Orofacial Myology News

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A big hello to all of you and welcome to our August 2021 edition of the Orofacial Myology News. The topics in this issue offer a variety of helpful suggestions to make your practice run more smoothly and make life easier for you. Learn about Virtual Assistants from Andrea McFarland's article; take some advice about working with your own family members from Becky Ellsworth; go a bit deeper into TMD with Dr. Karen Wuertz; consider how to approach and encourage new clients in the article by Yours Truly; get a grip on the differences among palatal vault, dental arch and palatal arch from Zohara Nguyen's very descriptive article along with her easy-to-visualize images of all three. Hallie Bulkin discusses her specialty area of pediatric feeding while Karen Masters updates you on her trip to Croatia and her myo adventures there. Enjoy our newest column, QOM Gems, that provides an interview with a Qualified Orofacial Myologist. This month's interview is with LeighAnne D'Avanzo, our grad who works with Vivos Therapeutics, Inc. and has her own practice as well.

More new things are on the horizon and we'll be updating you in the next edition of Orofacial Myology News. And don't be shy if you have something to contribute that you feel is newsworthy to share….

Wishing all of you good health and hoping you get the same joy providing your services to others as we do at Neo-Health.

"Tongue Rest Posture: Up, Down, In, Out? Less confusion for new clients…..

The intention of this article is to focus on an easy way to begin the explanation and communication process with new clients so they can be motivated to move forward with your treatment plans. An easy to understand explanation for the initial visit is often far more effective in setting the stage for treatment than accidentally overwhelming them with too much information at the get-go. While a short article cannot address all of the benefits or ramifications of lingual rest posture, we orofacial myologists agree on some basics that can be put into a simple outline.

Location, location and location!

A. The location of the resting posture of the tongue and its influence on speech production.

- If the tongue rests between the teeth, we orofacial myologists are not surprised that there is an interdental lisp. Why is that so? Because we begin speaking from the rest posture location and during every pause, we return to that habitual location.
- If the client is told by a parent, teacher or therapist to put the tongue up to the spot before making the S sound, can it be accomplished on a continuing basis? Not if the habitual resting posture is between the teeth.
- Only if the speech is slowed considerably or if there are only a few words to read or to recite might the sound come out somewhat clearly. This is why the important word "habituation" comes up so often and why we are often asked, "Why can't our clients' speech sounds move easily and smoothly from an isolated sound into words and phrases and eventually into rapid connected speech?" The answer is because it is impossible to move the tongue rapidly enough each time a tongue-tip-to-spot sound occurs in conversation if the tongue consistently returns to that undesirable between-the-teeth location. As many of you readers are aware, it is not only the obvious S and Z (lisp) that is affected, but many sounds are often quite imprecise.

B. The location of the resting posture of the tongue and its influence on dentition.

- Back in the mid and late 1900s, it was thought that the "thrusting" of the tongue caused malocclusions… and let's use an anterior open bite for simplicity. We know now that the brief pressure of the tongue during the "thrust" part of a swallow does not cause an open bite. We understand that it is… yes, here we go again…the RESTING POSTURE of the tongue that is somehow the culprit.
- The tongue seeks to make life easier by inserting itself into the open space which certainly makes more sense. If it did not do so, that space would allow food, saliva, and liquids to fall or spurt out! That space might even allow unwanted "things" to fly in (➢). The natural instinct is to plug that space with the tongue. This ties in with the speech scenario above and demonstrates the close connection of malocclusion and incorrect speech articulation. The difficulties noted in the patients and clients in the dental chair correspond with what the speech pathologists are seeing and vice versa.

Over the 40+ years that I have been actively involved with orofacial myology, we have discovered many more "myo" factors related to orthodontic relapse, articulation disorders, swallowing disorders, airway difficulties, ankyloglossia and much more. We have to take care not to pile on too much detailed information until we are certain that the client understands the basics. I hope this sparks some ideas that will help you during the important first meeting when you are educating them about your deeply needed service!

Karen Wuertz
DDS, QOM

Can Orofacial Myofunctional Therapy Help a TMD?

