Beyond Articulation:

Integrating Myofunctional Principles into School-Based Speech Therapy

OSSPEAC
October 13, 2026
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Disclosures

Financial: Michelle is the owner and Clinical Director of Oakland Myo and Wellness Institute and receives a salary for therapy services and programs. She is receiving an honorarium for today's presentation.

Non-Financial: Michelle 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 her own and do not necessarily reflect the policies or positions of her employer.



Learning Objectives

1. Analyze the physiological impact of oral-motor skills throughout a child's day
2. Differentiate between educational vs medical models
3. Identify myofunctional disorders and co-treat with your interdisciplinary team
4. Evaluate case studies to create effective educational treatment plans, and determine when services require medical/dental intervention
5. Formulate clear documentation for effective interdisciplinary referral pathways

Our Journey Today...

1. Why are we here? Wonders, guilt, shame; we go back to the basics!
2. SLPs: Real life super heros who know it all?
3. Educational vs Medical Models (hopefully a little deeper defining what you already know)
4. Co-treating Posture with your Team (the foundation we all need)
5. A Myofunctional Screening using the FAIREST-6 (and an intro to how to do a screening)
6. A Myofunctional Screening for school-based SLPs (transferring the SLP medical smarts we all have into school observations)
7. We'll look at mouths to look beyond "it looks like it should be able to talk!"
8. 2 Case Studies with help writing your observations
9. Nerdy resources to boost your smarts, if you want to dig deeper

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Part 1: Why are we here?

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Michelle's Why

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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 by their first name?
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 speech students?
5. Why did I hear so many a/ae substitutions in my most impaired (elementary) articulation kids?

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My Speech Room Wonders

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Solved!

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

Shame: "I am bad"

Blame: a defense

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Look at your uncomfortable data



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100 year old "modern" idea

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

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

1918: Dr. Alfred Rogers, and orthodontist, recruits speech therapists to do face and jaw exercises

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!
- Very easy to read - great to share!

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The “Myo” Confusion



Orofacial = Oral + Face



Myo = Muscle



Function!

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Myofunctional Timeline for SLPs

1918: Rogers orofacial muscles are “living appliances”; SLPs are recruited to lead exercises

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

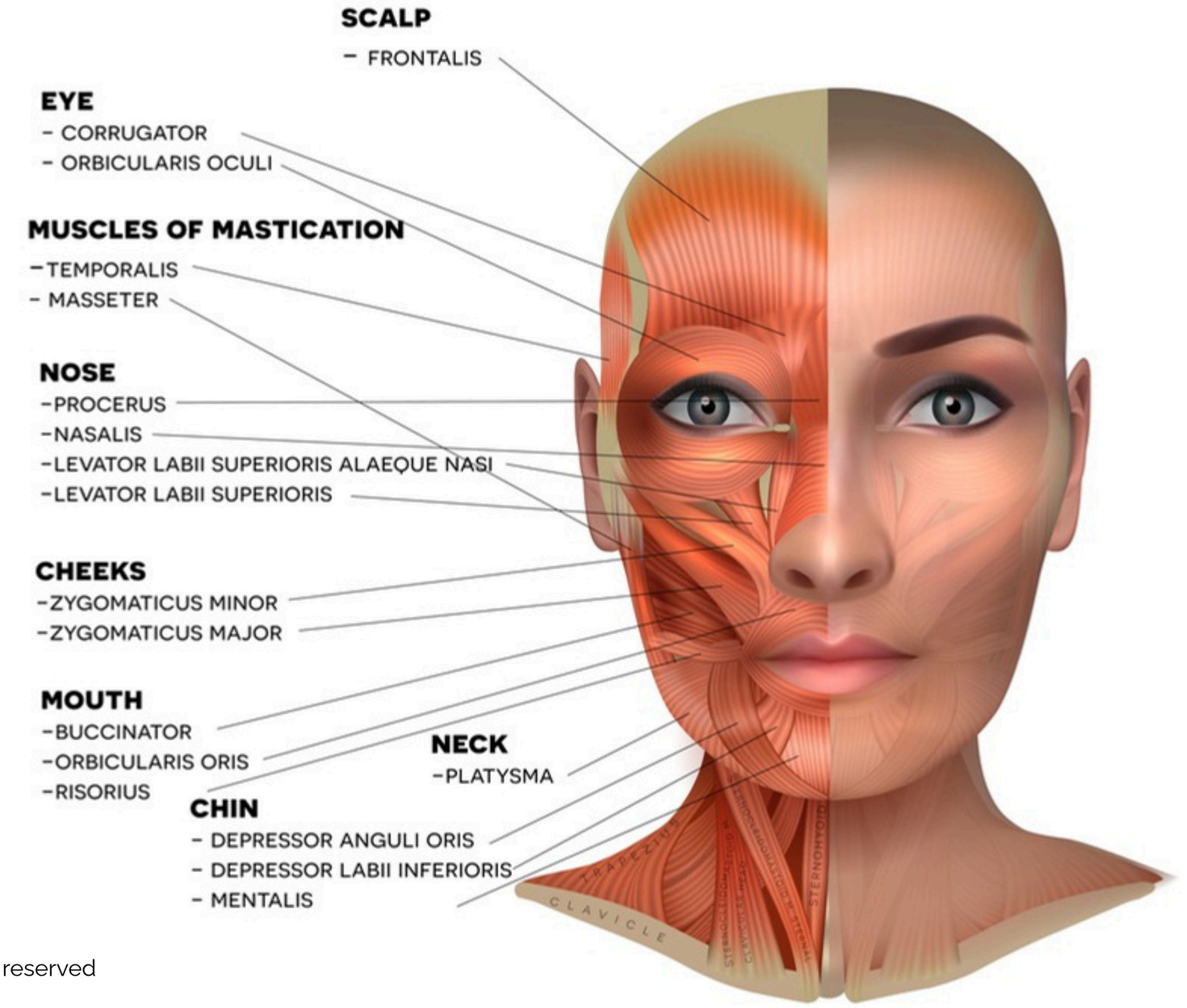
2018: ASHA adds OMDs to Practice Portal

2020: ASHA adds to CAA Graduate Standards

2027: ASHA removes from CAA Graduate Standards

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MUSCLES OF THE FACE



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Part 2: SLPs as real life super heros who know it all?

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Why does it matter?

- 2004 Gottlieb et al: **Sleep disordered symptoms** by parent report associated with impaired behavior and poor performance on standardized neurocognitive tests evaluating executive function, memory, and intellectual ability
- 2006 Kurnatowski et al: Apnea caused by **enlarged tonsils** reduces memory, concentration, attention, learning disability, low perception, sensorimotor integration
- 2007 Uema et al: Children with **obstructive sleep apnea** had worse results on learning tests vs controls
- 2008 Petry et al: Relationship between **daytime sleepiness**, increased risk for habitual snoring, apnea, mouth breathing, and learning problems
- 2008 Abreu et al: **mouth breathing** in children are **mostly due to allergies**, then large adenoids

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- 2009 Owens: A child with **sleep disordered breathing in first 5 years + untreated = 60% more likely to require Special Education by 8 years old**
- 2011 Gozal & Kaditis: **large tonsils and adenoids as primary cause of nasal obstruction**, causing obstructive sleep apnea, and consequent low school performance
- 2011 Bourke et al: Lower intellectual skills in children with respiratory disorders during sleep; higher rates of diffulties in executive functioning and school functions
    - 54.2% of students with learning disabilities reported nasal obstruction
- 2011 Fakier & Wild: “Adolescents who had sleep problems were more likely to use tobacco, alcohol, methamphetamine, cannabis, inhalants, cocaine, ectasy, and any other illegal drug. Adolescents with learning difficulties had more sleep problems.”

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- 2012 Bonuck et al: In a longitudinal study, children with sleep disordered breathing or behavioral sleep problems in the first 5 years of life had an increased likelihood of Special Education by 8 yrs
- 2013 Fensterseifer et al: children with **enlarged tonsils have more learning difficulties**
    - ***“(This study is) a warning to call the attention of the educational community concerning the need for respiratory assessment in children with learning difficulties.”***

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- 2016 Hunter et al: Large community sample highlighted the **significant impact of sleep disordered breathing**, especially in children with **moderate-severe obstructive sleep apnea**, and that even snoring alone affects neurocognitive functioning. **By limiting a child's skill development, there is concern for the amount of academic and adaptive skill attainment**.
  - **Need to increase awareness** of sleep disordered breathing, especially in children with more severe OSA
- 2018 Goyal et al: 40% of children with sleep disordered breathing develop ADD, ADHD, and/or a learning disability
- 2021 Jung & Kang: **More brain activity** viewed in brain imaging in
- than mouth breathers on working memory tasks
- 2023: Bergersen & Stevens-Green: **Nighttime mouth breathing had a major impact on 92% of symptoms** of sleep disordered breathing and their severities

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- 2022 Ogundele & Yemula:
  - “Up to **75%** of children and young people with neurodevelopmental, emotional, behavioral, and intellectual disorders are known to experience different types of insomnia compared to **3-36% in normally developing** population.
  - Sleep disorders affect **15-19% of adolescents with no disabililty**, **26-36%** among those with **moderate LD**, and **44% with severe LD**
  - Chronic sleep deprivation is associated with **significant risks of behavioral problems, impaired cognitive development and learning abilities, poor memory, mood disorders and school problems… increases risk of other health problems, such as obesity and metabolic consequences, significantly impacting the wellbeing of other family members**
- 2023 Oxygen Advantage: **Poor sleep quality can cause depression and anxiety.** *Cognitive difficulty, irritability, and fatigue are present in both conditions*, which make diagnosing sleep apnea more difficult.

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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)

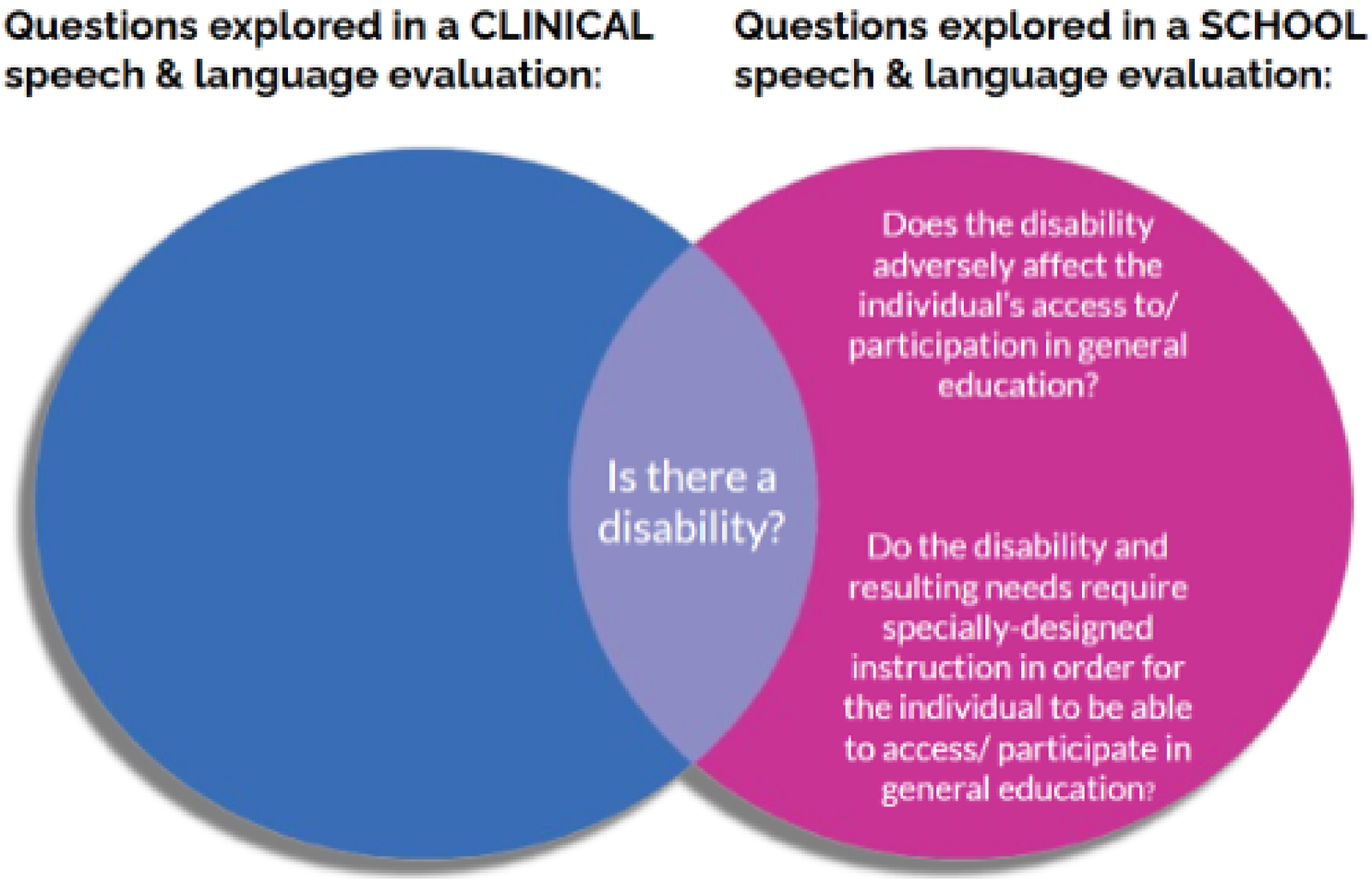
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Part 3: Educational vs Medical Models

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How does a student's disorder impact their ability to access or progress in the general education?

