experts have submitted some recommended reading for you to review before the live discussion (which will happen in this spot--instructions for "keeping up" with the event while it is occurring to be posted later).

All of these documents are in Adobe Acrobat PDF format. You can obtain the free Acrobat Reader software for viewing and printing these files from <http://www.adobe.com/>

[sysop](#) - 11:48am Sep 16, 2003 EST (#3) [{Bookmark}](#)

"Range of Movement and Strength in Oral Motor Therapy: A Retrospective Efficacy Study"

Debra A. Beckman, M.S., CCC-SLP
Carrie D. Neal, M.A., CCC-SLP
Jason L. Phirsichbaum, M.A., CCC-SLP
Lisa J. Stratton, M.A., CCC-SLP
Virginia D. Taylor, M.A., CCC-SLP
David Ratusnik
University of Central Florida

Attachments: [beckman.pdf](#)

[sysop](#) - 11:50am Sep 16, 2003 EST (#4) [{Bookmark}](#)

"Assessment and Treatment of Neuromuscular Impairments"*

Heather M Clark, Ph.D. CCC/SLP
Associate Professor
Department of Language, Reading, & Exceptionalities
Appalachian State University
Boone, NC

*This presentation is based on the manuscript
"Neuromuscular Treatments for Speech and Swallowing: A Tutorial" (in press, AJSLP)

Attachments: [ClarkHandout.pdf](#)

[sysop](#) - 11:52am Sep 16, 2003 EST (#5) {Bookmark}

"Oral Motor Training and Treatment for Apraxia of Speech"

Linda I. Shuster
West Virginia University, Morgantown

Attachments: [D2v11n4Shuster.pdf](#)

[sysop](#) - 11:52am Sep 16, 2003 EST (#6) {Bookmark}

"Nonspeech Oral Motor Treatment Approaches for Dysarthria: Perspectives on a
Controversial Clinical Practice"

Megan M. Hodge
University of Alberta
Edmonton, Alberta, Canada

Attachments: [D2v12n4Hodges.pdf](#)

Sessions at ASHA Convention in Chicago [sysop](#) - 12:01pm Sep 16, 2003 EST (#7) {Bookmark}

There will be a number of sessions regarding oral motor treatment at this year's
convention, including:

Thursday, Nov 13 2003 8:00 AM (60 Min)
McCormick Place Convention Center, N230
Physiological Rationale for Passive Exercise & Physical Modality Treatments

Presenter: Clark, Heather

Thursday, Nov 13 2003 11:00 AM (60 Min)

McCormick Place Convention Center, E354b

Assessments of Children's Oral & Speech Motor Skills: A Review

Presenter: Strand, Edythe

Thursday, Nov 13 2003 1:30 PM - 3:00 PM

Poster McCormick Place Convention Center, Hall E

Effectiveness of Oral Motor Treatment in SLP

Presenter: Lass, Norman

Thursday, Nov 13 2003 1:30 PM (15 Min)

McCormick Place Convention Center, N229

Specificity of Training in the Lingual Musculature

Presenter: Clark, Heather

Thursday, Nov 13 2003 3:15 PM (15 Min)

McCormick Place Convention Center, N229

Relationship Between Measures of Isometric & Isotonic Endurance

Presenter: Clark, Heather

Friday, Nov 14 2003 8:00 AM (120 Min)

McCormick Place Convention Center, E451a

Applying Exercise Physiology Principles in Oromotor Rehabilitation for Dysphagia

Presenter: Pfalzer, Lucinda

Saturday, Nov 15 2003 8:00 AM (60 Min)

McCormick Place Convention Center, E258

How to Decide Which Speech Treatment Approach to Use

Presenter: Kamhi, Alan

More Reading [sysop](#) - 09:06am Sep 17, 2003 EST (#8) {Bookmark}

"Nonspeech oral-motor exercises"

Karen Forrest

Indiana University

Attachments: [Nonspeech oral-motor exercises forum_1.pdf](#)

Reading Attachments [sysop](#) - 08:50am Sep 22, 2003 EST (#9) {Bookmark}

To read the attachments above, you'll need the free Adobe Acrobat reader (available for download from <http://www.adobe.com>). If, when clicking on the links above, you get a message asking what to do with the document, save it to your harddrive (make sure you know where you are saving it to, and give the document a descriptive name), then doubleclick the document to open it in Acrobat reader outside your browser.

Additional Reading [sysop](#) - 03:28pm Sep 22, 2003 EST ([#10](#)) [{Bookmark}](#)

"Coordination of Lip Muscle Activity by 2-Year-Old Children During Speech and Nonspeech Tasks"

by

Jacki L. Ruark, University of Tennessee, Knoxville

Christopher A. Moore, University of Washington, Seattle

*from*JSLHR, Volume 40, 1373-1385, December 1997

Attachments: [Ruark.pdf](#)

CPT Codes and Oral Motor Treatment [sysop](#) - 04:04pm Sep 23, 2003 EST ([#11](#)) [{Bookmark}](#)

Speech-language pathologists can use procedure (CPT) codes in the 97000 series (Physical Medicine and Rehabilitation) as well as procedure codes in the 92500 series (Special Otorhinolaryngologic Services); but not in combination.

A speech-language pathologist might use 97112 (neuromuscular re-education) when working on oral motor skills, but speech-language pathologists usually do oral motor work as part of speech treatment, which is reported under 92507 (treatment of speech and language disorders). To report 97112 and 92507 would constitute unbundling or duplicate billing as the vignette for 92507 includes improving oral motor coordination.

That being said, a speech-language pathologist working on tongue thrust without a speech problem might use 97112 to describe the treatment provided.

Questions? Contact Maureen Thompson (mthompson@asha.org or extension 4431) or Janet McCarty (jmccarty@asha.org or extension 4194, Tues. and Wed.).

More Additional Information [sysop](#) - 04:17pm Sep 23, 2003 EST ([#12](#)) [{Bookmark}](#)

For those of you who have access to a university library, you might be interested in the following article: "Oral stimulation accelerates the transition from tube to oral feeding in preterm infants" by Sandra Fucile, MSc, OTR, Erika Gisel, PhD, OTR, and Chantal Lau, PhD, published in the *Journal of Pediatrics*, 2002, 141:230-6.

FORUM TONIGHT!

Thanks to everyone for their interest in this topic and forum! ASHA and the sponsoring special interest divisions really appreciate your enthusiasm.

Right now, this forum is set to read-only, but at 8pm tonight it will switch to a full forum, with a blank white box at the end for your questions. When asking questions, please remember that we have five guests tonight.

During the event, hit the refresh button (on IE, a pair of green arrows pointing to each other on your toolbar; on Mozilla/Netscape, an arrow circling a document) every 5-10 minutes to update your screen and see what is being written.

If you need technical assistance, contact ~~engelcox@asha.org~~ (due to problems with ASHA's email system due to Hurricane damage) engelcox@hotmail.com during the event.

Joanne Robbins [Joanne Robbins](#) - 07:29pm Sep 23, 2003 EST (#13) {Bookmark}

This is a test message.

Greetings [sysop](#) - 07:31pm Sep 23, 2003 EST (#14) {Bookmark}

Hi, Joanne! Glad you could make it tonight. If the other presenters could also post a test message, that would be grand!

Karen Forrest [Karen Forrest](#) - 07:33pm Sep 23, 2003 EST (#15) {Bookmark}

Hi,
I'm also logged on.

Karen

Greetings [sysop](#) - 07:36pm Sep 23, 2003 EST ([#16](#)) [{Bookmark}](#)

Excellent, Karen. Thanks to you and Joanne, and our other presenters, for making yourselves available for this forum tonight!

We're still about 25 minutes before the actual start of this thing, so grab yourself something to drink and do some typing exercises to flex those finger muscles--it's going to be a fun and informative two hours, I'm sure!

Heather Clark [clarkhm](#) - 07:37pm Sep 23, 2003 EST ([#17](#)) [{Bookmark}](#)

Welcome everyone! I'm looking forward to the discussion.

Greetings [sysop](#) - 07:38pm Sep 23, 2003 EST ([#18](#)) [{Bookmark}](#)

And Heather makes three! I like this group--not just on time, but early. Wow!

Amy Weiss [louise](#) - 07:41pm Sep 23, 2003 EST ([#19](#)) [{Bookmark}](#)

Just so you'll know there's an audience out there, I thought I'd say hello to you all from Iowa City.

Greetings [sysop](#) - 07:44pm Sep 23, 2003 EST ([#20](#)) [{Bookmark}](#)

And hello back to Iowa City, home of the best creative writing program in the country! (Okay, so that was off-topic. Bad sysop, bad.)

Given the number of emails and phone calls I've responded to in the last week, I suspect there's a number of people in the audience tonight. I hope some of them have questions, too!

Joanne Robbins [Joanne Robbins](#) - 07:45pm Sep 23, 2003 EST (#21) {Bookmark}

Good evening. This is JoAnne Robbins in Madison Wisconsin. Please let me know who is on early (before 7 Central Time). Thanks.

Sherri Lovick [SLovick](#) - 07:47pm Sep 23, 2003 EST (#22) {Bookmark}

Good Evening from Post Falls Idaho!

Keeping up with the discussion [sysop](#) - 07:51pm Sep 23, 2003 EST (#23) {Bookmark}

Just a technical note--due to how some browsers "cache" information to the hard drive, make sure that when you use the REFRESH button to see what's been posted since you last refreshed, hold down the CTRL key, which will force your browser to get the most recent information from the Web.

Also, note that right under the heading, there's links to FIRST, PREVIOUS, NEXT and ALL. These can help you move through the discussion--FIRST takes you to message #1, PREVIOUS will jump you back a few messages, NEXT will grab the next few messages, while ALL will send the whole discussion to your screen (which might get pretty long given the interest on this topic!).

Patricia Burke [Pat Burke](#) - 07:51pm Sep 23, 2003 EST (#24) {Bookmark}

Hello from Melbourne, FL

Beth Muller [beth muller](#) - 07:53pm Sep 23, 2003 EST (#25) {Bookmark}

Hello from Bethel, CT

Sandy Ryan [sandy_ryan](#) - 07:54pm Sep 23, 2003 EST (#26) {Bookmark}

Hello from beautiful Flagstaff, Arizona!

Joanne Robbins [Joanne Robbins](#) - 07:54pm Sep 23, 2003 EST (#27) {Bookmark}

Heather,
I don't see the article from the SID13 Newsletter that I authored on Lingual Strength and Exercise listed in the above listed readings for this Web Forum. Wasn't Jean White or someone at ASHA going to post it?

Teresa Brobeck [tbrobeck](#) - 07:54pm Sep 23, 2003 EST (#28) {Bookmark}

Howdo from NMSU in Las Cruces! I'm running between this and my class tonite, but I'll keep hitting the "refresh" button as suggested :-). Thanks to all the discussion leaders for this forum!

Pat Bates [pat bates](#) - 07:54pm Sep 23, 2003 EST (#29) {Bookmark}

Good Evening from Lawrence, Kansas

Marlene Pettiford [maps1p](#) - 07:55pm Sep 23, 2003 EST (#30) {Bookmark}

Hello all from Columbus Indiana

Keeping up with the discussion [sysop](#) - 07:56pm Sep 23, 2003 EST (#31) {Bookmark}

It's great to see all these people from so many parts of the country! Thanks for

attending tonight's Web event.

Joanne, it looks like that may have been my mistake. I'll make sure to get that article posted tomorrow so that people can check back here to read it after tonight's discussion.

Heather Clark [clarkhm](#) - 07:57pm Sep 23, 2003 EST (#32) [{Bookmark}](#)

Joanne, I will attach it here

Attachments: [Robbins article.pdf](#)

Jill Georges [jgeorges](#) - 07:58pm Sep 23, 2003 EST (#33) [{Bookmark}](#)

Hello from Kansas City, KS

Introductions [sysop](#) - 07:58pm Sep 23, 2003 EST (#34) [{Bookmark}](#)

According to the clock on my computer here, it's time to get this show rolling!

