Myofunctional therapy

A structured, individualized treatment for retraining and restoring normal oral function

By Stephanie Wall, RDH, MS DH, MEd

Orofacial myology, or myofunctional therapy, is the treatment of an orofacial muscle imbalance, incorrect swallowing pattern, TMJ muscle dysfunction and/or the elimination of bruxing, clenching or nocuous oral habits. The main muscles of concern to the orofacial myologist include the temporalis, masseter, internal and external pterygoideus, buccinator, orbicularis oris and the mentalis.

Orofacial myofunctional therapy is a form of oral facial physical therapy. It involves exercises and stimulation designed to inhibit inappropriate oral behaviors and/or strengthen appropriate muscle functioning.

Resting postures of the tongue, jaw and lips are very important in normal oral growth. When the tongue rests between the posterior teeth, they may not fully erupt, resulting in an open bite appearance. If the tongue rests against the maxillary anterior teeth, especially if the upper lip is short or weak, the teeth may begin to protrude too far forward. When the lips are not in a closed resting position, the growth and development of the mouth can be adversely affected.

Excessive non-nutritive or non-speech oral behaviors, such as clenching, bruxing, thumb or digit sucking and nail biting, can also affect the condition of the teeth and health and functioning of the mouth, especially the jaw. When any oral behavior is excessive in intensity, duration and frequency, the pressures or collision forces can have a serious impact on normal facial appearance and orofacial health and functioning.

One of the most commonly seen disorders, tongue thrust, refers to a pattern of swallowing in which the tongue pushes forward and/or sideways against or between the teeth during swallowing. Swallowing occurs hundreds of times each day with little to no conscious thought. When the tongue presses against or between the teeth during swallowing, the pressure can have adverse effects on the position of the teeth, bone growth, soft-tissue condition and mouth functioning. Some of the symptoms that occur with tongue thrust include:

- aerophagia,
- difficulty swallowing pills or firm foods,
- the inability to wear dentures,
- a residual effect on the hard palate from a digital habit,
- chronic mouth breathing,
- continued nasal stuffiness,
- orofacial muscle strain and imbalance,
- chronic headaches or facial spasms or pain.

Additional types of patients the orofacial myologist may treat include individuals with the following:

- high arched hard palate,
- weak lip structure,
- facial grimace when swallowing,
- ankylosed lingual frenum,
- protrusion of the tongue when in repose,
- over developed mentalis muscle,
- sleep apnea.

Upper airway infections and obstructions are frequently identified as causes of orofacial myofunctional disorders, especially when these problems cause the mouth to rest in an open position. Reduced oral muscle tone or poor orofacial muscle postures appear to negatively impact the growing mouth and facial structures.

Long-term non-nutritive sucking habits can also malform the oral structure. Sometimes poor speech articulation patterns may indicate neurological or physical deficits. It is often difficult to determine why an orofacial myofunctional disorder exists because the behaviors can be the result of stimuli no longer fully obvious.

Regardless of cause, once inappropriate oral behavioral patterns are established, they tend to continue until some external stimulus or

National Museum of Dentistry presents a ‘Tooth Fairy Day’

What do fairies do with all those teeth? Grab your wand and put on your wings to meet the Tooth Fairy herself and find out at Tooth Fairy Day at the National Museum of Dentistry on Saturday, May 14, from 10 a.m.–4 p.m.

Discover how to have a sparkling smile during an afternoon filled with “tooth-riffic” hands-on activities and exhibits throughout the museum on a scavenger hunt to find out at Tooth Fairy Day on Saturday, May 14, from 10 a.m.–4 p.m. in the National Museum of Dentistry.

Kids can try their hands at fairy work by making a tooth necklace, decorating maracas, learning about animal teeth and exploring the museum on a scavenger hunt to learn about false teeth, including the most famous false teeth of all (hint: they belonged to the first president of the United States). In addition, children can explore hands-on exhibits throughout the museum about all things toothy and how to have a healthy smile.

Tooth Fairy Day is included with regular museum admission: $7 for adults, $5 for seniors, $5 for children, free for two and under and active duty military and immediate family.

The National Museum of Dentistry, an affiliate of the Smithsonian Institution, is located at 51 S. Greene St. in downtown Baltimore. Call (410) 706-0600 or visit www.smile-experience.org for more information.
Back to school?

The bachelor’s of science in dental hygiene degree is becoming more difficult to obtain due to the closing of many traditional four-year programs. This leaves many hygienists with an associate’s degree in hygiene. While an associate’s degree allows a graduate to practice dental hygiene, a four-year degree is preferable for many positions associated with dental hygiene. If one has aspirations of being employed in dental hygiene education, corporate positions, sales, etc., a bachelor’s degree is sometimes mandatory.

Degree completion programs are available to obtain a bachelor’s degree in dental hygiene and there are hygienists who wish to pursue that degree. For those interested in a career in dental hygiene education, this is usually the mandatory path. In many programs, full-time teaching positions may even require a master’s degree in dental hygiene education.

For the other positions, the course of study is much as important. Bachelor's degrees in other courses of study mix nicely with the profession of dental hygiene. Hygienists can often be heard saying they feel like counselors. Understanding the way human beings learn, think and are motivated help hygienists relate to patients. For these reasons, clinical dental hygiene is well complemented by a parallel degree in psychology.