Educational Model



From Guidelines for speech & language evaluation, eligibility and service delivery in schools (p. 8), by Michigan Speech-Language-Hearing Association, 2025, (Michigan Speech Language Hearing Association).

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What I write goals for

Academics / Curriculum
Social language
Literacy
Speech sounds
Fluency
Voice

What I might use briefly as a foundation to support my goals

Breathing
Oral rest posture

What I avoid in school therapy, but I educate the parents; What may limit my success in therapy

Poor sleep
Picky eating
Abnormal swallow (“tongue thrust”)
Poor skull growth, dental/structure problems (high and/or narrow arch, tongue/lip tie, “tongue is too big for mouth”, etc)

Adverse affect on ability to access or progress in general education curriculum

A functional problem
A structural problem
A medical problem

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Management of Swallowing and Feeding Disorders in Schools

EmilyMHomer.com

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Myofunctional Goals

We can try to coach

(but I'm going to be careful about how I do it!)

1)nasal breathing

2) lip seal

3) tongue posture

4) swallow (largely off limits in school)

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Part 4: Co-treating Posture with your Team

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Posture Matters!

- Proximal stability promotes distal mobility
  - A stable core gives movement options
  - Fine motor skills develop from a strong core

.

- Brain-body loop:
  - Breathing → Fight or flight OR open to learning

- Breathing → Phonation

- Collaborative work between OTs, PTs, and SLPs

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The slouching spiral

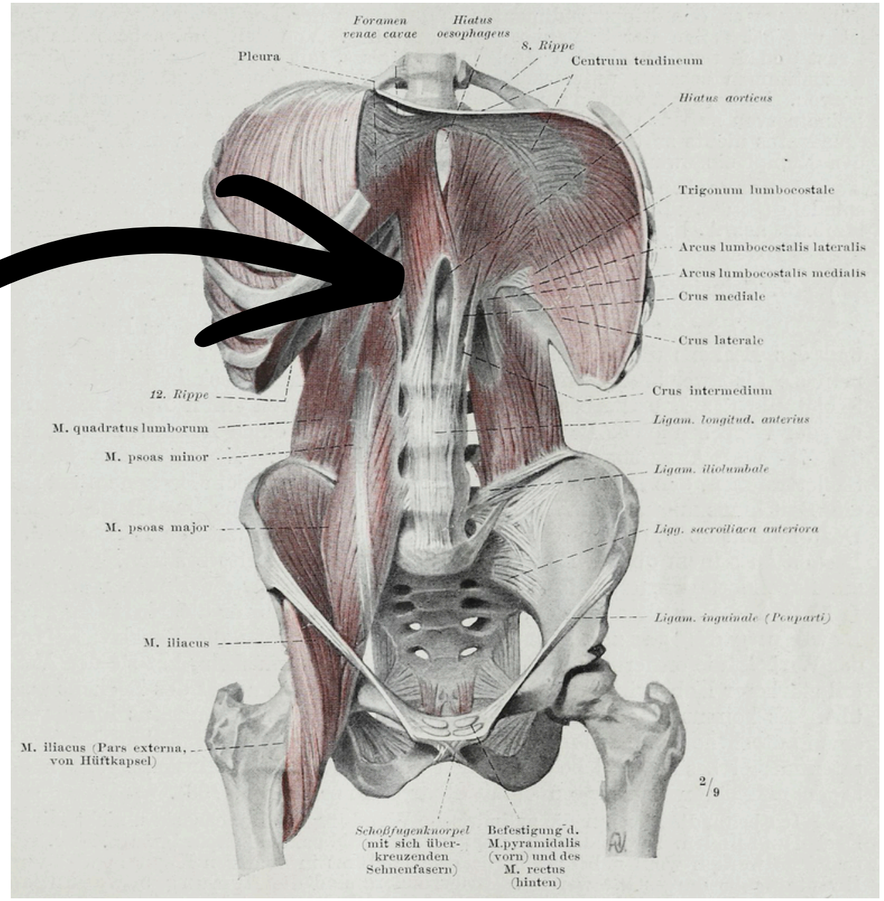
- It signals to the brain that we are in a protective state, increasing sympathetic nervous system (fight or flight) activity
- It can signal low arousal (which is the opposite of the active-alert state for learning)
- It makes breathing more difficult (diaphragm area is reduced; breathing becomes faster, more shallow / higher in the body)
- Reduces vagal nerve tone, which can affect learning

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Posture and Breathing

It's all about the diaphragm!

It connects to the spine!

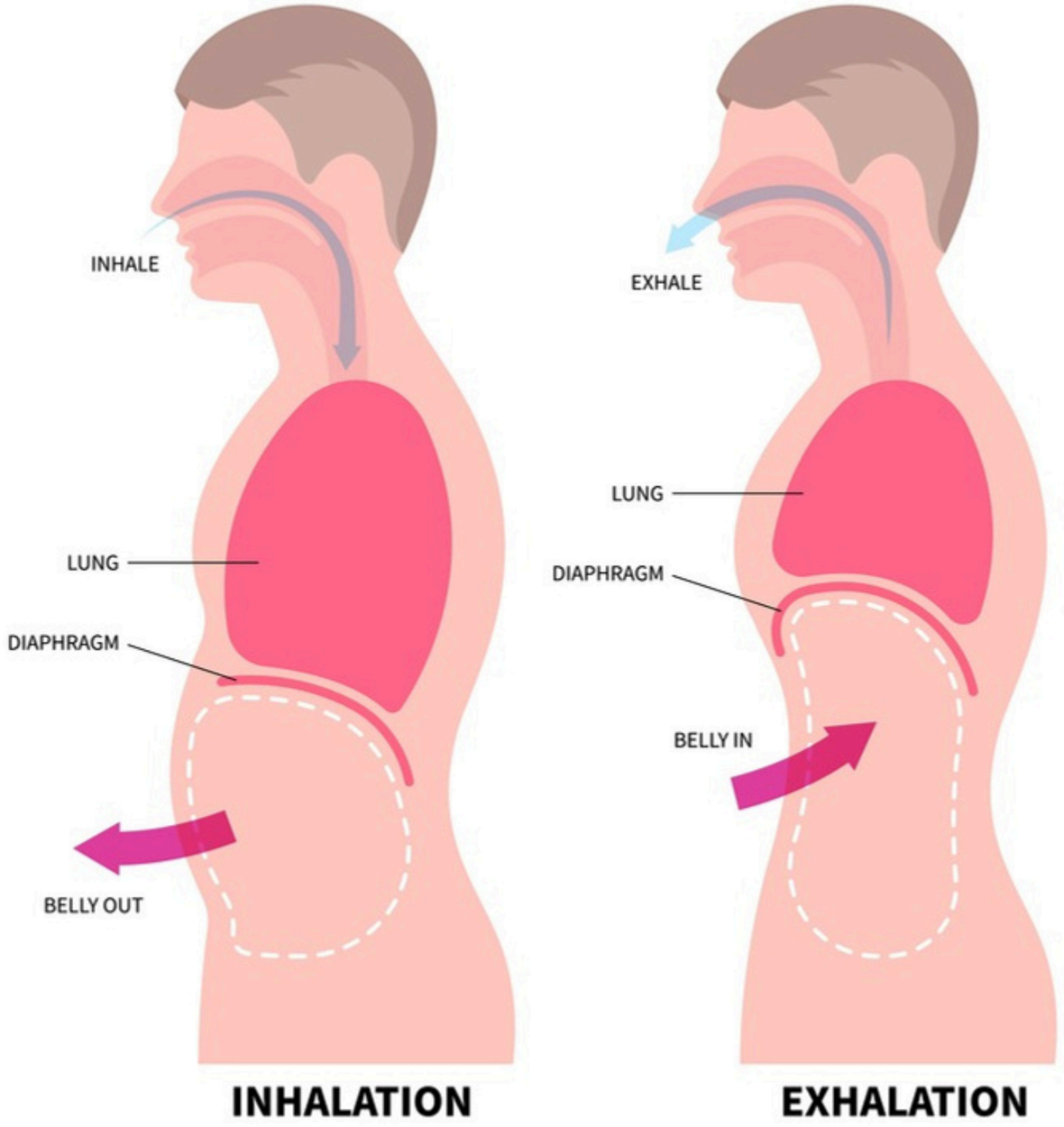




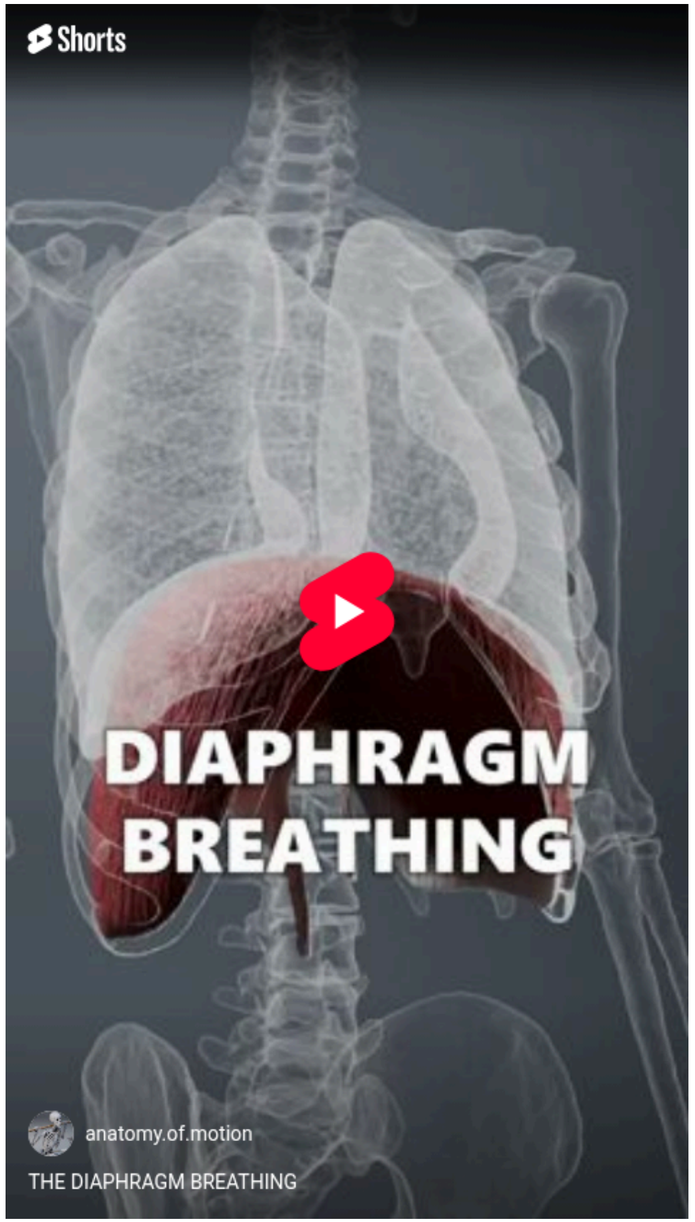
360 degree breathing: expand the ribs in all directions as breath is taken into the diaphragm