First off, I'd like each of the presenters to give a short introduction to themselves and their relation to oral motor treatment.

Sandy Ryan [sandy_ryan](#) - 07:58pm Sep 23, 2003 EST (#35) [{Bookmark}](#)

Would it be possible for someone at ASHA to post all the articles and resources mentioned tonight on the web page after the event?

Anne Marie Newman [anewman](#) - 07:58pm Sep 23, 2003 EST (#36) [{Bookmark}](#)

And also, a big hello from Naples, Florida.

Pamela Horrocks [pamela horrocks](#) - 07:58pm Sep 23, 2003 EST (#37) {Bookmark}

Hello from Willimantic Ct. Looking forward to this discussion!

Daniel Britchkow [DBritchkow](#) - 07:59pm Sep 23, 2003 EST (#38) {Bookmark}

Hi, I'm writing from U of Pitt. How effective is oral-motor exercises? What are the statistics or justification for them?

Dianne Handy [dhandy](#) - 07:59pm Sep 23, 2003 EST (#39) {Bookmark}

Hello from Washington, DC

Michael Hammer [mhammer](#) - 07:59pm Sep 23, 2003 EST (#40) {Bookmark}

And another warm greeting from Lawrence, KS. Hi Pat!

Heather Clark [clarkhm](#) - 08:00pm Sep 23, 2003 EST (#41) {Bookmark}

Hi, this is Heather Clark from Boone, NC. My interest in this topic is from the perspective of theoretical/physiologic rationale for oral motor treatments: How do they effect the motor system?

John Riski [JRiski](#) - 08:00pm Sep 23, 2003 EST (#42) {Bookmark}

Hi, from Atlanta.
Looks like we have a crowd already.

Jay

Fran Redstone [franredstone](#) - 08:00pm Sep 23, 2003 EST (#43) {Bookmark}

Dr. Clark,

Regarding strength and range of motion in children with oral problems, do we know how much is enough? Are there norms?

Jessica Goldberg [Jessica Goldberg](#) - 08:00pm Sep 23, 2003 EST (#44) {Bookmark}

hello from bronx ny

Linda Schmitke [Schmitke](#) - 08:00pm Sep 23, 2003 EST (#45) {Bookmark}

Hello from beautiful Oregon.....GO DUCKS!!!!

Gregory Lof [Gregory Lof](#) - 08:00pm Sep 23, 2003 EST (#46) {Bookmark}

Hi from Boston!

Heather Clark [clarkhm](#) - 08:02pm Sep 23, 2003 EST (#47) {Bookmark}

Fran,

Although many studies have reported that individuals with dysarthria and/or some types of dysphagia exhibit weakness, the relationship between strength and function is not clear enough to identify "how much is enough."

Clouding the picture is "how much is enough to move quickly" in addition to producing adequate force.

Archive of Tonight's Discussion [sysop](#) - 08:02pm Sep 23, 2003 EST (#48) {Bookmark}

Sandy Ryan asked "Would it be possible for someone at ASHA to post all the articles and resources mentioned tonight on the web page after the event?"

We will be making a "zip" file that contains this discussion and what articles/resources we can obtain permissions for available to members on the Web site, yes.

Jacquelyn Fowler [Jacquie F.](#) - 08:02pm Sep 23, 2003 EST (#49) {Bookmark}

Hi from Stafford, NY. I'm looking forward to learning via a web forum.

Barbara Lambiase [Barbara Lambiase](#) - 08:03pm Sep 23, 2003 EST (#50) {Bookmark}

Hi from New Jersey

Lisa McDonald [mcdonal](#) - 08:03pm Sep 23, 2003 EST (#51) {Bookmark}

Hello from Greensboro, NC

Jessica Goldberg [Jessica Goldberg](#) - 08:04pm Sep 23, 2003 EST (#52) {Bookmark}

is there any way to help paresis from a chronic bell's palsy?

John Riski [JRiski](#) - 08:04pm Sep 23, 2003 EST (#53) {Bookmark}

Fran

Great question. Do you think ROM and strength are always related?
Jay Riski

Caroline Bowen [Caroline Bowen](#) - 08:04pm Sep 23, 2003 EST (#54) {Bookmark}

G'day everyone, It's just after 10 am on Wednesday on a beautiful Spring morning here in Sydney, Australia. Thanks to the presenters and organisers for the terrific selection of articles. I have been reading for days!

Cindy Katzoff [cask51454](#) - 08:04pm Sep 23, 2003 EST (#55) {Bookmark}

Hello from Milwaukee. Will the whole discussion be available somewhere to read afterwards?

Louise [Louise522](#) - 08:05pm Sep 23, 2003 EST (#56) {Bookmark}

We are a three-some in Charlotte: 3 SLPs!

Karen Forrest [Karen Forrest](#) - 08:05pm Sep 23, 2003 EST (#57) {Bookmark}

Hi, This is Karen Forrest from Indiana University in Bloomington. I'm interested in treatment efficacy, in general, and particularly as it relates to children with speech disorders of unknown origin and adults with dysarthria. In line with some of the previous questions, I am interested in having empirical information about efficacy of oral-motor treatments.

Regarding Questions [sysop](#) - 08:05pm Sep 23, 2003 EST (#58) {Bookmark}

I'm going to be trying to keep track of the questions in another window, so that we can make sure they don't get lost in this wild online format.

Pamela Horrocks [pamela horrocks](#) - 08:05pm Sep 23, 2003 EST (#59) {Bookmark}

Can you provide some references for efficacy studies regarding oral-motor treatment?

Gregory Lof [Gregory Lof](#) - 08:05pm Sep 23, 2003 EST (#60) {Bookmark}

My concern is with how many people are using OME to change speech sound productions in children. The data seem clear to me that there is no relationship between non-speech exercises and speech sound changes. I prefer to let the data guide clinical practice....

Evelyn Cole [ebcslp](#) - 08:05pm Sep 23, 2003 EST (#61) {Bookmark}

Hello from TN

Joanne Robbins [Joanne Robbins](#) - 08:05pm Sep 23, 2003 EST (#62) {Bookmark}

Hi- Nice to have so much interest on line relative to the topic at hand. My work in this area is relatively focused on the use/effectiveness of oral exercise on swallowing and related outcomes, largely in adults although I also am interested in the younger population.

And Greg Lof, how long have you been in Boston? How many years of your life have I missed?!

Heather Clark [clarkhm](#) - 08:06pm Sep 23, 2003 EST (#63) {Bookmark}

Jay, I like your question. Certainly other neuromuscular impairments in addition to weakness can affect ROM. Hypertonia, particularly in the case of the jaw, comes to mind, and perhaps rigidity/hypokinesia as in Parkinson's disease.

Lindsay Geddis [Lindsay Geddis](#) - 08:06pm Sep 23, 2003 EST (#64) {Bookmark}

Hi from NY

Debra Lowsky [debraclowsky](#) - 08:07pm Sep 23, 2003 EST (#65) {Bookmark}

Thanks for having a forum. Debbie Lowsky from Columbia, SC!

Gregory Lof [Gregory Lof](#) - 08:07pm Sep 23, 2003 EST (#66) {Bookmark}

Hi, Joanne! Glad you are speaking from the swallowing point of view....as you know, I am in the "child phonology" point of view....

Jessica Goldberg [Jessica Goldberg](#) - 08:08pm Sep 23, 2003 EST (#67) {Bookmark}

with adults following strokes is there a minimum amount of tone which must remain to expect return in buccal/facial mm.?

Heather Clark [clarkhm](#) - 08:09pm Sep 23, 2003 EST (#68) {Bookmark}

Greg's response (speech versus non-speech) is related to issues of motor learning. Principles of motor learning indicate that "part to whole" practice strategies (breaking the movement down into its component parts and practicing each movement separately) are not as effective as practicing the whole movement.

Andrea Tobochnik [Andrea](#) - 08:09pm Sep 23, 2003 EST (#69) {Bookmark}

Question from Kalamazoo:

Is there data to support the effectiveness of any specific oral motor exercises for improving oral bolus control in adults with dysphagia?

John Riski [JRiski](#) - 08:10pm Sep 23, 2003 EST ([#70](#)) [{Bookmark}](#)

This is Jay Riski. I direct a craniofacial program in Atlanta and I am interested speech problems related to VPI and apraxia. I would like to hear anyone's experiences using OME in these populations with/without traditional speech therapy.

Aileen Montag [SLPAI](#) - 08:10pm Sep 23, 2003 EST ([#71](#)) [{Bookmark}](#)

Hi from NY

Effectiveness Questions [sysop](#) - 08:11pm Sep 23, 2003 EST ([#72](#)) [{Bookmark}](#)

Presenters, Daniel Britchkow and others have posted questions regarding effectiveness of oral-motor exercises. Is there a link or reference to an article that they can go to for studies of these? (Are their references to studies in the articles already posted here?)

Heather Clark [clarkhm](#) - 08:11pm Sep 23, 2003 EST ([#73](#)) [{Bookmark}](#)

Jessica,

I think one area where we struggle is even identifying/quantifying muscle tone. Are judgements based on degree of facial droop? Or do SLPs assess tone in ways that other disciplines do, by gauging resistance to passive movement.

I don't know of any norms for facial tone, much less information on predicting recovery from tone.

Karen Forrest [Karen Forrest](#) - 08:12pm Sep 23, 2003 EST (#74) {Bookmark}

Pamela,

To the best of my knowledge, there are very few, controlled studies of the efficacy of oral motor exercises in speech remediation. The studies that I know of are quite old. They include: Overstake, C. (1976). Investigation of the efficacy of a treatment program for deviant swallowing and allied problems, part II. Internl J Myology 1976; 2:1-6.

Christensen, M. & Hanson, M. An investigation of the efficacy of oral myofunctional therapy as a precursor to articulation therapy for pre-first-grade children. J Speech Hear Dis 1981; 46:160-167.

Dworkin, J.P., Abkarian, G.G., Johns, D.F. (1988). Apraxia of speech: the effectiveness of a treatment regimen. J Speech Hear Dis 1988; 53:280-94.

There are some related studies from the dental literature in which jaw exercises were implemented.

Sandy Ryan [sandy_ryan](#) - 08:12pm Sep 23, 2003 EST (#75) {Bookmark}

Would it be true to say that there is more efficacy data for OM exercises in dysphagia tx than in non-dysphagia related tx?

Debra Beckman [Debra Beckman](#) - 08:12pm Sep 23, 2003 EST (#76) {Bookmark}

Here is one of the most recent articles re: oral motor interventions and tube to oral transition:

Journal article citation: Oral Stimulation Accelerates the Transition from Tube to Oral Feeding in Preterm Infants, by Sandra Fucile, Erika Gisel, and Chantal Lau, Journal of Pediatrics, Volume 141, Number 2, pages 230 – 236.

Gregory Lof [Gregory Lof](#) - 08:13pm Sep 23, 2003 EST (#77) {Bookmark}

I think that if you want speech to change, you work on speech, not on things that

appear to be related to speech.

When practicing piano, a person will practice playing music, not practice fingering on a counter top to pretend they are playing the piano. If you want speech to change, work on speech!

Heather Clark [clarkhm](#) - 08:15pm Sep 23, 2003 EST ([#78](#)) [{Bookmark}](#)

I believe the efficacy reviews we have posted are more general, but perhaps Joanne can speak to the swallowing issue? My memory of the Bells Palsy literature is that behavioral intervention paired with appropriate medical treatments (e.g., steroids) speeds acute recovery, but I'm afraid I know less about chronic Bell's Palsy.

