Clinical Perspective

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ORAL HYGIENE: THE OROFACIAL MYOLOGIST'S ROLE

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To what extent is an orofacial myologist responsible for a patient's oral health? Where does the role of the dental office end and that of the orofacial myologist begin? Is there a distinction? Why should an orofacial myologist be concerned about oral hygiene?

Orofacial myologists come from a variety of backgrounds and professional training. Most are trained in the area of speech/language pathology, some are dentists or dental hygienists, and some come from other health-related fields. All have personal dental health care concerns. For some, oral hygiene is a topic of interest and importance. Unfortunately, for others it is a topic of ignorance, neglect or disinterest. The purpose of this article is to encourage those whose knowledge is less than adequate to get help, to study and to learn. For those who are invested in and practice good oral hygiene, this article's purpose is to suggest the incorporation of oral hygiene motivation into their patient care routine. Since orofacial myologists focus on the orofacial musculature, it would seem reasonable and prudent that they also be concerned about the health of the mouth. Healthy harmonious musculature creates a positive environment for stable healthy dentition.

Patient motivation, in terms of good oral health, begins with the orofacial myologist's personal commitment to oral health. Good oral hygiene, like orofacial myofunctional therapy, is not a spectator sport. It involves a lifetime investment. The orofacial myologist can be involved in motivating patients in this direction.

During the initial evaluation, the orofacial myologist assesses the patient's musculature, muscle control and the overall orofacial environment. Behavioral assessments are also made as the clinician notes predictors for success in the therapeutic process. Oral hygiene can be a valuable predictor as it provides insight into how the patient views the mouth, and can be an indicator of the patient's feelings of self-worth. Teeth which are crowded and malaligned, or teeth having poor (if any) contact might be cause for poor oral hygiene. If, however, the patient's overall personal *and* oral hygiene are poor it might indicate a potentially poor risk for a successful orofacial myofunctional therapy outcome.

If the patient does not practice acceptable standards of body hygiene it is very likely that the mouth will also be ignored or undervalued. A simple analogy which can be drawn is the type of care given a car. If the car is battered, worn and rusty it is less likely to be as well maintained than if it were new, shiny and had no "dings." People tend to take more pride in and care for that which

looks attractive. Orofacial myofunctional therapy may not be a high priority for a person whose body and teeth are not being cared for, particularly if the teeth are malaligned. On the other hand, with careful guidance and encouragement from the clinician some patients may be motivated to change such priorities.

If the clinician believes and demonstrates that improvement in the patient's oral hygiene can improve quality of life and dental health, then that may be sufficient to motivate change. The orofacial myologist may be the first person who is able to reach such a patient in convincing terms. After all, the musculature affects the teeth and tissue. Good oral hygiene will safeguard both if care is taken to establish adequate plaque control habits.

Unless the orofacial myologist is a dentist, a dental hygienist or a specially trained educator (e.g., plaque control therapist) s/he is not usually directly involved in oral hygiene instruction. However, as a member of a health care team (which may comprise the dentist, hygienist, medical doctor, orthodontist, allergist, oral surgeon, ENT specialist) the orofacial myologist can be instrumental in the motivational process which results in establishment and maintenance of optimum oral health. Oral health incorporates not only functional muscle harmony but also the dentition and the surrounding tissues. Failure to recognize potential dental problems and failure to refer patients with problems for professional consultation and/or treatment is a potential area of ethical and professional liability (Rowland, 1988).

Set an Example: Know It, do It.

It is the orofacial myologist's responsibility to be able to recognize overt problems of oral hygiene. It must be assumed that the clinician will personally practice techniques that result in optimal personal oral hygiene. Continuing education is recommended to prepare the clinician to identify signs of dental/periodontal problems. The clinician's role here is not that of diagnosis, rather to be alert to potential problems. One should then refer the patient back to the referral source reporting what "appears" to be a concern.

Disease is defined by Webster as "departure of health" (1968). It can be due to organic, mechanical or environmental factors. Oral disease in this article refers to chronic or acute inflammatory periodontal disease. This disease process is responsible for one of mankind's most widespread afflictions, the destruction of the tissue and bony support of the dentition (Ratcliff, 1978).

Seeing patients regularly gives the orofacial myologist a

unique opportunity to observe subtle changes in the tissue surrounding the dentition. Changes in color, texture and architecture, and signs of exudate are among those indicators which can be observed. By becoming proficient at identifying these early indicators of disease, the clinician can support the efforts of the dentist and hygienist by incorporating improved dental hygiene into the goals and objectives of the patient's therapy regimen. The clinician can take advantage of moments in therapy when the patient is receptive to learning. At moments such as these the clinician is able to educate the patient and reinforce even the most subtle improvements as a result of heightened awareness and increased attention to oral hygiene.

As specialists in motivation, orofacial myologists influence the behavior of their patients. This can be accomplished by organizing information and materials, by assessing the patient's motives and needs, by communicating in terms which have meaning for the individual patient, and by planning strategies for influencing behavior. Motivation occurs when information is presented in a way that arouses patient's needs and provides a means whereby those needs can be satisfied. Some of the most frequently identified needs which relate to oral health include: Relief of pain, restoration of function, maintenance and/or improvement of esthetics, freedom from family and social pressures, achievement of status, elimination of fear of pathologic and edentulous states, comfort, social acceptance, love of life, self preservation, elimination of halitosis, etc. (Shulman, 1974). The orofacial myologist can be instrumental in assisting the patient in understanding that s/he is susceptible to oral diseases that are preventable and/or correctable, and that the preventive and corrective efforts are more tolerable than the disease state.

