
Please stand by for realtime transcript. I will go over some housekeeping procedures before we get underway. First thing I will do is issue an electronic command that will mute everybody's phones. Sarah, you will need to press star mute -- star six to on mute your phone. Then, when we are ready to start I will begin recording the session. I want to remind everyone that this will be made public so any information that you put into the chat pod will become public in full so please be cautious about confidential information, personal identity, that sort of thing.

>> It is in the left corner and we will resize that in a moment. the first thing I will do is issue the mute command. You will hear an announcement. All guests have been muted, you can on mute your line by pressing start six.

>> Now you can see that your lines are muted. All of the red symbols next to the phone indicate that it is muted.

Sarah, are you on muted now?

>> I am on muted Cockayne you hear me?

>> Yes, I can.

>> David all, I am on muted also.

>> Once you hear the announcement that this session is being recorded then David, you can begin. One moment, please.

>> This meeting is now being recorded.

>> Thank you Randy and thank you to CBD were providing technical support for tonight's webinar. That evening I am David will then I am president of charts and him -- if you enjoyed this webinar which I know you will, and are not yet a member I hope you will go to our website at charge .org become a member. While there you can register for our 2013 conference, registration is now open, come experience the wonder tonight I am pleased to introduce Sarah Rosenthal Johnson, she has more than 35 years of experience as a speech language pathologist. She has spoken all over the world on oral motor speech therapy, she is truly an expert on speech, language and disorders related to charge syndrome. I know Sarah is reserving time at the end of her presentation for questions. Please feel free to put questions in the chat box. for privacy issues, again, I will caution everyone you might want to keep your questions general and exclude personal information. This is being recorded in the chat box gets recorded just like the webinar. So anything in their fully on our website and will be able to be seen by everyone.

>> Now, with that, I am looking forward to listening to Sarah and I will turn it over to Sarah. Thank you so much for spending your evening with us, Sarah. Let's start techniques to start improving reading skills and speech clarity.

>> Hello. Is everybody comfortable seated in a nice chair? We will have a nice hour together. I will try to share some information with you. Hopefully give you insights into some of the situations that you are seeing with your children. Then, at the end of the our presentation I am going to spend a half hour with the question and answer section. I look forward to sharing some of this in relation with you. You will see on your computer that you have, my PowerPoint. I have to start by saying I am recovering from a cold so please forgive my voice. In my occasional coughing. I'd take it was probably about 16 years ago that I met my first child with a diagnosed charge. As a speech language pathology it was an eye-opening experience because I was not compared to deal with the multiple deficits that this young child had.

>> In feeding and in speech and language it was very overwhelming for a relatively young therapist at that point. But I have to say, this child, whose name I will not mention because I did not ask her parents, changed me as a therapist. and showed me what you can do. Your expectations have to be higher than what you thought they were because then you might reach your peak. the presentation I will share with you tonight is an overview of the information that I would be teaching to therapist now. So it is probably six or seven days worth of therapy and information all put in one hour. So it will be a little general and hopefully we will get more specific with the actual question-and-answer time.

>> The first question I get frequently and I am trying to advance the slide show. It is not advancing.

>> Sarah can't did you click the right area -- Carol.

>> I did click the right arrow.

>> Sorry. Obviously this is my first webinar, forgive me for that. What is oral motor therapy? My purpose during this our presentation is to show you that there are so many different techniques for working with two children and your young adults and the adults as well. In that the names listed on the handout that you will be able to download our different professionals in this area of speech therapy who developed techniques to address individual needs. Feeding, language, speech, sensory. My particular area, that I specialize in is one of those balls hanging under that umbrella,

oral motor therapy and my is called oral placement therapy. It is an approach that looks at the sensory and the motor parts of speech and feeding. But instead of using a traditional approach which would be to save your child, look at what I do in, look at how I am eating, eat like a eat. What we do is work on the muscle skill that is needed for that active function.

>> Them by teaching a motor, or how to use those muscles and then we transitioned that into speech. Traditional speech therapy gives information auditorily for your ears, officially for your eyes. Picture and imitate what I say. This therapy does that as well, but it also puts something in the child's mouth or gives a certain queue to the child's mother where they can feel what you want them to feel. I think what I learned so much from that, this young girl that I worked with, was that the sensory, the sense of feeling your children is very different. As are the cognitive skills and medical conditions. But the sensory, how they feel in the mouth, how they feel in their hands is really the first door that you have to get through to so that they can then work with that child in an effective manner.

>> You will learn more as we go along. the next one, and for those of you who are needing research to understand more about what this therapy is, I have given you a reference. At your leisure you can download and go to the website that is the company I work for. I will give you that information at the end. This is something you can bring to your speech language pathology, as two what it is that we are talking about tonight.

>> You will also see that I will not get to all of the slides and your handout. the reason that I included ones that I know I will not get to is that I hope that you will get -- give that handout to your service so they can learn more of what I think of as a very exciting specialty within the field of speech therapy design to help your clients or children. the basic premise is speech divided or created by movement in a variety of muscles. If you start up on the right, it says the abdomen, the muscles were you generate airflow. The next one, heading down towards the right, the soft palate and that is where air is directed either through your mouth or through your nose. I know that you can see me talking and you can see that my job is moving up and down. I also use my lips, and forward or backward movement. You see I have cheek involved as well. What you cannot see is my tongue movement.

>> and oral placement therapist will identify or evaluate each of those areas, each of the six areas and find out which of those areas is difficult, difficulty for your child. Let's say they identify that there is not enough breath support. Then we have exercises to improve that. Or we find that the Lips are not working in a certain way. We have exercises that will then create that movement pattern. When I do an evaluation, I look at the parent who is sitting next to their child watch me work with the child.

>> the child is having so much difficulty performing the task I am asking for, I think this is great. Because now we know because of why your child is not communicating clearly or why your child is having trouble with chewing wounds or swallowing or manipulating foods and now we know what we can do to improve that skill. This is a muscle based approach that will help your child eat, skills and safety, speech approach which will improve the speech clarity. It is not a right which program. It does not replace any thing that your therapist is now using with your child. It can at on additional kind of exercises or activities.

