Clinical Perspective

What if ...?

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Suggested Citation

Hanson, M. (1983). What if ...?. *International Journal of Orofacial Myology*, 9(1), 18-19.

DOI: <https://doi.org/10.52010/ijom.1983.9.1.4>

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Clinician's Corner

What If . . . ?

As noted in an earlier issue, it was suggested that Dr. Marvin Hanson's creation, the "What If" list, be portioned out to various members to learn how they manage some of these irritating but inevitable problems. However, IAOM members are notably reluctant to produce written responses.

As an expedient alternative (temporary, it is hoped), notes were unearthed that were made at two Western Rap Sessions held several years ago. Dr. Hanson's list supplied the basis for discussion at each of these meetings. Some items were felt to be almost too easy, while others were debated all the way to extinction.

The following questions are from the first section of the list, and represent those items where there appeared to be a consensus regarding the responses. More later.

What If The Patient Is Unable To . . .

1. Pop the tongue?

Put peanut butter on the dorsum of the tongue and ask them to squeeze back.

2. Find the "spot" consistently?

Needs to have some conditioning. Stimulate the spot with a straw or applicator stick, icing, brushing – anything to stimulate the exact area.

3. Lift the sides of the tongue to the upper gums?

Pop the tongue with the teeth closed, or have the patient do many popping exercises. Tap the blade of the tongue gently so the sides of the tongue will curl up reflexively. Say T, D, N, L sounds, noting sensation in the tongue.

4. Lift the back of the tongue independently from the jaw?

Use the K sounds, gargle, or hold the tip of the tongue with tongue depressor and squirt water on the posterior tongue, then swallow. Use a ball of gum flattened against the palatal vault, or a thin strip of parafin dipped in warm water.

5. Trap water?

Use *firm* Jello on the tongue for kinesthesia. To gain control, take sip of water and trap it, then bend over and hold water for 10 seconds. Continue to note position of posterior tongue. If necessary, back off and terminate therapy for a period of time – 6 months may make a difference – but continue to work on the rest position.

6. Occlude the molars painlessly?

Is this a joint pain, or tooth pain? Does the tongue intrude on molars or bicuspid? We have the key to bringing these teeth down and many dentists don't understand what we do. If the tongue is the problem, the dentist can do nothing by taking enamel from teeth for better occlusion (occlusal equilibration). Use gauze or bite wafer between sore teeth until the muscles and teeth feel better.

7. Form a good bolus?

Closed lip chewing makes all the difference on bolus formation. Suck as the bolus is formed; the lips move food backward, the tongue moves food upward and cheeks move food inward.

8. Keep the under part of the tongue from coming forward?

Review the same old things again: popping, open and close with tongue up flat, rubber bands on the tongue, etc. May need to reinforce the posterior tongue. Have child trap water, then bite on a tongue depressor in bicuspid area and watch for under-thrusting. If only the tongue tip is holding, tongue eventually won't hold at all.

9. Swallow water without a gulp?

Sound caused by swallowing air along with the liquid. Indicates improper velopharyngeal valving. Merely have patient relax, and give him time.

10. Sweep the tongue clean of crumbs upon swallowing?

No sucking element in the swallowing pattern. Have patient suck as though they were going to pop the tongue. When eating solid food in therapy, always check the dorsum of the tongue for crumbs.

11. Suck the saliva back to the back of the mouth?

Don't let the tongue scoop up water. Hold an elastic on the tongue tip and then take sips of water. Use a "squeezing" sucking sound with lips closed to help get water back.

13. Swallow food with the lips wide apart?

Go back to the basics if having problems. Swallowing occurs behind the teeth, so you don't need the lips to swallow. May help to use the mirror. With food, chew food and form a bolus, then place the tongue as though there were an elastic on tip.

15. Habituate proper tongue resting postures?

Reasons for difficulty:

1. Physiological – severe Class II or III, so rest is difficult to habituate.
2. Functional – the rest posture is not an isolated activity but fits in with other parts of the swallowing pattern. Urge the patient to vacuum tongue up in the palate.
3. Allergy problems
 - a. if necessary, refer to an ENT for an evaluation.
 - b. habituation should be solid enough, if therapy is done well, so that the case will not relapse when the allergy flares up again later.
4. Anatomical
5. Very strong habit
6. Combination of above
7. Muscular deficiencies – poor control

Helps:

“Noisy nasal breathing,” forceful, frequent sniffing, may be necessary because of narrow nasal passage. Needs to clear out stagnant mucous in nose, use oral screen to aid nasal breathing.

Practice rest posture when tense during the day – associate with activities. Use taped cassette program – have individual meditate with tongue in the proper rest position and concentrate on it.

Have patient tell why they are having a problem with the rest position. Get patient more self-aware concerning the tongue and palate by brushing the

sides of the tongue, tapping the dorsum of the tongue to help tongue to cup, ice the spot and palate so it is protected by the tongue, stroke medial and sides of tongue. Use Stomahesive on the spot to help habituate.

Avoidance-dependency syndrome – don't let the child avoid you – use eye contact. The child *can* master normal posture.

Minimal problem syndrome – patient has a minor problem now, but will it get more severe in the future? Either define the problem or don't work with the patient.

26. The patient has an irremediable problem precluding nose breathing?

Do the best you can for them. Emphasize tongue posture and proper occlusal biting. Prognosis very poor.

29. The patient has an extremely narrow palatal arch?

Check with the orthodontist and see when and if palatal expansion is part of his treatment plan. Myofunctional therapy will not solve the problem by itself. Therapy should follow mechanical expansion.

30. The palate is high, but of normal width?

Really no problem to cope with. It is not necessary to get the tongue entirely up in the palate to form an oral seal. Use the alveolar ridge for suction. Let the bolus placement be more posteriorly on the tongue.