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Tutorial

Food in the therapy program

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appointment letter. This letter, confirming the date and time of the initial evaluation, should include a brochure giving information about orofacial myofunctional disorders. This gives the patient background information that will promote discussion at the first appointment.

A certain amount of paperwork is necessary during the initial assessment appointment. A signed consent form for the mutual exchange of information, an information sheet regarding office policies, a patient/parent observation sheet, (suggestions for home observation of the patient), and written guidelines to assist the patient to prepare for therapy are examples of written communication used during the initial evaluation appointment.

When treatment begins, it is beneficial to provide the patient with general guidelines for the therapy program. Outlining goals and objectives at this time will increase the overall success of the program. In addition, having the patient fill out a questionnaire during the active therapy phase provides a tool whereby the therapist can assess the patient's ongoing progress. During the habituation phase of the program when the patient is not seeing the therapist on a weekly basis, a mail-in form allows the patient to monitor his/her own progress and report this to the therapist. Using a mail-in evaluation allows for quicker identification of relapse in learned behaviors.

III. Communicating With Yourself — Record Keeping

Forms used in this category:

a. Initial patient intake information
b. Patient progress sheet

It is important that accurate records are kept for each patient. Using a system that is easy to duplicate makes this daily task a simple one. Each patient should have a manilla file folder. Keeping all the initial intake informaton, evaluation report, progress reports, and insurance information on the right side of the folder makes it easily accessible. On the left side of the folder is the patient progress sheet. This form provides space for written notes from each therapy session, a record of telephone messages and any other information pertinent to the therapy session. Color coding these notes: black for daily notes, red for a cancellation of appointment and green for observed airway problems, makes it easier to recall information. These notes, legibly printed in ink, and kept up-to-date allow for duplication for insurance purposes. Also, if litigation should occur, daily notes are essential in recalling past performance.

The overall goal of orofacial myology is to assist the patient in the successful change of a behavior. Creating an organized treatment plan is one way of achieving that goal. An organized system of written communication assists the therapist in the administration aspect of the treatment program.

Food in the Therapy Program

Anita Weinfield, M.A., C.O.M.

My personal philosophy encompasses the belief that not only is the tongue resting posture, saliva swallows, and lip posture important; but how the patient manipulates and swallows food is also important. I feel correct insertion of the food, chewing, gathering and swallowing of food is an integral part of the overall picture. This conclusion is not based on scientific data but on my own clinical data. I further feel if a patient performs the functions of mastication incorrectly it is our job as orofacial myologists to help these patients attain satisfactory oro myofunctional results in all areas that will insure a lifetime of correct function. (Pam Marshalla gave an excellent description of the normal mature swallow at the Convention in Minneapolis. I recommend you look at her literature.)

Like most therapists my treatment plan included an eating exercise. Basically this involved having the patient understand a correct swallow and then I incorporated a small cookie or cracker as part of the swallow. Most patients had no difficulty with this exercise and they were then instructed to use the "cookie swallow" with all foods. It wasn't until I took Donna to dinner (she was an adult patient and my last patient for the day) that I discovered that a perfect cookie swallow in my office didn't carry over to correct food swallows eaten at meals. Donna was an excellent patient with excellent cookie swallows and yet when we were eating in a restaurant the correct cookie swallows didn't carry over to meals. All the work we had done on food swallowing was non-existant. Shortly after my dinner with Donna I gave a picnic for my patients and again I discovered all the good "cookie swallows" disappeared in the social situation of a meal outside my office. These two experiences led to a re-evaluation of the food portion of my therapy program.

I've discovered that many patients don't know how to gather a bolus of food correctly. To help develop an awareness of how a suck feels I have the patient suck a finger and feel the sides of the tongue and the cheeks meet. I then have the patient remove their finger and place the tongue tip on the spot, explaining that when sucking saliva or a bolus of food the tongue tip is on the spot and the sides of the tongue contact the cheeks just as they did when they sucked on their finger. If they are still having difficulty sucking in their cheeks I use one or both of the following exercises. Be sure your patient understands that the suck they are working toward has the tongue tip on the "spot." 1. Kiss — purse lips and make kissing noises. The tongue tip is not on the spot in this exercise. 2. Suck noodle — Use well cooked (soft not al dente) noodles again. I only use this exercise if the patient is having difficulty sucking in the cheeks, because the tongue tip is not on the spot when you suck the noodle.