>> This one is very important. This overhead shows you why it is so critical to work on muscle movements. Pretend that you are with a -- at a circus or carnival and these are ever -- acrobats. The one on the top is balanced because one under needs that triangle is supporting them. In speech and in feeding we need to have skills in the muscles of the job, both sides of the faced equally in order to support what is called the dissociated movements of the lips or tongue. If your job is not strong enough to chew food or your job is not moving in that up-and-down pattern that I am using now, then that will affect your speech, you live movement in your tongue movement.

>> We will really spend a lot of time on exercises with the job. Let's say the two acrobats on the right had adequate skill to support the other ones, the left didn't. You would still have a collapse of the triangle or the spearhead because you have to have -- skills. When you talk to your therapist about this particular approach, you also want to ask is my child functioning differently on the right first is the left. If so, we want to spend more time on that weaker side.

Common deficits in charge syndrome. I remember when charge was called an association. That is how long I have been involved with their kids and truthfully loving everyone of the conferences that I have been invited to speak at. the deficit that affects feeding, each of this deficits may range from nonexistent to severe. In other diagnoses, because I also work with children with different diagnosis. There is not as much -- in the diagnosis of children. I have had kids that have had cognitive skills which are nor -- near-normal and others that have had cognitive skills that are very low. I have had children that have hyper cosmic bully and kids that have had hypotension and the deed. These are general characteristics that your therapist should be able to tell you if your child is evidencing any of these.

>> The next one, is visual impairment. I will go through them quickly because you already know this. I want to set up where I'm going with the Arabic. Visual impairment, hearing loss, chronic ear infections, those are infections are frequently related to early feeding. Right now I want to give you your first test, when your child is eating a shirt their

years are higher than their mouth. You do not want them flying out, you don't want to lie on the side, you want them in an upright position because there is a small tube that goes from your middle ear to the back of your throat, called the eustachian tube. Their little tubes -- muscles at the bottom called Specter muscles, the opening closed to keep food from going in your ears. If you have a weakness about your body, the chance of your Specter muscles working, is probably not very good.

>> In a line down position, -- lying down position you have a better chance of food going into that year. I have some feedback on my followed -- own -- I have feedback on my telephone.

>> It may range from minor and may affect spells. I am always amazed that Daniels who are told that their children are hypo [Indiscernible]

>> That did not stop it. Children that are described as having hypo sensitivity, will understand that in more generalized terms. The hypo sensitivity means that if I squeeze your child's hand, they feel it less. There is less pressure. So I hypo sensitive response, we will talk about why that is so critical, because speech is like touch. Your child does not have that required feedback or information from the touch, it can impact on their speech. But it also impacts the sense of smell, the sense of taste and sense of touch.

>> A lot of times a hypo sensitive child or a child who has a reduced sensory response will put food in his or her mouse, not to get your angry. I know a lot of parents think they did it just to make them bad, it is just that they cannot feel it in their mouth.

>> So she will want to put more in there. I've had parents tell me [Inaudible] she doesn't want to eat applesauce but if I put cinnamon in it, she will. Taste, smell, touch are all related to a sensory evaluation. You will see in this one-hour, I spend a lot of time on sensory because I think that is the one area that many speech pathologist that consult with me do not understand that issue. by the end of the first session of the darkness, you will need to get from them a diagnosis to make sure they are really looking at that [Inaudible]

>> Number five. It is not advancing. You know, technology is not my thing. Good thing I found therapy. Oral tactile sensitivity. Here is hypo sensitive which is an under reaction to sensory input. Hypersensitivity is an overreaction to sensory system, different parts of the mouth respond in different ways. Or fluctuating sensitivity. On Tuesday your child taste foods or movement of the time within the mouth in one way and on Wednesday it is different. Any of these diagnosis you can see could easily affect speech clarity and feeding.

>> They may differ from day-to-day. As speech language pathologist have to look at that. Tactile [Indiscernible] not a moment that your child -- when you go towards that child, I fear has developed. Your child has a fear of touch and does not want food put in the mouth, we need to look at that from a behavioral perspective. What happened to make your child fearful? It is not something you did on purpose. Is most likely that one did a really good sensory evaluation early on and has been giving foods or expecting speech movements that do not feel good to your child.

>> I think the most dramatic learning curve for me happened at one of the very first -- I want to. I looked out the window of my hotel room and there was a little guy down in a playground and he was licking sand. I said to myself, all my gosh, this kid, of course I had to go downstairs and meet him and find out what was going on. This is a child who wasn't eating because he couldn't taste any food. The more sensory your child is looking to get, that gives us therapists more information on what we need to do.

>> Number six correspond to deficit, number eight, the gap between receptive language and oral speech uses repressive this all the time. Because you children learn through touch and traditional speech therapy does not teach them movement patterns through touch, there understanding of language very frequently much higher than their ability to use I have also seen many kids who can sign or gesture or point. That is a motor skill. a motor skill when used by your physical therapist, and your occupational therapist to teach your children to walk and manipulate their hands.

>> Think of that therapy as physical therapy for your mouth. We need to get those muscles going so we can perform those tasks. Not only for speech but also feeding. You will see how swallowing is also affected. Week job musculature or not symmetrical, meaning equal skills on both sides. Versus many of you children that seem to have a preference or strength on one side and more of a weakness on the other. We want that so we have the ability to move her lips and tongue independently. the other is incomplete live closure, tongue mobility, controlled movement of the time. All of these result in limited retraction, plenty of pointing, all of those again directly related to speech movement.

>> My job is to evaluate what I talk to you about and then provide a program directly related to your individual child. That is what we do in therapy. Therapy is not general. I would never say children with charge need this, this and this. Children with charge need to be evaluated, motor system, feeding system, then we pray a program isolated for your child.