One might be tempted to try e-stim, but I am more familiar with that literature, and the data has been largely unimpressive, and e-stim may even have unintended side effects (e.g., synkinesis)

Jessica Goldberg [Jessica Goldberg](#) - 08:16pm Sep 23, 2003 EST ([#79](#)) [{Bookmark}](#)

thanks for responding, i dont know of any norms either. does anyone continue to work toward improving facial symmetry once speech intelligibility is WFL? (and of course deglutition is functional ie, no antreior loss)

John Riski [JRiski](#) - 08:16pm Sep 23, 2003 EST ([#80](#)) [{Bookmark}](#)

Heather,
you made the point I wanted to bring out about ROM... it can be affected by a number of variables and strength is only one of them.
Jay

Heather Clark [clarkhm](#) - 08:18pm Sep 23, 2003 EST ([#81](#)) [{Bookmark}](#)

I'd like to respond to Greg's comment, pointing out a key philosophical difference (perhaps contributing to the controversy around these techniques).

On the one hand, some clinicians feel that it is most appropriate to direct treatment at the functional behavior (if speech is the problem, have the patient do speech - see Greg's comment). On the other hand are the clinicians who reason that, if underlying motor deficits are contributing to observed speech or swallowing dysfunction, directing treatments at alleviating the underlying impairment may improve speech and swallowing.

Anyone have additional thoughts about philosophy?

Kim Ward [mcav0y](#) - 08:19pm Sep 23, 2003 EST ([#82](#)) [{Bookmark}](#)

Dr Lof,

What is your view on using OME with children who have sound sequencing difficulties or apraxia of speech? Has there been any research conducted in this area?

Karen Brown [Karen Brown](#) - 08:19pm Sep 23, 2003 EST ([#83](#)) [{Bookmark}](#)

Just so that we're all on the same page, maybe Joanne would define efficacy and explain the difference between efficacy and effectiveness.

Debra Beckman [Debra Beckman](#) - 08:20pm Sep 23, 2003 EST ([#84](#)) [{Bookmark}](#)

Jay,

ROM and strength are related. It is difficult to maximize strength for striated muscle fiber if range is limited. Typically, I try first to work for range at minimal competencies before focusing on movement against resistance to build strength.

Lisa Sokoloff [LisaLisa](#) - 08:21pm Sep 23, 2003 EST ([#85](#)) [{Bookmark}](#)

Jay & Heather, you make a good point. Many of my patients have Parkinson's disease, PSP, CBGD, etc and rigidity is a huge factor in their ROM. This significantly affects speech and swallowing. However, I find that exercises are often fatiguing and not that effective.

Lisa

PS - Hi Heather, from Toronto

Jessica Goldberg [Jessica Goldberg](#) - 08:21pm Sep 23, 2003 EST (#86) {Bookmark}

i too would like to hear about techniques people have found to be effective with velopharyngeal insufficiency, at times this particular deficit seems to have so great an impact on overall intelligibility, but i find it hard to target directly any ideas?

John Riski [JRiski](#) - 08:21pm Sep 23, 2003 EST (#87) {Bookmark}

Greg,
thank you for saying what a lot of us believe intuitively, even without any literature support. Speech is series of a gestural events that require coordination of respiration, phonation, velopharyngeal and oral articulatory functions. Simply working on oral motor exercises words the necessary coordination of the other subsystems.
Jay

Joanne Robbins [Joanne Robbins](#) - 08:22pm Sep 23, 2003 EST (#88) {Bookmark}

Jessica,
The patient's goals are important to bear in mind. While as the clinician, I am most interested in restoring swallowing function and facilitating improved speech intelligibility, if the patient's goal is to achieve improved facial symmetry, then I refer to a wonderful occupational therapist here at Univeristy of Wisconsn named Jackie Diehl. She has a specialized neuromuscular clinic for facial paresis and has wonderful outcomes. You may wish to follow up directly with her on her methods. She has published but more along the line of her methods and case reports - no clinical trial data.

Debra Beckman [Debra Beckman](#) - 08:23pm Sep 23, 2003 EST (#89) {Bookmark}

Fran,

Only minimal strength is needed for speech. The estimate is only about 3% of possible strength is needed in the oral area for function. That is why attaining even minimal competencies may produce improve control. Striated muscles change in levels of activation through the day for normals, that is why muscle averaging is not the best way to determine competencies.

Karen Forrest [Karen Forrest](#) - 08:23pm Sep 23, 2003 EST (#90) [{Bookmark}](#)

In response to Heather's question about additional philosophical thoughts - I agree that in many cases there may be underlying deficits that need to be addressed. My concerns are determining 1) if there are underlying deficits that are impacting speech and 2) what are the best procedures for altering the function for speech. Task specificity is a big issue in motor behavior, in general, so the treatment target probably needs to include the same complexity and organization as speech. I wonder, once you consider task issues, what is an efficient use of treatment time - determining exercises that may mimic the complexity of speech or just using speech? Again, I think that these are questions that need to be addressed empirically.

Caroline Bowen [Caroline Bowen](#) - 08:24pm Sep 23, 2003 EST (#91) [{Bookmark}](#)

I run a listserv <http://groups.yahoo.com/group/phonologicaltherapy/in> which 970+ participants discuss child speech research, development, disorders and intervention. Most participants are SLPs or Linguists.

Just to declare my hand - I am NOT an "oral motor exercises" person when it comes to functional speech disorders. But many on the listserv are devotees.

There are several issues that I have never been able to have answered satisfactorily.

People post to the list that they ASSESS thoroughly for "oral motor weakness". How are such assessments executed? What do you actually look for?

People post to the list that they work on "oral motor" as a preparation for traditional articulation tx, or phonological tx. Why?

SLPs working with special education populations appear to be particularly adamant that oral motor work is an essential component of therapy for speech sound disorders.

What concerns me about all of this is the lack of scientific references to support these strongly held views, and the tendency to quote "gurus" who promulgate an oral motor approach as the way to go.

Caroline

Heather Clark [clarkhm](#) - 08:24pm Sep 23, 2003 EST (#92) [{Bookmark}](#)

Jessica,

From a physiologic perspective (and with some data to back it up), Kuehn and colleagues' use of CPAP to provide resistance to the VP musculature during speech movements seems right on!

Kuehn, D. P. (1991). New therapy for treating hypernasal speech using continuous positive airway pressure (CPAP). *Plastic and Reconstructive Surgery*, 88, 959-66.

Gregory Lof [Gregory Lof](#) - 08:24pm Sep 23, 2003 EST (#93) [{Bookmark}](#)

I was asked what I thought about OME with DVD...these kids seem to be the WORST case for these exercises. By definition, these kids will need to have speech worked on because they have speech sequencing problems. Working on things that are not speech related would not help. If they had oral apraxia, then MAYBE OME MIGHT work, but if they have VERBAL apraxia, then work on the verbal.

Michael Hammer [mhammer](#) - 08:25pm Sep 23, 2003 EST (#94) [{Bookmark}](#)

To add to Dr. Clark's comments, there is at issue whether the non-speech treatment elicits movement/behavior which are really reflective of those required during speech. As Dr. Forrest's handout indicated, the forces generated during speech production are much smaller than the maximum effort tasks which are frequently employed in treatment. Any further comments?

Jessica Goldberg [Jessica Goldberg](#) - 08:25pm Sep 23, 2003 EST (#95) [{Bookmark}](#)

thank you joanne
i will take down her name and see what i can find

Alicia Multari [aliciaslp44](#) - 08:26pm Sep 23, 2003 EST (#96) {Bookmark}

What about OME with the birth to three population who are presenting with low tone, reduced babbling and texture/taste aversion to certain foods? Has the literature supported using OME with this specific population?

Joanne Robbins [Joanne Robbins](#) - 08:27pm Sep 23, 2003 EST (#97) {Bookmark}

Karen,
Efficacy is defined as change from intervention assessed in ideal circumstances and effectiveness is change assessed in routine circumstances. These are rough adaptations from Randall Robey's publications - by the way, he will be presenting at the NIH pre-ASHA program on Monday/Tuesday in Chicago in November. A great person(thinker) to read or hear....

Debra Beckman [Debra Beckman](#) - 08:28pm Sep 23, 2003 EST (#98) {Bookmark}

The face represents a dynamic web of fibers. The interactions between muscles and structures vary tremendously. In working with any part of the oral musculature, all parts are impacted. It is not really possible to isolate parts from the whole.

John Riski [JRiski](#) - 08:29pm Sep 23, 2003 EST (#99) {Bookmark}

Jessica,
Velopharyngeal incompetence is a broad disorder. Severe velopharyngeal incompetence will require some type of physical management (surgical or prosthetic.) Small VPI's might be addressed with therapy. Dennis Ruscello from West Virginia has an excellent chapter in the Bzoch textbook "Cleft Palate Speech" in which he reviews go to literature in this area.

David Kuehn and Jerry Moon demonstrated that the amount of velopharyngeal elevation is directly related to oral pressure for blowing tasks. Velopharyngeal movement for blowing and speech are very closely related and clinically we certainly see increased soft palate elevation when someone over aspirates pressure consonants.

GM [Gabrielle](#) - 08:30pm Sep 23, 2003 EST (#100) [{Bookmark}](#)

If oral motor exercises are not useful, what do you do for kids who absolutely cannot put or keep their tongues in the right position for /s/, /r/, /ch?, etc.

I am in agreement for the most part about abandoning OME except for the kids who cannot seem to elevate or tense their tongues adequately to make certain speech sounds...What do you attribute their difficulty to?

GM in Boston

Heather Clark [clarkhm](#) - 08:30pm Sep 23, 2003 EST (#101) [{Bookmark}](#)

To reply to Caroline,

My impression is that many times strength is inferred from symmetry and/or ROM (and as Jay highlighted, this may not be a valid inference).

Some commercial devices are available for objective measures of strength (particularly tongue strength - see Joanne's paper earlier in the discussion). However, when those aren't available, the standard "oral motor exam" may provide pretty useful information (see ref below).

Clark, H. M. , Henson, P.A., Barber, W. D., Stierwalt, J. A. S. & Sherrill, M. (2003). Relationships among subjective and objective measures of tongue strength and oral phase swallowing impairments. American Journal of Speech-Language Pathology, 12, 40 - 50.

Erin Dyer Olson [Erin Dyer Olson](#) - 08:31pm Sep 23, 2003 EST (#102) [{Bookmark}](#)

In my district, the OTs do a lot of oral motor work on students with Dyspraxia and Dysarthria. What kind of research has the OT profession contributed as far as the use

of OME?

Karen [Karen115](#) - 08:31pm Sep 23, 2003 EST (#103) [{Bookmark}](#)

Hi from Karen in Rochester, NY:

Is it not possible to assist a client in becoming more aware of his articulators through warm-up exercises, so to speak, that facilitate correct productions; especially considering the number of children being diagnosed with sensory difficulties along with artic issues?

Debra Beckman [Debra Beckman](#) - 08:31pm Sep 23, 2003 EST (#104) [{Bookmark}](#)

Tone is determined at the central nervous system level. However, many people use the term tone when they actually mean muscle strength, the ability of the muscle to activate to meet the work load of the task at hand, whether that is a speech or non speech activity.

Renee Hill [romotorre](#) - 08:32pm Sep 23, 2003 EST (#105) [{Bookmark}](#)

In response to the question about velopharyngeal insufficiency, Sara Rosenfeld-Johnson has developed a technique called "Oral-Nasal contrasts" which isolates the oral component and the nasal component in speech production. The complexity of the task increases with success. The success in my experience has been based on the ability to establish oral airflow and nasal airflow independently through a hierarchical oral-exercise approach prior to introducing the speech task.

Cheryl Harding [Cheryl Harding](#) - 08:33pm Sep 23, 2003 EST (#106) [{Bookmark}](#)

I have a dear friend whose mother was recently diagnosed with ALS. She has not had very much luck in finding an SLP experienced with this condition. Any ideas about research or SLPs experienced with ALS? (This woman lives in Texas, but would be willing to travel, especially to the Chicago area.)

