

The Similarities and Differences of Oral-Motor Therapy and PROMPT

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Recently a question was posed on the PROMPT web site, in which a parent requested information regarding the similarities and differences between Sara Rosenfeld-Johnson's techniques and PROMPT. The staffs of Innovative Therapists International and the Sara R. Johnson clinics have always valued both oral-motor therapy and PROMPT. In Sara's teachings, she states that PROMPT is one program component in working with apraxic clients. Sara's "Three-Part Treatment Plan for Oral-Motor Therapy" includes the concept of facial-cueing as a method by which to map out the motor plan for speech production.

PROMPT therapists and oral-motor specialists look at the speech system in similar fashions. Both Sara Rosenfeld-Johnson and Debra Hayden teach therapists about analyzing the child's system in terms of muscle capacity, respiration and resonance, jaw strength and grading, labial-facial relationships, lingual coordination and dissociation, co-articulation and motor-planning and the overall speech/language system. While different terminology is used in each unique course, both professionals value the importance of analyzing a child's entire system, and base a treatment plan accordingly. This differs from traditional phonological approaches, which analyze speech production in isolation without the relationship between oral motor skills, motor planning, and language issues.

The two philosophies branch more clearly in terms of program plan and treatment. Oral-Motor therapy is based on a child's natural development from birth. Just as children must crawl before they walk, and drink from a bottle before a cup, children develop pre-requisite speech skills through feeding, and sound play. Mouthing toys, chewing, babbling, and swallowing are all important factors in preparing the musculature for speech production. These activities are utilized in therapy to help our clients follow the natural steps taken in developing speech skills. In addition, a muscle-based phonological approach is utilized to determine the needed skills and jaw-lip-tongue placements for typically developing individuals. For example if an /m/ requires lip closure, and the child's lips are always held apart, oral-motor therapy would address exercises to close the lips in non-speech activities such as: removing purees from a spoon, blowing a lip closure horn and practicing an exercise called "Sponge-Balsa-Tongue Depressor." When the desired lip closure was achieved, the therapist would then transition this into speech production goals to include facial cueing, or PROMPT.

PROMPT's philosophy clearly states that there is no relationship between non-speech movements that can carryover into speech production. Ms. Hayden's courses teach the philosophy that the PROMPT cueing system provides a map for the child to sequence speech production. It is based on triggering the neurological system in order to achieve articulatory placement. The PROMPT Institute believes and teaches that the speech musculature does not need a great deal of strength in order for a person to produce speech. The PROMPT Institute also believes that oral-motor therapy has little value because PROMPT in itself works on developing the musculature and helps motor planning via speech itself. This one technique is utilized to treat various issues including stuttering, resonance, and articulation errors and is used to evoke language in non-verbal children.

Oral-Motor therapy does not exist in isolation, as does PROMPT. PROMPT is somewhat confining in that if a particular PROMPT does not facilitate the target sound, there is little change as to how the PROMPT is presented. Each phoneme is assigned a PROMPT cue, some with one option, others with 2 or 3 (for example myohyoid + facial cue or just the facial cue

alone.) When muscles are impaired, as in dysarthria or tongue thrust disorders, the client's system cannot always support the sound. At ITI we have found that an eclectic approach of combining oral-motor exercises, feeding activities, and facial cueing is a more effective technique because it allows for many variables, and options for the client. It is not the expectation or teaching of ITI that oral-motor therapy in isolation will in fact automatically result in sound production; however, it will help build the muscle-memory needed to support sound production.

Another difference between PROMPT and oral-motor is a sensory basis. PROMPT requires the child to tolerate constant touching of the back of the neck (to support the head) and the myohyoid, jaw, lips, nose, and face. This is somewhat difficult in children who are sensory defensive. Oral-motor therapy is based on sensory principles or targeting tactile, kinesthetic, taste, smell, and auditory cues. Oral-motor sessions often begin with sensory massage, deep tissue pressure, and desensitization of the oral-motor system. PROMPT focuses on tactile cueing alone.

Finally, there is the issue of the non-verbal child. PROMPT addresses voicing by two simple cues. One for /h/ and one which touches the throat. These are very basic ways to try and teach a child to evoke airflow for phonation of speech. Oral-motor therapists target phonation via various airflow activities to strengthen abdominal grading, in addition to teaching the child to associate air with sound, while working on muscle-memory for articulatory placement. For example the Talk Tools Horn Hierarchy works on these issues simultaneously, while providing a fun and rewarding activity for the child.

In terms of statistical research, Sara R. Johnson, Lori Overland, and various therapists have been doing clinical research for years. Oral-motor specialists do in fact recognize the need for research in this area because we know that it works. While some researchers believe that non-speech movements have no relationship to speech production, clinical trials have proved otherwise. Parent testimonials and clinical records are what we consider to be the most valued data of all.

In summation, oral-motor therapy and PROMPT are both very beneficial techniques for children with oral-motor disorders. It is not necessary to choose just one of these approaches, but to analyze what works most effectively for the individual client. A multi-sensory approach is most helpful for treating various types of speech disorders.

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