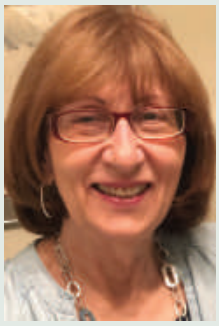
Orofacial Myology News

Founded 2000 | Orlando, FL July 2022 | Published Quarterly



Welcome to our midsummer edition. This edition contains so many interesting articles and perspectives on how we look at our field that it feels more like a "digest" than merely the "news." As you peruse the various articles, I hope you agree! You'll begin with some introspective thoughts as you read the front page article by Zohara Nguyen regarding the importance of remaining true to ourselves and our values. Dr. Karen Wuertz brings us something we've been asking for that explains that when it comes to sleep and breathing issues, "children are not merely little adults." You'll want to copy this article and keep it handy for easy reference. Greta Vigil has brought us a delightful collection of images she found while visiting in Peru recently. Are you able to determine which of these interesting artifacts have "myo" problems and maybe even what has caused the problems you see? It might amaze you to realize that you are a bit of a forensic archeologist in addition to a fine orofacial myology specialist! Lisa Butler gives us specifics to consider when establishing a new practice, something we receive many questions about frequently. Becky Ellsworth gives you the inside scoop and a bit of a "teaser" related to her upcoming teen and adult oral habit program, "Extinguished." It will soon be hot off the press!! And we are pleased to have received a submission from Raymond Mertens from the Netherlands, whose extensive background challenges us to observe and consider mild lingual restrictions with new eyes and to think "outside of the mouthbox." Catch up on the news of our graduates, see who is highlighted as our Featured Grad, and who is the highlighted QOM therapist. Learn about new class offerings and much more in this biggest ever Orofacial Myology News edition.

Using the Human Touch in our Modern **Myo**pic World

A few years ago, I anxiously had my first eye exam. "One, two" the optometrist briskly said as she flicked the lenses so that they changed. "One, two" she said again when met with silence. "Sorry, what am I meant to do?" I queried. At the end of the exam she handed me a script as she hurried me out of the room, "Is it astigmatism? Myopia?" I demanded with the little "eye jargon" I had. I did not feel at ease or taken care of by a "professional" who had just invaded my eyes. If a robot had assessed my vision I may have at least been greeted with pre-programmed niceties. Since then, I've avoided booking eye exams with that provider.

Now more than ever using a "human touch" is essential to healthcare business and practice as a vital ingredient to gaining client trust and retaining client loyalty. We may be new clinicians so focused on executing the steps in the session, or experienced clinicians on "auto-pilot", that we forget to use tact and therapeutic reassurance that put our clients at ease. Clients disclose their vulnerabilities to us as therapists as we navigate inside the landscape of their mouth, so using a human touch is the least we can do to validate and reassure our client's experiences (whether this is in-person or through teletherapy!)

Zohara Nguyen
CCC-SLP, CPSP, QOM

Everyone wants to feel that they are being taken care of and that their presenting issues can be addressed with an individualized treatment plan. A rigid set list of exercises for every client that can be completed in x amount of weeks, or an app of myo exercises to replace an orofacial myologist would not be good practice. Clients require the expertise of a well-trained orofacial myologist (with a thorough treatment program), utilizing the "human touch" of individualized feedback, the tweaking of their technique, and clinician support to best set the client up for success.

Our Neo-Health team has always used the "human touch" within our Orofacial Myology training courses. Our class attendees have reported that they are very appreciative that we have retained our ability to impart the human touch within our virtual "real time" classes as well. As the world continues to become more automated and impersonal, you can preserve the human touch in your myo practice through implementing any of the unchecked boxes (as well as adding your own ideas). You can reinforce the empathy and understanding that drew you to work in this fulfilling, niche field by avoiding robotic professional **myo**pia.

How do you provide a "human touch" to your therapy and work environment?

Do You?

- ☐ respond personally and promptly to potential clients and current clients?
- ☐ have an age-appropriate icebreaker to ease the client before "talking business"?
- ☐ anticipate the client's needs: put water, tissues/paper towel in front of them?
- ☐ provide an overview of the session plan?
- ☐ ask for initial consent to approach/touch them?
- ☐ explain to the client generally what you are about to do before looking into their mouth?
- ☐ explain the purpose of the tools you introduce and how the client interacts with them?
- ☐ pace the flow of the session to the client's age, mood, and capabilities?