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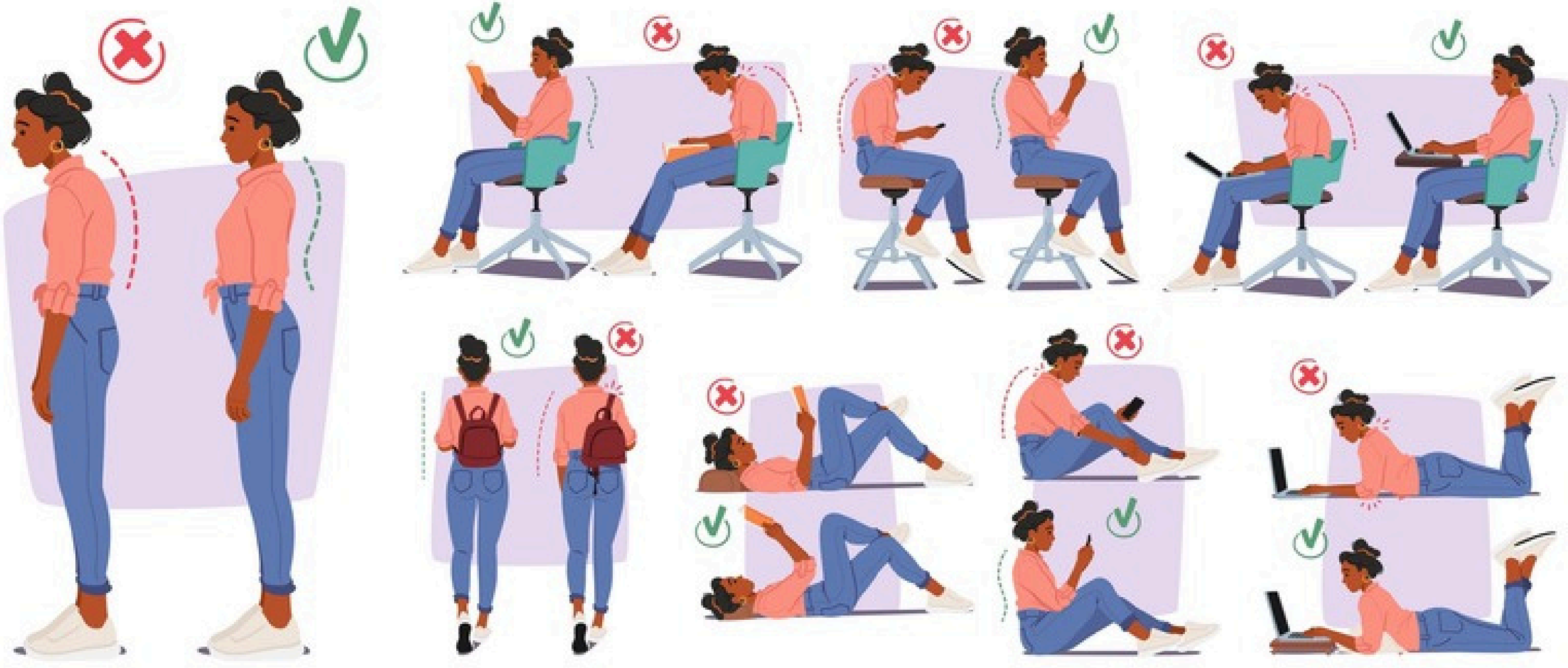
DIAPHRAGMATIC BREATHING



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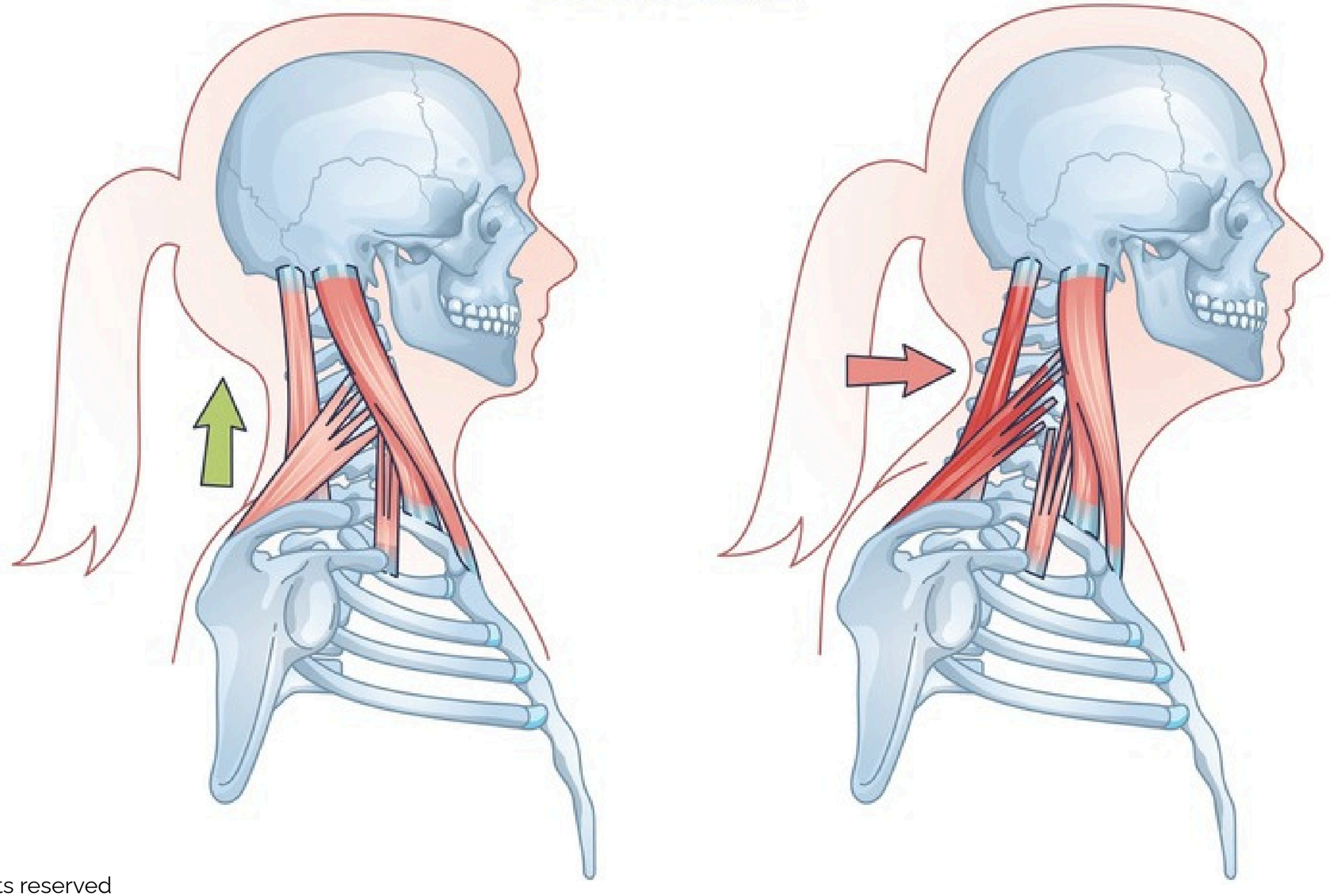
Tech Neck and Forward Head

- Puts stress on the laryngeal muscles
- Can promote mouth breathing
- Common in the presence of a tongue tie

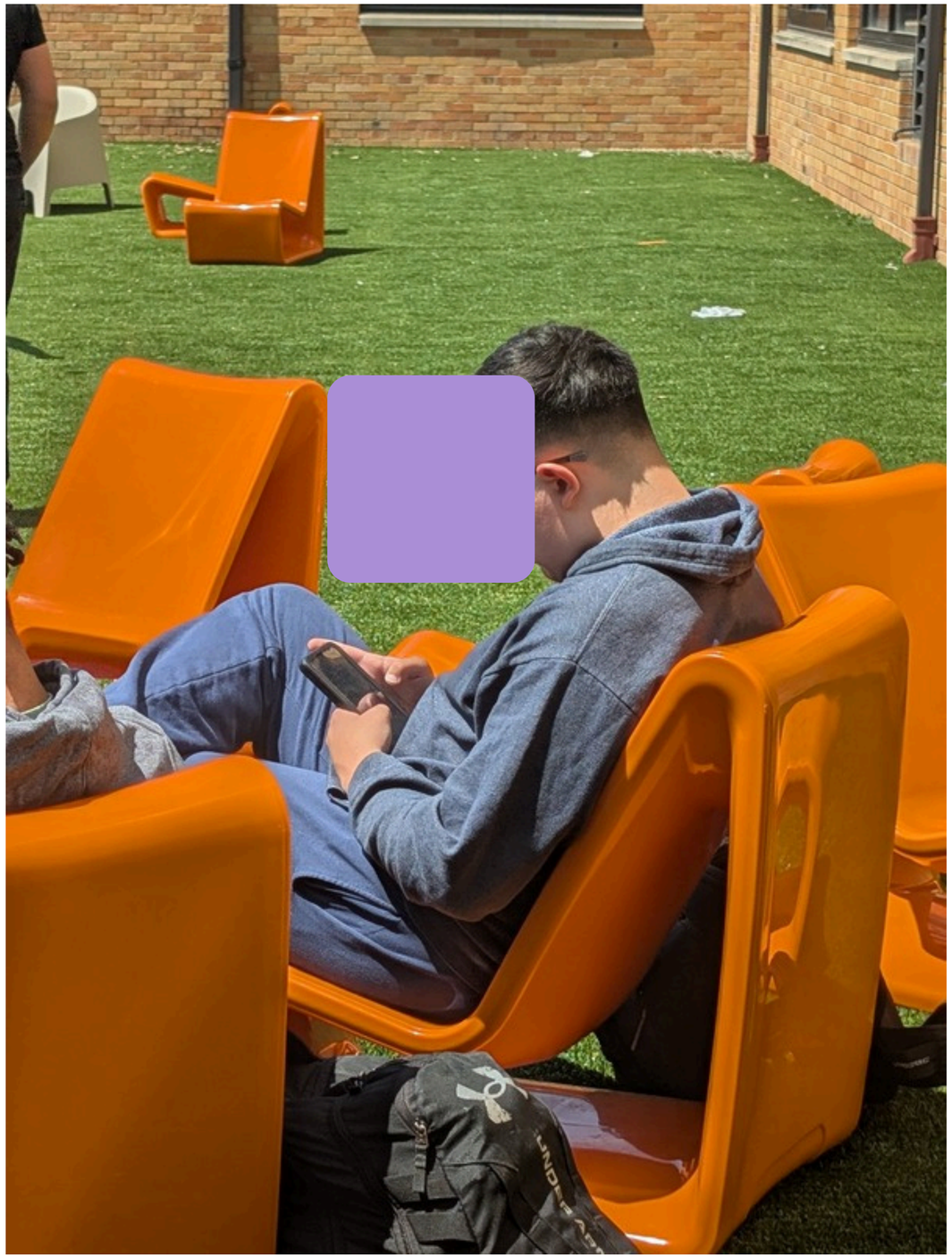


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FORWARD HEAD POSTURE



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Posture Tools

1. Use your team!
    a. What will meet the individual needs of the student? (sensory, activity level, size/height of furniture, is a prop helpful?)
    b. What fits your needs as an SLP? (raise monitor for screen at eye level, check your chair height/ prop to raise the floor?, write on a vertical surface)
2. Adjust or change chairs (and desks) to meet the student's size so feet can be flat on the floor
    a. Aim for 90 degrees of hips, knees, ankles, elbows whenever possible
3. Start with the pelvis; lengthen the spine; get the chin level

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Let's try it!

