Literary Review

A review of: Oral-Motor Function and Dysfunction in Children, edited by Janet M. Wilson (1978)

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Oral-Motor Function and Dysfunction in Children

Edited by Janet M. Wilson

208 pages with illustrations.

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Available from the Division of Physical Therapy, Department of Medical Allied Health Professions, School of Medicine, Wing C 221H, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina 27514. Address all requests to *PROCEEDINGS*.

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This publication is based on a conference, "Oral-Motor Function and Dysfunction in Children," which was presented under the auspices of the Division of Physical Therapy, Department of Medical Allied Health Professions, University of North Carolina at Chapel Hill, May 25-28, 1977. The text is presented in three sections and covers a wide scope of information which should prove helpful to the orofacial myologist who is involved with the feeding and speech problems of young children.

Section One presents five chapters which describe the "Structure, Function and Neural Control of Oral and Pharyngeal Mechanisms." Contributors are Suzann Campbell, John Werner, James Bosma, Constance Evans, and Sandra Radtka. Chapter 2, "The Cranial Nerves," by Dr. Joan Werner, is reprinted in its entirety in this issue of *IJOM* by permission of the author and the editor.

All seven chapters in Section II are contributed by Dr. Suzanne Morris, who provides a neurodevelopmental approach to the assessment of oral-motor problems in children. In Chapter One, "Interpersonal Aspects of Feeding Problems," Dr. Morris presents "... an overview of the human factors involved in the feeding process." She stated that the human interaction between the child and the

feeder is the basis on which all of our work rests. Mothers of handicapped children are said to feel inadequate as parents when their children are poor eaters. They may communicate their tensions and frustrations to the child both verbally and non-verbally. At the same time, they may misinterpret the non-verbal actions of their babies. A child with a basically abnormal nervous system may show no feeding difficulties until four or five months of age. Neurological changes at that time may result in hypersensitivity to touch and movement which releases strong withdrawal responses. The mother's misinterpretation of these and other non-verbal actions leads her to feel rejected by the child. The therapist must "... develop a treatment program which either makes it physically possible for the child to respond in a more reinforcing way or provides other types of feedback or reinforcement for the parent."

In Chapter Two, "Oral-Motor Development: Normal and Abnormal," Dr. Morris describes "1) sucking and swallowing of liquids, 2) spoonfeeding of semi-solids and 3) development of chewing," abnormal oral-motor patterns, and implications for treatment. The following chapter, "Sensorimotor Prerequisites for Speech and the Influence of Cerebral Palsy," outlines the normal development of such behaviors as head control, coordinated respiration and phonation, feeding patterns, and ear-motor control for phonological development. Interference in development caused by abnormal postural tone, released tonic reflex activity, and retention of primitive reflex patterns is then described.

In the chapter entitled, "Principles of Oral-Motor Assessment," Dr. Morris details information to be elicited in a careful case history and oral-motor observations to be made by the clinician. She teaches the clinician to respect the personal life space of each individual and gives valuable suggestions for examining in an unobtrusive manner.

Dr. Morris describes, in the latter portion of Section Two, a "Pre-Speech Assessment Scale," its evaluation, and a "Glossary of Terms Describing the Feeding Process." The Scale provides for examination of 26 pre-speech performance areas in sensori-motor

impaired children. Dr. Morris stresses the interrelationship of assessment and treatment.

A given behavior is assessed for the purpose of determining treatment needs and priorities. The child's responses to treatment are evaluated in order to determine the appropriateness of the treatment program. Because of this assumption, the child's behavior may be scored during a formal evaluation session or in the course of several treatment sessions (p. 140).

In the Glossary, Dr. Morris describes various patterns of behavior with which the therapist should be familiar and provides observations to help distinguish abnormal from other occasional behaviors. The following quotation provides a typical example:

A Tonic Bite Reflex is defined as a strong closure of the jaw when the teeth or gums are stimulated. It is often difficult for the child to release the bite and open his mouth after the tonic bite has been elicited. Occasionally both the normal child and the handicapped child with fluctuating tone in the jaw will use a firm bite on the spoon or cup as a way of providing external jaw stability. This bite is generally easily released and does not possess the obligatory reflex quality of the tonic bite reflex (p. 160).

Section III presents principles of treatment and a problem-solving approach to therapy for children with oral-motor dysfunction. In addition to general principles needed in any oral-motor remediation program, the following specific problems are discussed along with guidelines for treatment:

Problem 1: Child takes only strained food and refuses to eat solid foods.

Problem 2: Child is hypersensitive around the face and mouth.

Problem 3: Child gags frequently or vomits food.

Problem 4: Child refuses to eat certain kinds of food.

Problem 5: Child refuses to take liquids from a glass or cup.

Problem 6: Child has poor control of his jaw during eating and drinking.

Problem 7: Child pushes food out of his mouth when he eats.

Problem 8: Child is not able to use his lips to help remove food from the spoon.

Problem 9: Child does not chew.

Problem 10: Child drools profusely. Program guidelines are carefully explained and helpful illustrations are provided.

In "Selection of Food and Equipment for Effective Feeding Therapy," Dr. Morris discusses the influence of the texture of food on the type of tongue, lip and jaw movements to be elicited. For example, "Softer foods are sucked and swallowed, harder foods are bitten and chewed." Some of the textural questions to be considered by the therapist are: Is the food heavy, light, grainy, smooth, lumpy? Does it stick together, melt, or break up into diffuse pieces? It is pointed out that children with swallowing problems usually manage thicker foods and liquids more easily than thinner ones; they manage foods that stick together in a solid bolus more efficiently than those which break apart and which may cause

coughing and choking. Children with tactile hypersensitivity seem to be intolerant of lumpy food. Sweet foods should be avoided for the child with a drooling problem because they create excess amounts of saliva.

A helpful list of feeding equipment is provided, including such generally available items as latex-covered spoons, the soft-bite spoon, Tupperware cups, etc.

Dr. Morris and Sandra Stockdale Weber present an outline of "Abnormalities of Oral-Motor Function and the Development of Speech," and Janet M. Wilson provides other "Helpful Hints for Feeding Children with Oral-Motor Dysfunction." Dr. Morris closes the textbook with a bibliography on the assessment and treatment of oral-motor problems.

While the book represents only one approach to assessment and treatment, the approach is based on sound

principles and would certainly be useful in the repertoire of anyone designing treatment programs for children with feeding, swallowing, pre-speech, and neuro-motor speech problems. "The program was designed for physical, occupational and speech therapists, educational specialists, physicians and other persons interested in the assessment and treatment of the child with oral-motor dysfunction" (p. vi). I highly recommend it for all those professionals, for the orofacial myologist, and for the parents of handicapped children.

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