Beyond the Plateau:

Unlocking Progress via Oral Mechanism Exams and Myofunctional Strategies Across the Lifespan

Michigan Speech-Language-Hearing Association
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Disclosures

Financial: I am the owner and Clinical Director of Oakland Myo and Wellness Institute and receive a salary for therapy services and programs.

Non-Financial: I have been a school-based Speech-Language Pathologist for 23 years and continue to serve part-time in a public school setting. The views expressed in this presentation are my own and do not necessarily reflect the policies or positions of my employer.

Learning Objectives

1. Analyze the physiological impact of oral-motor restrictions across clinical settings

2. Correlate tongue tension and myofunctional deficits with specific speech and fluency disorders

3. Formulate effective interdisciplinary referral pathways

We are healthcare providers

Regardless of the setting, we support "patients".

We all entered this field with a desire to help others and an interest in education and health.

The plateau that's felt by the clinician, patient, and caregiver

Shame: "I am bad"

Blame: a defense

Look at your uncomfortable data

100 year old "modern" idea

1907: Dr. Edward Angle, an orthodontist, identified:

- The tongue is an "obstacle"
- Nose breathing impacts tongue posture and malocclusion

2019: Linda D'Onofrio, an SLP, publishes "Oral Dysfunction as a Cause of Malocclusion"

- Echos Angle's statements
- Includes a *plethora* of additional research since his claim!

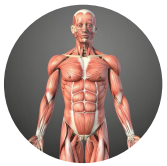
Myofunctional Timeline for SLPs

1918: Rogers orofacial muscles are "living appliances"

1948: Lischer coins "myofunctional"

The "Myo" Confusion

Orofacial = Oral + Face



Myo = Muscle

Function!

Myofunctional Timeline for SLPs

1918: Rogers orofacial muscles are "living appliances"

1948: Lischer coins "myofunctional"

1972: Myofunctional organization formed

1991: ASHA adds OMDs to Scope of Practice; 2016: explicitly in "Speech Production" and "Feeding & Swallowing" domains

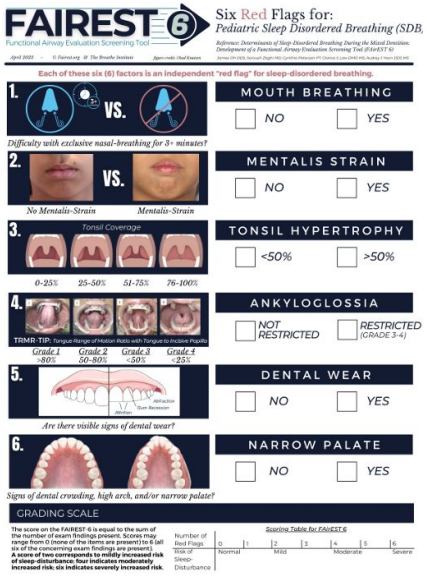
2018: ASHA adds OMDs to Practice Portal

2020: ASHA adds to CAA Graduate Standards

"

Patient does not have a cleft palate!

1. SLP: *"Something isn't right"*
2. Refer to ENT
3. ENT: *"They're fine! They need therapy!"*



The FAirEST 6

- Created by a multidisciplinary team
- Outlines "red flags" for Sleep Disordered Breathing (SDB)
- Provides objective score
- Guides referral to medical or dental provider
- Looks at the root cause

S is for Sleep*

*A biological need, not a luxury

The ADHD Red Herring

AAP and AASM guidelines state clinicians MUST refer for a sleep study if snoring or daytime sleepiness is present before concluding an ADHD diagnosis