- Step 1: Slouch
- Step 2: Place your hands under your sit bones
- Step 3: Adjust your pelvis backand forth to find where the bones make the most contact with your hands/chair - freeze your hips there!
- Step 4: Lengthen your spine
- Step 5: Adjust your chin to a neutral level
- Step 6: Acknowledge that this may not feel normal, but it is neutral. This is your most ideal position!

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Part 5: A Myofunctional Screening using the FAIREST-6 (and an intro to how to do a screening)

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“

Patient does not have a cleft palate!

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1

SLP: *“Something isn’t right”*

2

Refer to ENT

3

ENT: *“They’re fine! They need therapy!”*

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Doctors & dentists look at the structures

Therapists look at the function

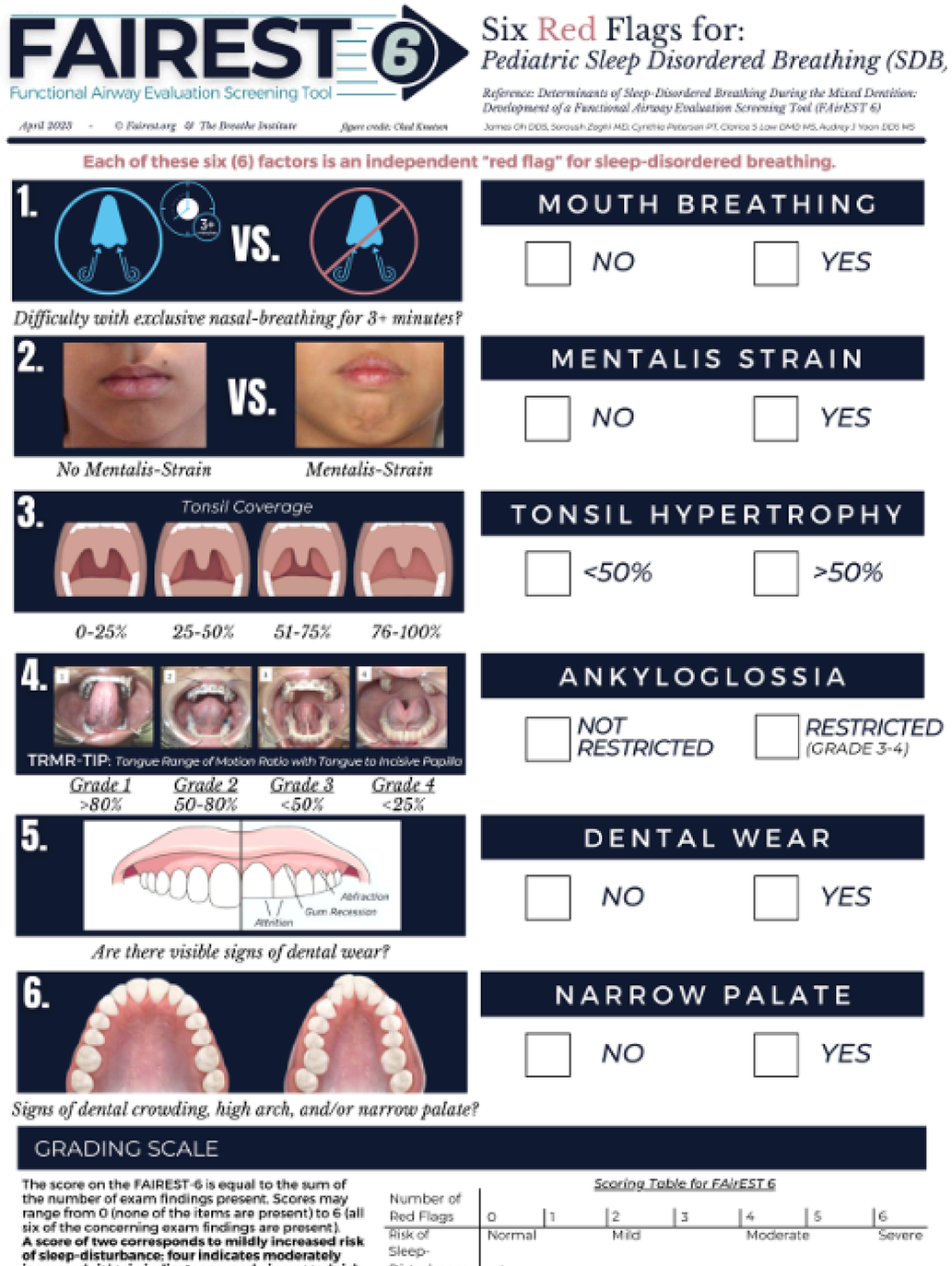
The plateau that's felt by the clinician, student, and the caregiver and other professionals

Shame: "I am bad"

Blame: a defense

No one is taught this in medical or dental school;
A very rare SLP has instruction on this in grad school

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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

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S is for Sleep*

*A biological need, not a luxury



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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

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#1
Nose vs Mouth Breathing



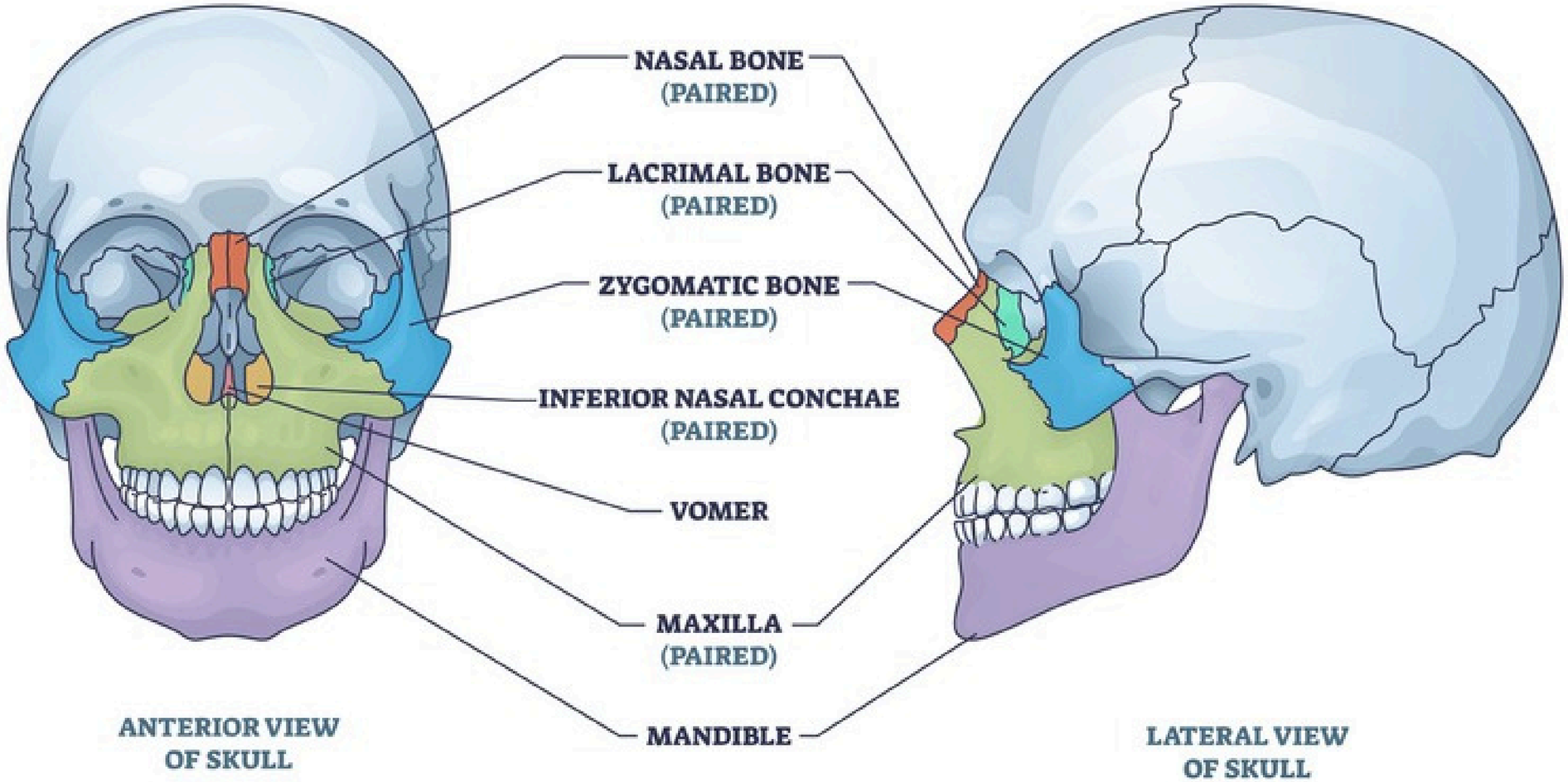






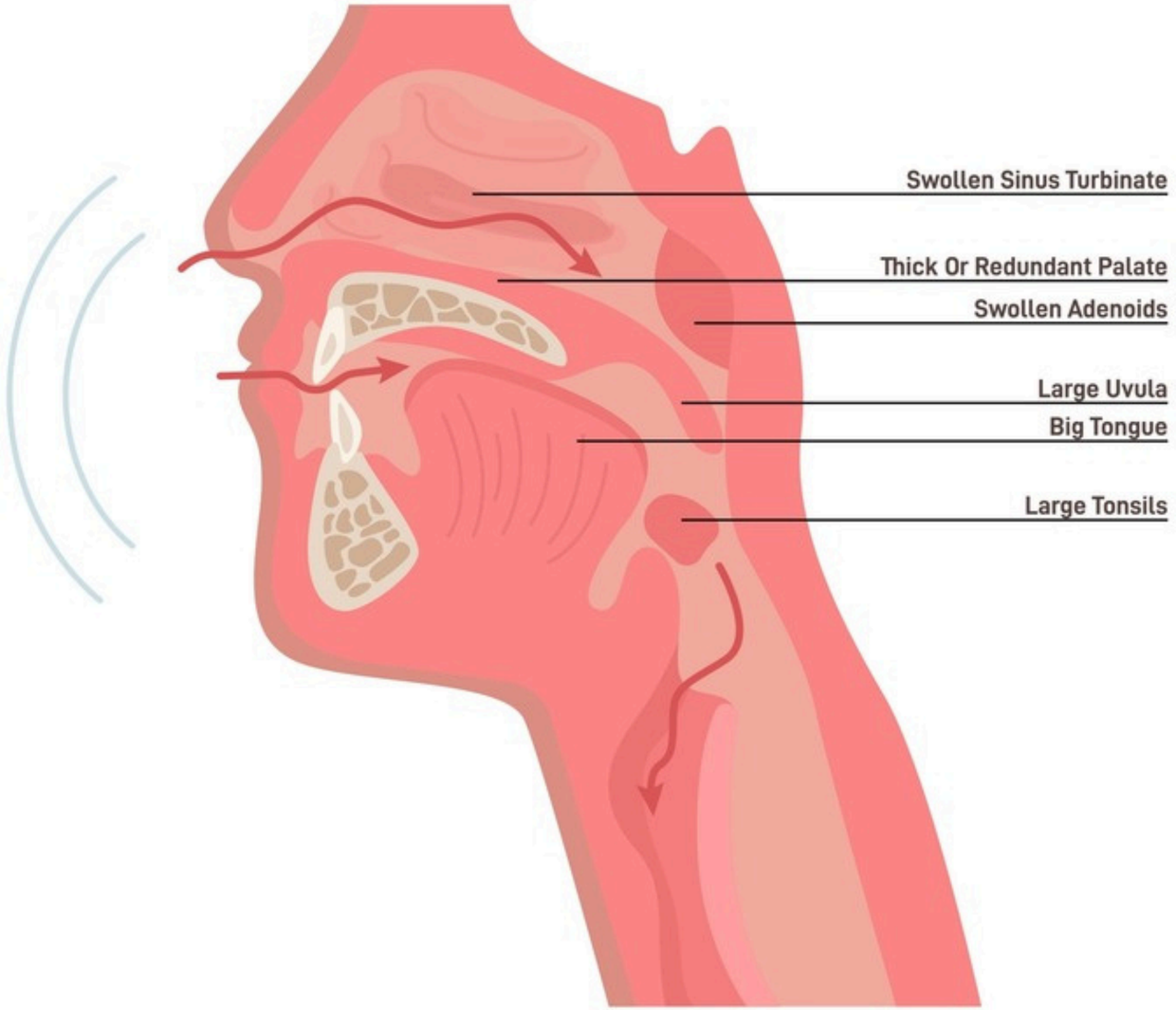
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FACIAL BONES