When it comes to sleep & breathing, Children are NOT little adults! (Part I)

Karen Wuertz
DDS, QOM

I'm sure many of you have heard this phrase. But when it comes to Pediatric Sleep and Breathing disorders, it is extremely important to understand and recognize the differences between children and adults. It's a complex topic, but let's take a closer look.

Pediatric Obstructive Sleep Apnea (OSA) affects approximately 1-8% of children and is most common between 2-8 years old. One of the major risk factors includes enlarged adenoids and tonsils in otherwise healthy children.

In comparison, the prevalence of adult Obstructive Sleep Apnea today has a wide variance, but on average affects approximately 15-30% males and 10-15% in females with increasing risks with age and obesity. There are some very obvious (similar) signs and symptoms that children and adults may both present with. But it's the subtle ones in children that we need to pay closer attention to.

What's most confusing and frustrating, is that there is still no clear-cut classification of OSA severity in children and no uniform acceptance. This makes it even more important that we identify these children and provide the opportunity for early intervention and treatment. So, if a child presents with one or more of the following clinical symptoms listed below in red, it warrants further evaluation and a referral to a Pediatric Board-certified Sleep Physician for a definitive diagnosis.

Stay tuned for Part II where we'll look at the different screening tools available to identify children and adults that may be at high risk for OSA.

Children	Adults
Snoring – but not in all children	Loud Snoring (more common in men)
Pauses in breathing	Pauses in breathing
Nasal congestion	Nasal congestion
Restless sleep	Restless sleep
Hyperactivity (ADHD) impulsivity, aggression	Excessive daytime sleepiness (common in men)
Snorting, coughing or choking while sleeping	Snorting, coughing or choking while sleeping
Mouth Breathing (dry mouth, sore throat)	Mouth Breathing (dry mouth, sore throat)
Nighttime sweating	Nighttime sweating (more common in women)
Bed-Wetting	Frequent awakening to use the bathroom
Sleep Terrors	Nightmares
Enlarged tonsils & adenoids (Hyponasal speech)	Morning Headaches (more common in women)
Behavioral problems	Mood changes (depression)
Poor school performance, learning issues	High Blood pressure
Poor weight gain or obesity	Decreased libido (both men and women)
Family history of snoring or OSA	Insomnia (women)
Craniofacial structures (genetic)	Heart palpitations (men and women)
Orthodontic issues	Craniofacial structures (genetic)
History of premature birth	Smoking
Asthma, exposure to smoking	
Ankyloglossia, Macroglossia	

Dr. Karen Wuertz serves as the Dental Representative to the Neo-Health Services (NHS) Team and is the Credentialing Chair for the American Board of Craniofacial Dental Sleep Medicine. She received her Doctorate of Dental Surgery at the University of Texas Health Science Center in San Antonio and completed her General Practice Residency at the Barnes-Jewish Hospital in MO.

She attended Tufts University Dental Sleep Medicine Mini Residency and the American Academy of Craniofacial Pain (AACP) TMD Mini-Residency, and received her Fellowship in the Academy in 2014. She is a Diplomate of the American Board of Laser Surgery (ABLS), a Diplomate in the American Board of Craniofacial Dental Sleep Medicine (ABCDSM), and has earned the Qualified Dentist Designation in the American Academy of Dental Sleep Medicine.

She has served on the Dental Faculty of Creighton University, The University of North Carolina Chapel Hill and The University of Texas Health Science Center.
Dr. Wuertz is currently a full-time faculty member at The University of Texas at Houston, School of Dentistry, and serves as a Group Director in the Department of General Dentistry and Dental Public Health.

Grads Corner

Karen Masters
MS, CCC/SLP, COM, QOM

Learning as well as a commitment to a lifetime of learning has always been my "thing." I was that person who loved school, loved preparing for tests and just loved everything about college and grad school. Starting down the myofunctional path with Neo-Health back in 2014 has helped me continue with that passion. I have taken loads of classes, attended many online learning opportunities and am part of several group chats going on at all times with like-minded myo nerds! Recently, I have received referrals for some challenging cases and this one in particular is worth sharing because of the lessons it taught me.