Joanne Robbins [Joanne Robbins](#) - 08:34pm Sep 23, 2003 EST (#107) {Bookmark}

Mike,

Yes, Karen's work does indicate that speech requires sub-maximal pressures, quite small. Our work is indicating that while swallowing also requires sub maximal pressure generation, functional swallowing requires GREATER pressure than does speech production. The requirements, in terms of maximal pressures, increase depending on the viscosity of the material being swallowed (e.g., thin liquids do not require as much strength as do more viscous or solid foods and so strengthening exercises may be useful in the swallowing realm.

Jessica Goldberg [Jessica Goldberg](#) - 08:34pm Sep 23, 2003 EST (#108) {Bookmark}

thanks heather

how is cpap applied, i have only heard of this term in regards to ventilator settings

thank you john

i will definitely try the overexpirating pressure consonants the next time the issue comes my way

how wonderful to have access to all of your brains!

Billy Irwin [Billy Irwin](#) - 08:35pm Sep 23, 2003 EST (#109) {Bookmark}

Please comment on the fact that there is very limited evidence to support OMEs for specific deficits and that there seems to be a gap in the literature between improving strength and ROM (the targets of OME tasks) and speech and swallowing deficits. Is there someone out there who has some data to make this less of a leap?

Debra Beckman [Debra Beckman](#) - 08:35pm Sep 23, 2003 EST (#110) {Bookmark}

Gregory,

Most athletes will tell you that cross training, working on many associated muscle

activities, improves the control needed for specific activities. For example, strengthening upper body aids in improving aim and coordination for golf or tennis. But in addition, one must indeed practice the specific movements for the target tasks. I see specific oral motor interventions focused on improving minimal competencies for range and strength as one part of a complete program for an individual who is not progressing with traditional "listen and say" interventions.

Barbara Buwalda [Barbara Buwalda](#) - 08:36pm Sep 23, 2003 EST ([#111](#)) [{Bookmark}](#)

Debra Beckman,
What makes your protocol different from other OME like blowing toys and such

Heather Clark [clarkhm](#) - 08:37pm Sep 23, 2003 EST ([#112](#)) [{Bookmark}](#)

Debra,

Thanks for your comment, I think muscle tone is poorly understood by SLPs. As you say, the CNS contributes greatly to tone, as do some peripheral reflexes (e.g., stretch, tonic vibratory).

I believe some oral motor treatments are purported to target muscle tone, by stimulating the muscle spindle (which respond to changes in muscle fiber length). Many of us need to be reminded that many muscle groups we work with don't have muscle spindles, or the spindles don't elicit reflexes in the same way as muscles in the limbs. The lips, tongue, and jaw opening muscles are examples. Only the jaw closing muscles have muscle spindles and stretch reflexes like the limb muscles.

Karen Forrest [Karen Forrest](#) - 08:37pm Sep 23, 2003 EST ([#113](#)) [{Bookmark}](#)

Gabrielle,

It sounds as though you have used OME for children who can't get adequate muscle tone for consonants. Can you give us some indication of the effect of these exercises on the children's speech? That is, can they produce the sounds after the exercises?

We have been investigating this issue and have not had much success. That is, we use OME with children with multiple speech sound errors and due extensive probing of their production of the target sound in words. We have not found any increase in the

production of the target sound after many weeks (up to 8 weeks, now) of OME. This research is ongoing so there haven't been that many subjects yet. I'd be interested to hear of other people's experiences.

Andrea Tobochnik [Andrea](#) - 08:37pm Sep 23, 2003 EST (#114) {Bookmark}

How does one know what specific oral/lingual exercises to work on to help someone swallow material with greater viscosity?

Sandy Ryan [sandy_ryan](#) - 08:39pm Sep 23, 2003 EST (#115) {Bookmark}

Given several comments here tonight, it appears that there is evidence (or at least a good hunch!) that integrating behaviors gives you more performance change than isolating them. In LSVT the treatment focused on increasing voice loudness but not via respiration exercises. In recent aphasia literature, isn't there a move toward integrating verbal and written expression tasks, for example? Perhaps the same is true for OM function????

Billy Irwin [Billy Irwin](#) - 08:41pm Sep 23, 2003 EST (#116) {Bookmark}

When working with a patient for whom OMEs make sense, do you usually provide instructions and train the pt. to perform these outside treatment time? It seems that the pts who will benefit from OMEs will be the Pts with the cognitive ability to perform and monitor performance independently and frequently, and not the pts who only perform the OMEs in the presence of the clinician. Ms. Beckman, could you respond?

Gregory Lof [Gregory Lof](#) - 08:42pm Sep 23, 2003 EST (#117) {Bookmark}

I am NOT a VPI specialist, but my latest review of 30 years of literature seem to support that the VP complex can be strengthened by blowing exercises....but there will still be speech problems. Some structures are used for different functions. Strengthening the VP complex probably will not lead to better speech productions.

Heather Clark [clarkhm](#) - 08:42pm Sep 23, 2003 EST (#118) {Bookmark}

Hi Billy (from down the hall!)

I believe that the data just aren't out there. But I'd like to offer some suggestions about WHY they aren't out there (in addition to the obvious, which is that maybe there is no benefit). Many researchers are philosophically opposed to motor treatments (see earlier comments) and are thus disinclined to study their effects. The fact that many popular treatment programs lack clear theoretical foundation further complicates the issue – it is difficult to develop the rationale for a treatment study incorporating such treatments. Perhaps even more troubling is the lack of standardized measure for many motor function characteristics (e.g., muscle tone) so that it is difficult to identify key outcomes. Not to mention, treatment research is slow and costly. Taken together, it may be more surprising that there are ANY studies out there at all!

GM [Gabrielle](#) - 08:42pm Sep 23, 2003 EST (#119) {Bookmark}

Karen,

I use OME as a LAST resort and I have actually had little success with it (for functional articulation errors). I cannot figure out though, what accounts for these kids inability to make the sound if it isn't some difficulty with some aspect of the oral motor system....

Gabrielle

Debra Beckman [Debra Beckman](#) - 08:43pm Sep 23, 2003 EST (#120) {Bookmark}

Barbara,

The difference between Beckman Oral Motor and other oral motor strategies is two fold. First, there is a quantified baseline protocol to determine minimal competencies for range and strength for the lips, cheeks, jaw, tongue and soft palate. This protocol uses assisted stretches and stretch reflexes, so that cognitive participation is not required, although this protocol can be used with individuals who do follow commands. The baseline information is function specific, not age specific. Second, the interventions are assisted stretches, and do not required expensive equipment or kits of materials to provide the movement. The interventions can be combined with other modalities or activities to enhance muscle skill development. The strategies used are muscle

compression before elongation, assisted movement to activate contraction, contraction against resistance to build strength, slow movement, muscle deep pressure, slow movement and movement toward midline.

Jessica Goldberg [Jessica Goldberg](#) - 08:45pm Sep 23, 2003 EST (#121) {Bookmark}

andrea,

it would seem to me that "effortful swallow" would be most helpful and perhaps base of tongue to posterior pharyngeal wall, trying it out myself as i type perhaps producing saliva swallows with lips parted is another way to force greater tongue pressure just some thoughts - no research involved

Joanne Robbins [Joanne Robbins](#) - 08:45pm Sep 23, 2003 EST (#122) {Bookmark}

Andrea,

We don't have enough evidence yet to directly recommend specific exercises to improve swallowing specific viscosities. However, we are conducting a clinical trial now and our data thus far are compelling with regard to the consistent findings of improvements in lingual strength with lingual resistance exercises and our patients' reports of diet expansion/upgrades associated with those outcomes. Our data analyses are also revealing that the strengthening exercises not only result in increased strength but also faster pressure building. We are pursuing the relationship between strength training and changes in coordination. A finding of improved coordination from resistance exercises would be most wonderful for our patients but we haven't determined that yet with enough patients. It's still a hypothesis we are testing.

Licia Coceani [Licia](#) - 08:45pm Sep 23, 2003 EST (#123) {Bookmark}

Hi Caroline,

Did you have the chance to read some of the articles published in the International journal of Orofacial Myology? There are several studies regarding oral motor exercises and their efficacy in different populations and different age range.

Ciao from LA

Heather Clark [clarkhm](#) - 08:46pm Sep 23, 2003 EST (#124) [{Bookmark}](#)

Billy, I know of at least one case study (see below) where the client completed tongue-strength training outside of treatment, with clinic treatment comprised of performance level targets (I hope I'm not in error about these details). These authors reported success.

Solomon, N. P. & Stierwalt, J. A. G. (1995). Strength and endurance training for dysarthria. ASHA Special Interest Division 2 Newsletter, 5 (2), December, 1995. 13-16.

John Riski [JRiski](#) - 08:46pm Sep 23, 2003 EST (#125) [{Bookmark}](#)

Sandy

Wonderful observation. Monica McHenry (American Journal of Speech Language Pathology year?) Demonstrated that nasality was decreased by increasing loudness in speakers with dysarthria. I think the results of her investigations, Moon and Kuehn and the Lee Silverman technique have a similar theme. Increasing/improving speaking effort improves function across-the-board.

Debra Beckman [Debra Beckman](#) - 08:47pm Sep 23, 2003 EST (#126) [{Bookmark}](#)

Billy,

I include the caregivers as well as the individual, since many of the individuals on my case load cannot provide their own practice in movement. I agree that small amounts of movement through out the day, whether speech practice or oral motor practice is more desirable than long segments of time, which may result in fatigue, rather than improved control.

Roberta Wacker Mundy [Roberta Wacker Mundy](#) - 08:48pm Sep 23, 2003 EST (#127) [{Bookmark}](#)

I've been thinking about Greg Lof's comparison to playing the piano. My piano teacher always had us practice the scales before each lesson and each practice session. I believe that was because it tended to get our fingers moving in the way they would need to to play a song since the movement of the fingers for playing the piano is

different than the movement for other activities. We didn't move our fingers and pretend to play the piano, but we did move our fingers up and down the keyboard in such a way to simulate piano playing and "warm up". Also, this (I assume) helped us, and our fingers, to "remember" the movement pattern. So, what does this mean? I guess that it appears that, using this analogy, working on the specific movements that need to be made for the production of (a) particular sound(s) could be effective. But practicing unrelated oral movements (movements that are not important for the production of particular sounds) would not be.

Karen Forrest [Karen Forrest](#) - 08:49pm Sep 23, 2003 EST (#128) [{Bookmark}](#)

Gabrielle,

That's a good question! First, I'd like to know if the problem really is tongue position. We have seen some children, and adults, who have incredible difficulty with some sounds and when we measure things like nasal or glottal airflow, we find some problems. We worked on airflow with a flow feedback protocol (AEROWin) and had some success. I want to emphasize that these were not controlled investigations in any way. Perhaps Jay can give more insight into this possibility - i.e., sound specific VP problems?

John Riski [JRiski](#) - 08:50pm Sep 23, 2003 EST (#129) [{Bookmark}](#)

Gregory,

You are exactly right. It seems, that the focus should be on increasing respiratory support (possibly first for blowing) but transitioning quickly to increasing respiratory support for the aspirate consonants.

Janice Flanzbaum [J.Flanzbaum](#) - 08:50pm Sep 23, 2003 EST (#130) [{Bookmark}](#)

Hi, Janice Flanzbaum from Pleasanton, CA and an Indiana University Alum
Renee posted mention of Sara Rosenfeld-Johnson's program. I wonder what the group thinks about the effectiveness of straws and horns for improving tongue retraction and for OME.

Fran Redstone [franredstone](#) - 08:51pm Sep 23, 2003 EST (#131) [{Bookmark}](#)

I agree strongly with Sandy (and Greg indirectly). OME might be useful although one should know exactly why they are doing a specific exercise. However, integration of OME into a function is critical.

Dr. Clark--what does 3% of possible strength actually mean? It sound quite minimal.

John Riski [JRiski](#) - 08:54pm Sep 23, 2003 EST (#132) [{Bookmark}](#)

I typically hear from proponents of oral motor exercises that nonspeech movements must be learned before speech movements can be learned. I would like to point out some research from Chris Moore and his colleagues that demonstrate that the motor movements they investigated (mandible and lip) developed in parallel not in sequence and seemed to be mediated by different control mechanisms.