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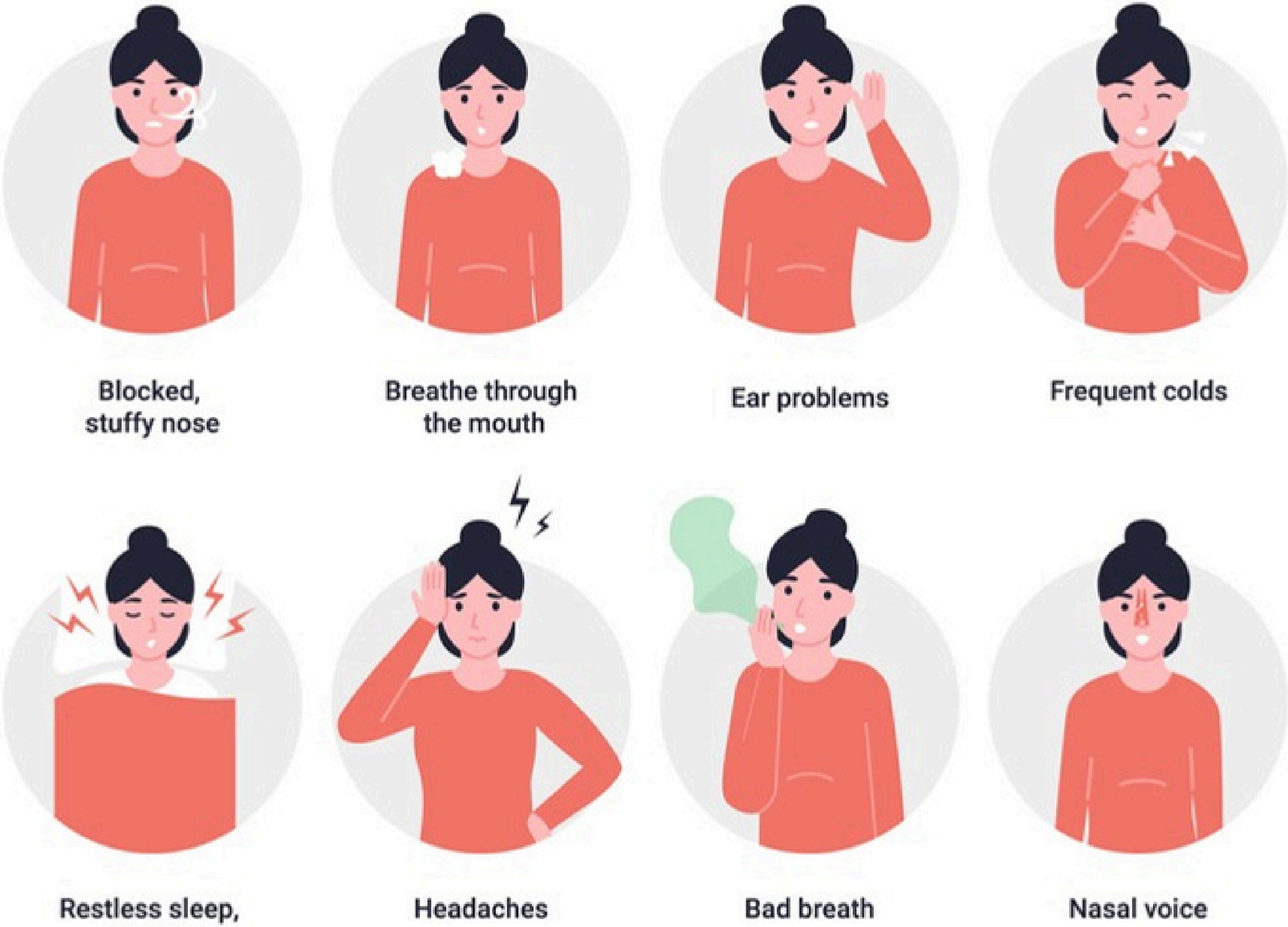
Causes Of Blocked Airway



The Presence Of One Or More Abnormal Anatomical Structures In The Face Can Lead To Obstructive Sleep Apnoea

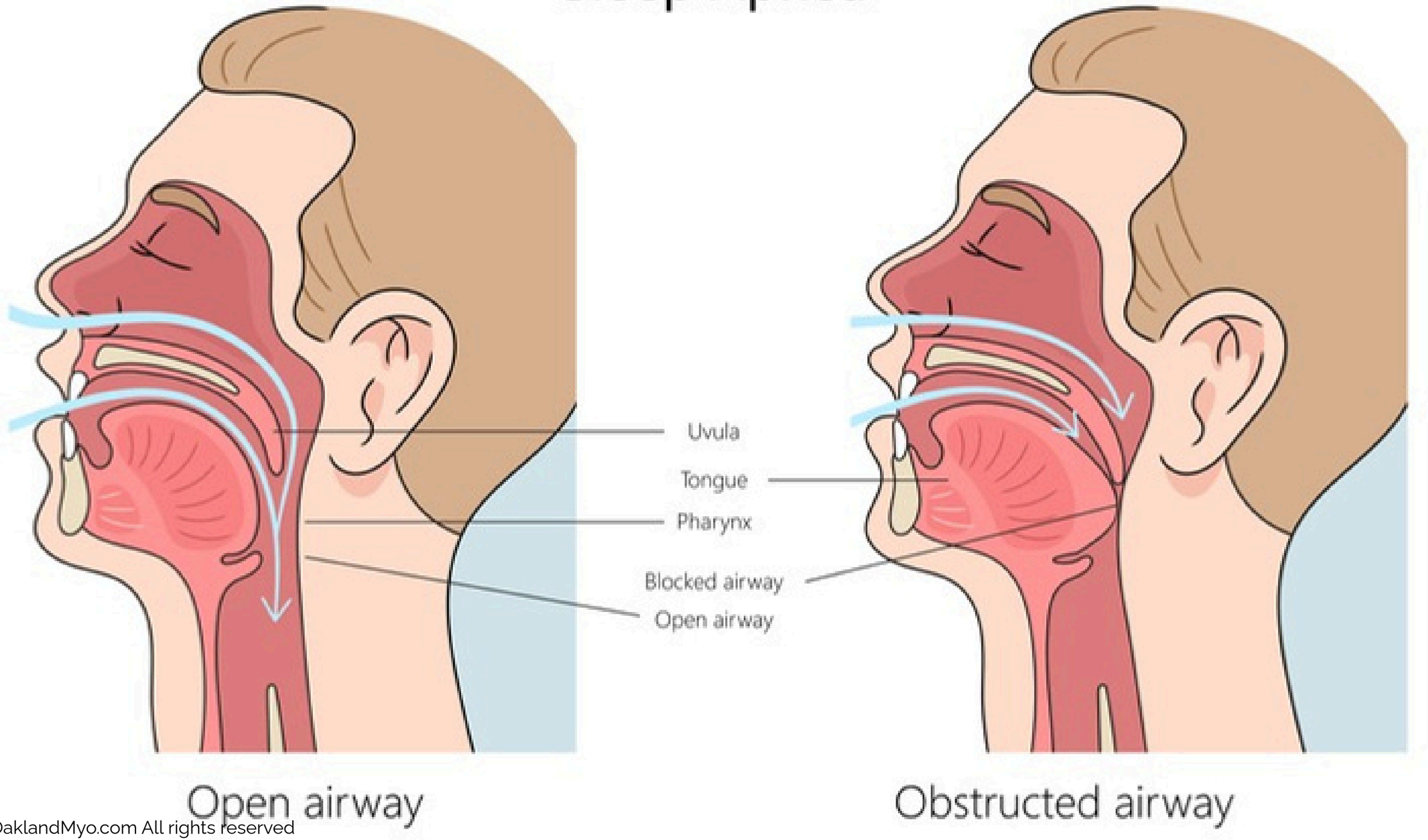
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Symptoms of enlarged adenoids



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Sleep Apnea



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Your Breathing Options

MOUTH BREATHING

Smaller airway (nostrils, nasal cavity doesn't develop as much!)

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

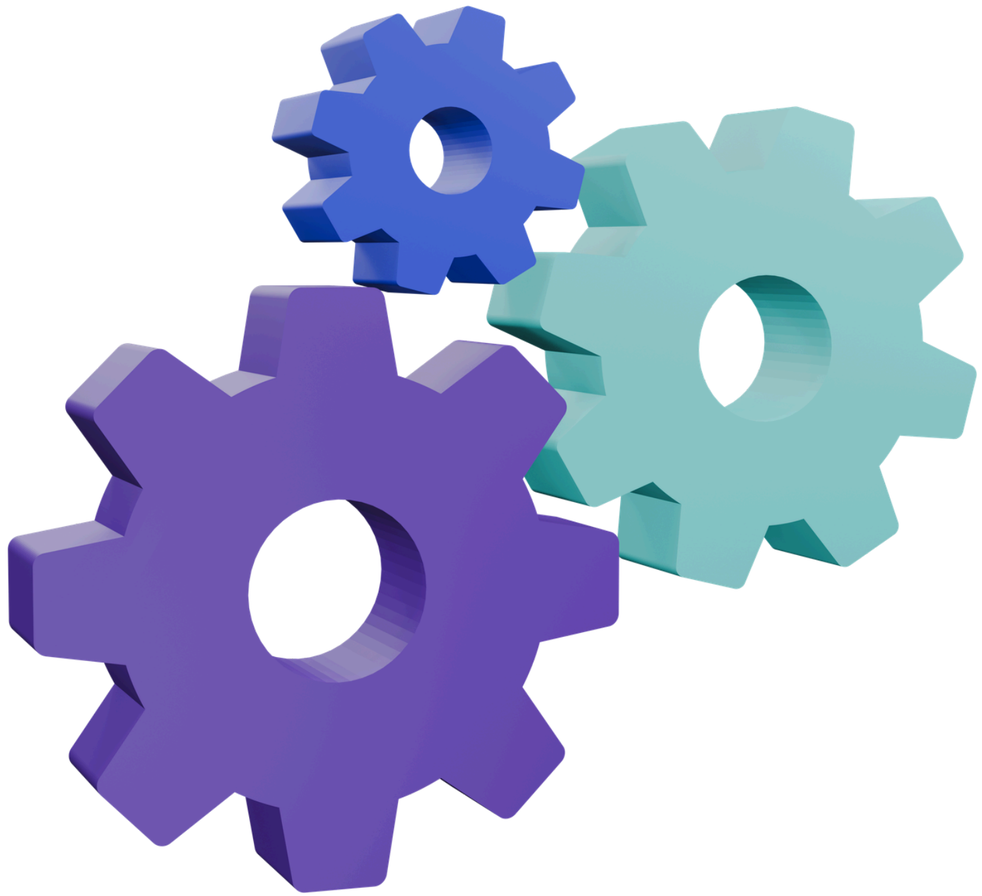
Optimal head + face development

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

Increase circulation throughout our body

Reduce anxiety

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Interplay of the:

breathing mechanics

(breathing deep into diaphragm, expanding ribs)

psychology

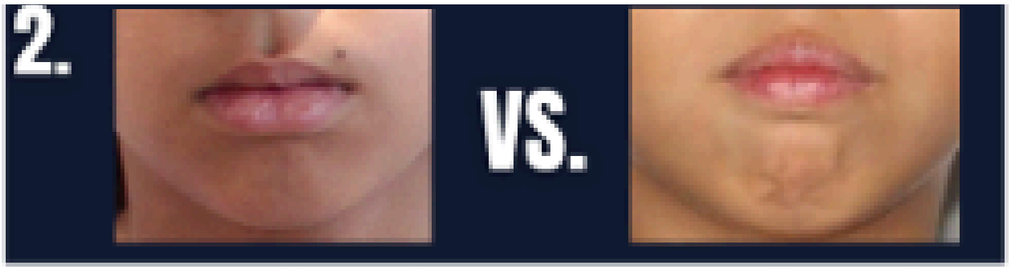
(anxiety vs calm; sympathetic vs parasympathetic)