#1 Nose vs Mouth Breathing

Your Breathing Options

MOUTH BREATHING

Smaller airway

Sleep disordered breathing

- snoring, UARS, apnea, daytime sleepiness

Suboptimal facial structure growth + esthetics

Reduce mental and physical health

Behavior problems

- inattention, hyperactivity

Reduced cognitive functioning

NOSE BREATHING

Healthy orofacial muscle development

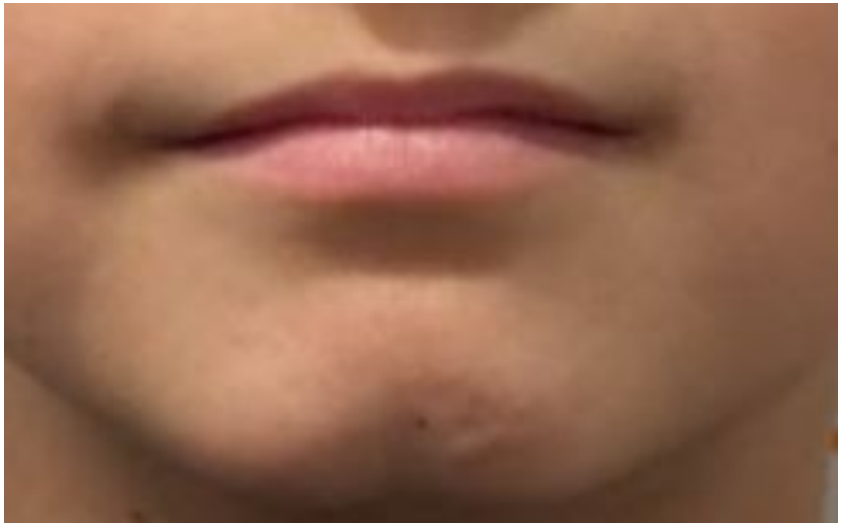
Optimal head + face development

Filtering, warming, & humidifying air before it enters our body

Increase circulation throughout our body

Reduce anxiety

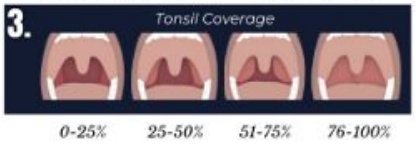
#2: Lip Closure, Mentalis Strain



Breathing & Oral Rest Posture Referrals

- Lips naturally close at rest / are able to close without facial strain, chin wrinkling
  - If not, refer to a clinician specializing in orofacial myology
- Resting position of tongue is up, behind front teeth
  - If not, support in therapy
- Nasal breathing can be sustained for at least 3 consecutive minutes
  - If not, refer to physician / ENT for upper airway assessment
- Breathing is quiet
  - If not, refer to physician / ENT for upper airway assessment
  - Can support slow, diaphragmatic breathing in therapy

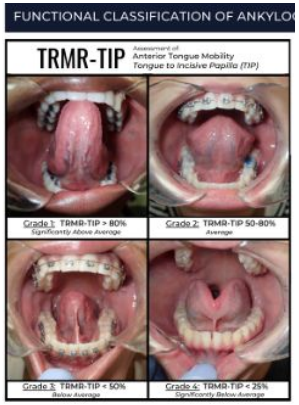
#3 Hard & Soft Palates, Pharynx



TONSIL HYPERTROPHY

☐ <50% ☐ >50%

#4 Tongue Range of Motion: TIP



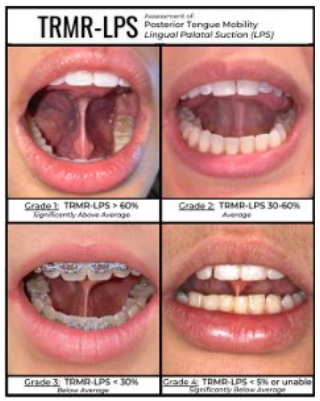
Maximum Opening (comfortably):_____

Tongue to the Incisive Papilla (TIP) : _____

TIP / Maximum Opening: _____
by measurement
(we still need to look at FUNCTION)

Grade 1, 2: normal functioning
Grade 3 = 25-49%, "moderate restriction"
Grade 4 = <25%, "severe restriction"