Initially I have the patient use a mirror for all food

exercises; later I discontinue use of the mirror and have the patient concentrate on how the process feels. Some of the exercises I use to achieve correct food swallows are:

Peanut Butter Swallow — Dry the roof of the mouth, have the patient draw air through the mouth to further dry the roof of the mouth, spread a thin layer of peanut butter on the hard palate behind the spot (do not get any on the spot). Have the patient place the tongue tip on the spot, suck tongue up to the hard palate, bite back teeth together, swallow with lips open, close lips, suck some saliva into the mouth with tongue on the spot. Repeat until the peanut butter is gone.

Pudding or Custard Style Yogurt — 1. Watch for an infantile grasp of the spoon. It has been my experience that many tongue thrusters hold their utensils improperly. Improper grasp of the utensil makes it difficult for the food to be properly inserted into the mouth. 2. Look in a mirror. 3. Use a metal spoon; if the patient is using their teeth it allows you to hear the teeth bite the spoon, if they are biting, the probability is they are not sucking properly. 4. The tongue should not come out to meet the food! "Ah" position places the tongue in the proper position to receive food. 5. Close lips. 6. Suck as spoon is removed from the mouth. 7. Tongue to "spot." 8. Suck food to posterior portion of tongue. 9. Bite. 10. Lips open and swallow. Having the the patient swallow with the lips open allows you to see if any pudding has pushed forward between the teeth.

Knox blox or banana — 1. Watch for infantile grasp of the utensil. 2. Use a metal fork (most thrusters very carefully remove the food with their teeth). 3. Remove the food with the dorsum of the tongue, compressing the food against the roof of the mouth. Some patients will remove the food by curling the tongue back as they remove the fork. If they have difficulty removing the food with the dorsum I then have them practice the "Ka" exercise until they can elevate the posterior portion of the tongue. 4. Chew on molars; I usually say, "chew on your back teeth." 5. The tongue *should not* wipe the mouth while chewing. My written instructions to the patient reads as follows: Look in mirror — Food into mouth — Press food up against the roof — Remove fork lips closed — Chew on back teeth — Suck — Bite — Swallow lips open (swallowing with lips closed happens after correct meal swallows are achieved).

Meal — **Use a mirror.** A meal consists of meat, vegetable, salad, and dessert. I don't allow ground meat as it is too easy to chew. Since the purpose of the meal is to learn how to manage all textures of food, I prefer sliced roast beef or sliced turkey. If you need to substitute a meal you can use pancakes, French toast, and a thick slice of cooked ham or McDonald's Egg McMuffin (separated). During the meal watch the size of the bite, thrusters seem to take large bites and swallow with their teeth apart. Lips should be closed when the utensil is removed from the mouth you *should not* hear the teeth on the fork. For a correct swallow at meals follow the same steps that were used in the Knox Blox/Banana exercise. In addition, at meals I've found that if a patient places an elastic on the tip of the tongue after chewing and gathering and then completes the swallow it serves as a "Myo Swallow Detector." If the tongue tip stayed on the spot while swallowing the elastic will still be on the tip of the tongue when the swallow is completed. Using an elastic also helps the patient determine if the bite is too large; if the bite is too large it is difficult to execute a swallow and keep the elastic in place. Have the patient use an elastic with both the initial swallows and the clean up swallows. Additional things that can be done to help a patient think about good food swallows are: 1. Put a "good swallow" reminder sign on the table. 2. Use a special placemat. 3. Have a special glass or mug. 4. Place a colored rubber band around the handle of the spoon or fork (as long as you don't use your good silverware it is dishwasher safe). 5. Count good swallows (put 50 toothpicks in a small container and remove one after each correct swallow). This list is only limited by you or your patient's imagination. This exercise is done for several weeks, as the patient becomes very proficient I then eliminate the elastic and then I eliminate using a mirror and have them think about good food swallows as they eat.

Finger Food — Finger food consists of sandwiches, cookies, donuts, pizza or any other food that is eaten using the hands rather than silverware. Have the patient put the food down between bites; the hands should not be touching the food until the initial and clean-up swallows are completed. Instructions to the patient are: 1. Think about the swallow. 2. Don't take another bite until the first bite has been completed (it may take several swallows to complete a bite). 3. Feel the swallow, be sure the teeth are together at the completion of the swallow. 4. Swallow with lips closed. I do not use a mirror for this exercise. It is used to help the patient feel a good swallow.