Current literature reports approximately 12% of people (10 million Americans) in the United States experience temporomandibular joint disorders (TMD) at any one time. Women appear to be affected more often than men, with 9 women to every 1 man experiencing severe pain and restricted jaw movement. The exact cause of a person's TMD is often difficult to determine because discomfort can be due to a combination of factors. These include genetics, arthritis or a jaw injury. Bruxism occurs as a result of jaw clenching or grinding of the teeth during the day. If it occurs during sleep it is known as nocturnal bruxism. It is thought that approximately 85% of people who brux as they sleep, may have an undiagnosed Sleep Related Breathing Disorder. Signs and symptoms of a TMD may include:

- Pain or tenderness of the jaw.
- Pain in one or both of the temporomandibular joints.
- Aching pain in and around the ear.
- Difficulty chewing or pain while chewing.
- Aching facial pain (especially in the temple and lower jaw muscle areas.)
- Locking of the joint, making it difficult to open or close the mouth.
- Headaches in the temporal or base of the skull areas.

TMD can also cause a clicking or popping sound or a grating sensation when one opens their mouth or chews. If there is no pain or limitation of movement associated with a jaw clicking or popping, treatment might not be necessary. A comprehensive head and neck exam is required by a dentist or qualified clinician to first determine if the pain origin is from within the joint or outside the joint. When an exam reveals that the pain is localized to the muscles that control jaw function, it may be related to myofascial pain. Getting to the root cause of the muscle pain is essential to finding the appropriate treatment and therapy. Recent studies have shown a close correlation between jaw pain, airway resistance and Sleep Related Breathing Disorders.

Orofacial Myologists are uniquely trained to identify compensations such as mouth breathing and may be instrumental in enhancing a person's quality of life, especially if they are in pain from their jaw joint constantly working in muscle dysfunction.

In orofacial myofunctional therapy, a main goal is to establish nasal breathing and correct oral posture. Additionally, TMD may show improvement by identifying and eliminating oral habits, evaluating chewing and swallowing difficulties and identifying airway concerns.

As with all therapy, doing the least invasive treatment first is always best. By providing Orofacial Myological treatment, a more harmonious muscle pattern can be achieved and may improve a muscle-related TMD.

Grads Corner

Karen Masters
MS, CCC/SLP, COM, QOM

Hello Myo Friends!

I am writing to you after just returning from a fabulous trip to Croatia! Those of you that have known me for some time know my travel antics! I turn on those myo eyes in airports, hotels and restaurants whenever I travel. I have been landlocked since COVID so I was excited to see what Croatia had to offer!

My first stop was Zadar where I spotted a sign for an Ordinacija! The kind doc caught me photographing his sign and asked me why. I told him I was a speech pathologist and he said: "ahhh logoped!" Apparently, I am a logoped! He went on to tell me that the Croatian University system accepts only 50 students per year to become logopeds! He told me how competitive it is and how great the need is. He was impressed learning about my practice and orofacial myology. It's so rewarding to feel so valued!

On the ferry to Hvar, I saw these two adorable boys trying to get their tongues to their noses! They were having the best time just playing with their mouths! No tablets or phones…just old-fashioned fun! When not playing, they had their lips together and were nose breathing!

I noticed something that got me thinking. On the beaches in Korcula and elsewhere in Croatia, families didn't bring big bags of chips and pretzels. No pizza boxes. No "fast food." They had meat and cheese with bread and fruit. Fresh loaves of bread with peppers and tomatoes to snack on. I saw very little soda or energy drinks. No juice boxes or sucky pouches either. I also saw very few mouth-breathing, tongue thrusting, open bite, oral habit people to photograph! Could it be that their diet and lifestyle compared to ours in the US is the reason? They have meat and vegetables at every meal. Both require more chewing than a diet heavy in processed foods or soft foods and purees. I saw NO BABY FOOD! Babies ate table food cut into small pieces!

When I am home, I don't eat gluten or dairy products. I avoid tomatoes, peppers, potatoes, and eggplant because they are nightshades and known to cause inflammation. In Croatia, I ate all of those things and had no ill effects! No joint pain or bloating. NOTHING! Is our food chain compromised in the US? What's different? I would love to hear from you on what you have seen and learned in *your travels!*

Don't forget to join our Myo Masters meeting, "Exercises 2.0", on August 29, 2021 at 7pm. We are taking a deeper dive into the myo exercises we do with patients. Get your myo eyes ready!