#4 Tongue Range of Motion: LPS

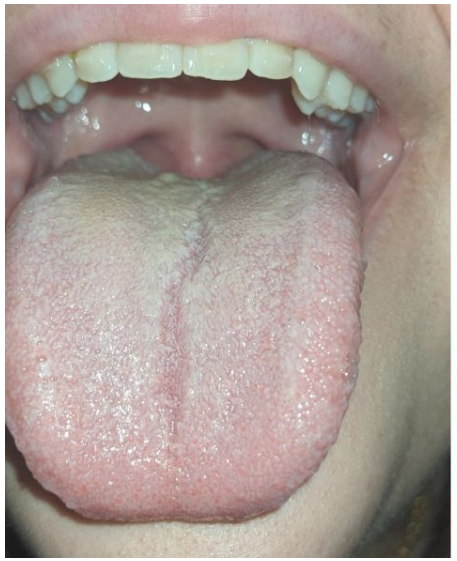


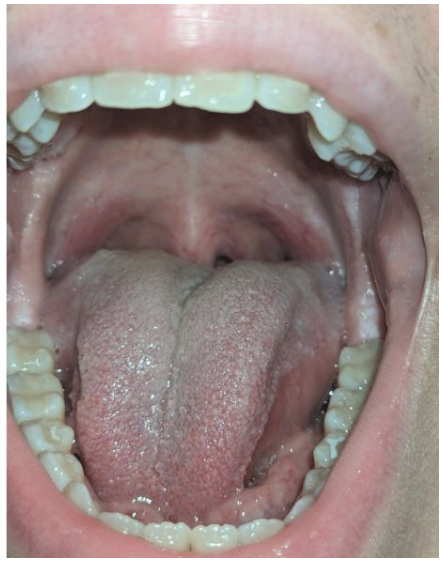
Maximum Opening (comfortably):_____

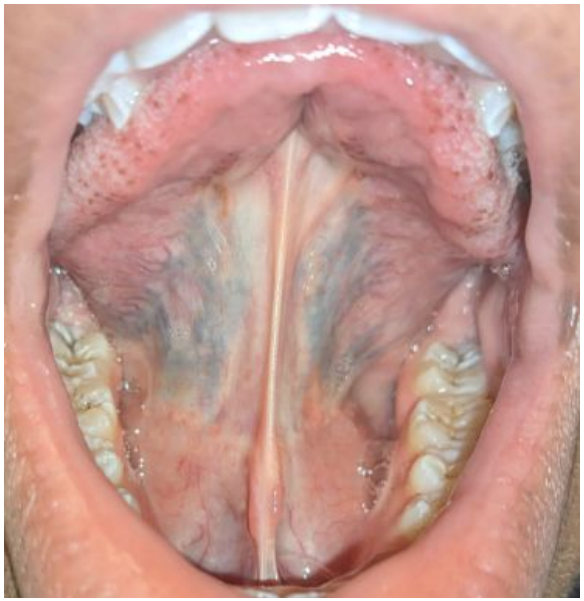
Lingual Palatal Suction (LPS) : _____

LPS / Maximum Opening: _____
by measurement
(we still need to look at FUNCTION)

Grade 1, 2: 30 - >60% normal functioning
Grade 3 = <30%, "moderate restriction"
Grade 4 = <5%, "severe restriction"



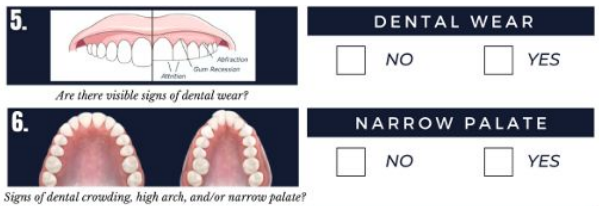


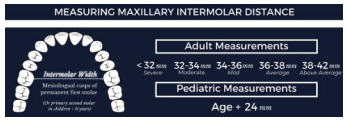


Lingual Functioning Referrals

- Tongue Range of Motion Ratio Grade 1-2, tip is >50% elevated towards incisive papilla when mouth is fully opened
  - If not, refer to clinician specializing in orofacial myology
- Lingual Palatal Suction (LPS) shows adequate space for the tongue to fit within it; tongue does not overflow over the middle of the teeth bilaterally
  - If not, refer to dentist for growth check (2-4 years old) or evaluate for orthodontic expansion to allow lingual palatal suction
- Tongue can sweep molars
  - Can support oral motor skills in therapy
  - If not, refer to clinician specializing in orofacial myology