For those interested in a sales position, a degree in business may prove to be a good parallel degree. A hygienist who wishes to write might want to consider a degree in journalism. Those with a patient base that speaks languages other than English may benefit from a degree in a foreign language. Clinicians interested in research might want to consider majoring in a field they would like to research, such as biology. A four-year degree in something other than dental hygiene may open doors to other career opportunities if one decides to leave the dental hygiene profession.

These degrees can be obtained in a variety of ways. There are the traditional classroom courses, such as attending courses on a campus. However, this may not be the most convenient for working adults. With the inception of non-traditional learning, the working adult population can continue to work and complete a four-year degree.

There are universities that offer evening classes in an accelerated format that meet in person and/or online. A quick inquiry of local colleges and universities can provide information about one’s options.

For an education up front might pose a hurdle for some students. Adults can apply for financial aid. This is a relatively easy process and filing an application will let a potential student know what assistance is available. If one is not eligible for grants or scholarships, student loans are another option. These loans often have low interest over a long period for repayment.

Acquiring a bachelor’s degree is doable and well worth the time and effort. If you have been thinking about going back to school, there is no time like the present to do some investigating. There are various options: get all of your ducks in a row and actually “take the plunge.” You will likely not regret having expanded upon your educational horizons.

Best Regards,

Angie Stone, RDH, BS

California children continue to face oral health epidemic

Despite being one of the most prevalent of all diseases, tooth decay continues to rank as the most widespread public health issue for California children, according to the California Dental Hygienists’ Association (CDHA). The warning comes on the heels of a report identifying California as being “off track” when it comes to addressing the dental needs of children.

“Poor oral care contributes to speech impediments, low self-esteem and a wide range of health problems involving infections,” said Ellen Standley, CDHA president. “It is unfortunate that one in four children have never even been to a dentist and that tooth decay is five times more prevalent than asthma.”

The Pew Center, a not-for-profit organization dedicated to improving public policy, which issued the report, issued a “C” grade to California, where it says more than 750,000 elementary school children had untreated tooth decay in 2006; conventional wisdom suggests that number is now closer to 1 million, according to the CDHA.

According to the Pew Report, California falls short in these key oral health-care policy benchmarks:

- Only 27 percent of California drinking water supplies are fluoridated — far less than the national average of 75 percent.
- Nationwide, the percentage of dentists’ fees reimbursed by Medicaid is 60 percent, while California lagged behind with 54 percent.

The CDHA continues to voice related concerns. For instance, many dentists are not comfortable treating infants or very young children, and instead they refer them to a pedodontist. CDHA officials say this demonstrates why the role of a dental hygienist is so vital.

“The dental hygienist can provide mothers of infants and young children with simple nutritional counseling to help prevent dental decay,” said Standley. “We are a trusted and reliable source of information about everything from proper brushing to the safe use of hot bottles and sippy cups.”

Additionally, disparities exist across race, ethnicity and type of insurance when it comes to the length of time between dental care visits. Most dental practices don’t accept Medicaid-enrolled children of any age, said Standley, and children are seen on an average of 10 times in a medical office before the first dental exam is ever scheduled.

“The CDHA continues to make it a priority to raise awareness of pediatric oral health among policy makers, parents and the public health community,” said Standley. “The good news is that with knowledge and public education, we can make headway in reducing tooth decay in our children.”

The CDHA is the authoritative voice of the state’s dental hygiene profession. The organization was established 25 years ago when two regional associations merged to form a unified professional group. The CDHA represents thousands of dental hygienists.
treatment alters enough of the patterns so that new behaviors can be learned. Sometimes the changes of the oral environment by an orthodontist may bring improved oral functioning.

However, orofacial myofunctional therapy may be necessary when there are indications that dental treatment or orthodontic intervention alone may not bring about the desired changes in oral behaviors. Adverse oral behaviors can often interfere with dental or orthodontic treatment and the stability and condition of the mouth.

Orofacial myofunctional therapy is a structured, individualized treatment for retraining and restoring normal oral function. It seeks to inhibit incorrect muscle movements and develop normal, easy functions of oral rest posture, oral stage of swallowing and speech articulation. Therapy may include any or all of the following:

- elimination of damaging oral habits,
- reduction of unnecessary tension and pressure in the muscles of the face and mouth,
- strengthening of muscles that do not adequately support normal functioning,
- development of normal resting postures of the tongue, lips, jaw and facial muscles,
- establishment of normal biting, chewing and swallowing patterns.

The length and timing of therapy depends on the severity and nature of the disorder. In most cases, therapy is a short-term process with the active stage of treatment lasting about three to six months. Follow-up visits may be required with decreasing frequency over a period of six to 12 months.

Orofacial myofunctional therapists have received specialized training to evaluate and treat oro-facial myofunctional issues. Some clinicians have additional professional training in the areas of speech-language pathology, dental hygiene, dentistry or another health-related field. Most are members of the International Association of Orofacial Myology (IAOM). The IAOM regulates how orofacial myology is practiced, how the course material is constructed and delivered, and monitors the certification process that assigns the credential of Certified Orofacial Myologist (COM). Certification is not required in order to practice, however, it is highly recommended.

To learn more about the IAOM and the profession of orofacial myology, please visit www.iaom.com.