Sincerely

Karen

Find this and other Myo-Designs at:
society6.com/zoharanguyen

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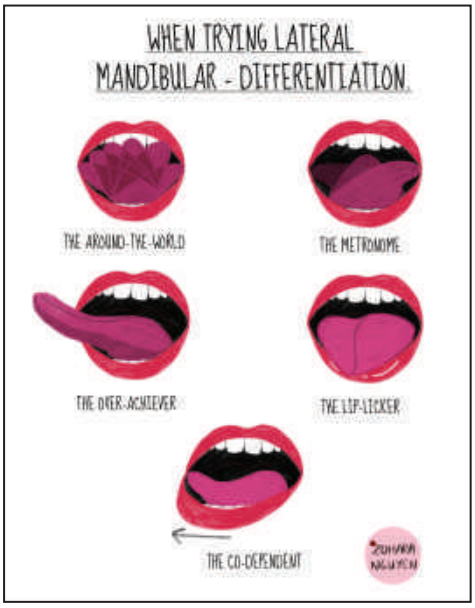


Featured Graduate

Elizabeth (Betsy) Sullivan
MA, CCC/SLP, COM, QOM

We are especially pleased to highlight Elizabeth (Betsy) Sullivan as our featured graduate. Betsy affirms that everyone on her team has been trained by Neo-Health Services and that all are on the same page with evaluation and treatment. We are very proud of her accomplishments and happy to share her thoughts with our readers.

Hello to all my Myo friends! I have run my private practice for the last 21 years after working in various medical centers around the country where I mostly treated adults with neurological communication and swallowing disorders.

Once I began my journey in private practice in 2000, I started to get sporadic calls about kids who were tongue tied and was asked if I treated this. I was miffed. A tongue tie? What was that? I knew nothing. Why did I know nothing?

Most the of the kids I was seeing had already been in speech therapy for a long time. Many of them had similar mouths, crowded teeth, behavior challenges, and were mouth breathers. Now enter Sandra Holtzman, who was teaching a 2 day course in Billings Montana, 2 hours from me called "Oral Motor and the Missing Link". I was in and hooked more than 15 years ago.

Since that time I have made it a mission to spread the word to other SLPs to begin to learn about this specialty area. My private practice now has 5 other SLPs who have either completed or are on their way to Qualification in Orofacial Myology with Neo-Health Services. Orofacial Myology really is "The Missing Link" and I am so so grateful I found it. Thank you to Sandra, Becky, and everyone on your growing Neo-Health team for all you do about spreading the myo-word!!

Why Every Practice Needs a Virtual Assistant

Andrea McFarland
MA, CCC-SLP

Launching and maintaining a private practice requires taking on many tasks and responsibilities. At times, these responsibilities can feel completely overwhelming. You need help. But, what if your budget or physical space doesn't allow for a full-time assistant?

Enter your dream support staff: a Virtual Assistant (VA).

As the name describes, a VA is an assistant who provides support for your practice virtually or online. Having an assistant support you from afar benefits your practice in several ways. Hiring a VA is much more cost effective than hiring in-house staff. You can hire a VA hourly, per project or on an ongoing basis, via monthly retainer. You also don't have to make physical space for your VA. This benefit is especially convenient for teletherapy practices. Hiring a VA also saves you time and money by avoiding long interviewing and onboarding processes.

To save on expenses, new or small practices often attempt to do everything themselves that the practice requires . Even the most talented solo practitioners are at risk of experiencing one of the following problems:

(1) Doing everything to run the practice, but not doing anything particularly well.
(2) Burnout.

By hiring virtual support staff, you can outsource any tasks that don't have to be completed specifically by you. This frees your time to focus on the reason you started your practice to begin with, serving your clients and their families.

Not sure where to begin with what tasks to outsource to a VA? Here are just a few examples of what a VA can do for your practice.