>> Weakness in the soft palate, many of you kids when they talk will over access -- over exaggerate nasal. Or you ask them to blow and the air comes through the nose or eyes Fursce. Everything comes out of the mouth and nothing

comes out of the nose. In English if you're mild -- chat -- go between oral and nasal movements all the time. For example, if this was the back of my throat and this was my soft palate, when I say, the palate is to make contact with that wall so the speech goes out of the mouth.

>> When I say them, the air has to come up with go of the nose. the word mom would look like this, mom look at how fast we are talking now, putting all those sounds in your voice, that is why your kids frequently sound like they are omitting sounds.

>> This varies with the language, for example, French has a lot of nasal sounds. When I worked with children and trans who have charge, this is an area where I do not have to be so worried about. As a English speaker I need to look at children in a different way.

>> [Indiscernible] 12, is a blocked nasal passage. a lack of energy sounds, number 13 motor skills. Many times I hear there is say to the parent, your children have apraxia. Apraxia of speech and live like that. Then you go to the Internet and you look it up and you get really scared because Internet as good information but it also does not have rate information.

>> So what I would suggest you to understand motor planning deficits or apraxia which is a motor planning disorder, is if I gave you an object, for example, let's say I showed you this box here. You have never seen this box before, I would give it to you and you would know to open and and two close it. Just by the existence of it being there. Children with motor planning problems to not know how to do those motor plans. So for speech they may understand what you're saying, they may actually feel what they are saying is correct. But it is not correct because their brains are not telling their miles how to do that. Again, and oral placement program looks to teach the motor plan of how to build a sound or how to eat before we give you food.

>> Number 14, difficulty coordinating oral, [Indiscernible] reduction. One of the very basics of speech is being able to generate oral airflow, on purpose and then move your mouse to shape those movements. If your child cannot low bubbles or cannot blow a horn, that is a major concern to me as a speech language that colleges because that is generating oral airflow. You will see if are involved in an oral motor program, Floyd bubbles, which children think -- worked with engineers and chemists to create the different types of therapy tools, the bubbles we use to create the movement patterns that are necessary for speech.

>> If your child is not blowing, I would strongly suggest you get involved in a program where you can teach them, to help them vocalize. We will talk more about that later. Goals of oral planning therapy. Number one to increase the awareness of the oral mechanism. That was area I was talking about before. Let's say that right now you and I are in the same room. There was a lot of people in the room and a lot of noise. I could still talk to you, maybe people in the front row in by talking to you I wouldn't know that my speech was normal or clear because I can't hear. There's too much background noise. I also don't know that my speech is clear or understandable to you by how it looks because I don't use a mirror.

>> What I use is a sensory feedback system which tells me that my town is in the right spot, the job is in the right space, I have enough air. All those muscles, muscles that I identified early on coordinate together that awareness is critical. That is what we are looking at from the standpoint of evaluation. Does your child have all those parts? If we find out they have too much of a response, it may be perceived as painful. On the right side of the mouth, they feel it but nonetheless they do not. All of that sensory information will affect how they chew. How they eat food safely. How they control the Bose or form who takes after you chew it a few times.

>> After the evaluation our goal is to improve that. I use the word normalize. Normalized means that formality in some cases only works to a certain point. When you are a young therapist you go out there and say, I will have everyone talking, I will have everyone speaking clearly, I will have everyone eating. But if the inmate or neurological or motor system is impaired to a certain degree, many times we cannot get beyond a certain point of those goals. I will not use the word normal, I will use the word normalized.

>> Number three is to teach for normal movement patterns. That is a coordination of the job, lips and tongue for number four to improve reading skills [Indiscernible] speech pathology, why did she call about -- whether she care about beating? Why's that so critical to look at? The answer is muscles you use in feeding and the muscles used in speech are the same. There used differently, but they are the same pathways to mobilize them. If your child sticks that come out when they eat, they are going to stick their tongue out when they talk. We will look at that coordination of how is speech and reading related. We need to look at both. I'm always amazed when I speak to a therapist, okay, you are referring this child to me for an assessment. You have given me all the speech information. What is the feeding like? I'm not talking about swallowing, I am talking about the oral prepared. Stage of eating.

>> They will say I have never seen them eat. Then you are missing a huge part of movement pattern. Why do I do this? Do I really have -- what I have is my primary goal is what I want for your children. Your children have as much

to say, I want everyone to understand all of that. What they want to say, the language component, their cognitive skills and initiation. So many people -- children having cap. When there is a cap did what your child is saying and what you can understand, that is oral placement therapy. Again, remember that we can also raise this standard with other forms of therapy. At no time should you only do oral placement therapy. You need to look at the whole system. Receptive language, expressive language, movement, feeding.

>> the next one. Here are sustain us to consider. I think parents sometimes don't understand why it is that their child is doing something. Why do you not monitor our speech but it sounds or looks. Instead we base our assumption when we're speaking intelligently on how it feels. Like I said before with a noisy room. Another thought, why despite child by everything in their mouth but avoids certain foods. That is a big one in this diagnosis. When you bite on something you can then take it out when food is put in your mouth, then the hand is removed when you are being bad or when food is put in your mouth. You'd then have to do something with that food. When people tell me that a child has behavioral feeding disorders and they go through this whole process of having the child feel the food, play with food and feed other people input food in the mouth and spit it out. I say, wait a second. the reason the child is afraid to eat or does not want to eat is when the food is in there and they don't know what to do with that.

>> I may have issues of manipulation of the food, they may have strength issues, they may have taste issues. But purely feeding -based programs is not going to under line -- beating and sensory can not be separated. There is not a feeding problem that does not have a sensory side of it. Number three, why does my child grind his teeth? Sunkist am? the answer to all that is sensory. Actually, it is such an important component that I have written a whole book on the relationship between teeth grinding, thumb sucking and speech. Because the job, there is a point here call the temperamental joint which is the primary source of -- and the human body.

>> Baby suck their thumb to calm down. Passive buyers are called that because they calm you down. a fountain, bottle, teeth grinding, or thumbsucking or tongue sucking or hitting your face are all giving signs to calm down. Many times you find muscles in the job are not strong enough to support that Chaucer your child needs that teeth grinding to calm down. We really want to see sensory as the first door to open to get your child on a path for safe eating and improve speech clarity.

