

# Orofacial Myofunctional Therapy – The Critical Missing Element to Complete Patient Care

by Joy Moeller, BS, RDH, COM

## Educational objectives

Upon completion of this course, participants should be able to achieve the following:

- Define orofacial myofunctional therapy.
- Recognize oral and facial muscle pattern abnormalities.
- Understand proactive intervention modalities that a dentist or orthodontist in private practice can utilize.
- Educate the professional as to the value of early treatment and prevention.
- Learn how noxious habits might affect growth and development.

I have been a dental hygienist and a myofunctional therapist for more than 30 years. I learned about myofunctional therapy in 1978 from the dentist I worked with. My son, who had TMD, a low tongue rest posture, no lip seal, crowding, mouth breathing, (I am sure he had apnea symptoms), and chronic headache pain was helped tremendously by a combination of myofunctional therapy, cranial osteopathic therapy and a bite splint. Not only did his headaches and TMD issues improve, but his palate widened and allowed his teeth to erupt in a more normal position. I continue to spread the word that this treatment works to stabilize the muscles and address the cause of many problems instead of chasing the symptoms.

This is a “green” treatment, which your patients will love. They *want* this treatment because they actually have an active role in correcting the problem, which is proactive in preventing major issues and in treating orofacial myofunctional problems when they do occur.

The purpose of this article is to give you an overview of oral myology, which is the critical missing element to complete patient care. You can find a qualified therapist in your area by visiting the directory page on [www.iaom.com](http://www.iaom.com). The interdisciplinary approach to patient wellness is important because the teeth, the bones and the muscles must work in harmony to attain occlusal stability.

The goals of oral myology are.

1. Promoting a lip seal.
2. Promoting a palatal tongue rest position.
3. Promoting a posterior, tooth together swallow.<sup>i</sup>
4. Facilitating bi-lateral chewing and correct drinking.<sup>ii</sup>
5. Keeping hands and objectives away from the face.
6. Facilitating nasal breathing.
7. Developing a harmonious peri-oral muscle pattern.
8. Correcting dysfunctional habit patterns.

Myofunctional therapy, also called orofacial myology, is the neuromuscular re-education or re-patterning of the oral and facial muscles. It might include muscle exercises, which create a normal freeway space dimension.<sup>iii</sup> Therapists are trained to eliminate negative oral habits through

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behavior modification techniques and promote positive growth patterns. We train people to breathe through their noses if their airways are not compromised, and if the oral breathing is an acquired habit; we teach people how to properly position their tongue at rest; we teach how to chew and swallow correctly, and we emphasize the importance of proper head and neck posture patterns.

The history of myofunctional therapy dates back to the 1400s in Italy. In the United States, in 1906 Alfred Rodgers, an orthodontist experimented with facial muscles exercises and in 1918, wrote a paper titled, "Living Orthodontic Appliances," in which he cited that muscle function alone would correct malocclusion with no need for retention. In 1907, Edward H. Angle, an orthodontist wrote an article on the effects of habits on occlusion. In 1925, Harvey Stallard, a dentist in San Diego, researched 7,000 children on sleep position and malposed tooth buds. He maintained that sleeping on the face, during a child's formative years, could create malocclusion.

In the 1930s, Weston Price, a dentist, researched primitive or traditional cultures.<sup>iv</sup> He looked at people all over the world, examined what they ate and evaluated their oral health. He found that primitive cultures, when compared to "modern" cultures, had very little dental disease and their jaw relations and occlusion were healthy. In the 1960s, Walter Straub, an orthodontist, published research on bottle feeding and how it affects occlusion.<sup>v</sup>

