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Case Study

Achieving Positive Outcomes with Oral Placement Therapy

Karen Massey*

Independent Speech and Language Therapist, All About Speech Therapy, UK

***Corresponding Author:** Karen Massey, Independent Speech and Language Therapist, All About Speech Therapy, UK.

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Abstract

The overall purpose of this article is to highlight the valuable place that Oral Placement Therapy has within Speech and Language Therapy for children who require additional sensory input. This additional sensory layer to therapy has proven beneficial for a range of client groups, improving function where muscle weakness and reduced muscle coordination are barriers to clear speech. Many children require an eclectic approach to therapy. With traditional approaches using visual and auditory channels, progress can be very slow. Adding in an additional tactile layer can make a big difference to speech success.

Keywords: Oral Placement Therapy (OPT); Talk Tools TM; Speech and Language Therapy

What is oral placement therapy?

Oral placement therapy (OPT) is a multi-sensory approach that takes into account that, for some clients, just looking and listening is not enough; they need to feel what they are doing with their mouths in order to know how to eat, drink and speak and to provide the additional feedback that their brain appears to need.

Talk Tools TM describe OPT as, "an important addition to traditional speech treatment methods for clients with placement and movement deficits" [1].

Whereas traditional therapy for speech relies on the auditory and verbal channels, OPT adds a tactile-proprioceptive layer, allowing clients to 'feel' what to do with their mouths. For example, instead of simply saying and showing how to say the sound/l/ a tool can be used to add sensory input to the tip of the tongue and the alveolar ridge, enabling clients to achieve the sound more easily.

Who are we?

We are a group of Speech and Language Therapists working in the NHS and the independent sector with children with learning difficulties, supporting them in various settings, including their homes, mainstream schools and nurseries and special schools. We have all accessed Talk Tools training and meet regularly to support each other and share good practice.

We use OPT with children who have muscle-based weakness as part of their condition, suchas Down Syndrome, Cerebral Palsy and motor speech disorders. Often these children have more significant needs than their typically developing peers and therefore it is necessary for therapists to add more tactile therapy techniques when traditional speech therapy alone is not effective. Through discussions with other allied health professionals working with similar client groups, such as our physiotherapy colleagues, it would appear that they too agree thatadditional tactile techniques are often required, over and above demonstrating (visual) and explaining (auditory) a task.

Based on the evidence why do we use OPT and what are the findings?

Alhaidary [2] highlighted that, "in children who have a normal developmental profile… nonspeech oral techniques lack supporting research". However, therapists are advised, "to base their assessment on evidenced-based research, their client's needs and wishes, and their own clinical experience supported by theory". It is our clinical experience that has led toour continued use of OPT for clients who we feel make progress with their speech through the implementation of OPT. As the article explains, Alhaidary's findings are based on a typically developing population, whereas the children we work with all have developmental difficulties. It is therefore not possible to generalise the findings highlighted by Alhaidary to our clinical practice.

Also, one of the biggest oppositions to OPT is the argument that non-speech oral motor exercises (NSOMEs) do not directly improve speech production. However, this assumes that OPT falls under the NSOME umbrella. OPT differs from NSOME in the way that it is underpinned by the need to link all therapy activities to functional eating, drinking and speech skills i.e. practising speech sound production alongside the OPT. Flipsen [3] made a distinction between: "Oral-Motor Activity - any therapy activity involving the use of the oral musculature (e.g. lips, teeth, mandible, cheeks, velum) that does not include the production of speech sounds at the same time". He gives examples of activities such as blowing on horns, using chew tools or repetitive bubble blowing, with the goal of improving the function of the musculature and "Speech-Motor Activity - any therapy activity involving the use of the oral musculature (e.g. lips, teeth, mandible, cheeks, velum) that includes the production of speech sounds at the same time. The goal of such activities is to practice real speech while providing supplemental and/or augmented input". He gives examples such as sound shaping, the moto-kinaesthetic approach and the PROMPT approach. Flipsen states that a method can come under the 'speech-motor activity' heading "so long as real speech (i.e. at least a complete phoneme) was being produced during the activity".