There are a variety of motivational tools available for education and reinforcement: Textbooks, photographs, charts. *Recognizing Periodontal Disease, Color Plates* (Parr, 1984) is an excellent visual aid. This set of two books is designed to teach dental students how to identify periodontal disease and to do pocket probing. (This recommended reading is in no way suggested as a means whereby the orofacial myologist becomes competent or qualified to do such a probing.) For the orofacial myologist, it is valuable in providing an understanding not only of periodontal disease but in visualizing exactly what a patient (perhaps the myologist) has experienced at the dentist's office when a probing was done. There are numerous opportunities for clinicians to ease unwarranted fears of appliances and/or dental procedures. When the clinician has an understanding of the procedures the patient is anticipating, that clinician can communicate understanding and thereby elicit trust and confidence in the procedures and their value.

It is suggested that orofacial myologists consult with their referral sources regarding philosophies and individual attitudes toward the clinician's role in motivating the patient in dental hygiene. The clinician might then selectively use the *Color Plates* as a teaching and motivational resource. This book contrasts healthy and diseased tissue and documents the disease process in

radiographs and color photographs.

Intraoral photographs are an excellent motivational opportunity in terms of hygiene as well as orofacial myofunctional therapy. Photographs taken at the initial evaluation can establish a baseline from which changes can be observed and documented (Zimmerman, 1988). The clinician can photograph each phase of the patient's changes and use the pictures as reinforcement. For example, after teaching the patient to identify plaque and adjacent redness in the gingiva, a photograph could be taken to document the finding. It is critical here that the clinician makes careful notations regarding specific areas of concern, and that photographs are taken thereafter with account to angulation, distance, and dental landmarks.

Having taken a photograph to document current status, the clinician can then encourage the patient to establish achievable goals to remedy the situation. Such goals might be to have no visible plaque in that area and/or to have the redness gone by the patient's next appointment. (Sometimes the patient is not aware of having missed or overlooked a given area, and just creating an awareness of the problem is all that is needed for correction.) During the following therapy visits, the area should be monitored, noting changes in the patient's file with documentation by photograph. Over a short sequence of photographs (taken weekly or bi-monthly) visual signs of control can be seen, and the patient can learn to self-monitor. (Developing the film quickly or using a close-up instant developing camera, and having photographs readily available for patient feedback, is of utmost benefit in this motivational process.)

Intraoral photographs of prior patients (before and after oral hygiene motivation) can be helpful in motivating current patients. Patients with specific disease symptoms can be catalogued and drawn upon as similar symptoms surface from the patients within the clinician's practice. These photographs can be mounted in a photo album or filed in a card-file according to description. Sharing these photographs can accomplish several objectives: 1. Patients can see that their condition is not unique; others have been able to deal with it. 2. The patient can see positive results from taking better care of the mouth; change is possible. The patient gains hope. 3. The patient can visualize a personal goal to achieve with the guidance of the clinician and support of the dental specialists. For the protection of the patient's privacy and legal rights a release must be signed by the patient (parent or guardian) in advance of using photographs in this manner.

Charting areas of concern is an excellent motivational tool available to the clinician. A simple tooth chart can be used for sequentially documenting what is observed by the patient and therapist: Areas of redness, bleeding, swelling, plaque and calculus. Color coded markings can be utilized as a monitoring device which directs attention to specific areas of concern: Red for red tissue (inflammation), yellow for plaque, blue for visible accumulations of calculus (tartar), purple for swollen areas. This chart is also useful for marking architectural contours: Cratering of the papilla, enlarged gingival margins, floss

abrasions, etc. The initial use of the chart is the most time consuming. It is the time where the patient is focusing on a single quadrant of the mouth (start with a quadrant and later expand to the whole mouth). Using a mirror and flashlight the clinician assists the patient in identifying what s/he sees. (The clinician is encouraged to clearly distinguish between "looking" and "seeing." Seeing incorporates a degree of understanding of what it is that is being observed.) Together the patient and the clinician may explore the findings. The patient is encouraged to participate in forming goals to remedy any negative findings. This is a critical time for the clinician to find an area where the patient is doing well. A compliment which focuses on patient achievement in one area will encourage effort in another. Oral hygiene instruction and motivation must be positive.

After finding the areas of strength and weakness, this information is documented by the use of color codes on the chart. The chart is then duplicated for the patient to take home as a resource and a reminder. On returning to therapy the patient brings the chart and is encouraged to verbalize reactions, procedures and feedback as

to how the "attack" on the plaque was accomplished. A brief examination of the teeth and tissue provides the clinician and patient with an opportunity to reassess the assigned area. Notes can be taken on the patient's record and on the next sequential chart. Areas of improvement are indicated by fewer or lighter marks. Areas of continued concern are marked on the second sequential segment. Over time the patient has a record of several visits' progress.

In the process of charting and taking photographs the patient has been taught how to "see" and what to "look" for. The patient has been given an opportunity to own the pride s/he feels in the improvement. The patient also has gained the perspective that dental hygiene is a continuum of energies invested throughout a lifetime, not just a biannual visit to the dentist. The orofacial myologist has functioned as an important member of a team of professionals by supporting the dentist's and the dental hygienist's instruction and by appropriately utilizing his/her specialized skills in motivating the patient to achieve optimal personal oral well being.

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