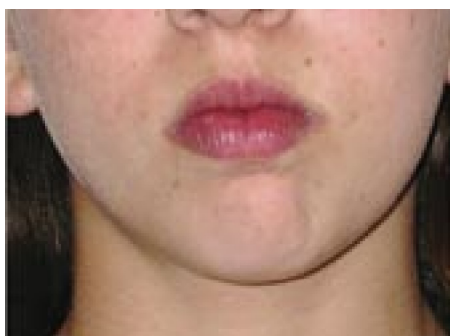
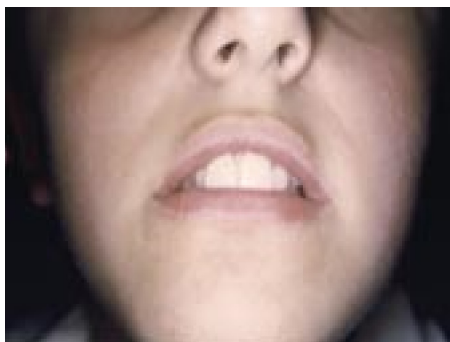
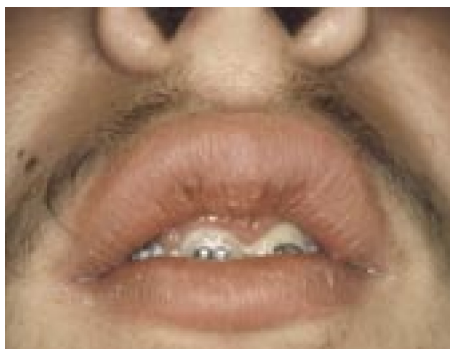
Many times oral habits, beginning in infancy, are carried forward into childhood and then adulthood. Some well known ones are thumb, tongue or finger sucking, cheek, lip or tongue chewing, nail biting, clenching or grinding, hair chewing, leaning on the face, pen or pencil chewing and many others. I call this the "remembered endorphin rush," which starts in infancy with sucking. As a myofunctional therapist, I promote replacement of the habits with having the tongue resting up on the palate. In my experience this seems to stimulate enough endorphins to help stop the noxious habit.

Some of my patients are habitual gum chewers. Gum chewing is not damaging if done in moderation. I have three rules when it comes to gum:

1. Chew only after eating.
2. Alternate chewing on both sides to prevent a TMD or bite problem.
3. Limit chewing to five or 10 minutes only. (Of course, with xylitol gum only!)

Mouth breathing might cause the tongue to rest down and is often associated with "long faced syndrome," orthodontic relapse, allergies, periodontal disease, and sleep disorders.<sup>vi</sup> What causes mouth breathing? Otolaryngologists and ENTs cite several causes, including what I call "sensitivities to the three Ds: dust, dairy products and animal dander, which might contribute to congestion and nasal airway obstruction and might encourage mouth breathing. Mouth breathing, sucking habits and tongue thrusting are all etiological factors to orofacial myofunctional disorders. Also, tight lingual frenum attachments can cause a low tongue rest position. A tight labial frenum could be associated with a short upper lip. This leads to a lack of lip seal, which is important for good occlusion.<sup>vii</sup> These, in addition to grimacing when swallowing are some things to look for in the evaluation of oral facial myofunctional disorders.

Diagnosis of an oral muscle pattern problem might include chewing with the mouth open, smacking and other irritating noises while chewing, an overdeveloped mentalis muscle and a facial grimace during swallowing, and especially a low tongue rest position. If the tongue habitually rests down, the palate might not develop properly, and a high vault palate is a common occurrence in orofacial myofunctional disorders.<sup>viii</sup>



Mouth breathing and a low tongue rest posture are often associated with a forward head posture. The person brings their head forward in order to open the airway. Carrying heavy back packs or poor posture while working at the computer seem to exacerbate the overall postural problem.<sup>ix</sup>

Myofunctional therapy might enhance a person's quality of life. The occlusion, the airway, and posture may change due to the muscle adaptation.

Some other etiologies of a myofunctional problem might be artificial or incorrect infant feeding,<sup>x</sup> short or restricted labial or lingual frenum,<sup>xi</sup> not being held enough as an infant,<sup>xii</sup> genetic predisposition, large palatal tonsils,<sup>xiii</sup> oral trauma,<sup>xiv</sup> brain injury,<sup>xv</sup> allergies,<sup>xvi</sup> or macroglossia.<sup>xvii</sup> Also, pacifiers and bottle-feeding might create a sucking habit and push the mandible down and back interfering with proper development.<sup>xviii</sup>