. Social Media | Set-up, Content Creation, Channel Management, Community Engagement, Optimized Bio
. Administrative | Data Entry, Email Management, Organization, Event Planning, Project Management
. Research | Competitor Analysis, Market Research, Data Collection, Review of Analytics, Surveys
. Marketing | Email Marketing, Lead Generation, Sales Funnels, Ad Creation & Management, Visibility Plans
. Client Service | Booking Management, CRM, Proposals, Contracts, Invoicing
. Copywriting | Content for Blogs, Websites, Sales Pages, Email Sequences & Social Media, Editing
. Technical | SEO, Website Maintenance, Telepractice Set-up & Moderation, Cloud Storage Organization
. Design | Graphic Design, Web Design, Social Media, Video Editing

When deciding what tasks to delegate to a VA, first ask yourself the following questions: (1) Is this task urgent or can it wait? (2) Does this task give me energy or drain my energy? (3) Does this task have to be completed by me specifically? The very first tasks to outsource are those that fit into the urgent/energy draining/can be completed by someone else category. You'll be amazed how getting this category out of your to do list will give you increased productivity and creativity. The goal in delegating tasks, is to eventually be completing only those that give you energy and have to be completed by you. This allows you to operate fully in the areas where you're most competent and most fulfilled.

A special thanks to our Grad, Andrea McFarland, for giving our readers this information. She has so much to offer to those of you who want to find a VA that perfectly fits your practice. And as a gift to our Neo-Health family, her company is offering two hours free with the purchase of a 10 hour VA package. Visit http://www.61marketing.com/va-services Be sure to mention that you are eligible for the Neo-Health promotion.

QOM GEMS

with LeighAnne D'Avanzo

(RDH, QOM) Vivos Therapeutics, Inc., Myo Correct

What does it mean to be a QOM?

After taking the course (Orofacial Myology: From Basics to Habituation) you can treat patients, but obtaining that Qualification shows that you took that extra step, that you are willing to really pour yourself into helping your patients.

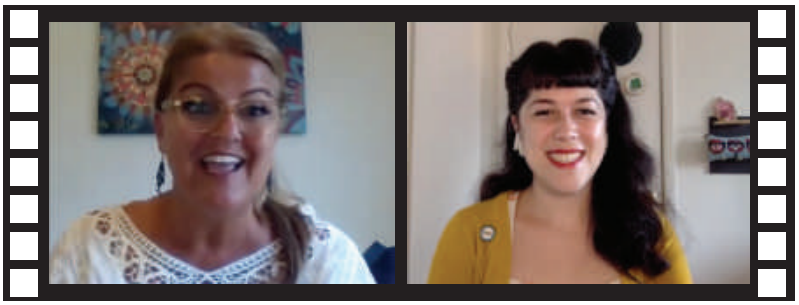
What qualities should a QOM have?

A QOM should have the flexibility to think outside of the box. To assess: Where is the patient's weakness? Where will we begin? Just seeing the patient to be able to maneuver the muscles the proper way, it's so exciting!

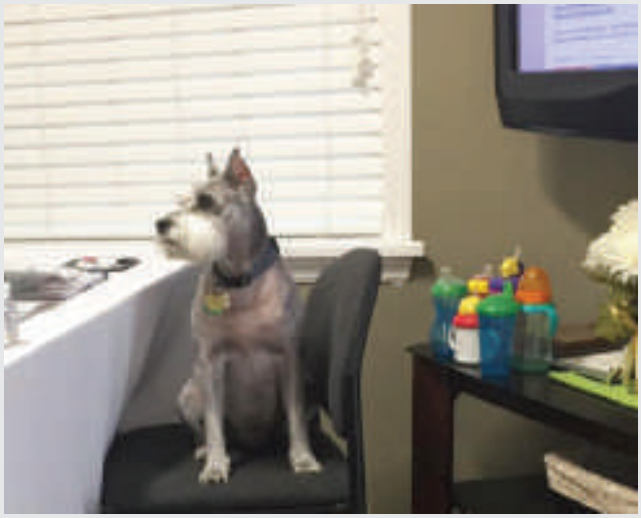
Advice for RDHs considering the QOM process?

I highly suggest to do it. A lot of times when you've been in a practice for so long, and with a team so long, it's easy to create a fear to step away… do it afraid! Step away and research what myofunctional therapy looks like. Really pursue it and go for the QOM! It really gives you that credibility to show that you are capable of treating your patients.

Watch the full interview here: https://fb.watch/7isEOwlHhl/



Henry
2008-2021
by Greta



I met Henry when he was adopted by Sandra 12 years ago. He immediately became one of those dogs that people will remember as a dog full of personality. Henry attended all the in house Orofacial Myology trainings and learned like a pro. He mastered perfect chewing and swallowing mechanics with treats. He even managed to pass the section on finger foods, cheating a little bit by using toes instead of fingers. He knew how to lick properly, and how to control and shape his tongue. These abilities permitted him to integrate everything in Phase Three of the Myo Manual Treatment program directly into his lifestyle, and individualized activities were created for his specific daily patterns.