Solid and Liquid — Solid and liquid swallows may be: cereal with milk/cream, soup (other than broth), chili, grapes or any other food that consists of both a solid and a liquid. Instructions to the patient are: 1. Use a mirror. 2. Place the food in the mouth *do not let the tongue come out* to meet the food. 3. Chew once or twice. 4. Bite. 5. Swallow the liquid. 6. Complete the swallow using a correct food swallow. The mirror is eliminated when the patient is able to consistently do correct swallows.

Habituation Snacks — Foods we use for this exercise are: popcorn, cheerios, small round pretzels, and small bite size crackers. Once again the list is limited only by your imagination. The food should be bite size. Some patients can comfortably handle 3 pieces of food at a time, while others can only handle 1 or 2 pieces of the snack food. At this point your patient

should be able to judge the correct amount of food for him/herself. The assignment is: 1. Eat 15 or so bites of snack food thinking about and feeling for good food swallows. 2. Do not let your tongue reach out for the food, put the food into the mouth. (After the patient is comfortable with this exercise have them do it while they are doing another activity i.e. listening to music or watching T.V.)

The length of time it takes to complete the food portion of therapy depends on the patient. During the meal assignment after I've determined the patient knows how to swallow correctly, I purposely distract the patient with conversation to see if they can eat, talk, and still maintain a correct swallowing pattern. In the beginning you will find that the patient reverts to their old swallowing pattern when they are distracted. However, when the patient consistently demonstrates a correct food swallow in a social environment you know the patient has achieved habituation.

It is difficult to convey in an article all the information that I was able to present in the lecture/demonstration at the Minneapolis Convention. If you have any questions about how I handle food swallows in my practice you may contact me at 2604 Dempster, Des Plaines, Illinois 60016. I encourage you to take a look at your therapy program. Ask yourself, "How do I handle food swallows in my practice?"

Sequencing Therapy

Sylvia Zante, M.A.

The goal of therapy is to establish and maintain correct swallowing patterns and correct resting lip and tongue postures. Because these activities consist of complex acts it is necessary to break them down into small enough components so the patient can achieve control and success and then gradually integrate these patterns into more advanced activities. Therapy therefore follows a sequence that advances the patient to a new level after he has successfully developed the prerequisite skills necessary for the next level.

This sequencing is generally divided into four phases. The first phase, or stage, focuses on developing new muscle patterns necessary as a foundation for the correct swallow and correct resting lip and tongue postures. Emphasis is not on strengthening muscles, but rather for these muscles to function using new and different placements and movements. The muscle training sequence begins with the anterior portion of the tongue and progresses to the middle and posterior portions. The second phase integrates the newly established muscle movements into functional patterns. The patient is now ready to put these new muscle patterns in the correct sequence for swallowing food, saliva, and liquids. Phase three is a continuation of the second phase with emphasis placed on strengthening new learned behaviors and transferring them to a stabilized, habitual level. Auditory, visual, and tactile reminders are often given to assist in this process. Phase four provides for recheck visits to aid in monitoring retention of the learned patterns and behaviors.

Tongue and Lip Resting Postures

Lucia E. Moore, B.A.

No one would deny the importance of tongue and lip resting postures. In fact, many persons in the dental community are placing higher importance on tongue resting posture than on swallowing habits. Referrals are being made for this problem alone despite the fact that I have yet to see a tongue posture problem *without* a tongue thrust problem.

What most therapists want to know is how to correct the posture problems. This can be done through strengthening, posturing and habituation. Following are tried and true exercises to bring about these goals:

I. Lip strengthening exercises
   A. Button tug-of-war — place button on string between lips and teeth; gently tug for 5 minutes making sure musculature is balanced. Use in one or two of the lessons about halfway through therapy.
   B. Lip smacks — can be used in any of the lessons.
   C. Button-on-string trick — button is on end of 2 feet of string/dental floss; object is to raise button to mouth using *lips* to draw string and button upward. Add more buttons as skill increases.
   D. Kissing — loud kisses, high-pitched kisses.
   E. Whistling
   F. Blowing — blow cotton ball from one end of table to other, sort of cotton-ball soccer.

II. Tongue strengthening exercises
   A. Peanut butter on hard palate — remove by sliding tongue from front to back of hard palate. Use early in therapy as resistive exercise.
   B. Tongue pulls — tongue is 'stuck' by suction to roof of mouth as mouth is opened and closed. Do every lesson in OMT series.
   C. Tongue push-ups — resistive exercise with forefinger placed on tongue blade and tongue blade on tongue as tongue pushes blade to hard palate without jaw moving. Do 15 repetitions for 1st 3 lessons.
   D. Tongue clicking — 20 clicks — one lesson.
   E. Water Trapping — with mouth open, trap water