& chemistry

(O_2, CO_2 in blood; hold more CO_2 to reduce breathing)

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#2: Lip Closure, Mentalis Strain



No Mentalis-Strain *Mentalis-Strain*

MENTALIS STRAIN	
☐ NO	☐ YES

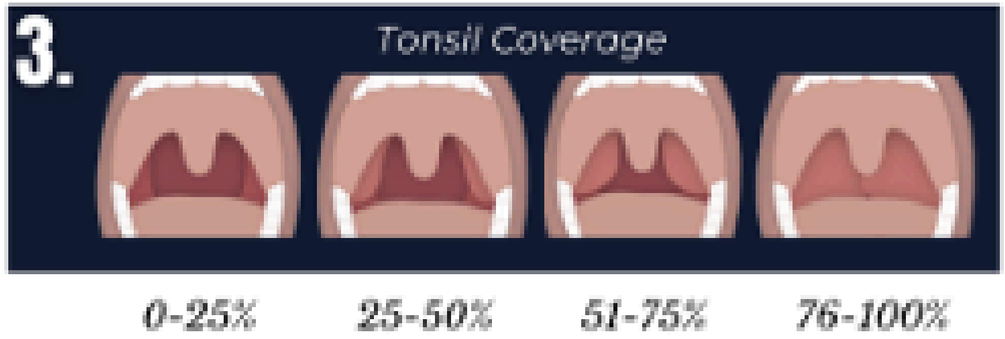
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Breathing & Oral Rest Posture Referrals

- 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

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#3 Hard & Soft Palates, Pharynx

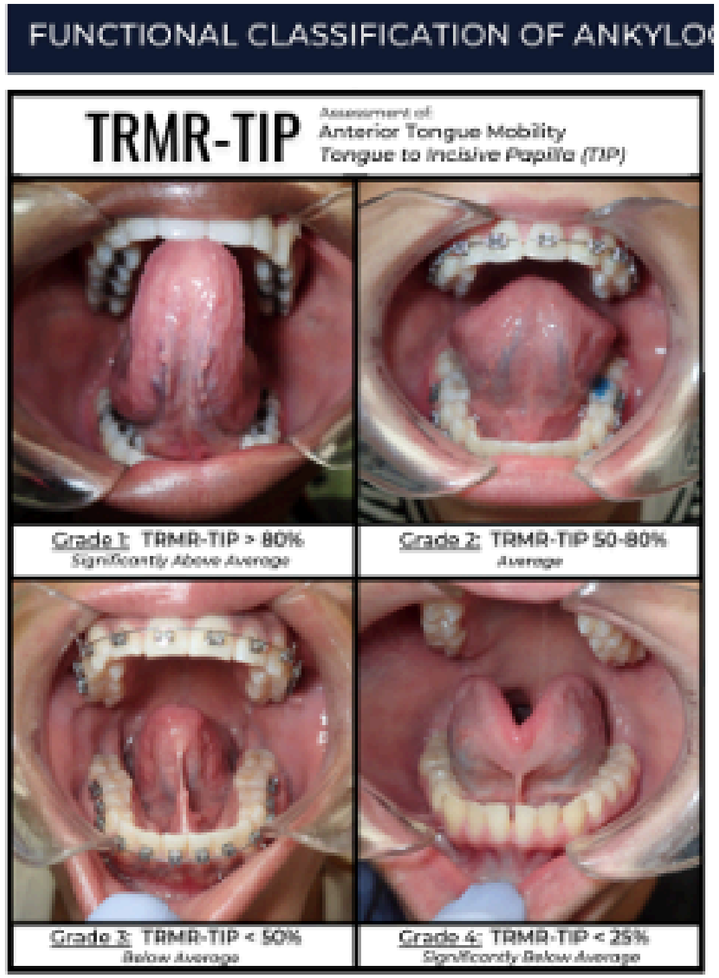


TONSIL HYPERTROPHY

☐ <50% ☐ >50%

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#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”

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#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”

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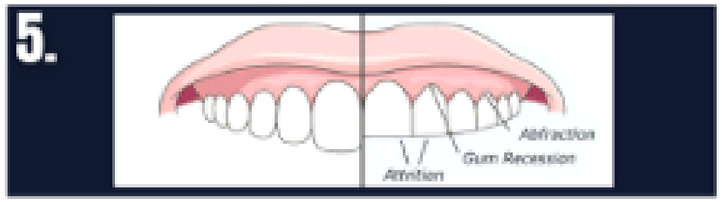
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Lingual Functioning Referrals

- 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

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#5, 6, 8: Dentition



Are there visible signs of dental wear?

DENTAL WEAR

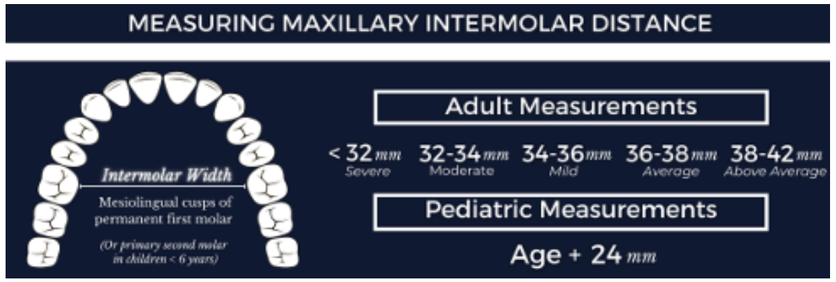
☐ NO ☐ YES



Signs of dental crowding, high arch, and/or narrow palate?

NARROW PALATE

☐ NO ☐ YES





Assess for tongue space limitations: Look for tongue overflow while the tongue is held in Lingual palatal suction (LPS).

TONGUE OVERFLOW

☐ NO ☐ YES

☐ NORMAL ☐ MILD ☐ MODERATE ☐ SEVERE

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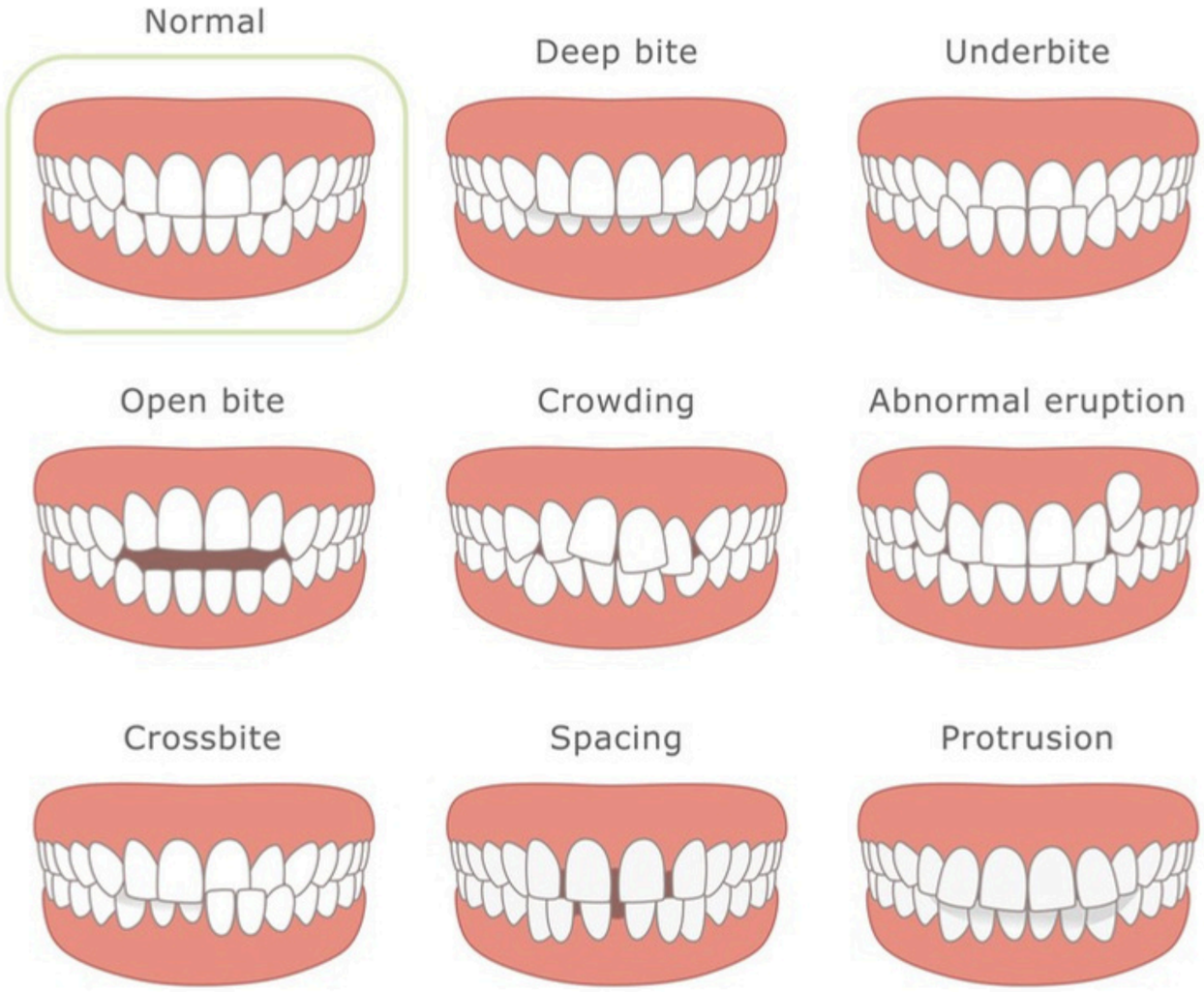
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Dental Wear!