References below the 1997 article is posted here.

Moore CA, Ruark JL.

Does speech emerge from earlier appearing oral motor behaviors?
J Speech Hear Res 1996 Oct;39(5):1034-47

Ruark JL, Moore CA.

Coordination of lip muscle activity by 2-year-old children during speech and nonspeech tasks.

J Speech Lang Hear Res 1997 Dec;40(6):1373-85

Heather Clark [clarkhm](#) - 08:54pm Sep 23, 2003 EST (#133) [{Bookmark}](#)

Janice,

I'll let Karen or Jay comment on the specifics, but from a purely "rationale" perspective, blowing and sucking are, in themselves, complex movement patterns that AREN'T SPEECH! Therefore, principles of motor learning would not predict that tongue retraction displayed during blowing/sucking would necessarily generalize to speech movements.

In fact, if benefit is observed, it would be more easily explained from a sensory awareness perspective (can you feel how your tongue is shaped?) than from a motor program explanation.

Andrea Tobochnik [Andrea](#) - 08:56pm Sep 23, 2003 EST (#134) {Bookmark}

Joanne,

I'm glad this type of research is ongoing. We used to do oral motor exercises all the time for oral dysphagia, then we stopped altogether when we became aware that there was no evidence-base for it. But I suspect the "truth" lies somewhere in the middle - there are probably specific exercises which will help specific deficits... we just don't know what they are yet.

Carol Healy [Carol Healy](#) - 08:57pm Sep 23, 2003 EST (#135) {Bookmark}

I have a 2 year old that I have just started to work with that is non-verbal, using ACC, had gross motor involvement and self stims with arm movement. He also grinds his teeth, which I also feel is self stim. Any suggestions for the teeth grinding?

Bellingham [sharlaurie](#) - 08:57pm Sep 23, 2003 EST (#136) {Bookmark}

Roberta that was a good point. I have had excellent success in teaching children to make an /f/ by having them practice biting on their bottom lip repetively to retrieve a cheerio. We practice that movement first then we add the sound. I have found this can work better than just asking them to make the sound because then they produce the error sound. I think practicing the movement they will need to produce can help. I don't beleive in using just oral motor techniques without speech. When a child can not make a sound you have to find away to help them to learn to do so.

Joann Smithpeter [Joann Smithpeter](#) - 08:57pm Sep 23, 2003 EST (#137) {Bookmark}

Orofacial myology is used daily in our office. We see incredible results. As Licia mentioned above, the International Journal of Orofacial Myology has published several articles on the efficacy of this treatment.

Kay Jellison

Gayle Merrefield [Gayle Merrefield](#) - 08:59pm Sep 23, 2003 EST (#138) [{Bookmark}](#)

I have used Beckman's oral motor protocol for several years, and it has become an important component of my assessment and treatment. I end up with excellent baseline data against which I can measure change over time. It is not the only aspect of treatment I provide (my caseload is mostly preschool), but correctly applied it certainly yields physical and functional changes.

Alesha & Amy [aheafner](#) - 09:00pm Sep 23, 2003 EST (#139) [{Bookmark}](#)

We are graduate clinicians in the ASU CD program. We have been in practicum settings where one supervisor is totally against oral motor exercises in relation to speech and another supports oral motor exercises for the remediation of articulation insufficiencies. Given these opposing views and our lack of experience it is difficult to determine whether oral motor should be used. Presently (under strict supervision) we are trying to decide whether or not to incorporate oral motor exercises to address a lateral lisp and to remediate the /r/ sound.

Heather Clark [clarkhm](#) - 09:00pm Sep 23, 2003 EST (#140) [{Bookmark}](#)

Fran,

I'm not sure if there was a typo - the range of force used during speech movements that I've read is usually around 20%, give or take.

These figures, of course, were developed from instrumental measures, not subjective judgments, so it's hard to translate that into "meaning" (e.g., what does 20% "look" like?)

I alluded to this before, but minimal competence (to use Debra's term) for FORCE is surely well below "normal" maximum, however, some authors (e.g., Erich Luschei) argue that strength may be necessary to move the articulators (especially the tongue) quickly. This remains an empirical question.

Billy Irwin [Billy Irwin](#) - 01:39pm Feb 27, 2003 EST (#141) [{Bookmark}](#)

Joann,

Do you have any references handy for the efficacy of orofacial myology treatment. And exactly what does that involve? Is it a specific protocol or program of treatment?

Marlene Pettiford [mapslp](#) - 09:00pm Sep 23, 2003 EST (#142) {Bookmark}

Heather, I would agree with your observation. In my experience, I have always felt that improvements in speech movements that I occasionally see in my therapy using OME (ie. blowing, sucking) are a result of increased sensory and proprioceptive abilities.

Jodi Mitchell [Jodi Mitchell](#) - 09:01pm Sep 23, 2003 EST (#143) {Bookmark}

What about back sounds such as /k/, /g/ when a child (kindergarten age) cannot lift back of the tongue? Maturity? I don't think so.

I appreciate everyone's input. This is very helpful to each of us in deciding our treatment and especially our REASONS behind it.

Debra Beckman [Debra Beckman](#) - 09:02pm Sep 23, 2003 EST (#144) {Bookmark}

Andrea,

I posted the citation regarding tube to oral transition with preemies using specific oral motor interventions that did show a significant improvement in the group receiving the interventions as compared to the group that did not. I agree with you that an all or nothing approach to oral motor will probably not be helpful. We do need to continue research to find out the specifics for different populations and different areas of impaired function for those populations. The interventions used should be prescriptive and fit the need of each person. Is ASHA currently funding research projects regarding this topic?

John Riski [JRiski](#) - 09:02pm Sep 23, 2003 EST (#145) {Bookmark}

Janice, let me begin by citing the Evidence Based Medicine (scores)

- 1- Randomized Control Trial
- 2- Prospective Cohort
- 3- Retrospective Review
- 4- Case Series
- 5- Expert Opinion

I am about to give you a number 5. When trying to modify tongue position I start with a speech sound it already has the correct position and I modify the production to the desired sound. For example, the "s" is interdental-or lateralized let the "t" is post dental and central. Simply prolonging the "t" will generally produce a post dental and central "s". But, notice I am using the motor plan of one speech sound to create another. Now, with that said did I understand the question correctly?

Jay

Jodi Mitchell [Jodi Mitchell](#) - 09:04pm Sep 23, 2003 EST (#146) {Bookmark}

What about back sounds such as /k/, /g/ when a child (kindergarten age) cannot lift back of the tongue? Maturity? I don't think so.

I appreciate everyone's input. This is very helpful to each of us in deciding our treatment and especially our REASONS behind it.

Aileen Montag [SLPAI](#) - 09:04pm Sep 23, 2003 EST (#147) {Bookmark}

hello - I had a question regarding bottles and pacifiers- was looking for some suggestions to decrease/ eliminate their use. I have 2 little girls with significant open bites, drooling, om posture and severe articulation deficits. One is on a bottle and the other a pacifier. thank you!!

Jessica Goldberg [Jessica Goldberg](#) - 09:05pm Sep 23, 2003 EST (#148) {Bookmark}

it would seem there is need for OM in oral dysphagia, but this can be done in functional methods. one particular that i often employ is chewing on a straw and having the patient lateralize it to each side using tongue (no hands)while keeping lips tight enough to prevent straw or saliva from leaking out.

Karen Forrest [Karen Forrest](#) - 09:06pm Sep 23, 2003 EST (#149) {Bookmark}

Alesha and Amy,

I sympathize with your situation. I have spoken with a number of our previous students who have been asked to do OME in their clinical externships. It really does put the student in a very awkward position. You may ask your supervisors to provide some references to help you get an idea of their perspective and why they want you to do OME. In general, the protocols that I have looked at suggest OME and then "traditional speech therapy." Because speech therapy also is included, it is difficult to determine if changes were because of OME or speech treatment.

Debra Beckman [Debra Beckman](#) - 09:06pm Sep 23, 2003 EST (#150) {Bookmark}

Regarding k and g, I often use a non food item between the molars on one side or the other to enhance posterior tongue elevation as I cue for production of h, with high back vowels to get k or g in isolation, then work to get the same production with no tactile cue, and on to production a rapid syllable and then to word and phrase production.

Joanne Robbins [Joanne Robbins](#) - 09:07pm Sep 23, 2003 EST (#151) {Bookmark}

Andrea,

Thanks for the encouraging words. We are imaging muscle with magnetic resonance and are finding that muscle mass in head and neck (e.g., particularly tongue) diminishes with age just like we all know that limb musculature diminishes with age. So exercising head and neck muscles may be particularly justified and beneficial in elderly individuals. We are quantifying outcomes including strength and muscle mass and are pleased to find, thus far, a positive relationship between the two. Our hope is to determine if strengthening exercise will, in the long run, prevent reductions in muscle strength and mass - so well documented in limb musculature of older individuals. The effect such intervention has on swallowing is promising but not shown convincingly as of yet.

I agree with you, it is important to have a justification for the specific exercise we have patients do - I have seen lots of lingual protrusion exercises being done by clinicians and wondered what functional application such a task has for swallowing (or speech).

Jacquelyn Fowler [Jacquie F.](#) - 09:07pm Sep 23, 2003 EST (#152) [{Bookmark}](#)

Similarly to Gabrielle...

What about those children for whom they have a difficult time with tongue protrusion and tongue movements (anterior and posterior). If they have a difficult time moving their tongue on command, how do you teach them tongue placements (especially for L and R) without doing some sort of oral motor/tongue exercises, so they know where their tongue is in space??? Any suggestions.

P.S. Hi Karen from Rochester.

Karen [Karen115](#) - 09:08pm Sep 23, 2003 EST (#153) [{Bookmark}](#)

I have strictly empirical data suggesting that for some children with limited lip and tongue control/awareness, doing 5 minutes of "warm-up" exercises that raise the metacognitive and sensory awareness can assist in the production of sounds...this is not the focus of the intervention...speech is the focus...I agree with the readings suggesting limited, targeted and careful use of the OME

Debra Beckman [Debra Beckman](#) - 09:09pm Sep 23, 2003 EST (#154) [{Bookmark}](#)

Jessica,

What do you do for the individuals that cannot follow commands?

Renee Hill [romotorre](#) - 09:11pm Sep 23, 2003 EST (#155) [{Bookmark}](#)

I can't believe or understand how anyone can not agree that we use the same muscles for speech and non-speech movements. I have found that many of my client's with speech disorders also have difficulty with non-speech and feeding activities. If a child cannot blow a horn without compensating for the lack of strength in the target muscle group (ex. lip closure on a mouthpiece without biting for support) and I see that the same child cannot make a specific sound with that same muscle in deficit (bilabials), why is it so difficult to believe that if I target the muscle outside of speech, it will improve their production.

Gregory Lof [Gregory Lof](#) - 09:12pm Sep 23, 2003 EST (#156) {Bookmark}

Karen, I would LOVE to have the reference to the empirical data you mentioned about OME and warm-ups. My review of the literature has not turned up any such published articles, so I would be excited to review these data.

Alesha & Amy [aheafner](#) - 09:12pm Sep 23, 2003 EST (#157) {Bookmark}

Thanks, Karen, for the advice. :)

Kelly Lynn Guilmette [kguilmette](#) - 09:14pm Sep 23, 2003 EST (#158) {Bookmark}

Back to OME with the Birth to Three population. I too am looking for opinions and research to back up OME exercises with children who have low tone, specifically Down Syndrome. Thanks!!!

Jodi Mitchell [Jodi Mitchell](#) - 09:15pm Sep 23, 2003 EST (#159) {Bookmark}

Thank you Debra for the information. And thanks to everyone for their input tonight.