#5, 6, 8: Dentition

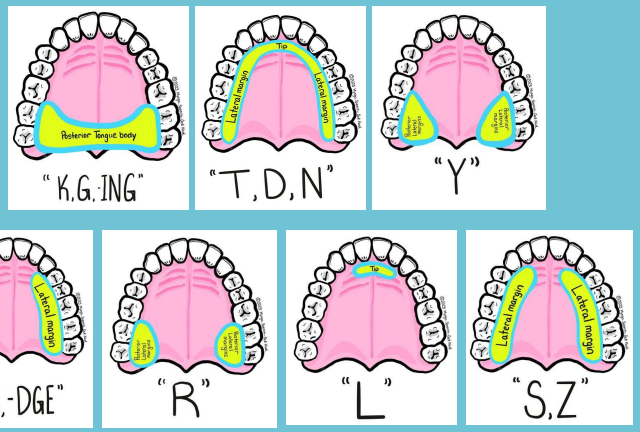




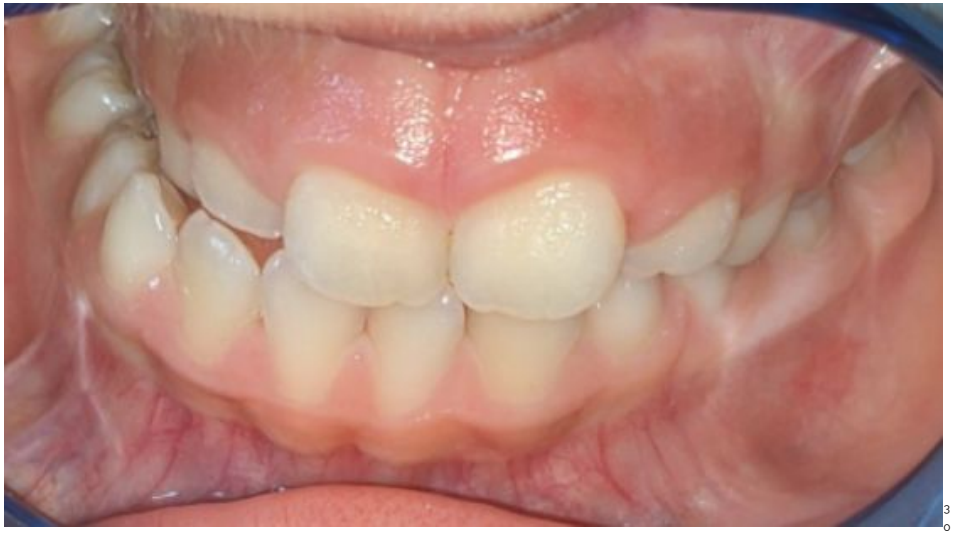
Intraoral Structure Referrals

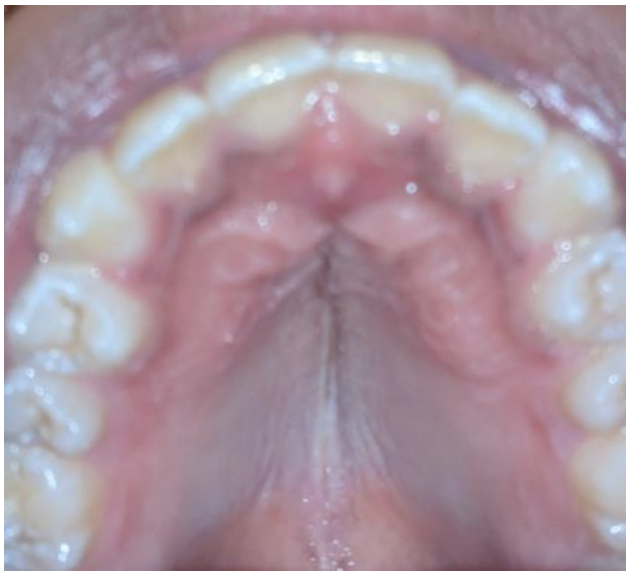
- Palate is U-shaped, is <7mm high, no signs of crowding
  - If not, refer to dentist for growth check (2-4 years old) or evaluate for orthodontic expansion to allow lingual palatal suction
- Tonsils: Brodsky Grade 1-2, >50% oropharynx
  - If not, refer to Physician/ENT: airway obstruction impacts tongue placement at rest / in speech, swallow
- Teeth do not show dental wear / no observed or reported clenching, grinding
  - If not, refer to Physician/Dentist: sign of airway compensation
- Friedman: Class I-II
  - If not, monitor as therapy progresses; can note to Physician/Dentist