>> I will show you a couple of therapy tools to give you a visual. This is a tooth at an eight to that with vibration. It is used to evaluate the sensory system. There are a few things a goal of this. Obviously if your child has a seizure disorder epilepsy or types of seizures, they have a seizure that is related to vibration, I would not use this tool. But in most cases I am able to do that. Able to identify for me if I have a hypo sensitivity, a hypersensitivity or fluctuating sensitivity. This is something that you might want to ask your therapist, have they done the sensory exam. They say no, I don't know how to do it, you might want to reprint them to this approach.

>> Because everything that I have created in mind work with children with charge is a therapy tool. Remember we need therapy tools in order to get that feel of speech or field of food so that we can put something in the mouth to shape those muscles safely. Everyone of those comes with directions. I have been accused of being anal, and I love it. You can accuse me all you want. What I will do is give so many more instructions so that you do it correctly. If you do something wrong, unfortunately it is get a step, you waste two or three months, having to go back and get that child to trust you again. Working slowly, working from the outside in is very important. When I had a young therapist, and takes eight to that and goes for the child's mouth before it touches the body, I say, okay, let's hold off on that permanent. That's see if he will let you touch his knees. Let's see if he likes his back rub. We are going very slowly.

>> Again, this is a tactile system. Tactile sensitivity and under reaction to input. Tactile movement is movement of the job, tactile is food, or spoon, it could be anything. Under reaction, we need to make that information stronger. We will disgrace the number of food, we will use vibration, we will use [Indiscernible] a variety of different things I will show you in a moment. Number two would be hypersensitive, the exact opposite. You would not have a child who would be hypo sensitive and hypersensitive another day. Hypersensitive is an over reaction. By working with a child I will talk in a softer voice. I will use sensory input which is less invasive. I will be very careful not to put anything in their mouth that they are not comfortable with.

>> Number three, fix sensitivity is any combination of hyper, hypo and normal. I have seen this commonly. I will have a child who will say a talk sound and if you say this with me. Two, you can feel how the tip of your tongue touches right behind your front teeth. Two, two. But will not say are. You say to, your tongue close-up of the front. When you say car your tongue goes up in the back. If this child has a normal sensory response in the front, Phil touch their teeth. They don't have one in the back, they may not say that case sound because it does not feel good.

>> Again, I hate to be redundant, it is critical that you have your speech pathologist do a sensory exam. Number four is fluctuating tactile sensitivity response may change over time. If your child has an additional diagnoses of -- syndrome or being on the autistic [Indiscernible] syndrome you would see a fluctuating tactile sensitivity. I have

worked with children, we have become friends, everything is good, we are in a session, everything is working well. The heater goes on and I lose that child. That child could not take one more piece of sensory information and still were with me.

>> We want to be very careful with that in the last one I talked about, tactile descents of this is learned. Many people say, he is afraid of touch, therefore he must be hypersensitive. That is not true. I have may consider afraid of touch and somebody puts food in the mouth and they swallow and they did not feel it, they choked on it and learned area past, I don't want to eat that food. They really want to make sure you don't make assumptions that just because your child is afraid of touch that it is a hypersensitivity.

>> Okay, before you begin to work on either feeding our speech we have to evaluate the sensory system. If there is that fear, we have to eliminate those patterns by establishing trust. Then we treat the sensory deficits. I know you have incredible therapist and speak at your conferences and I have met with them. You go to the conferences summer I would encourage you to go to those presentations because OT's really have a good handle on sensory, normalizing sensory skills in the body. Speech pathologist really focus in the mouth. But combination is very important.

>> When you are listening to this, one of the biggest problems that parents have is that you want your child eating tomorrow or you want your child talking tomorrow. I have all of these skills that I need to develop. As a speech language pathologist, what I do in the evaluation is I tell you what the problems are so that you have an idea of why I am working on each area, getting towards that speech movement. Many of you, right now have to really think about the loan your therapist is little more time to work on the [Indiscernible] skills rather than jumping right into speech. What I have learned with working with kids with special needs, it may be difficult to teach them but it is twice as difficult to have them online something that has been incorrectly -- my goal with your kids is maximum speech clarity -- clarity and normalized eating.

>> Okay. Oral placement or muscle based [Indiscernible] we use non- food items, muscles of the abdomen, for airflow, John, lips and tongue as a prerequisites [Indiscernible] and feeding we teach these movements prior to introductory of food.

>> I will show you some other therapy tools and we teach the movement. Again, if you would have come to me 20 years ago I would have used food to teach your child to eat. I don't do that anymore. I want to make sure they can manipulate that food, they can feel good and they can be functional with that food with that movement before I give them that food. Many of your kids are [Indiscernible] if I could ask you one thing. It your child is being to bed so late, please at the same time you're feeding them, associate movement in the mouth was beating, have them blow bubbles, have them chew on the tube, so that muscles used in feeding are the same muscles used in speech.

>> When these children receive medical -- working on the oral can also improve swallowing. One of the techniques I used to improve oral skill or speech is a strong drinking hierarchy. There are eight straws in this hierarchy. They get progressively more difficult, because more muscles have to work harder to get the liquid into the mouth. Many of your kids are not approved [Indiscernible] I can still use that program was little tiny pieces of tissue paper where the child will drop in and they strong, holding tissue paper on the bottom, hold it and then drop it. What we are finding with her gastroenterologist and feeding specialist, is that children who are being to bed use that activity, increase the swallowing proficiency. Because the harder you work the mouth the more you are getting those specter muscles to [Indiscernible] you really want to think about oral placement therapy with both feeding and non- bidding kids as an approach to improve those skills.

>> Why is fitting so important, nutrition, muscles and feeding are used in speech. Let's talk about how oral laser therapy help my child speak more clearly. Again, traditional speech therapy, presents visual and auditory stimuli, but many individuals have trouble listening with their eyes and ears. Please remember, we don't stop at the traditional, which is at this time. This is a little piece of the pie that needs to be added on to a program that your child is already participating in.