A physical therapist sent a 29 year old woman to me with swallowing issues post covid. Officially termed a "long covid" case, it intrigued me. I knew my "myo eyes" would be useful and agreed to evaluate her. She described eating Chick-Fil-A on night 5 of Covid; yet on day 6 she couldn't swallow scrambled eggs.

She shared a history of reflux, asthma, anxiety, and poor sleep. My assessment showed a low forward rest position of the tongue, poor food management and bolus control, a “thrusting” swallow, imprecise sound production and a VERY limited diet. I jumped in with both feet. I called all the treating doctors, the therapist who read the swallow study at the hospital, and even the "long covid team" in NY. I spent hours learning as much as I could from the people she'd already been to. We started therapy after outlining treatment goals. All she wanted was to be able to eat but I knew I needed for her to improve her function in order to make way for more food choices. Our sessions were productive and progress was measurable. I had to draw on my best counseling skills to help her with her mindset and beliefs about her future with food. She would talk about "bad swallow days at work" and I would remind her of the progress we were making. I introduced some foods that really made her happy and her confidence grew. I was thrilled that she was starting to see the progressive movement that I was seeing.

Then, she decided she couldn't afford to come for therapy anymore. I understand the financial commitment our patients make and I respect their choices, but I was crushed. I had taken an advanced course in certain manual techniques that could be applied for her type of situation, and she was benefiting....and I was benefiting both from the unique condition she presented with that allowed me to grow personally, but also from the pleasure of her success to that point. I took her off my schedule knowing I gave it my all++ and am satisfied that I gave her the best treatment to help with the condition for which she presented. There will be more patients to help and to learn from. There is no shortage of oral dysfunction. Just go sit at an airport or mall. It's everywhere! Enjoy the rest of your summer and make sure you log on to the Myo Masters monthly meetings!

Featured Graduate

Roberta Kelley,
MS/CCC-SLP, QOM Track

I never thought I would still be working in my mid-70’s! But I find that my interest in orofacial myofunctional disorders and treatment have only been heightened as the years have gone by! In the 1970’s, as a clinical instructor in Speech-Language Pathology at the University of Washington, I received a telephone call from my father, an orthodontist, asking “What do you know about tongue thrust?” “Nothing” I answered. His response was “You’d better find out.” (He had been to an ortho meeting and heard about it…). I found the Institute for Myofunctional Therapy and spent my first week in OMT training with Daniel Garliner in Coral Gables, Florida. And then I found the IAOM and was introduced to such greats as Bob Mason and others. And locally, Joe Zimmerman became my mentor. I received my COM in 1980 after Joe and Dianna Zimmerman observed me for a day seeing OMT patients. Many wonderful conferences in the States and abroad ensued, meeting great people (Sandra Holtzman was one!) and learning lots! My studies continued as I pursued classes with other organizations. My views broadened, and I started receiving referrals from Sleep Medicine physicians as well as orthodontists.

I continued serving the OMT population in my full-time practice as an SLP at Virginia Mason Medical Center here in Seattle. After 29 years there, I “retired”. The orthodontist who was a primary referral source was so disappointed that I decided to develop a small private practice in orofacial myology to support her and continue to see her patients. During the pandemic, I looked for some training in orofacial myology available via ZOOM.

I had never taken Sandra’s Neo-Health Services course, and thought it would be a great refresher. Not only did the course support previously learned information, but it provided me with many new techniques in assessment and treatment! It was so rewarding to immediately use these techniques in my next OMT assessment. We are so lucky to be involved in such a rewarding and satisfying profession!

Ancient Peruvians and Orofacial Myology disorders

by Greta Vigil

An interesting surprise during my last trip to Peru was an invitation to the Larco Museum. The museum's galleries exhibit magnificent treasures from Ancient Peru. Among them is a collection of ceramic sculptures that seem to portray individuals with malformations, minor anomalies, mutilations, and possible genetic syndromes.

What disorders of the mouth and face do your “myo eyes” see in these pictures? It is unclear if the Ancient Peruvians were able to correct these facial differences, but they were able to observe and reproduce them in their vases as an important way for information to be recorded and preserved.

It was interesting to learn that they punished people by cutting their noses, a very particular situation that apparently derived in an inevitable open mouth, as observed in the following vases:

While it may be difficult to see the details in this old vase, it portrays an old fashioned device to forcibly seal the mouth closed. Feel free to use this picture as a deterrent and argument that maybe Myo Therapy is better!

