

Feeding Profiles in the Down Syndrome Population

By Heather Peterson, MS, SLP-CCC

It wasn't until recently that I realized that I hadn't written any articles on feeding development, feeding difficulties and the relationship of feeding and speech development. Perhaps it's because I have been treating a lot more children these days with severe feeding difficulties that it has come to my attention. However, no matter what degree of feeding difficulties your child has or not, there is a dramatic relationship between feeding development in the way it relates to your child's oral motor function and speech clarity. Here is a description of the types of feeding difficulties that walk through my door daily and why they occur:

Child A eats everything that the family eats, stuffs his mouth, and is quite messy during mealtime. He drinks from a straw but his tongue wraps under the straw and can often be seen protruding from his lips. His parents often don't think he has a feeding difficulty. **WHY:** This is a child that either has some chewing ability or none. He often chews 3x then swallows his food whole because his tongue and jaw are not working properly to hold food on his molars while chewing. He often cannot feel what's going on in his mouth. He has unresolved tongue protrusion and a low open jaw position which affects his speech development. This child has dysarthria of speech.

Child B eats only crunchy dissolvable things like crackers/chips and prefers purees and softer foods like bananas, cheese, ground meats (chicken nuggets) etc. This child lacks fresh fruits, vegetables and often meats. **WHY:** He eats crunchy dissolvable foods because these foods provide him with sensory awareness when they crunch. He can feel "these" specific foods but has such reduced sensation and overall oral skills that dissolvable foods are safest. Soft solids are also safe because he can mash them with his tongue on the roof of his mouth and suckle/swallow them without chewing. You may think he chews because his mouth looks like its going up/down, but it's really his tongue movement, not his jaw. These children have tongue protrusion, open mouth posture and decreased speech clarity. This child also has dysarthria of speech.

Child C drinks only 1 type of juice, eats the same limited brand-specific bunch of foods each day. You have to pack food for this child every time you eat out at a restaurant. His diet is often nutrient depleted. **WHY:** His food choices are controlled by subconscious or very obvious fear. He has extremely limited skill in his jaw, tongue, and lips. He watches you make, place and feed him his food. His oral sensory profile may be characterized as Tactile Defensiveness or Mixed Sensation. Tactile Defensiveness is a learned tendency to respond negatively or emotionally to tactile input. Mixed sensation means a child can have a combination of hyper (over reaction to stimulus) , hypo (under reaction to stimulus) or normalized sensitivity all within their oral cavity. This can be very confusing for a child to process, and manage food. These children often have Apraxia of speech coupled with dysarthria.

Child D is over the age of 3 and only drinks milk or pediasure from a baby bottle and perhaps eats purees/baby food, but maybe not. This child is nutrient depleted. **WHY:** This child lacks the ability to move his jaw up and down in a chewing manner because he has never done it. He may swing his jaw side to side regularly. He has very low muscle tone and strength in his entire body and has practiced an infantile suckling pattern for years on his baby bottle. His tongue thrust is large and he would not know how to manage food if he tried, which he NEVER would. This child is hyposensitive in his mouth. This child is void of a variety of nutrients that children need to grow and interact. This child can be mistakenly diagnosed with Apraxia but needs intensive oral motor work to strengthen and create motor patterns for speech development.

All of these feeding difficulties are caused by low oral tone, low muscle strength and differences in sensitivity.

They can all be improved and better normalized with therapy targeting the above areas. These children all have speech clarity difficulties because all of the above mentioned oral skills need to be present while learning to speak and while producing speech daily. I'm happy to talk to you more about your child. Please contact me if you think your child needs an Oral Placement and Feeding Evaluation: heather@happykidstherapy.com