Heather Clark [clarkhm](#) - 09:16pm Sep 23, 2003 EST (#160) {Bookmark}

Passive treatments and physical modalities:

This is a follow-up to Debra's question about what to do when a patient can't follow commands. Often passive treatments or physical modalities are recommended in this scenario.

The trick is recognizing which of these strategies are applicable to the orofacial musculature, given the lack of the muscle spindles/stretch reflexes.

Quick stretch, tapping, and vibration all act on the muscle spindle and therefore would not be expected to impact tone of the lips, tongue, face, or jaw opening muscles.

Some modalities that MAY have application in the musculature of interest are:

Heat elevates the threshold for pain so people can move farther (increased ROM) without pain. The most obvious application of this technique would be for people with severe TMJ or pain related to cancer resection.

Cold decreases nerve conduction velocity and is traditionally used to relieve spasticity. It will probably be most effective for muscle groups with stretch reflexes (jaw closing muscles). Remember cold is also used to heighten sensitivity of touch receptors (e.g., thermal stimulation for swallowing) but this is separate from the effect of cold on the neuromuscular system.

Massage has a relaxing effect on muscle activity. It is used to reduce hypertonic or non-organic hyperfunction (e.g., functional hyperphonia). It would be expected to work similarly on all muscle groups, but the few studies that have been conducted have only examined effects on laryngeal muscle groups.

Meredith [Meredith](#) - 09:17pm Sep 23, 2003 EST (#161) [{Bookmark}](#)

I've had no trouble teaching central air flow for a lateral lisp, r position or any other position without the use of nonspeech OME. I've found using visual cues, some tactile feedback, shaping from other speech sounds, using minimal pairs/contrast, achieving the sound contextually, etc have been more than sufficient to remediate articulation and phonological errors. Even in a child who has never produced a k or g volitionally, (nonpeech) OME would not be my choice.

Denise Ruscio [Russpeech](#) - 09:18pm Sep 23, 2003 EST (#162) [{Bookmark}](#)

Regarding the strategy of placing the cheerio on the lower lip to facilitate a "precursor" motor act to production of / f /, I'm assuming you're holding the cheerio, and it's placed centrally on the lower lip, correct? Ever used mini m and m's for this? Also, I had a question with a phonological basis, although I recognize this forum is focusing on oral motor issues. Thought I'd take a chance! What strategies would you recommend for a 4 year old child who is producing stops for fricatives?

Karen Forrest [Karen Forrest](#) - 09:18pm Sep 23, 2003 EST (#163) [{Bookmark}](#)

Renee,

I would agree with you that children with a deficit in one function often demonstrate deficits in other behaviors. And, very often, a person who has a severe disability in one area (e.g., speech) will also have a severe disability in another area (e.g., feeding, walking, handwriting). It's very hard to make causal relations when you are looking at correlations. I think that that's part of the difficulty that we have in researching this area.

Renee Hill [romotorre](#) - 09:18pm Sep 23, 2003 EST (#164) [{Bookmark}](#)

I think part of the effectiveness of oral-motor therapy IS that it increases sensory awareness. Especially with the Apraxia/Dyspraxia population. Oral-motor therapy is tactile and gives information to the brain in a different way. If the child isn't following a verbal or visual cue, why not give them a tactile cue of what you want them to do. Isn't that another way of developing the new motor-plan for a movement. Then I can add the voicing to the tactile cue and eventually remove the tactile cue all-together. Isn't that "oral-motor therapy"?

Roberta Wacker Mundy [Roberta Wacker Mundy](#) - 09:18pm Sep 23, 2003 EST (#165) [{Bookmark}](#)

Aileen,

How old are those children? I'm not sure what you mean by suggestions for getting them off the bottle/pacifier.

[{Next}](#) [{First}](#) [{All}](#) [{Outline}](#) (71 following messages)

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topic created 11 Sep 2003 by **SYSOP**

NOTE: This discussion is now a read-only archive. Members who wish to continue this discussion among themselves are encouraged to start appropriate topics in the [Speech-Language Pathology Discussion area](#) here on the Member forums.

Straws and whistles, bite-blocks, nuk brushes, sensory and motor stimulation -- the list of oral motor treatments goes on. Do they work? How do they work? When do they work? How do you know if they worked for a specific client? A panel of experts helped members explore these questions on a Web forum held September 23, 8-10 pm, ET. The event was sponsored by Special Interest Divisions 1 (Language Learning and Education), 2 (Neurophysiology and Neurogenic Speech and Language Disorders), 4 (Fluency and Fluency Disorders), 5 (Speech Science and Orofacial Disorders), 13 (Swallowing and Swallowing Disorder), and 16 (School-Based Issues).

DISCLAIMER: All comments are the opinions of the individuals who took part in this Web forum and do not necessarily reflect the official opinion of the association, nor does a mention of a commercial product here imply a recommendation for such a product by the association.

[{First}](#) [{Previous}](#) [{All}](#) [{Outline}](#) (165 previous messages)

John Riski [JRiski](#) - 09:19pm Sep 23, 2003 EST ([#166](#)) [{Bookmark}](#)

Hi Kelly,

I would like to add one observation in response to your question. Children who appear to have low oral tone- open mouth posture and tone forward may be doing so to maintain a patent oral airway because of nasopharyngeal obstruction. Again this is only expert opinion that we routinely see children with swallowing problems or diagnoses of "weak" oral tone who actually have Nasal/nasopharyngeal obstruction.

Debra Beckman [Debra Beckman](#) - 09:20pm Sep 23, 2003 EST ([#167](#)) [{Bookmark}](#)

Heather,

I find that many therapists use the terms stimulation and intervention interchangeably, but they are different in impact, as you point out. I would define quick stretch, tapping, vibration, heat, cold and e-stim as stimulation modalities, not interventions, that should be followed by work for the muscles (interventions), either assisted movement or active patterns (eating, talking).

Heather Clark [clarkhm](#) - 09:20pm Sep 23, 2003 EST (#168) {Bookmark}

Renee,

I think the explanation comes primarily from an understanding of motor learning and motor unit recruitment. The brain learns to recruit the appropriate motor units needed for a specific exercise, so part of the "strength" gained during exercise is from the brain knowing better how to get the muscle to contract. If the target movement outcome doesn't match the exercise, the brain hasn't learned that recruitment pattern, and won't necessarily be "stronger" for that movement.

However, Joanne's research showing changes at the muscular level provides some hope that muscle fiber hypertrophy can also occur, which has more general effects (at least that's the case in the limb musculature). We'll await her findings.

Aileen Montag [SLPAI](#) - 09:21pm Sep 23, 2003 EST (#169) {Bookmark}

hello Denise- I have found working on s blends successful for these children since they just need to add a fricative to a stop and then they may get frication with other sounds. "Targeting intelligible speech" is a good resource

Janice Flanzbaum [J.Flanzbaum](#) - 09:21pm Sep 23, 2003 EST (#170) {Bookmark}

Jay

Using the 't' context to motor plan for the 's' seems to work in isolation yet carryover is difficult. So, I wonder if tongue retraction exercises i.e. straw drinking would have the same effect as multiple repetitions of the 't' sound. The 't' method is blowing out air as we do with speech the straw method uses muscles for sucking.

Licia Cocceani [Licia](#) - 09:21pm Sep 23, 2003 EST (#171) {Bookmark}

For Carol Healy

I recall a study by Dr. Lefebvre (spelling?) pointing out that teeth grinding (bruxism) is a central problem (nervous system) and not a peripheral problem (malocclusion) as

thought for a long time. Still, it's a big problem. I don't know if bruxism in a two-year old child is self stimulation, but maybe an experienced orthodontist, one that treats children with neurological dysfunctions, may be able to help you. Maybe a mouthguard or something similar?

Debra Beckman [Debra Beckman](#) - 09:23pm Sep 23, 2003 EST (#172) {Bookmark}

Heather,

Do you know what research ASHA is currently funding regarding efficacy of oral motor interventions and speech?

Renee Hill [oromotorre](#) - 09:25pm Sep 23, 2003 EST (#173) {Bookmark}

Thank you Karen, I just really think it's disheartening to hear so many people in our profession who sound "close minded" in my opinion to the possibility that there are actually "oral-motor programs" that are actually working. I also find it sad that colleagues who have looked into doing this reasearch as dissertations for PhD's have been rejected because of the controversy. Isn't it safe to say at this point that we SHOULD be doing the research BECAUSE of the controversy? Unfortunately, most of us out there are simply "therapists" who just want to provide the best therapy we can. Why aren't (or can't) the researcher's do more to find out why there are so many of us who are saying this is working?

Heather Clark [clarkhm](#) - 09:25pm Sep 23, 2003 EST (#174) {Bookmark}

Debra,

Thank you for that clear response highlighting the difference between sensory and motor effects. Again, I'm not sure most SLPs are as confident in differentiating targets (sensory awareness versus neuromuscular integrity) given the same procedure (e.g., tapping).

It seems to me that most SLPs lack foundational knowledge about how motor treatments are intended to impact the motor (or sensory) system . Our textbooks and training programs do not generally include even the theoretical foundations for motor treatments, so clinicians have very little information on which to base judgments about whether specific treatments even make sense. This is unlike our preparation in other

treatment areas, where theoretical models of intervention are discussed in detail so clinicians can evaluate specific programs for theoretical soundness.

Bellingham [sharlaurie](#) - 09:25pm Sep 23, 2003 EST ([#175](#)) [{Bookmark}](#)

Hi Denise, I find working on fricatives in the final position first then using a paired stimuli approach for example. "Ice"..."e". I use alot of silly visuals to make it fun. I have used this approach with many children aged 3 to 5 with great success. Hope it helps.

Meredith [Meredith](#) - 09:25pm Sep 23, 2003 EST ([#176](#)) [{Bookmark}](#)

Renee,
I don't consider tactile cues to be in OME if they aren't done "drill like" (lots of tongue tickles just for sensory input). I give tactile cues at times when teaching a placement (esp for R) but don't teach repetitive nonspeech movements or spend time stimulating/stretching articulators. I find multimodal cues to be very necessary, but don't find nonspeech movements to give as much feedback as my tactile cues to lips, tongue, etc.

John Riski [JRiski](#) - 09:26pm Sep 23, 2003 EST ([#177](#)) [{Bookmark}](#)

Janice,
You are right if you only work on single words-I should have finished my thought. This is incorporated into the traditional therapy process. Progress quickly to carrier phrases, etc. we also review the family's daily routine so that every pair of "Sox", every "stop sign" is a therapy opportunity-that is therapy is done throughout the day almost from the outset.

Fran Redstone [franredstone](#) - 09:26pm Sep 23, 2003 EST ([#178](#)) [{Bookmark}](#)

Jodi,
Depending on the specific problem of the child, often inhibiting the front of the tongue

(with a tongue depressor, lollipop, your gloved finger), while the child attempts to produce the /k/ or /g/, leads to successful productions. Then fade the direct physical prompt.

Aileen Montag [SLPAI](#) - 09:26pm Sep 23, 2003 EST (#179) {Bookmark}

may need to get off the chat soon- anyone with insight on getting children with significant artic and om issues off of bottles and pacifiers??

Erin Dyer Olson [Erin Dyer Olson](#) - 09:27pm Sep 23, 2003 EST (#180) {Bookmark}

Here's an idea that I have found successful. With my students who exhibit verbal dyspraxia, I use a verbal cueing system that does not just include a model. I tell them specifically what to do with their articulators:

For /s/ - "Teeth together, bite and blow"

For /l/ - "Tongue tip on the Magic Spot" (alveolar ridge)

For /f/ - "Top teeth on your bottom lip, bite and blow"

I give them the verbal cue for each production. They have gotten so used to the specific statements, that if either I or their parent says it incorrectly or differently, the child will correct us!

Betty Maxwell [Betty](#) - 09:28pm Sep 23, 2003 EST (#181) {Bookmark}

Hi from northern California:

I use OME as a last resort. It did help to stop one of my CP students from having to wear a bib as a result of drooling.