>> Stability in the bottom -- body, critical. Feeding posture, stability in the body, and stability in the mouth. As a pathologist and trained in something called narrow development. As a therapist feel comfortable creating a pattern or suggested feeding patterns for your child. Many speech pathologies are not forget would be very important for you to consult with a PT to find out what will give them stability. Right now I ask you in your chair, lift your be, sit there with your feet off the floor. You will find you start moving your legs, you want to point your toes. You are looking for stability. We need to have stability was beating, that will go smart access to the oral skills. Two things we have learned, air higher than mouth, stability in the body, stability in the model.

>> -- in the mouth your there is a pariah the of placements used for spoon feeding. If you put the spoon coming out of the side of the mouth, that works with closure which is your speech sounds and BMP. The spoon coming out of the front of the multiword Omni -- sounds. When we're looking at the feeding program, we are not only looking at

children who are to that, we are looking at children who are oral feed but are not using those muscles in the same way. In America, I would say probably across world, people eat three or four times a day, this perfect time to work on muscle development. You mothers with younger children who are feeding your children, or fathers, sorry that was nice. You know I am talking to all of you. Grandma's comment grandpas out there. When you are feeding, please make sure it that the spoon goes in flat, the child closes the lips before you remove the spoon. Many of you are scraping the food on the teeth are dumping it in the mouth. That may be getting that food down, not safely, but it is also eliminated that wonderful connection between feeding and speech. That live closure on the spoon is directly related to, M sounds, be sounds and she sounds. Widger. Early learned.

>> Cup tracking, sippy cups are they right for my child? a sippy cup is not a cup it is, it really is a bottle in another form. I will encourage you at the end of this to go to the website and look at the articles that are listed there. One of them, and article written in the Wall Street Journal many years ago. About white sippy cups are really bad. Again, it is on that website. It is very important. Cup trekking, the alternative to the ones on top. the nosy cops, the cut cups that you can use to be your child but keep the head in the correct position. Remember we don't want your child to drink like this, that will allow the liquid to go in the years and we don't want an ear infection.

>> There is a variety of different types of cups your therapist might recommend. Here is the straw hierarchy. This would be straw number one, a comes with directions. I want to show you how this therapy works. Strong ever one is the easiest. It will increase skill at position one which is the back of the blade of the town. This overhead here is a tongue blade. When you draw the lives in or you use a little piece of paper to draw up, that back part of your tongue starts to work.

>> The reasons there are eight locations on your tongue that we use all those locations independently of each other for speech. For example, a K is made at positions one, two and three. a team is made at position four, five, six and seven. and S is made at position six and seven and burgers made position eight. The way I'm talking now, think about all that movement that is needed in the town laid.

>> -- tongue blade. Stop number one looks like this, straw number two looks like this. You notice it is already getting harder. the straw has a bend in it, it will make your child work eight teeny bit harder. Because I don't want your child to fail. If you go from certain skills, you take a step that is too big, you child is going to not only reviews that straw because it is too hard, they might refuse all straws. This therapy is based on increasing skills through very small levels of difficulty but really getting or maintaining that skill for a while before you go to the next. Your child could be on straw number two for two months, or three months, depending on the skill level. Again, that will depend on their innate neurological level, the level of muscle -- muscle strength and cooperation.

>> That is the killer, if you don't get these kids to work with you, the best therapy technique in the world will not work might references always, if you have a therapist that works into child and your child really likes that therapist, this one is easy to learn. Getting a child to want to work with you is a challenge. That is why my tools look like toys. Children should not know this is therapy, it looks like it just break, number three [Indiscernible] Mark complex, number five, six, seven, as they say, this is the last straw. It is a long one in a goes up to the back of your tongue, that is positioned eight. Widger showed you before. There is a direct correlation between these straws and speech clarity. The last area of foods is solid. Cuba or Julian. Q is it about 1 half inch or sometimes 1 quarter inch square. Julian, that is a shape of a french fry. We want those foods place on the back molars. Why is it important for my child to chew on their back molars? Because these are the muscles for speech. the next time you see your child eat, chew a little bit, maybe four or five times. They are chewing on the side here or in the front, they are using the muscles, they are actually able to eat the food but the speech muscles for the job are back here. So we want placement at the back so the child will use those muscles. Those muscles in the back or call the Maximus muscles. We will not only do a feeding program there but an exercise program as well.

>> Why? the jaw joint stimulation to an alternative to teeth grinding. The programs that we will develop or talk about our implemented when your child is granted. Teeth. They are at home and watching TV or watching it and you'll and they start adding their teeth or hitting their faces are biting on their arms. They are thinking, mom and dad, come work on my job, I need stimulation here. These are very good times. I remember talking to parents, and saying I would like you to do these exercises three times a day. a parent will come and say, that is way too much.

>> They take about 15 minutes a time, so we're talking 45 minutes over the day. Oh no, that is too much. That was crazy. I can't do it. Only do it when he is granting his teeth because grinding teeth drives me crazy, yes I will do that parent says. That I will come back next week and ask if they can do it 10 times a day. As you increase those muscles, the child will no longer need to bite their arm or bite you are branded teeth. As the muscles skills improve, you face of the there are play tool. The goal is not to have your child on these tools for years and years of his to give them the skills, was they have the skills we transition to beating and transition that skill into speech immediately so they don't

need to work on the activity.

>> These are magic tubes. They are in a hierarchy of difficulty. The first one is a red one, you may have recognize them from occupational or physical therapist giving them to you for sensory input. I don't use them in that way. I use them coming out of the side of the mouth. I have a child waiting on the tube to compress it. Read first. Then there is a hard -- hierarchy of repetitions. If you child is not able to compress, fully compress this read to, five times above sides of the mouth. They are not safe for soft foods like cheese, or pieces of bread. They don't have the strength. After the red, then you do the yellow, and the purple, then the grain. You child cannot compress the grain 10 times on both sides, they should not be eating meat. Again there is that correlation on working on those exercises and improving not only speech movement because as you child gets stronger your lips and tongue also do, you can talk more clearly. But beating safety is really critical.