Starting a Business

Orofacial Myologists can start their own business by following a few quick steps.
It isn't as hard or intimidating as it may seem.

Here's what you'll need:

#1

Set up your Business Entity

First, decide on a name for your practice. Be sure to search your state for other businesses with the same name.

Next, choose a business entity; S or C-Corp, Partnership, LLC, or Sole Proprietor.- I suggest reaching out to your accountant/lawyer for advice on the type of entity that is best for you.

Benefits of an LLC and S or C-Corp - they protect you from personal liability in most instances, your personal assets like your vehicle, house, and savings accounts won't be at risk in case your LLC faces bankruptcy or lawsuits.

#2

Apply for a Government Issued Tax ID Number (TIN/EIN)

A Tax Identification Number (TIN), also called an Employer Identification Number (EIN), will be necessary for tax purposes for your private practice.

You can apply for a free TIN/EIN online through the IRS website.

#3

Obtain an NPI Number

NPI stands for National Provider Identifier number. Having an NPI is required to bill insurance or for patients to submit for reimbursement if you are out of network. You need an NPI even if you decide to be a cash only practice. An NPI is like a social security number in that every provider has a unique and individual number. Unsure if you already have an NPI? You can search the NPI public directory for your name.

#4

Set up a HIPAA Compliant Structure

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a law that protects clients' privacy. HIPAA regulations govern the way that businesses provide privacy and security.

Lisa Butler, MS CCC-SLP, QOM

Thank you to Lisa Butler for contributing this information. Lisa is the owner and director of Back Bay Speech Therapy. She works with children and adolescents with speech, language, swallowing and literacy disorders. Lisa's passion in conjunction with her enthusiasm for working with young children has set the core values and standards of Back Bay Speech Therapy.

BACK BAY
SPEECH & OCCUPATIONAL THERAPY

Outside of the "mouthbox"

The Inside Scoop on Extinguishing Teen and Adult Oral Habits

by Becky Ellsworth, RDH, BS, QOM

As Orofacial Myologists, we have likely encountered some of those "older" individuals with oral habits. ("Older" referring to teens and adults rather than children). We are aware that we cannot proceed with treatment until the oral habit is "extinguished". While there are a variety of programs for children, how do we proceed with this "older" population?

Some clients will come to us and ask for help, and others are discovered to have oral habits during the evaluation. The former client is already heading in the right direction and will probably be compliant with suggestions… but what about the others who are not at all aware of their habit or are perhaps in denial about it?

As many of you know, with the help of my team, I have been creating *Extinguished! Oral Habit Control for Teens and Adults,* a program geared specifically for teens and adults to answer all of the questions related to this population. The question arises, "Where should we start in order to gain their trust and confidence?" We should be prepared and well-practiced in opening the discussion with clients, have information handy, be able to explain and present a plan, and offer encouragement that they can eliminate this barrier to success in therapy.

For teens and adults to be successful in tackling their oral habit, it is important for them (and for us!) to understand certain concepts including the following:

What happens in the brain in order for habits to develop?
How does age play a factor in the ease of developing or breaking a habit?
What potential interventions can be utilized for different types of oral habits?

Beyond these, are there another major hurdles? Yes, the next challenge is to determine the client's potential to achieve victory over their habit. While many factors play into this, such as the FID (frequency, intensity and duration), the bottom line is twofold: *confirming that they are aware of the habit and confirming that they have the desire to extinguish it.*

From this point on, it is a matter of finding out what intervention(s) will work best for each client; setting up time frames and small rewards for weekly successes; and instilling in them a personal belief that they will meet with success. Working with the "older" population, I have come to see that, similar to the effect on young children, the internal changes that occur during the process tend to create an empowerment in the client that wasn't there before. That in itself is a gift!
Til next time, Becky

Free virtual classes

Common Questions About Your Myo Manual

We are offering free virtual classes to assist those Myo Manual owners who have not already attended our Neo-Health training courses. It is an informative hour addressing common questions about the Myo Manual Treatment Program, a brief review of the tools and their expanded purposes, and the opportunity to connect with the author and highly respected instructor, Sandra R. Holtzman, MS, CCC-SLP, COM, QOM. Due to the success of earlier offerings, we have arranged two additional classes intended for therapists seeking product knowledge and insights into our treatment program.