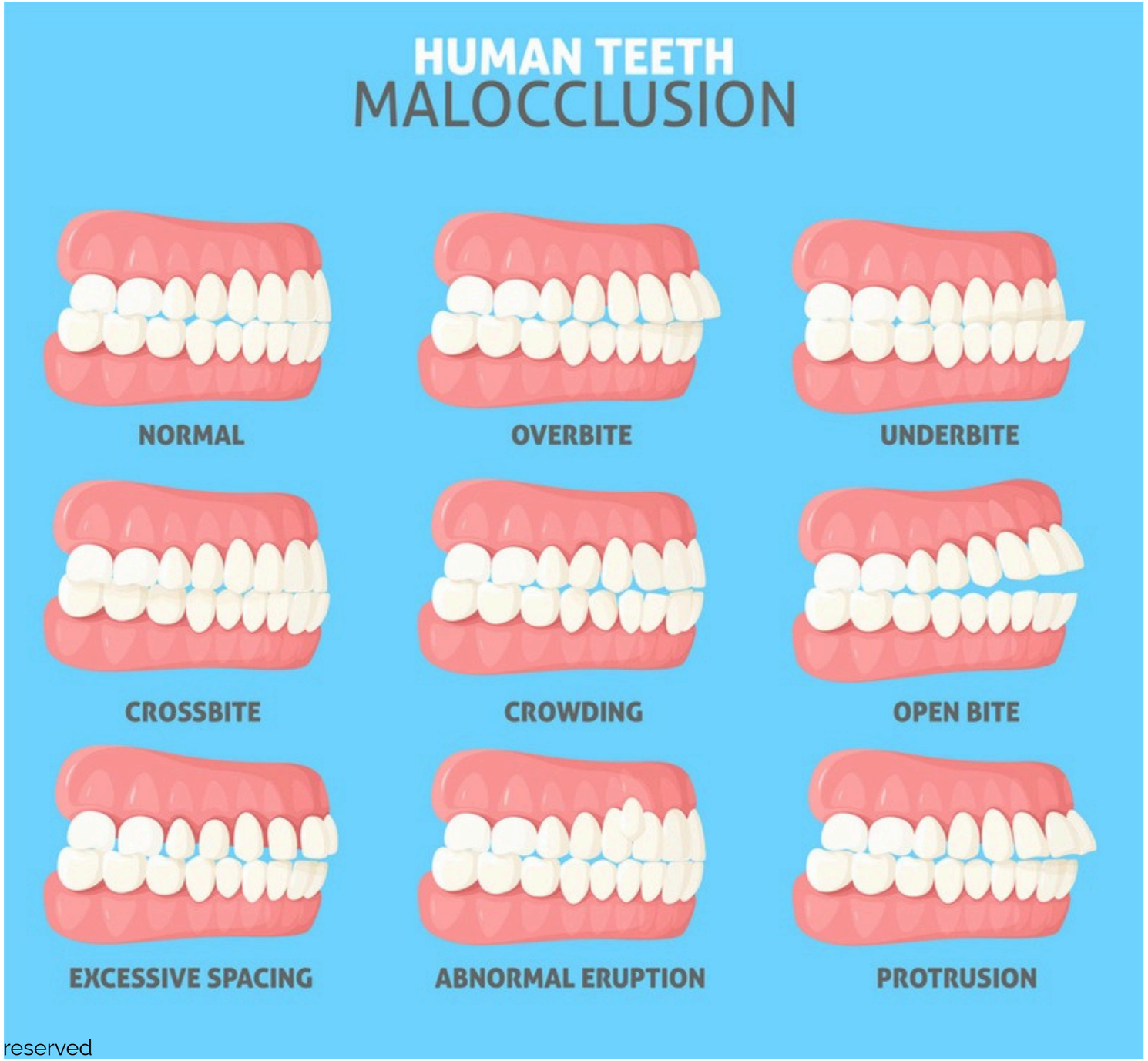


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Types of maloclusion



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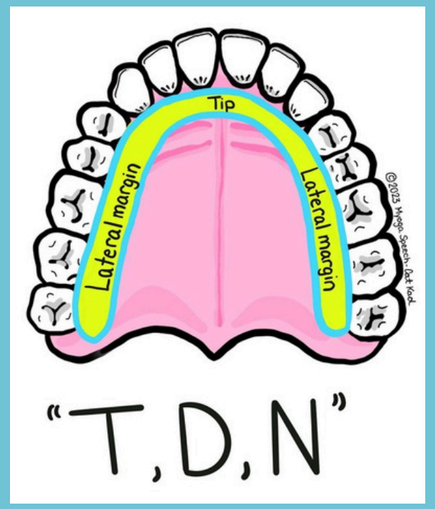
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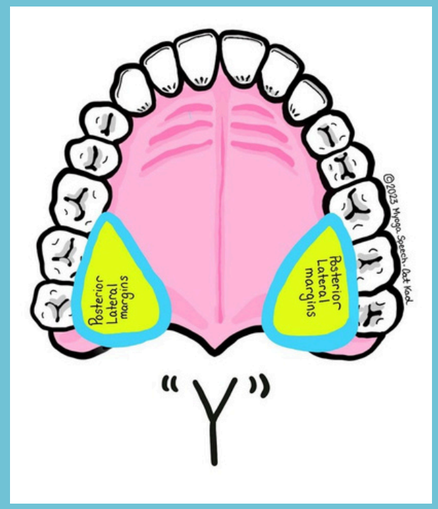


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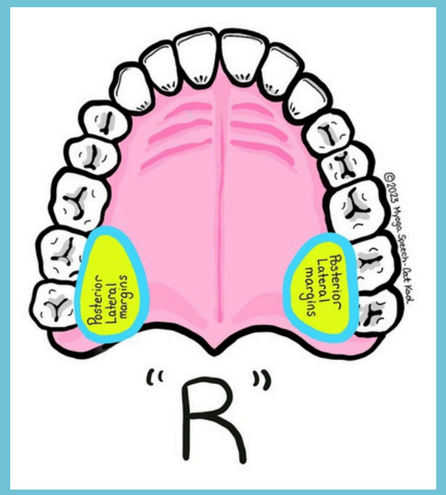
Articulation Stabilization

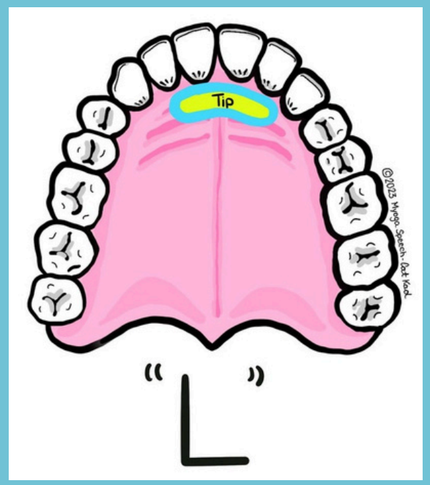














From Pamella Marshalla

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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

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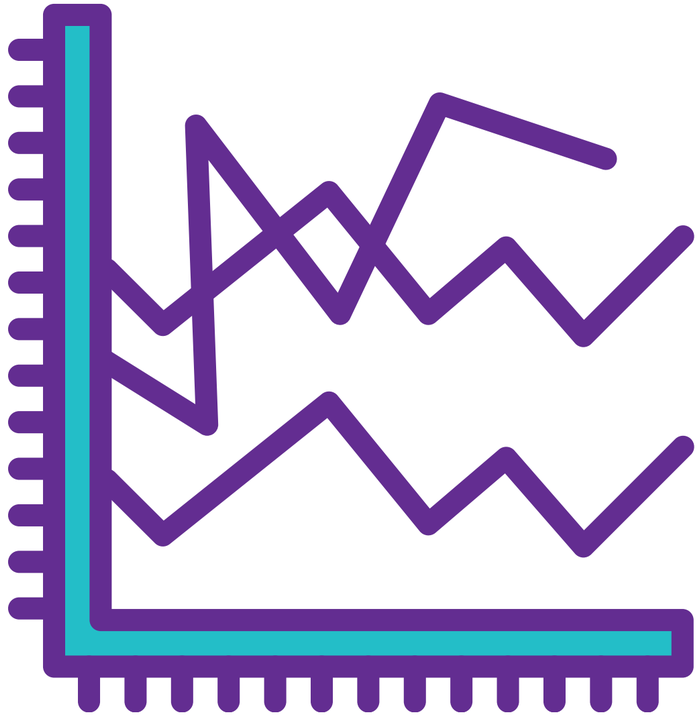


Root cause?

COMPENSATIONS?

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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

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Exercises to use tomorrow

1. **Identify “The Spot”.**
2. **Nose breathing**. Try a timer for a visual. Explain the benefits.
3. **Teach Oral Rest Posture**: tongue on The Spot, Lips close. Try to invite space between teeth.
4. *Jaw differentiation (grading / stabilization)*
5. *Lip differentiation “ooh-eee”*
6. *Molar stabilization “t, d, n”*
7. **Core 4: Tongue in All Directions**: (*tongue differentiation*) (Rollercoaster face; move SLOWLY; stabilize jaw then do independently, 10x in a row)
    a. Tongue from The Spot, then down.
    b. Out-In
    c. Side-to-Side
    d. Puppy tongue - Lizard tongue (licking)
8. **Lingual Palatal Suction** (start with clicks)

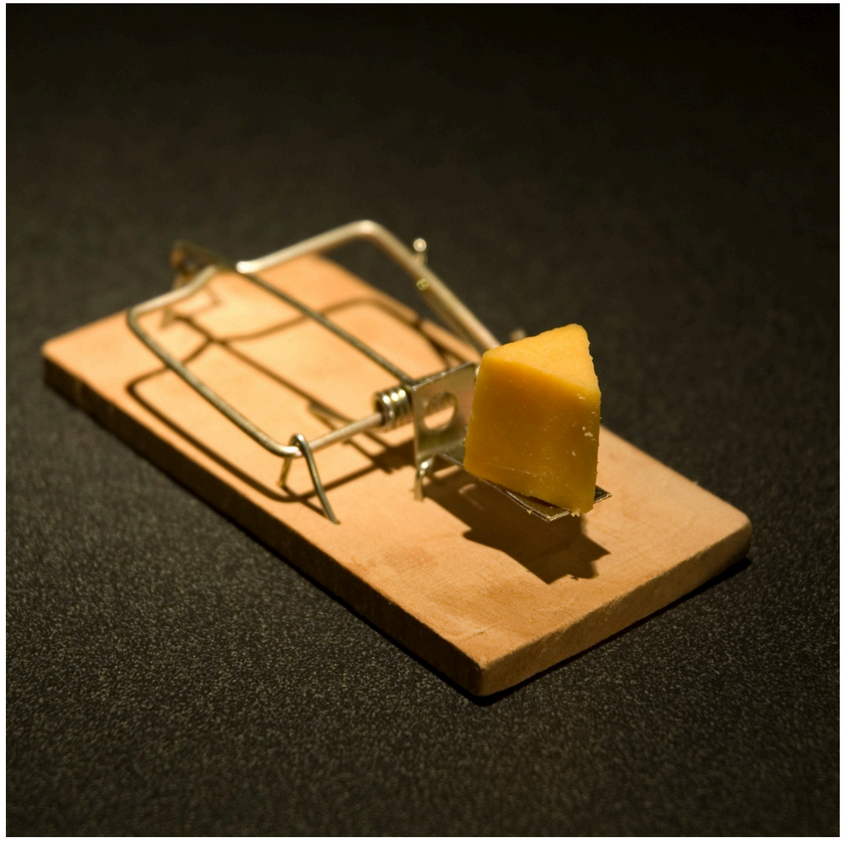
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Watch the Ableist Trap!