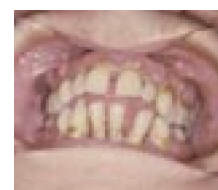
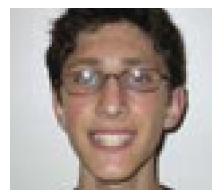
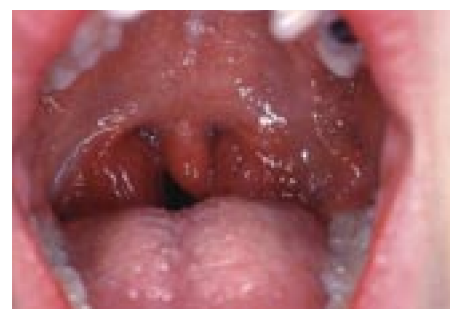
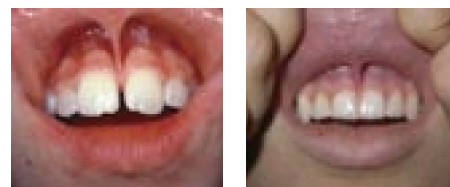
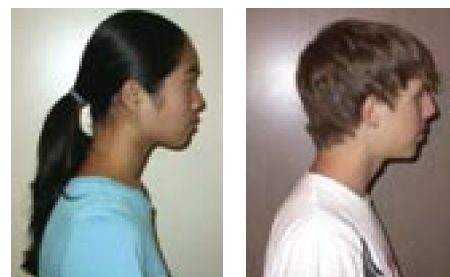
Frenum attachments, both labial and lingual, that restrict proper function, should be released by an oral surgeon, a periodontist, an ENT, or a trained dentist as soon as possible. Historically, as soon as a baby was born, the baby's frenum was released. Breast feeding was a matter of survival and if the baby had a difficult time latching on the breast, the baby could die. Now we have an option to bottle feed our babies. What we do not realize is that the baby who is bottle-fed exclusively, might later develop an orthodontic problem.<sup>xix</sup> If the children are tongue tied, their tongue rests low on the floor of the mouth most likely contributing to a development of tongue thrust or high narrow palate. Also, they cannot swallow properly. At least two percent of all infants born need to have their frenums clipped.<sup>xx</sup> It is much easier to have the tongue and lips frena done early and prevent as much as possible speech, dental, and orofacial functional problems. Now that lasers are commonly used in dentistry, some dentists use a soft tissue laser to sever the connective tissue frenum, unless it is a lingual posterior tongue-tie, which would require an oral surgeon to surgically assist by releasing the muscle fibers. Some oral surgeons feel that lasers might leave scar tissue to cause more problems. I have found if the patient will do myofunctional exercises after the surgery, scar tissue is minimal and function is adequate or optimal.

We work hand in hand with ENTs and Allergists in promoting correct nasal breathing and lip seal. Working together with the patient, we can achieve a palatal tongue rest posture, which will assist the orthodontist or functional dentist in achieving long term occlusal stability.

Large or infected tonsils might cause problems with swallowing. If the tonsils are large or infected constantly, the back of the tongue has to come forward to swallow because there is no room or it is painful to swallow correctly. Also, the airway might be blocked and the mouth breathing causes the tongue to rest down and forward.

Periodontal disease is now linked to heart disease and diabetes.<sup>xxi</sup> If a patient mouth breathes, anterior gingivitis is prevalent.<sup>xxii</sup> When will periodontal therapy include orofacial myofunctional treatment? Also, when the tongue is resting down and forward, the pressure of the tongue against the teeth may weaken the periodontal ligaments leading to traumatic occlusion and recession.

As dental hygienists, we all took vows to prevent dental disease. The proactive "green" treatment of myofunctional therapy might enhance the quality of life for many patients. Anterior or lateral tongue thrust patterns or resting positions are associated with open bites and swallowing pressure is directed forward and down rather than up and back.<sup>xxviii</sup> This







might lead to a patient swallowing air, contributing to stomach aches, bloating, hiccups, burping and acid reflux, also called GERD.<sup>xxiii</sup>

Habits might affect the TMJ.<sup>xxiv</sup> Harmonious muscle pattern is important to correct a muscle related TMD. Myofunctional therapists are trained to eliminate habits, which might affect the TMJ. Also, habitual grinding and clenching affect the masseters and temporalis muscle function. It is always best to do the least invasive treatment first.

Orthognathic surgery relapses and orthodontic relapses might, many times, be prevented by myofunctional therapy.<sup>xxv</sup> We can adapt the muscle patterns to the new bite and bone structure. In this way, we can be an important team player in the maintenance of a stable result.

Many dentists and orthodontists are now using functional appliances like the ALF appliance, the Bioblock, or the D&A appliance and myofunctional therapy to get fabulous results. Many times myofunctional therapy is built into the treatment plan from the beginning.

Myofunctional therapy might help the dental practice because patients want this treatment. In difficult financial times, people will understand the benefits of therapy. It is proactive and patients will really appreciate the referral. Thumb sucking therapy alone might make a huge lifestyle enhancement. We make it fun and easy to quit and the child feels proud and in control of his/her body. No more fighting the tongue and we might help to avoid orthodontic relapse from a low tongue rest position.