Dates and Times (Eastern Time USA): August 1, 2022 (7:30-8:30)
September 12, 2022 (7:30-8:30)

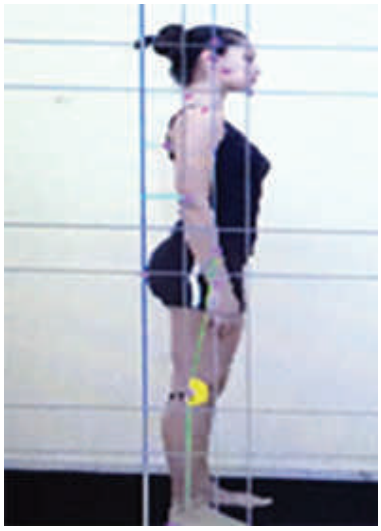
Eligibility is limited to those using the Myo Manual Treatment Program.
To register, contact Carma@orofacialmyology.com Be sure to specify which date you want to attend.

I was so happy to be a part of the virtual offering. The time flew by so fast! It definitely stimulated me to learn more. I found especially helpful when you reviewed all the offerings of your website. I also love the way you wrote and put together the Myo Manual in more of an outline style with divider tabs to quickly assess different sections. Thanks again.
Respectfully,
Faith

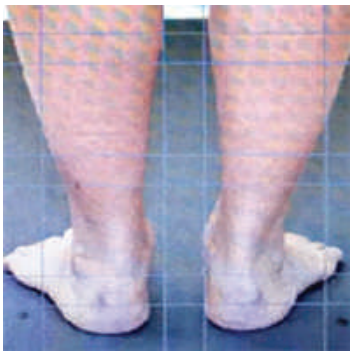
The symptoms of a short frenulum outside the "mouthbox"

Raymond Mertens – D.O.

Osteopathy relies on manual contact for diagnosis of lesions, deviations from the normal and treatment. Osteopathy uses therapeutic manual techniques to improve the impaired or altered function of skeletal and related vascular, lymphatic, and neural elements.



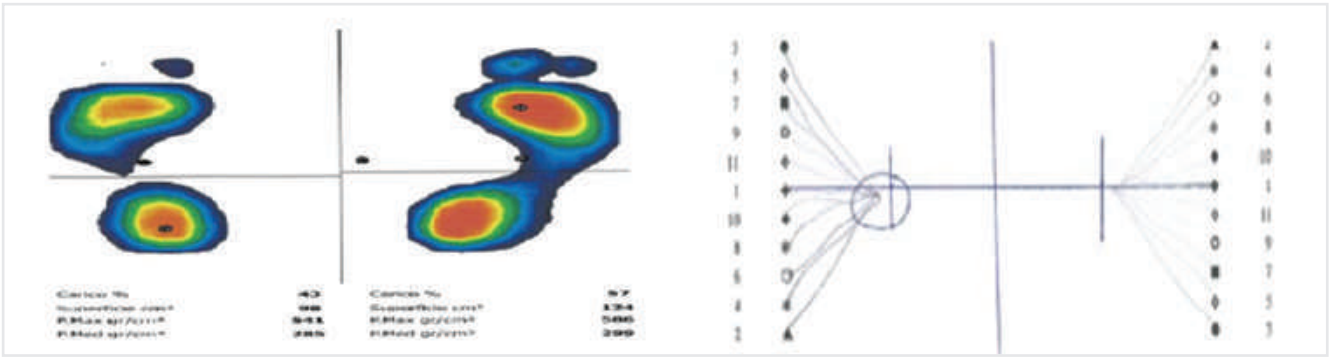
Example of a postural osteopathic examination of the lingual chain, head position and back of the foot (Mertens 2022).



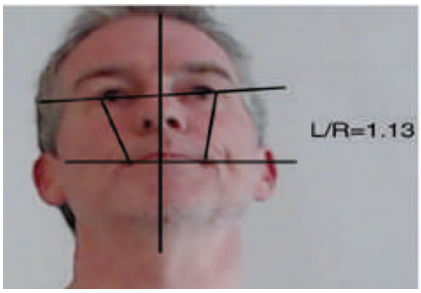
The lingual frenulum is a residual sublingual embryological tissue on the midline between the lower surface of the tongue and the floor of the mouth. Even moderate restrictions of the frenulum, and especially in true ankyloglossia, can cause a modification of the tongue-hyoid mobility and its movement preventing a physiological deglutition which tends to reharmonize the cranio-cervico-facial muscular tension balance and therefore the overall postural balance of the body (Saccomanno and Paskay, 2020). This affects the lingual chain, a set of muscles and aponeuroses, starting from the apex of the tongue in the antero-medial region of the body in a longitudinal sequence. At a biomechanical level the lingual chain controls the anterior gravity line described by John Martin Littlejohn (1865-1947), stretched between the chin symphysis and the pubic symphysis (Scoppa, 2005).