>> Many speech pathologies are not taught about reading. In their caseloads they are presented with children with reading problems and they feed those children like children that do not have a motor best -- deficits and that will create patterns of fear. Related to beating.

>> How does blowing a horn help my child speak so others can understand. Again, does your child have enough air to talk like I'm talking now? We have a series of 12 hours. If they can't low, and they get progressively harder. They can only blow horn one, the only skill then they have is to use a one syllable word. So we can see a correlation between working on the horns and your child to be able to string more words together. the average can string 13 up to 17 words together before they need to take a breath. Also the more difficult the horn is to blow, the more mobility you get in that soft palate, the more strictly need in the jaws, lips and tongue. Again related to speech.

>> The need for practice. Oral placement activities must be practiced a minimum of three times per week. When you're therapist sends Homer, is another one of the things I strongly encourage you to say to your therapist. Whatever you are doing and therapy, sent home for me. I want to practice it. Because if you do not practice something and you only rely on the therapist to be doing, seeing your child one time a week or in a group. Progress will be much slower. Even ask for just one thing to do, and oral placement activity or language skill. Whenever my clients leave my office they have homework 15 minutes per day. Why do I say five times a week. You go to the gym, you do and exercise program one time a week, you will not make a whole lot of progress. If therapy is based on the same model of improving muscle skills throughout the whole body. It is based on exercise physiology. I was fortunate 40 years ago to meet my husband who was a physical education teacher at the time. He has taught me more about muscle movement than any university I never went to.

>> Looking at the way muscles interact with speeches again how we developed this program. Once the skill is mastered it must be transitioned into function which is again speech and feeding, oral placement and traditional therapy work together. We are not going to choose one over the other and the best part is because the therapy tools are disguised as toys, the kids will have fun and so will you. In this approach what I sent home for homework is your child's highest level before failure. I will not say to you, he did five times in my room I want him to do it six times at home. Because then he will fail. There are three people involved. I want you to be happy, I want your child happy so your child will work with you and I want to feel good at the end of the day that I helped somebody.

>> If you, if you child is not child does not have been doing activity, please do not do it. Because that is what creates that fear and these setbacks. Burkle of miracles, it is eight oh 1:00 p.m. I cannot believe I made it to the exact moment because I have never done a webinar before. Now we have a half-hour of questions. I know there are many of you out there. There are 87 families out there. We will not have time for all of your questions.

>> We have a generous offer. The e-mail address, he says that if you write a question, a personal question, they will be shared with anyone about your child, one of our therapist will get back to you on specific answers. We may not be able to tell you, this therapy is based on field. So a lot of us have to put something in the child's mouth. We will do our very best to help you. One of the worst things to do is to educate a parent and then say goodbye, you are on your own. We will try to help you in any way we can. Thank you very much.

>> Sarah, this is Kathy McNulty. Lori Swanson and I are both on the education committee of the charge foundation. We will be helping you navigate what you correctly set. There are a lot of questions here tonight. If you want to join me over in that chat box. There were a few and they had to do with grinding teeth. That first one from Jennifer, what is the best thing for teeth grinding if offering a chewy tube is work very well?

>> I read an entire book on that. There is a lot of things you can do. You can use vibration on the side of the base when the child is granting. I really want you to hear is that they grind their teeth because they have muscle weakness. If you are giving one of those tubes and holding it in the front or side of the mouth and not to those back muscles, that placement will not help your child. A lot of therapist will give you tubes to chew on or toys to chew on. That satisfies the need at the moment, but it doesn't go to the underlying reasons for the problem. So that bite to hierarchy that I

showed you, we also use bite locks which are a series of activities where you bite on a firm surface. a bite five, this is an interesting therapy tool. You can see, hopefully, there is a variety of sizes. So the skinniest one would be your speech movement for each. I would put it in the mouth and pull, when you pull that is when you get that Mister muscle strength. Bite blocks might be part of your program. Children who teeth grind are also on very soft diets. When they are on soft I say don't get that stimulation to the job. You want to work on giving them crunchy foods in the back of the mouth. a lot of times, that you stick, not a hard vegetable, very crunchy like a Chito, something like that. That sensory information will stop the grinding.

>> What you don't want to do is say to your child stop that. Because they can. They need it. So if you can think of teeth grinding as a child's need and wanting having information back there, he would accept it a little more. Again as you increase that skill in the muscle of your child will not to tease grind. The book I was referring to is assessment and treatment of the job. It is part parents and therapists. They could shoot at least 10 exercises or activities to address that component of teeth grinding her it is a sensory need that we need for sensory skill.

>> Our next question, it has to do with chewing and swallowing but there is quite a few questions related to that as we go along. So I'm thinking we can address that in a question that we will get to in a little bit. But Judy and Raul, Judy has to do with it the problem is a flap on the esophagus and it does not work correctly. Raul is asking if you would comment on when there is, I believe, a tracheotomy involved. Your comments and thoughts on those two conditions.

>> a swallow is a response to comment triggered at the back of the throat. If you are talking about the epiglottis, is that which are talking or you suffer this. That is a lower area. We don't have any exercises to mobilize that. Although there are some treatment patterns that are being developed now through increasing temperature or giving electrical stimulation to move that flap. That is not something we can address as speech language pathologist from an oral point of view. We don't have any techniques to do that. the other one, tell me what the second one was.

>> One had to do with the tracheotomy.

>> If you child has a trick, those of you who don't have children with a tracheotomy. That is a whole year in which it enables the child to be able to brief because there is a problem in the upper system. With those children, if this is a permanent trick, there is a bride-to-be of different types of bloggers. I don't want to endorse any company. As the child is speaking, block set air off so the child can direct the air from the mouth. What I do in my therapy is if I want that system to work I will use use one of those blockers and I will still have that child work on the oral structural movement because my goal is, the medical community is going to somehow correct that situation. I still want to work on the muscles of the mouth. The child is not talking while they have a tracheotomy, they will not have that exercise. Both of those cases, you are talking about medical conditions that are inhibiting a child from either swallowing safely corporal speaking clearly.