Four options I offer are:

1. Habit elimination therapy such as thumb sucking therapy.
2. Mini-Myo Program for the young child.
3. The standard myofunctional program.
4. A program for patients with special needs.

I currently teach four-day continuing education courses available to dentists, hygienists, and speech pathologists. It could be another profit center for the practice as well as helping patients proactively solve their orofacial myofunctional problems.

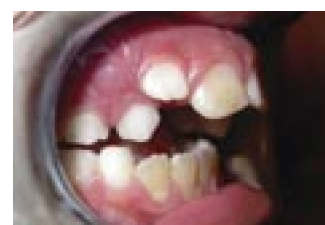
Osteopathic physicians who specialize in manual medicine understand the value of myofunctional therapy. They deal with birth trauma, airway issues, headaches, and many, many problems. They help by releasing the restrictions in the proper movement of the body and might be a great asset to a multidisciplinary team that includes orofacial myologists.

Because sleep dentistry is rapidly becoming a major part of dental treatment today, myofunctional therapy might be a valuable asset to aid in obtaining a better result.<sup>xxvi</sup>

By adapting the muscle patterns to the sleep appliance, and re-patterning the lip seal and the tongue rest posture, oral myologists might make wearing a sleep appliance more comfortable, which will contribute to a higher compliance of consistent use.

Treatment planning includes

1. Parafunctional habit elimination.
2. Intensive phase of a series of exercises to teach tongue rest position and establish a lip seal.
3. Introduce proper chewing and swallowing and correct functional head and neck posture.



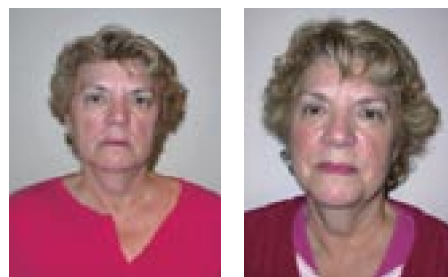
#### 4. The habituation phase which reinforces correct muscle memory pattern.

Therapy usually starts with establishing nasal airway (after clearance from an ENT and an Allergist) and developing a lip seal. If a patient habitually breathes through his/her mouth, the tongue rests down and the mandible drops down and back. The palate, in turn, might not develop correctly. A good myofunctional therapist will assist the patient to clear his/her nose, use correct abdominal (diaphragmatic) breathing, and then establish habitual nasal breathing.

Aesthetic changes from oral myology can motivate the patient to take a more active role in restoring teeth to create beautiful smiles.

The interdisciplinary or team approach is always the best. We must know what each other does and how together we can influence the prognosis for the best result possible and the best care possible.

If you would like to start a myofunctional aspect of treatment in your practice, send your hygienist or you, yourself, can attend a four-day class taught in areas all over the country. Go to [www.myofunctional-therapy.com](http://www.myofunctional-therapy.com) or [www.iaom.com](http://www.iaom.com) for more information. ■



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#### Author's Bio

**Joy Moeller, BS, RDH, COM**, is a Certified Orofacial Myofunctional therapist and a licensed registered dental hygienist. She is currently an elected member of the Board of Directors of the International Association of Orofacial Myology (IAOM) where she is the dental hygiene liaison. She is currently holding a position at the UCLA Sleep Medicine Mini Residency Program where she will be doing research on the effects of myofunctional exercises on sleep apnea. She is a former associate professor Indiana University School of Dentistry, and has been practicing OMT for 30 years. She is an on-going guest lecturer at USC, UCLA, and Cerritos College to ortho, perio, and pedo dental residents and hygiene students. She attended the Myofunctional Therapy Institute in Coral Gables, Florida and the Coulson Institute in Denver, Colorado. She is currently a founding member of the Academy of Orofacial Myofunctional Therapy and has taught courses in OMT at USC Davidson Center (Cont. Ed.), the Gutenberg University in Mainz, Germany, Freiberg University in Freiberg, Germany, Louvain, University in Brussels, Belgium, and many other locations around the world. She has worked with Children's Hospital and in public schools as a health educator. She is currently in the exclusive practice as an orofacial myofunctional therapist in Pacific Palisades, California and Beverly Hills, California. She teaches an IAOM approved four-day course in orofacial myofunctional therapy with Barbara J. Greene, COM. Contact [joyleamoeller@aol.com](mailto:joyleamoeller@aol.com).



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