I have found OME has helped improve stability of the jaw, increase awareness of oral musculature, positioning, and movement of the tongue back into the mouth, all precursors for improved articulation success. It has helped to reduce gag reflex and improve production of /k/ and /g/ which was being distorted due to production by the blade of the tongue.

I have had little success using it for VPI: my student can blow the blow toy at the top of SRJ's hierarchy as well as suck fairly viscous liquids through a straw. The plastic surgeon insists with those skills he should be able to obtain VP competency during

speech. Certainly increasing aspiration of pressure consonants helped intelligibility, but it has done little for his hypernasality. I've also tried SRJ's suggestions of alternating nasal vs other speech targets but my client stills sounds very nasal to me. Any suggestions?

Joanne Robbins [Joanne Robbins](#) - 09:28pm Sep 23, 2003 EST (#182) {Bookmark}

Heather and REnee,

The response to the intervention, in the case of our work - strengthening, may be two fold - central (brain) and more peripherally (muscle). So Heather, I agree with your perspective and appreciate your comments. We are collecting functional MRI of the brains of our strengthening patients and quantifying a measure we call (brain effort) in addition to muscle mass with the anatomical MR imaging of muscle. It is a very interesting process....can't wait to see what we find. The problem is, it will take a couple of years to complete and as we see from this very busy WEB forum, as usual we would like to have some practice guidelines before the data are in!

Roberta Wacker Mundy [Roberta Wacker Mundy](#) - 09:29pm Sep 23, 2003 EST (#183) {Bookmark}

Aileen,

Again, how old are these children? And is it the children who are having difficulty getting "off" the bottles and/or pacifiers, or the caregivers who are having difficulty "getting" the children "off?"

Heather Clark [clarkhm](#) - 09:29pm Sep 23, 2003 EST (#184) {Bookmark}

I am unaware of any oral-motor treatment projects currently funded by ASHA or any other agency, but I hope this is just ignorance. Joanne's work is at least one example related to swallowing, but I just don't know about other funded work - Karen or Joanne, do you know more?

Jacquie [Jacquie F.](#) - 09:30pm Sep 23, 2003 EST (#185) {Bookmark}

Erin,

I like your verbal cueing system. I try to do a similar cue, however, I have the hardest time with the /r/. Any ideas?

Linda Schmitke [Schmitke](#) - 09:30pm Sep 23, 2003 EST (#186) [{Bookmark}](#)

Several of us have mentioned the "integration factor" in associating OM ex. and speech or swallowing. Karen (8:31pm) mentioned that clients "become aware of articulators", Sandy (8:39) speaks of "integrating behavior", later others mentioned "increasing sensory and proprioceptive abilities" and OM "exercises to increase metacognitive awareness".....seemes reasonable to me that indeed, we do stimulate a number of holistic factors which should, depending upon an individual's capacity to be stimulated in these areas, enhance ability to approximate speech movements. I think the key word here might be "holistic" approach??

Joanne Robbins [Joanne Robbins](#) - 09:31pm Sep 23, 2003 EST (#187) [{Bookmark}](#)

Karen Forrest's work is funded by the NIH, isn't it Karen?

30 minutes to go [sysop](#) - 09:31pm Sep 23, 2003 EST (#188) [{Bookmark}](#)

We've only got thirty minutes left to the forum tonight, and I know there's a bit of a backup on questions (kudos to our guests for doing so well at keeping up with so many of them!). I'd like to ask our audience to go ahead and post any final questions now, to give our presenters time to answer them before we end this at 10pm ET.

Jessica Goldberg [Jessica Goldberg](#) - 09:31pm Sep 23, 2003 EST (#189) [{Bookmark}](#)

debra, i'm sorry i was away for a couple of minutes
to be quite honest i can't remember working with someone specifically for oral dysphagia, who could not follow directions. if they were unable to follow dir. due to dementia i often find that the deficits they present with are cognitive related and not primarily muscular. and those people who may have severe language deficits affecting

comprehension to the point of not being able to follow commands with a model and/or other cues, i don't remember hvaing a pt. like this and working on oral dysphagia at that stage

Kathleen Church [kate church](#) - 09:31pm Sep 23, 2003 EST (#190) {Bookmark}

Hi, I see a 6 year old girl with Down Syndrome who is apraxic. What are your thoughts? I personally feel that oral motor exercises are not effective but I am open to different opinions. Any thoughts? Thanks.

Joann Smithpeter [Joann Smithpeter](#) - 09:31pm Sep 23, 2003 EST (#191) {Bookmark}

I can't remember who requested this info, but here are a couple of the studies that I have on hand.

International Journal of Orofacial Myology Volume XVII
Hahn and Hahn
Efficacy of Orofacial Myofunctional Therapy
Pages 21-23

IJOM
Denkert
1997 Volume XXIII
Pages 35-46
The Effectiveness of orofacial myofunctional therapy in improving dental occlusions

Certified Orofacial Myologists have created their own treatment programs. A great book to learn more is by:

Hanson and Mason
Orofacial Myology 2nd edition
Publisher: Charles C. Thomas
Springfield, IL

Kay Jellison for Joann Smithpeter

Debra Beckman [Debra Beckman](#) - 09:32pm Sep 23, 2003 EST (#192) {Bookmark}

Joanne,

What kind of exercises are you including in your current research? Are the exercises only for those who can follow commands?

Renee Hill [oromotorre](#) - 09:32pm Sep 23, 2003 EST (#193) {Bookmark}

Janice,

Working on the straw drinking exercise (and I am referring to Sara Rosenfeld-Johnson's hierarchical approach, not just putting a straw in the mouth) achieves the retraction they are lacking in my experience. Once I see tongue retraction, teaching the sound is through awareness. If the tongue is in a protruded or forward position at rest or during feeding, I see the same in speech. It seems that many of these children learn to compensate in some way (often by clenching their teeth together) but can never carry the movement over into co-articulation. We have begun a "research study" looking at children's ability to drink from a straw in Sara Rosenfeld-Johnson's straw drinking hierarchy (Straw #7 if you are familiar) and their ability to produce the /s/ and /z/ sound. I've been to 20 day-cares and over 90% of the time, those children who had an /s/ or /z/ distortion, could not drink from this straw using lip protrusion and tongue retraction. Unfortunately, I am not a research scientist and cannot tell you why that is. I can only question that there must be some correlation in these skills.

Denise Ruscio [Russpeech](#) - 09:33pm Sep 23, 2003 EST (#194) {Bookmark}

Regarding the comments on understanding the relationships between the articulatory and other systems - I have a wonderful O.T who acts as my resource guide. Also, when I teach my classes on speech-language development, I always discuss the correlations across domains, and connect communication with development in other areas. Gaining insight into SID has made my therapy much more successful, in terms of selected stimuli, organizing the client, providing proprioceptive input prior to production work, etc. Multidisciplinary treatment, when available, should be utilized.

Aileen Montag [SLPAI](#) - 09:33pm Sep 23, 2003 EST (#195) {Bookmark}

hello Roberta- children are 3 1/2 and 4 years old. In terms of the child with pacifier- child leaves it at home during school time but screams for it all day at home and parent insists that it is needed to fall asleep at night! Child on bottle is close to 4 years old-

has a hard time drinking from a cup- major oral motor issues but can do so with assistance. thanks!!!!!!

Kathleen Dauer [kdauer](#) - 09:33pm Sep 23, 2003 EST (#196) {Bookmark}

Renee,

My question would be even if the oral motor movements and speech movements were similar, which thus far there is no data, why wouldn't you just want to kill to birds with one stone by working on both at the same time.

By doing speech movements you are definitely also working on oral motor movement.

Roberta Wacker Mundy [Roberta Wacker Mundy](#) - 09:35pm Sep 23, 2003 EST (#197) {Bookmark}

Linda,

Yes. Or a multi-modal, multi-sensory approach. Some children learn better through modalities which are different from the modalities other children learn better from. Shouldn't we utilize all of the modalities rather than just one? Articulation is a motor skill. If children have not learned to produce sounds correctly through the auditory and visual channels, then why not try an additional modality (motor, sensory) (not instead of, but in addition to)?

Karen Forrest [Karen Forrest](#) - 09:35pm Sep 23, 2003 EST (#198) {Bookmark}

Renee,

Actually, there is some research that is ongoing in this area. We have NIH funding to investigate a number of factors that influence speech sound acquisition, including treatment protocols. We are doing a direct comparison of OME and production training in children with very limited phonetic inventory. We have just finished our first year of funding so we don't have much to offer by way of results.

Actually, I think that "simply therapists" may be a very good source to obtain good data. Even single-subject studies would be helpful, especially if there are replications of the studies.

I'd agree with you that stopping research because it is controversial is nuts! I believe that the controversy that exists is spurring some researchers to develop studies to

investigate the issue more objectively.

Erin Dyer Olson [Erin Dyer Olson](#) - 09:36pm Sep 23, 2003 EST (#199) [{Bookmark}](#)

Jacquie,

I, too, have difficulty with those various R phonemes. I'm going to look into it more & would like to discuss it with you after the Forum. You can email me at dyere@belleville.k12.wi.us

John Riski [JRiski](#) - 09:37pm Sep 23, 2003 EST (#200) [{Bookmark}](#)

Betty,

if the child is hypernasal I suspect they have a residual velopharyngeal incompetence. It sounds like a full evaluation of velopharyngeal mechanism is in order. This might include Nasometry, pressure flow, and nasal endoscopy (or multiview videofluoroscopy if endoscopy is not available). I have the greatest of respect for my surgical colleagues but there are very few I would actually trust to evaluate velopharyngeal functioning- especially if they are the ones that if the initial surgery.

Renee Hill [romotorre](#) - 09:37pm Sep 23, 2003 EST (#201) [{Bookmark}](#)

Kathleen,

I think that with many of the clients that I work with who have little to no intelligible speech production, you can't kill 2 birds with one stone. If I can't get a lingual alveolar sound without tongue protrusion, I can't see why I would want to work on production of the sound in error. I see it more beneficial to correct the tongue placement first and then target the sound if necessary.

Joanne Robbins [Joanne Robbins](#) - 09:38pm Sep 23, 2003 EST (#202) [{Bookmark}](#)

Yes, Debra, the 8 week exercise protocol we are testing requires the client to follow instructions and actively perform. In essence, they are pushing the tongue against a

resistance and obtaining feedback indicating how close to the target pressure they are achieving. The target is set at 60% of their maximum pressure for the first week and moved to 80% of target maximum pressure for the next weeks. The protocol reflects that advocated in Sports' Medicine literature. Patients perform the protocol 3 days/week for the 8 weeks. We collect our data points pre-protocol, at the 4 week point and at the end of 8 weeks. So far, our findings are very promising but it is early.

Debra Beckman [Debra Beckman](#) - 09:38pm Sep 23, 2003 EST (#203) [{Bookmark}](#)

Kathleen,

Speech and non speech movements are not related in a linear fashion, but rather in a dynamic fashion, and our system for orofacial movement is wonderfully adaptive, so that if one movement is not working well, other muscle groups help, for example, weak lower lip is assisted by increased mentalis activation. Function is impacted when the compensatory movement patterns are not adequate for function, either speech or non speech activities.

Erin Dyer Olson [Erin Dyer Olson](#) - 09:39pm Sep 23, 2003 EST (#204) [{Bookmark}](#)

Say, Karen, would you be willing to discuss some single subject research designs with me after the Forum sometime?

I believe that in the schools, we have a wealth of subjects and potential researchers. We just need help getting organized!

Heather Clark [clarkhm](#) - 09:40pm Sep 23, 2003 EST (#205) [{Bookmark}](#)

There seems to be a lull so I thought I'd add some thoughts on topics not yet discussed:

With respect to strength training, several other issues are relevant (in addition to speech/non speech):

Strength training is generally contra-indicated for individuals with hypertonicity, although some rehabilitation professionals have argued that strength training can be conducted when tone has first been reduced using passive stretching and physical modalities. Clinicians therefore must be able to identify hypertonicity.