Henry loved the face-to-face classes where he met most of our grads, and often sat at the head of the class, observing that everyone was attentive. When we went online, he was suspicious at the beginning, but he then learned to adapt, and loved being on Sandra's lap to observe the exercises.

He loved the "single sips" as much as the "continous drinking" but there is no doubt that the "multiple bite foods" was his favorite part of the program.

He was also the one who encouraged the 3-day classes, because he truly believed that more than three days in front of a screen was too much for any living creature!

Henry will be greatly missed by many, but none more so than his mom. She loved him with all her heart. The pain she feels without him is great, but nothing compared to never having had him in her life.

Besides his mother, Henry leaves many amazing friends that he met throughout the years, and uncountable pictures of his myo-adventures.

RIP, Dear Henry.

Outside of the "mouthbox"

To do therapy or not to do therapy, That is the question…

As therapists, we have all experienced the challenge of working with a child that starts out a bit shy but once comfortable, they show their true personality. Not in a bad way usually, but in a more real "this is truly who I am" way. It is actually a compliment to the therapist in creating a comfortable environment, but it can play havoc with staying on task at times!

As you can see from my picture, I have been blessed with 7 beautiful grandchildren! As of now, the four oldest all have Myo issues...really? All have low tongue rest postures related to various causes: airway, allergies (currently under control), and two with lingual restrictions (both released).

That being said, I have, of course, taken it upon myself to see if I can be of assistance to help them normalize their rest postures and functions. It is always tricky when working with any family member and there is one main consideration to take into account. Will the child respond to instruction from someone so familiar?

Many, many times it is best to have someone that is not part of the family work with them. Any close association could cause the old adage, "familiarity breeds contempt" to rear its ugly head! Sometimes you will know right away if it will not work, out but if you think there is a chance it might, I say go for it!

As for my brood, I started working with one of my grandsons and we made it through 5 sessions before he had had enough. He did make some improvements though and we will start again when he is a bit older.

My two older ones will start in the fall when school begins. So far from what I can see, my other grandchildren are looking good!!!
Till next time, ☺
Becky

Becky Ellsworth
AAS, RDH, BS, QOM

Hallie Bulkin
MA, CCC-SLP, COM

Hi, I'm Hallie,
Years ago, I was an SLP traveling from school to school and silently freaking out every time I heard the words, "This student has trouble swallowing…" *Gulp.*

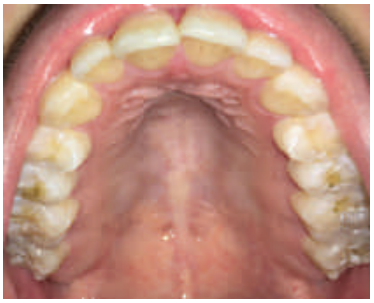
Grad school hadn't prepared me for the unique challenges and requirements of working with a pediatric population, so every year, I saved up and spent hundreds of dollars (sometimes thousands) going to conferences and multi-day workshops. I wanted to serve my patients at the highest level and stop resorting to referring them out every time I felt overwhelmed… And all told, it cost me tens of thousands of dollars spent over a decade to feel confident in calling myself a Pediatric Feeding Therapist. And the biggest thing I learned? There just aren't enough Pediatric Feeding Therapists to help the children in need today.

Since then, I've felt a calling to help ALL SLPs and OTs, with a desire to work with pediatric feeding and swallowing cases to visit Feed the Peds™. They will learn about the Foundations of Pediatric Feeding and Swallowing in a comprehensive 12-week course to becoming a Pediatric Feeding Therapist. We'll be focusing on the foundational development of children from birth through 3 years of age, but this training will apply to older patients too!

Learn more at FeedThePeds.com

Arches & Vaults - The Architecture of the Oral Cavity

Zohara Nguyen
CCC-SLP, MSPA, CPSP, QOM



Orofacial Myologists often use building and construction terms to explain the oral structures in the mouth and how they function. We often say "the palate is the roof of the mouth" or "the palate is the floor of the nasal cavity". Then we even weave in more sophisticated architectural terms to further explain our ideas, "narrow V-shaped arches" and "high vaulted-palate". I imagine hard palates are like the many vaulted ceilings I've been in awe of in the many cathedrals I've visited in my travels. Using these architectural descriptors helps us to decode the form of the palate, how it may have formed that way and what functions it could be helping or hindering.