>> We want to still work on those muscles all those medical conditions are being addressed.

>> I have one more question, before I pass it over to Lori Swanson. Lisa has some questions, how do you move past oral feeding of just parade. She was not the only guest tonight Sarah, one guest is asking for advice for a child that was swallowing parade foods of two stage two for a few months and now doesn't want to do that. Was asking what advice you would have. There is a number of questions around this issue of purÃ©ed foods.

>> Paredes are very easy to swallow for a lot of children because they are of a consistent consistency. Which means what you feel in your mouth is only one thing. You can do that pretty well. When you look at progressing beyond Paredes, a lot of times therapist who really don't have an understanding of feeding will sometimes smashup or get a graham cracker or something else and put it in what this child is proceeding as a safe food. That child feels that stuff is being snuck into that safe food and it scares them. They will frequently go from a stage to back to a smooth parade. They don't trust that would anymore. That is why this presentation I really wanted to show you that the way you progress with foods is not by giving the food. The way you progress through foods is bite giving the skill. for example, say you have a bucket list and life, I would like for companies that make baby foods to get rid of stage three and four. They were never around when our kids, probably none of you had stage three and four. There was stage one stage two and then you went to silence. Stages three and four are dangerous. Because, think about the skills you need for those higher level foods. You have a breakout you have something a little harder, then you pieces of carrot. What you and I would do is we would put that food in her mouth, we would probably swallow the parade, move the silent to the side, chew it up and then swallow it. That is what we do with soup soup is a difficult texture. You have to swallow the liquid and move the solid peer if you do not have that motor skill, to lateralized that food you will have a lot of difficulty dealing with what you call next textures.

>> You want to go from a smooth or even stage two, which is thicker but still smooth to teach chewing with those tubes and then working on those back molars. Then you could go to another food source. I think a lot of parents and therapists have look at those stages and said this is what we need to do. If you don't see it in any other country but

America, I think it is just a marketing so we keep kids on baby food a little longer. I would encourage parents to go from stage one and two and work on those tubes to get those jobs going and then go to some solids. That is how we progress.

>> Sarah, this is Lori Swanson. The next question is from Ms. Fisher, she asks how does having a cleft lip and palate repaired or not affect speech and feeding?

>> Repaired or not is a big difference. If not repaired the child is at really high risk of severe feeding problems. A child who does not have a repaired club, for those of you that do not know what a cleft palette, the bones of the pallet, when they came together, the bones from the bottom of the skull never really meant the. You could think of a cleft palette as a soft spot that never came together. If you have a cleft palette and you have tissue covering it. That would be called a mucus cleft. Sometimes those are missed, the child might be hyper nasally. If you have a clot -- cleft that is open, you would have to feed your child as a paper feeder. In a child that is not repaired, unfortunately in many countries that I go to, they don't have the opportunity to have this surgery every because of where they live. We will put food in what is called the bugle cavity, you teach the child to hold her head in a certain way, they swallow in a certain way. Once a repair is done, a lot of people think that everything should move normally and that is not the case.

>> a repair puts the muscle in the right position but then you have to exercise it. Again, we will use a variety of therapy tools to exercise those muscles so that then you can handle the speech. It would be like breaking an arm and having it in a cast. So you don't moment. Then you take a cast off and that just say, move your arm. I have never really moved by her, I don't know how to do it. Specifically with a club lip, which was part of the question, once that suture line is made, years ago you used to see a lot of young people as young adults had a little cleft appeared. We don't see that now because we get these children to move their lips forward, exercise that new muscle system.

>> In that diagnosis, if you are not working on the muscle, you will not be seeing any progress or sufficient progress and that is the therapist that really don't have this knowledge is part of their education, will encourage these parents to teach these children to sign. Sign is a motor system. If you child can learn to sign, I think they can also learn to speak. They can use that motor system in a similar way. I do teach sign, if children cannot communicate their thoughts they will be frustrated. But I do not give up on speech until these kids cannot do anymore exercises, meaning that I cannot get any better muscle skills. I hope that answers that.

>> Betsy asked. My son was eating table food spuds stopped one and a half months ago and now it just plays with table foods. Do you think this could be a tactile defensiveness? How do we get back to where we were feeding.

>> You have to find out who is working on feeding with him. Because a lot of times, again, therapist who does not have the understanding of the criteria may have given him something that didn't feel good here so now he is afraid of that. As a therapist, what I do, I look at what he is doing now and what can I do one more step closer to getting him back to that. There may be digestive issues. Not all of the things that affect your children and things that you can see. Perhaps there is an intrusive or something has changed medically in a child that one they swallow the silence, there is some type of pain or discomfort. for I do anything with that child I would go to the gastroenterologist and see if there is a physical reason for this. The worst thing you can do is not find because.

>> I am a big person of, don't tell children to stop doing something or start to do something. You want to know why, why are they doing that? What is the reason? If it is a sensory reason, then I will go back to that. If it is a muscle skill level, I will go to muscle skills and then go back to the food. If it is a medical condition I am going right to the doctor and say, is there a cause here. There's something called reflux that probably many of you know about. When food, sometimes you don't even see this food, sometimes the stomach acids go up into the throat. It is not necessarily related to a meal. It could be later on. You can get stomach acids, that happens in this child over and over again, doesn't mean you will see anything, you will develop something that causes you to hurt women swallows. You should check out a medical condition.

>> Another topic that was discussed in the chat room was electrical stimulation. Can you speak on the effectiveness of electrical stimulation and improving swallowing?

>> I always get that question. That is a killer question because sometimes it is really effective and other times it is not. It depends not so much on the physiology of the child, but it depends on the perceived pain associated with this. I've had kids that started with a variety of different kinds of treatment patterns. They do really well and then the system kind of stops. So think of electrical stimulation as activating the muscle and then you have to practice that activation.