In this description, OPT as we use it, to support speech clarity, comes under the umbrella of a 'speech-motor activity'. We may use tools such as bubbles, horns, cheerios or a tongue depressor to give tactile input, but the activity would also always involve the attempt at production of the speech sound. It is our experience that children have been discharged from therapy with unresolved difficulties or have not received therapy for their speech difficulties because therapists are not aware of OPT and are not confident in assessing oral movements for speech and adding in the additional tactile level of input necessary to supportthem. We do not recommend OPT as a standalone therapy, but as a valuable part of a Therapist's toolkit that can be used effectively alongside other therapy techniques.

In approaches such as Talk Tools, there are hierarchies to enable the precise measurement of baseline skills as well as measurements of progress. These hierarchies were used in the cases described below.

Case Studies

Child A was six years old and attended a special school. He presented with severe speech difficulties, producing only open vowels and /g/. He rarely attempted verbal communication. Assessment revealed weakness in the tongue and inability to achieve alveolar placement. He successfully followed the Cheerio for Tongue Tip Elevation programme, which aims to teach tongue tip dissociation and this led to production of alveolar sounds. Used in conjunction with the Nuffield Dyspraxia Programme, in 18 months he was able to produce all consonant sounds in single words. His speech was intelligible to familiar adults in context.

Child A's parent said: "He has progressed so much from the child who couldn't say a single word 18 months ago".

Child B had been working on bilabial sounds using traditional articulation therapy but this had been unsuccessful. The introduction of a tongue depressor between his lips to give a tactile prompt, and then the 'apraxia shapes' to help him differentiate between the bilabials, very quickly resulted in accurate production of the sounds 'm, p and b'.

Below are some other examples of using OPT to help children achieve individual speech sounds which they were not able to achieve using traditional therapy methods alone:

- Using a cheerio placed on the lower lip so that the child can feel the placement by scraping it with their top teeth leads to the automatic retraction of the lower lip and encourages the production of /f/, as the picture below demonstrates:

Figure 1: Apraxia shape tool for /m/.

Figure 2: Apraxia shape tool for /p/.

- Using a cheerio placed behind the bottom teeth and held in place by the tongue tip encourages tongue tip depression and leads to the correct placement for the velar sounds /k/ and /g/.
- Using bubbles or a horn with a round mouthpiece supports the child to achieve the sound /w/.
- In each example, the sounds are immediately practiced after the supplemental input has been given.

Figure 3

Conclusion

The one evidence based systematic review on non-speech oral exercise revealed "insufficient evidence to support or refute the use of OMEs [oral motor exercises] to produce effects on speech" [4]. Therefore, when you are describing the method of adding tactile cues and supplemental input into a child's speech therapy programme, it would appear that collecting practice-based evidence, as we are continuing to do, is essential in gaining greater understanding of the impact on speech sound development. In all the cases outlined in this article, the children had received traditional therapy approaches with limited success prior to OPT being added to their treatment programmes. Our clinical experience highlights that the addition of a tactile cue can be invaluable in helping children with developmental disorders and muscle-based weaknesses achieve correct sound placement and improved speech clarity.

Bibliography

1. https://talktools.com/pages/what-is-opt

2. Alhaidary A. "Treatment of speech sound disorders in children: Non-speech oral exercises". *International Journal of Pediatrics and Adolescent Medicine* (2019).

3. P Flipsen. "(Personal communication, February 17, 2011) in Bahr, D. (2011, Nov.). The oral motor debate – Part II: Exploring terminology and practice patterns". *Oral Motor Institute* 3.2 (2011).

4. McCauley RJ., *et al*. "Evidence-based systematic review: effects of nonspeech oral motor exercises on speech". *American Journal of Speech and Language Pathology* 4 (2009): 343-360.

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