Clients with incorrect swallowing or short lingual frenulum may present following symptoms (Saccomanno and Paskay, 2020):

- hypertonia of the lingual chain
- posterior hypotonia
- forward head position
- facial asymmetry
- limitation of the mouth opening, measured with the Quick Tongue-Tie Assessment Tool (QTT)
- divergent binocular vision pattern, measured with The Van Orden Star
- tendentially a varus position of the rearfoot complex
- displacement of the body's center of gravity in standing position



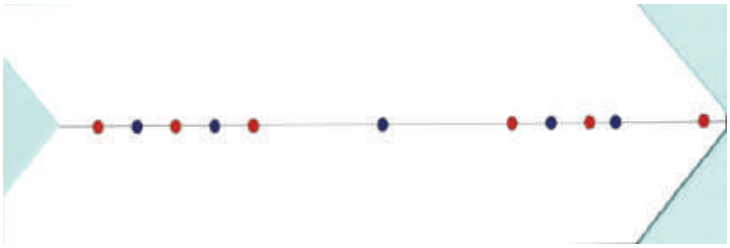
Example of examination of the pressure distribution and the van Orden Star drawing to gain insight in the patient´s binocular behavior pattern.



A facial asymmetry can lead to decreased fixations, tracking and saccades of the eyes. Fixations refers to all metrics related to the stopping point (fixation) of the eye. Pursuits refers to all metrics related to the movement of the eye in relation to an object (smooth pursuit). Saccades refers to all metrics related to the quick movement of the eye to relocate foveal vision (saccade).

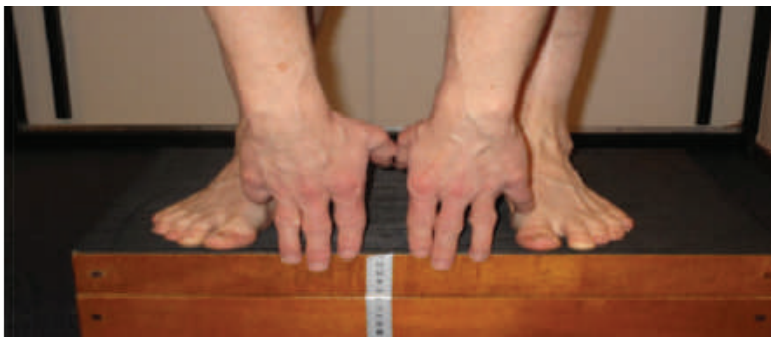
Example of a morphometric calculation of facial asymmetry (Akbari et al., 2015 - modified).

The facial asymmetry may lead to a Convergence Insufficiency of the eyes. Convergence Insufficiency (CI) is characterized by a decreased ability to converge the eyes and maintain binocular fusion, while focusing on a near target. CI is usually accompanied by a reduced near point of convergence. The examiner holds a penlight about 16 inches in front of you and slowly moves it closer to you until either you have double vision, or the examiner sees an eye drift outward.



Example of the Bern Convergence Test Chart (Mertens, 2022)

The client holds the chart against his nose bridge in standing or sitting position. The client is instructed to alternate fixation and focus from one red or blue dot to the next, in the direction of his nose bridge, while maintaining awareness of physiological diplopia. The amount of convergence can be measured in inches.



An example of the osteopathic manipulative treatment inside “the mouthbox” would be a mobilization of a frenulum shift in lateral and/or anterior direction and measuring the effect of the mobilization by the fingertip to floor distance in inch.

This is summary of observations due to a mild restriction or short frenulum outside the “mouthbox” in my osteopathic practice. Next time when you see your client in the office, you may have new viewpoints and ideas.

References:

Akbari MR, Khorrami Nejad M, Askarizadeh F, Pour FF, Ranjbar Pazooki M, Moeinitabar MR. Facial asymmetry in ocular torticollis. J Curr Ophthalmol. 2015 Nov 23;27(1-2):4-11.