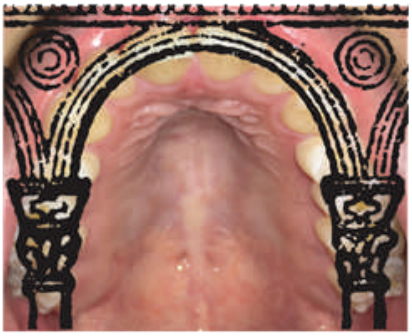
I like to split my observations of the palate into three descriptions:

The dental arch (a.k.a maxillary arch) - I firstly follow the curve of the maxillary teeth and figure if the arch is a nice U-shape, or more V-shaped, and whether this arch appears narrow or broad. Identifying the shape is helpful for our purposes as orofacial myologists because the tongue has to be able to fit inside of the dental arch not just for tongue rest posture, but during speech and swallowing the lateral edges of the tongue need to brace inside of the dental arch for stability. Narrow dental arches are often seen in people with a low tongue rest posture and/or sucking habits - anything that creates disharmony between the buccal, labial, and lingual intraoral forces.

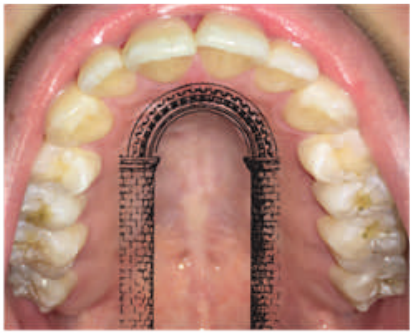
The palatal arch - Sometimes a dental arch can be a beautiful, wide U-shape; however, on closer inspection the palatal arch may be a different shape from the dental arch. The palatal arch may be narrower and even be a V-shape compared to the broader dental arch. Discrepancies such as these make me query if the teeth have been straightened for the dental arch to have a beautiful form, while the palatal arch still echoes the remnants of the underlying dysfunction. Perhaps an oral habit such as thumb sucking or mouth breathing has contributed. We should question if there are oral habits and if potential barriers to therapy are still active.

The palatal vault - We can also observe the height of the hard palate. Ideally the center of the palate should be broad and somewhat "flat" so the tongue can contact the palate, stripping off food during the oral phase of the swallow. A high palatal vault can look like a thumb print inside of the middle of the palate - forming a crevice that often throws a shadow upon observation. A high palatal vault can also indicate dysfunction during development or due to habits including pacifier use, thumb sucking, mouth breathing, and possibly put them at risk of sleep disordered breathing. A high palatal vault is often observed with a narrow palatal arch. People with high palatal vaults may not be able to rest or contact the dorsum of the tongue to the middle of their palate due to the height. In my clinical observations, some people with steep palatal vaults suction the bolus into the vault but are not always successful at propelling the bolus on the first swallow, and may need numerous swallows or to dislodge the bolus manually.

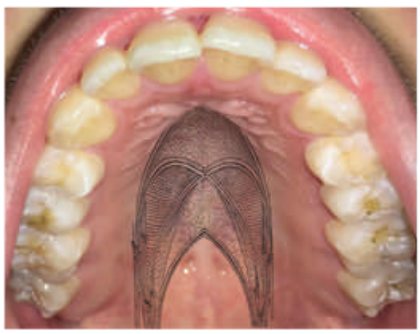
Dental arch



Palatal arch



Palatal vault



This course is presented by real-time virtual instruction and provides an online learning enviroment that offers LIVE INTERACTION between the instructors and you. By participating in group discussions, individual/partnered opportunities during evaluation and treatment training, and lively Q&A sessions, you will feel as though you are in a live classroom setting!

Orofacial Myology: From Basics to Habituation

Sandra R. Holtzman MS, CCC-SLP, COM, QOM
Becky Ellsworth RDH, BS, COM, QOM
Zohara Nguyen CCC-SLP, CPSP, QOM
Jamesa Treadwell BSDH, RDH, COM, QOM
With contributions by **Karen Wuertz** DDS, QOM

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