Articulation Stabilization



From Pamella Marshalla





My Speech Room Wonders

1. Why did some produce /s, z/ with lower incisors?
2. Why were my students the most disruptive in their classrooms and often known throughout the school?
3. Why were so many of my students referred for evaluations for Learning Disabilities?
4. Why were 5/6 of the slowest running students in Gym class my students?
5. Why did I hear so many a/ae substitutions in my most impaired articulation kids?

My Speech Room Wonders

Solved!

1. Why did some produce /s, z/ with lower incisors?
2. Why were my students the most disruptive in their classrooms and often known throughout school?
3. Why were so many students referred for evaluations or Learning Disabilities?
4. Why were 5/6 of the slowest running students in Gym class my students?
5. Why did I hear so many a/ae substitutions in my most impaired articulation kids?

Root cause?

COMPENSATIONS?

Common Plateaus

Articulation:
- Must use slow speech
- Unable to move into conversation
- Poor molar stabilization
- Unstable jaws
- Poor lip and/or tongue dissociation
- Poor range of motion

Feeding/Swallowing:
- Picky eating
- Slow eating
- Messy eating
- Poor oral health
- Digestive issues
- Muscle Tension

Fluency:
- Breath support
- Muscle Tension

Language:
- Just the minimum (verbal or written)
- Late talkers
- Delayed development

Voice:
- Breath support
- Muscle tension
- Head position/posture

2023-2025 Research Peek

Dyslexia: Tongue dysfunction may be an early marker for learning disorders (Burlea et al 2025)

Autism: 81% of autistic individuals show oromotor abnormalities (Maffei et al 2023)

Voice: 91.6% of MTD patients improved after myofunctional therapy + release (Summersgill et al 2023)

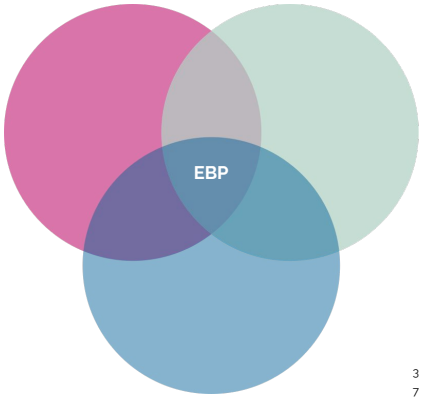
Obstructive Sleep Apnea: Poor **voice** assessment vs control group without snoring (Martins et al 2025)

Cerebral Palsy: Releasing tethered oral tissues "unlocks" mobility for sleep and swallowing (Baxter & Merkel-Walsh, 2025)

EBP

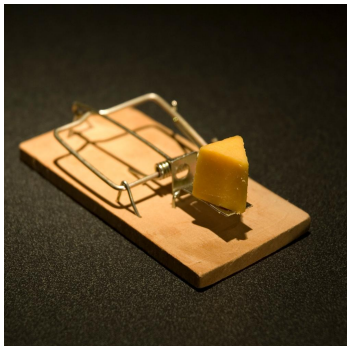
ASHA's Model

Medical Model



Watch the Ableist Trap!

"That's just how they are"



> *Plateaus are an opportunity to re-evaluate what we may be missing*
>
> enhanced oral function assessments create stronger evaluations, faster progress, higher outcomes

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