Patients vulnerable to fatigue or with disabled recovery mechanisms probably can't benefit from strength training. Instead, completing exercises will fatigue them, actually making their functional abilities worse, without any hope of ultimately gaining strength.

It seems like strength-training is often prescribed for individuals without weakness (but rather with perhaps disrupted movement patterns?). It's hard to see how this is appropriate.

Renee Hill [oromotorre](#) - 09:40pm Sep 23, 2003 EST (#206) [{Bookmark}](#)

I am in agreement with Erin! If I can find someone (ANYONE) that is willing to give me guidance, I would LOVE to become more involved in research. I just don't know the parameters, etc...that are involved.

Karen [Karen115](#) - 09:41pm Sep 23, 2003 EST (#207) [{Bookmark}](#)

Greg,

I used the term empirical to denote my own observations and experience with children who were unintelligible and made very slow progress with traditional methods alone and who upon the introduction of targeted OME along with continuation of traditional methods, made progress at an increased rate. This does not meet the requirements delineated above in the evidence-based practice, nor is it published. In my practice, that introduction/change is what WORKED (albeit in combination with the other methods.)

Debra Beckman [Debra Beckman](#) - 09:41pm Sep 23, 2003 EST (#208) [{Bookmark}](#)

Joanne,

When you are ready to research the response with individuals who cannot follow commands, I have some interventions to contribute. In fact, I am willing to help with any prospective, randomized double blind, ababa design study with specific oral motor interventions. The University of South Florida is in the planning stages for such a design. I will definitely keep you posted on the progress of that endeavor.

Billy Irwin [Billy Irwin](#) - 09:44pm Sep 23, 2003 EST (#209) {Bookmark}

Gotta go. Thanks to the SIDs and participants for this exchange.

Lisa McDonald [mcdonal](#) - 09:45pm Sep 23, 2003 EST (#210) {Bookmark}

All the information has been very interesting this evening. Thanks for the abundance of facts, opinions, and helpful resources.

N. [teknomom](#) - 09:46pm Sep 23, 2003 EST (#211) {Bookmark}

I have an 8 year old on my caseload who has been diagnosed with dysarthria - he exhibits interdentalization of /s/, low affect, reduced prosody and intonation, affecting intelligibility of speech. Has anyone tried to incorporate elements of LSVT into their treatment plans with school-aged kids?

Meredith [Meredith](#) - 09:46pm Sep 23, 2003 EST (#212) {Bookmark}

From Texas: Thank you so much to all the experts. I just wanted to say that I have enjoyed *all* of the information and points of view. The time has flown! I have certainly dusted off some speed reading techniques tonight.

Debra Beckman [Debra Beckman](#) - 09:47pm Sep 23, 2003 EST (#213) {Bookmark}

To All,
Thank you so much for your participation in this forum. I am certain that eventually, research will address current practice to help us all better target functional improvement for those we serve.

Karen Forrest [Karen Forrest](#) - 09:48pm Sep 23, 2003 EST (#214) {Bookmark}

I'd love to help design some single subject studies! I think that collaboration between researchers and clinicians is a great idea. So, please contact me. Also, this might be a good topic for an ASHA convention session.

As far as oral myofunctional therapy, aren't the references that are cited more related to tongue thrust, swallowing and occlusion? Do any of the references relate the therapy to speech?

Heather Clark [clarkhm](#) - 09:49pm Sep 23, 2003 EST (#215) [{Bookmark}](#)

This is not a wrap-up, I just wanted to catch people before they sign off. I was asked to post contact information for each of the discussion leaders (this info is also at the beginning of the web forum).

Debra Beckman, MS, CCC-SLP
Beckman & Associates, Inc.
Developmental Therapy Clinic
Winter Park, FL

Heather M. Clark, Ph.D. CCC/SLP
Associate Professor, Department of Language, Reading, & Exceptionalities, Appalachian State University
Boone, NC

Karen Forrest, Ph.D.
Professor, Department of Speech and Hearing Sciences, Indiana University
Bloomington, IN

John E. Riski, Ph.D., CCC-S, FASHA
Director, Speech Pathology Laboratory
Clinical Director, Center for Craniofacial Disorders
Atlanta, GA

JoAnne Robbins, Ph.D.
Professor, Department of Medicine, University of Wisconsin
and
Associate Director for Research, Geriatric Research, Education and Clinical Center (GRECC)
Wm S Middleton VA Hospital
Madison, WI

Joann Smithpeter [Joann Smithpeter](#) - 09:49pm Sep 23, 2003 EST (#216) {Bookmark}

Billy - I hope you got the information on Orofacial Myology. Please feel free to e-mail us with any further questions:

spchpathpc@aol.com

Kay Jellison

Michelle Ferketic [Michelle Ferketic](#) - 09:50pm Sep 23, 2003 EST (#217) {Bookmark}

For funding information, please see the American Speech-Language-Hearing Foundation's web page. Also, the ASHA Research unit provides information on funding sources and grants. Both can be accessed from the ASHA web site.

DeAnna Trujillo [dltslp](#) - 09:50pm Sep 23, 2003 EST (#218) {Bookmark}

Karen,

Thank you for expressing the sentiments of what surely must be MANY "non-official researchers" in our field. While we may never be published in a journal, our practical applications and day-to-day observations provide valuable insight which should not be easily discounted.

DeAnna

Joanne Robbins [Joanne Robbins](#) - 09:51pm Sep 23, 2003 EST (#219) {Bookmark}

Karen,

If you wish to go to ASHA next year and consider a session, I may join you in developing it. It might be fun to think a session through together. Let me know your level of interest - I'm not even sure where the meeting is next year!

Kathleen Dauer [kdauer](#) - 09:51pm Sep 23, 2003 EST (#220) {Bookmark}

Renee,

In my opinion approximations of sounds are better than no sound at all and I can always shape those sounds. I allow close approximations with all my apraxic kids and shape the sounds. The kids that I am talking about do not demonstrate feeding or swallowing issues.

Erin Dyer Olson [Erin Dyer Olson](#) - 09:52pm Sep 23, 2003 EST (#221) [{Bookmark}](#)

I just have to mention that 25 years ago I was first employed as an SLP at the Institute of Logopedics in Wichita, KS. It was founded by Dr. Martin Palmer. IOL was a private institute dedicated to working with children and adults with communication disorders. I believe that Dr. Palmer did maintain that non-speech movements and speech motor movements were the same. Many a person with Cerebral Palsy who attended IOL learned to speak based upon this premise and the types of OME which were incorporated into their therapy programs.

I look forward to seeing more research occurring in the future that will provide additional insight into this issue. I've always found the topic fascinating.

Renee Hill [oromotorre](#) - 09:53pm Sep 23, 2003 EST (#222) [{Bookmark}](#)

I definitely would love to look further into some research possibilities. I will be in touch! I really think Sara Rosenfeld-Johnson's work should be looked into further as it has changed my therapy completely. It is so nice to have a measurable program that has taught me how to combine an oral-motor approach with what I have already learned in addressing production.

Heather Clark [clarkhm](#) - 09:54pm Sep 23, 2003 EST (#223) [{Bookmark}](#)

Please also see a message posted early in the forum related to sessions at this year's ASHA that address this topic.

Wrap-up [sysop](#) - 09:54pm Sep 23, 2003 EST (#224) [{Bookmark}](#)

For the ASHA support staff, including Michelle Ferketic, Colleen Robbins and ESPECIALLY Jean White (who coordinated the setup between all the special interest divisions), and for the SIX! special interest divisions who joined together to organize and publicize this event, I'd like to thank our five presenters tonight: Debra Beckman, Heather M. Clark, Karen Forrest, John E. Riski, and JoAnne Robbins.

This has been the most eagerly anticipated forum we've ever had, and also the most attended (we went over our discussion board license for how many "page views" per day (good thing we get a grace period on that)! Woohoo!).

I'd like to ask the presenters for any final words before we close this and make this discussion read-only.

Erin Dyer Olson [Erin Dyer Olson](#) - 09:55pm Sep 23, 2003 EST (#225) [{Bookmark}](#)

With regards to approximations for speech sounds, many years ago there was a book published by Dr. Madge Skelly of the VA Hospital St. Louis. It dealt with Compensatory Speech. It may be a helpful tool, particularly with children with CP.

Gayle Merrefield [Gayle Merrefield](#) - 09:55pm Sep 23, 2003 EST (#226) [{Bookmark}](#)

Yes, thanks to Karen and Renee for expressing the thoughts of many of us whose lives run much closer to the therapy room than to the research lab. It has been an interesting discussion that I hope ASHA will offer again.

Karen Forrest [Karen Forrest](#) - 09:55pm Sep 23, 2003 EST (#227) [{Bookmark}](#)

Joanne,
I'm really interested in doing this. I agree with DeAnna that clinicians have a wealth of information to share with researchers. I may be on the program committee in motor speech disorders, and this discussion is making me lean in that direction, so I can suggest it to the other people and see if it flies. The convention is in Philadelphia next year (at least that's the info that I was given. I'll be in touch.

To the other participants -

I'll reiterate what others have said, this has been great! Thanks for the input.

Gregory Lof [Gregory Lof](#) - 09:55pm Sep 23, 2003 EST (#228) [{Bookmark}](#)

Joanne and Karen, I am in charge of the phonology/articulation section of the 2004 convention in Philly. We need to talk about this!

Caroline Bowen [Caroline Bowen](#) - 09:55pm Sep 23, 2003 EST (#229) [{Bookmark}](#)

Thank you SIDs, experts and all participants - especially for the "readings". This has been wonderful - worth sacrificing two hours of Australian sun on my day off! Caroline

John Riski [JRiski](#) - 09:56pm Sep 23, 2003 EST (#230) [{Bookmark}](#)

DeAnna and Karen,
as you are alluding to... A good clinician is a researcher and yes all of us need to clinician's impressions about the success of therapy techniques. I hope you to extend your interest into formal single subject design research. You will be able to contribute greatly to our understanding of this very complex area. All best wishes to you both.
Jay

Joanne Robbins [Joanne Robbins](#) - 09:56pm Sep 23, 2003 EST (#231) [{Bookmark}](#)

Thank you all for the opportunity to participate in my first WEB Forum. It was an honor to be part of this very respectable "cast of characters". We certainly have confirmation of the need for the work we are doing in this area to determine "best practice".

Erin Dyer Olson [Erin Dyer Olson](#) - 09:57pm Sep 23, 2003 EST (#232) [{Bookmark}](#)

I missed DeAnne's comment. Could someone submit the gist of the idea? Thanks

Heather Clark [clarkhm](#) - 09:58pm Sep 23, 2003 EST (#233) {Bookmark}

Let me also express my thanks to ALL the participants in this forum. It's been a great opportunity to "step out" of the lab and/or the therapy room to explore an issue from a variety of perspectives.

Renee Hill [oromotorre](#) - 10:00pm Sep 23, 2003 EST (#234) {Bookmark}

I am so glad to see ASHA in an "open" discussion. I hope to see more of these in the future!

Closing [sysop](#) - 10:06pm Sep 23, 2003 EST (#235) {Bookmark}

Once again, thanks to everyone for attending tonight's Web forum!

I'm closing this discussion and setting it to read-only. An archive of this forum and its associated resources will be made available on the Web site for members later this week. In addition, members wishing to continue this discussion among themselves are welcome to do so by starting appropriate topics in the [Speech-Language Pathology Discussion area](#) here on the Member forums.

Follow-up [sysop](#) - 10:39am Sep 24, 2003 EST (#236) {Bookmark}

ASHA Professional Development will be presenting a Teleseminar on Oral Motor Treatments on Tuesday, February 10 from 1-3 PM. Presenters for this event will be Dr. Norman Lass and Dr. Dennis Ruscello, professors at West Virginia University Department of Speech and Audiology.

More information about this teleseminar will be available after November 1 at <http://www.asha.org/about/continuing-ed/ASHA-courses/>

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