>> [Inaudible] eight to set -- the child can get lip rounding, then I take it out and they lose it. I put that in the mouth, they get the lip rounding again. If I don't put it in the mouth I cannot expect to get lip rounding. What that means is the sensor creates the motor movement and many children that electrical stimulation stimulates the movement that is then learn in transitions into a really good swallow. For other kids it does not. There are advocates pros and against. My feeling is you try, but seems to work, then go ahead. But with my patients because I work with a therapist that uses

this a lot. My patients cry during the stimulation, I feel really uncomfortable. I do want any kids to have a negative response. They may learn to swallow but they may avoid foods later on because of the fear.

>> This is not a black-and-white issue. This is one that is related to the skill of the child, the skill of the therapist, most cases I would say it is worth a try if there is not an adverse reaction. You have to go to someone who knows what they're doing. There is a lot of training that goes in to that.

>> the last question before I handed back to Kathy. Could you please just discuss these and a method of evaluating swallow.

>> the fees program is highly respected. There is a lot of research that has gone into that process. Rather than explained the process can I just say it is good. Is that good enough? I don't want to teach it. It is not up to me to do that. the protocol has been well analyzed and evaluated. They can be very effective for many of our clients. It does look at the sensory and motor components of beating that are critical to understanding before you get to that food level.

>> Sarah, there is a question here from Susan Graham she writes that her son has a long pallet, small job micro and I apologize, micro Mattia.

>> That means the bone structure of the lower jaw is very small compared to the upper. The job has two parts. Has the upper and lower job connected with the joint, she is saying the lower part is much smaller than the upper part. Which makes big pallet probably not aligning with the lower part. That why she says longer pallet.

>> She is looking for some advice because I think she feels that her son is plateauing. She provides background information that he feeds and enjoys exotic foods except the spicy stuff. He does not like bland food. He never had a G2, he is receptive, not an expressive communicator and inconsistent with vocalization. He is six years old and has a proxy a and dysplasia and the SOP did level one with you.

>> I was just going to say I really want this kid to have oral placement there be. This is the exact type of child we are looking at. a child who has a hypo sensitivity. They want higher labor foods which means this child cannot feel his tongue and lips moving enough to give out enough feedback to the brain to learn to say that again. He also has something called apraxia. Which is how to speak. the best way to explain what a proxy it is this when we say a word, we don't know, to say we know what happens in the brain is really primitive we as scientists and we know, but it keeps changing. It is a very fluid system. Actually the research that was done prior to 2008 has pretty much been thrown out because now we know the brain can learn at any age. You can learn at any age. There is no age limit for muscle skills, no person is too old. Six years old to me is still young. With apraxia again, when we say a word, all of us that do not have that diagnosis. We have a file cabinet in her head, where that were goes.

>> When we say that word we go there to get it again. We don't know how that happens, but that is what language and communication is. I need what you want to say and being able to say. In apraxia children will understand speech, they might try to use speech, they might even say words and then lose him because they don't start any place. Oral placement therapy for the child, that we are describing here, he is the perfect candidate because we are not going to teach him through look at me, we will teach them through, feel this, he will say, that is what you mean. I will store that right here. When I need to say that word again I will remember, health and I will say it.

>> Another chat -- problem is he is hypo sensitive. I will use a therapy tool for him, let's have the byte blocks. Over that but block in his mouth but I will hold a vibrator next to it. Or do but in something that tastes, maybe a flavored powder so he can really feel it or taste it. So when the muscle is working you will know what he is doing. the fact that she has a therapist that has taken a level one class. Encouragement therapist to take more classes. Especially one by RenÃ© Bruegel. There is a video, DVD system -- to know the exact name? I want to give you the exact work. Muscle based approach to childhood apraxia speech, is that right? a muscle based approach to childhood speech and children, by RenÃ© Roy Hill. She has developed a program using plastic discs, they don't :-colon the mouth, the goal in the lives or to allow the child to feel a speech pattern. This would be a wonderful program for this child. There are five levels. She has more knowledge. We encourage her to keep going.

>> Thank you, Sarah. That was very helpful for me. This whole webinar has been terrific Sarah.,

>> I was nervous, I didn't know how it would work.

>> It was brilliant, just really had. Sarah we do have quite a few more questions. I scrolled through them and I think all of them would probably require more than just a one hundred second response from you. So I'm thinking, can you repeat again what folks could do with the questions that we will not be able to get to tonight.

>> Do you see the last slide in my presentation where it has the e-mail information and talk tools.com. Talk tools has agreed, if a question is sent to that location and you will want to reference, you might want to say charge webinar questions. When that question comes in, there are numerous therapist that deal with this population. It may, the answer may not come for me, but it will come from one of us. One of our therapist will be talking at your conference in

Phoenix. Whitney is becoming an expert in this area. She has been with me for over five years. Whitney has also agreed to answer some of these questions. We will get to you as soon as we can. If hundreds come in, you will have to wait a little bit. We will certainly take our time. The end result of any of these questions might be that you need to have an assessment by someone who is looking at the muscle taste skill.

>> Again, a lot of therapists are not trained in this. It is a relatively new specialty. I'm very bonded to children, we will help you in any way we can. They have changed me as of therapist and I share that information when I teach. I will be teaching a class two days from now in Atlanta and I talk about my experience with your children. So in closing here I want to thank you for allowing me to share this information and also to thank you, those of you who have met me in the past. To learn what to do with your children through experiment. Truthfully, it was all trial and error. It has been a great gift working with your group. I'm sorry that I was but that another conference a summer but I would've loved to have come. Please keep inviting me.

>> Thank you Sarah Olivet I will will pass it back today but will for some closing comments.

>> Sarah, thank you so much on behalf of the charge syndrome foundation. We appreciate it and we look forward to seeing you in person in 2015. We are sorry that you can join us in 2013, but we do look forward to having talk tools present and for everyone, this is been a fantastic learning experience. I know there was a tremendous amount of information shared. It will be about our website and the near future. So for everyone who wants a refresher on what was said and exactly what was in the slides, it will be up there. Sarah, thank you again. Have a wonderful evening and all this talk about feeding. Sounds like it is time to eat. Take care.

>> Good night.

>> [Event Concluded]