Scoppa F. Glosso-postural syndrome. Annale di Stomatologia 2005; 54(19):27-34

Saccomanno S. and Paskay L. New Trends in Myofunctional Therapy: Occlusion, Muscles and Posture (2020

Raymond Mertens is born in 1972 in the Netherlands. After he graduated high school he received his bachelor degree in physical therapy in 1995, his DO-Osteopathy degree in 2002 in Belgium and his master degree in Osteopathy in 2016 at the Dresden International University. Raymond is a Neuro-Visual Rehab Trainer (Padula), international Buteyko and Heartmath Certificated professional with an Applied Kinesiology education. He works as independent health care provider in the Netherlands and Germany.

Contact details: **Raymond Mertens Osteopathie**
www.atstillalive.com
Email: info@atstillalive.com

The Sad Thumb
(who wanted to become "Unplugged")

As therapists we often use images to help us tell stories. Although reading might be difficult for small children, they easily relate to visual representations. Since its publication, the Sad Thumb has become an important therapeutic tool that easily explains to kids the damages of thumb sucking and other oral habits. Although we want the child to be responsible for his decision to quit, we don't want him or her to feel guilty or judged. So we put the burden on our little thumb... asking "Thumb" to be the one explaining all the undesirable effects of a negative sucking habit. We hope it serves you and your patients well.

orofacialmyology.com/product/the-sad-thumb-book/

Tool Quiz:"This tool does what?"

We're going to show you some specialty tools that you may or may not be familiar with. Guess each one's function and get a point for each correct answer. At the end, see how your score stacks up.

1

2

3

4

5

6

7

8

9

a	Used at the end of therapy to provide a means of practice and review.
b	Used as a mandibular stabilization tool that can be oriented two ways.
c	Used to perform a quick test for tongue-tie and general oral and facial measurements.
d	Used individually or with a "Buddy" to improve lip closure and resistance.
e	Used as gentle reminders to keep the tongue in the correct location and to maintain the correct resting postures.
f	Used as a stabilization tool that can be oriented in three positions.
g	Used to establish a baseline and to demonstrate lip improvement during treatment.
h	Used as a reminder to keep hands, thumb and fingers away from the mouth.
i	Used to coordinate and improve lingual/ labial/mandibular differentiation at the end of Phase One.

Answers
1g 2h 3c 4i 5f 6d 7a 8e 9b

9	Perfect score! If you have taken the time to understand the tools, we are sure your therapy approach is as good as your score.
4 - 8	Hmm.... Consider reviewing the quiz because you may be missing some good resources to help your patients.
1 - 3	Oh well, don't despair! These tools were created to support you and your patients. We invite you to learn about them to see how they can drive improvement in your practice.

QOM GEMS with Joann Amoroso, RDH

What did you learn while doing the QOM process?
I have taken other Myo Courses before but learning through the Neo-Health Services Team and working through the manual has helped me really put all the pieces of the puzzle together that I did not really understand before.

What does it mean to you to be a QOM?
It is SUCH an honor to be part of such an incredible group of professionals who are always willing to share and grow from each other's experiences. It means the world to me to be a part of that!

How has attaining the QOM helped you professionally or helped your practice?
It has helped me to really understand how to make what I am doing really productive for my clients. What could be more important?

What qualities should a QOM have?
I think you need to be willing to listen and grow ALWAYS. We are always learning and that is so very important for us professionally and for our clients.

What advice do you have for your peers who are doing/want to do the QOM process?
Go for it! You will have the most incredible professionals always there to help you and teach you. It is a family :)

Testimonial:
I can't say enough about what a wonderful experience this has been for me. I encourage anyone who is practicing myofunctional therapy to become part of the Neo-Health family and to think about becoming a QOM. It is an amazing group of providers to be part of!

Orofacial Myology News is brought to you by Neo-Health Services, Inc. to keep you posted on policy, state of the art treatment methods, conventions, noteworthy therapists, products, and other topics related to Orofacial Myology. This newsletter is meant to provide a connection among all of us who practice or have strong interest in this specialty area. It is important for us to maintain a strong link from state to state and from nation to nation, so that we can grow as individuals and as a respected profession.
The views and opinions expressed are those of the authors and do not necessarily reflect the position held by Neo-Health Services, Inc.