“That’s just how they are”



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> *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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Part 6: A Myofunctional Screening for school-based SLPs

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ORAL MECHANISM & FUNCTION EVALUATION

A myofunctional screening tool for school-based Speech-Language Pathologists
based on the FAirEST-6 Sleep Disordered Breathing Tool

Name: _____ Date of Birth: _____
Teacher: _____ Administered: _____
Grade: _____ Age: _____ SLP: _____
District/Building: _____ SLP Contact Info: _____

Posture

Team assesses: The student can have feet flat on the floor when seated; The student can adjust pelvis to improve posture

The student's preferred seated work / listening position: Upright, Slouched, ONE / TWO knee(s) tucked, Hand supports holding head up, Leaning back, Lean on desk, Sitting on a leg, Head on desk

Evaluate the remainder of the evaluation when the student is in ideal seated posture:

Forward head position (ear canal is forward of middle of shoulder)
Neutral head position (ear canal is centered on middle of shoulder)

Oral Rest Posture

Lips are open wide, Lips are closed
Tongue rests with tip up, Tongue rests low in mouth
Tongue rests interdentally, Tongue protrudes between lips
Tongue presses against UPPER / LOWER teeth

Breathing

Nasal, Mouth, Mixed Nasal-Mouth
Silent, Audible at rest, Fast, shallow, Slow, deep
Able to pass 3 minute nasal breathing test, Unable to pass 3 minute nasal breathing test

Lips

Close without mentalis strain, Close with mentalis strain
Normal, Dry/chapped, Short upper lip
Poor lip closure /p, b, m/

Palates & Throat

Tonsils are less than 50% of airway, Tonsils are more than 50% of airway
Soft Palate has normal color (not blueish, no ridges suggestive of submucosal cleft)
Tongue can fit within the palate, Tongue unable to fit within palate
High, Narrow: ANTERIORLY / THROUGHOUT

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Let's try it!

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ORAL MECHANISM & FUNCTION EVALUATION

A myofunctional screening tool for school-based Speech-Language Pathologists
based on the FAirEST-6 Sleep Disordered Breathing Tool

Name: _____ Date of Birth: _____

Teacher: _____ Administered: _____

Grade: _____ Age: _____ SLP: _____

District/Building: _____ SLP Contact Info: _____

Posture

Team assesses:

- ☐ *The student can have feet flat on the floor when seated*
- ☐ *The student can adjust pelvis to improve posture*

The student's preferred seated work / listening position: ☐ Upright ☐ Slouched

- ☐ ONE / TWO knee(s) tucked
- ☐ Hand supports holding head up
- ☐ Leaning back
- ☐ Lean on desk
- ☐ Sitting on a leg
- ☐ Head on desk

Evaluate the remainder of the evaluation when the student is in ideal seated posture:

- ☐ Forward head position (ear canal is forward of middle of shoulder)
- ☐ Neutral head position (ear canal is centered on middle of shoulder)

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Oral Rest Posture

- Lips are open wide
- Lips are closed
- Tongue rests with tip up
- Tongue rests low in mouth
- Tongue rests interdentally
- Tongue protrudes between lips
- Tongue presses against UPPER / LOWER teeth

Breathing

- Nasal
- Mouth
- Mixed Nasal-Mouth
- Silent
- Audible at rest
- Fast, shallow
- Slow, deep
- Able to pass 3 minute nasal breathing test
- Unable to pass 3 minute nasal breathing test

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Lips

- Close without mentalis strain
- Close with mentalis strain
- Normal
- Dry/chapped
- Short upper lip
- Poor lip closure /p, b, m/

Palates & Throat

- Tonsils are less than 50% of airway
- Tonsils are more than 50% of airway
- Soft Palate has normal color (not blueish, no ridges suggestive of submucosal cleft)
- Tongue can fit within the palate
- Tongue unable to fit within palate
  - High
  - Narrow: ANTERIORLY / THROUGHOUT

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Tongue Range of Motion

Tongue to the Tip: *Keeping a wide open mouth, ask student to elevate their tongue to aim toward The Spot (or behind the front teeth)*

- Tongue can elevate at least 50%
- Tongue elevates less than 50%
- Floor of the mouth is engaged

Lingual Palatal Suction: *Ask the student to create a lingual palatal suction (LPS), then open wide, but maintainging a strong suction)*

- Unable to create a LPS
- LPS is weak
- LPS can be held with good range of motion (2 fingers width)
- LPS requires excessive jaw closure to obtain suction (<2 fingers width)

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- Tongue splays onto occlusal surface of teeth _____%
  - *if 7mm or more, orthodontic expansion may be necessary to allow space for tongue to position and stabilize for connected speech

Sweep the Molars: *Necessary for oral hygiene. Ask the student to sweep their molars. Support motor skills to determine it is not the causing failure, but truly is a lack of range of motion.*

- Able to sweep molars
- Unable to sweep molars

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Tongue Appearance

- Lingual frenulum is SHORT / HIGH INSERTION (>50%)
- Pink
- Coated
- Pull at tongue tip
- Midline tension
- Lingual frenulum tense, visible at rest

Dental

- Dental wear is not observed
- Dental wear is PRESENT SIGNIFICANT
- Diastema: MAXILLA / MANDIBLE
- Occlusion appears healthy
- Occlusion concern: OVERJET/RECESSED JAW OPENBITE CLASS III (underbite) CROSSBITE

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Behavior Concerns & Observations

- Inattentive
- Active
- Impulsive
- Easily dysregulated
- Not engaged
- Appears tired, lethargic
- Easily agitated
- Easily distracted
- Anxious
- Excess saliva
- Picky eating
- At risk / low performance
- Withdrawn

Speech-Language

- Delayed language
- Speech sound disorder
- Stutter / Dysfluent
- Voice disorder or hoarse quality observed
- Mumbles / Unclear
- Hyponasal
- Hypernasal
- Dentition appears to be affecting articulation
- Tongue mobility and range of motion appears to be affecting articulation in connected speech

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Example wording you need to run by your administration first:

- Given observed challenges with tongue elevation and extension for “l, th” and elevation and retraction for “r”, structural factors may be impacting STUDENT’s ability to achieve these sounds in connected speech. This information is provided for consideration by the family, as appropriate. Speech therapy will continue to focus on treating functional articulation goals in the educational setting.

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My Speech Room Wonders Revisited

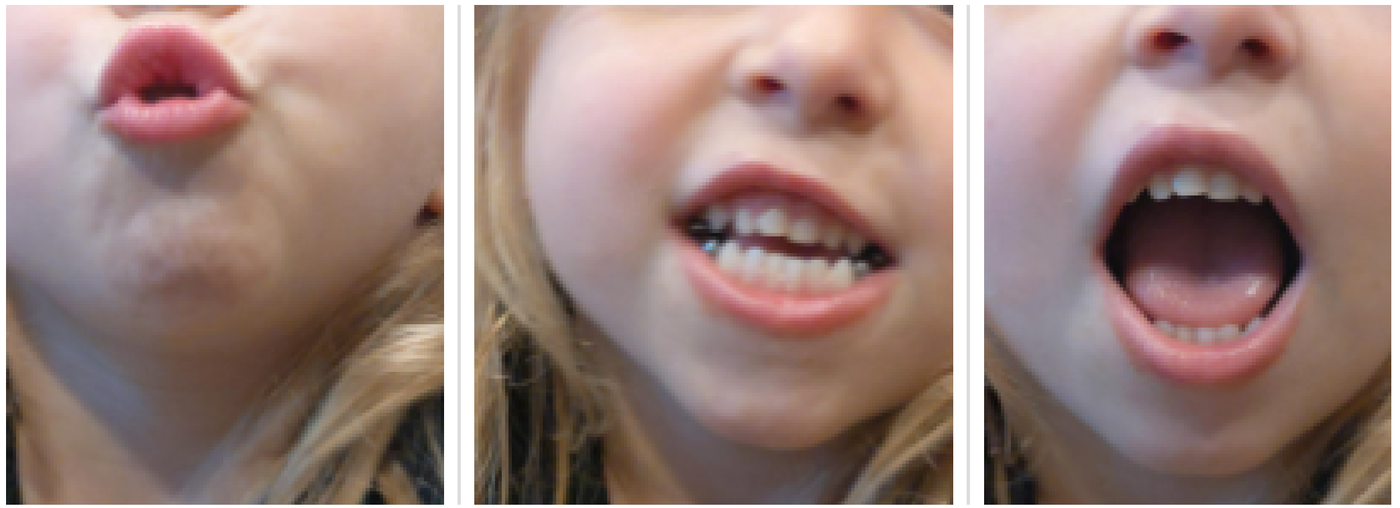
1. Why did some produce /s, z/ with lower incisors?
2. Why were my students the most disruptive in their classrooms -and often known throughout the school by their first name?
3. Why were so many of my students referred for evaluations for Learning Disabilities?
4. Why were 5/6 of the slowest running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

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Part 9: Let’s look at mouths!

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“ooh eee ahh”

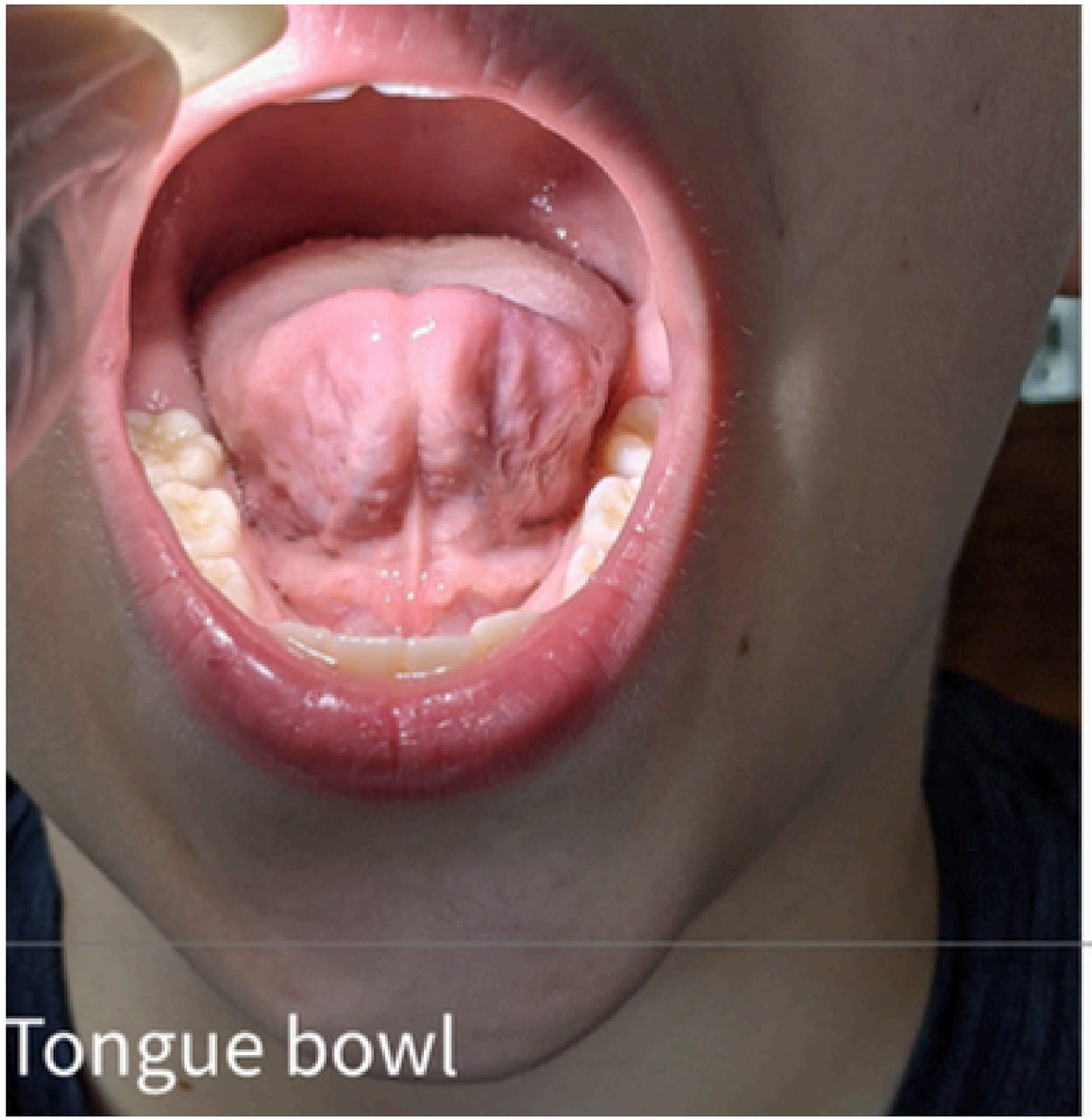


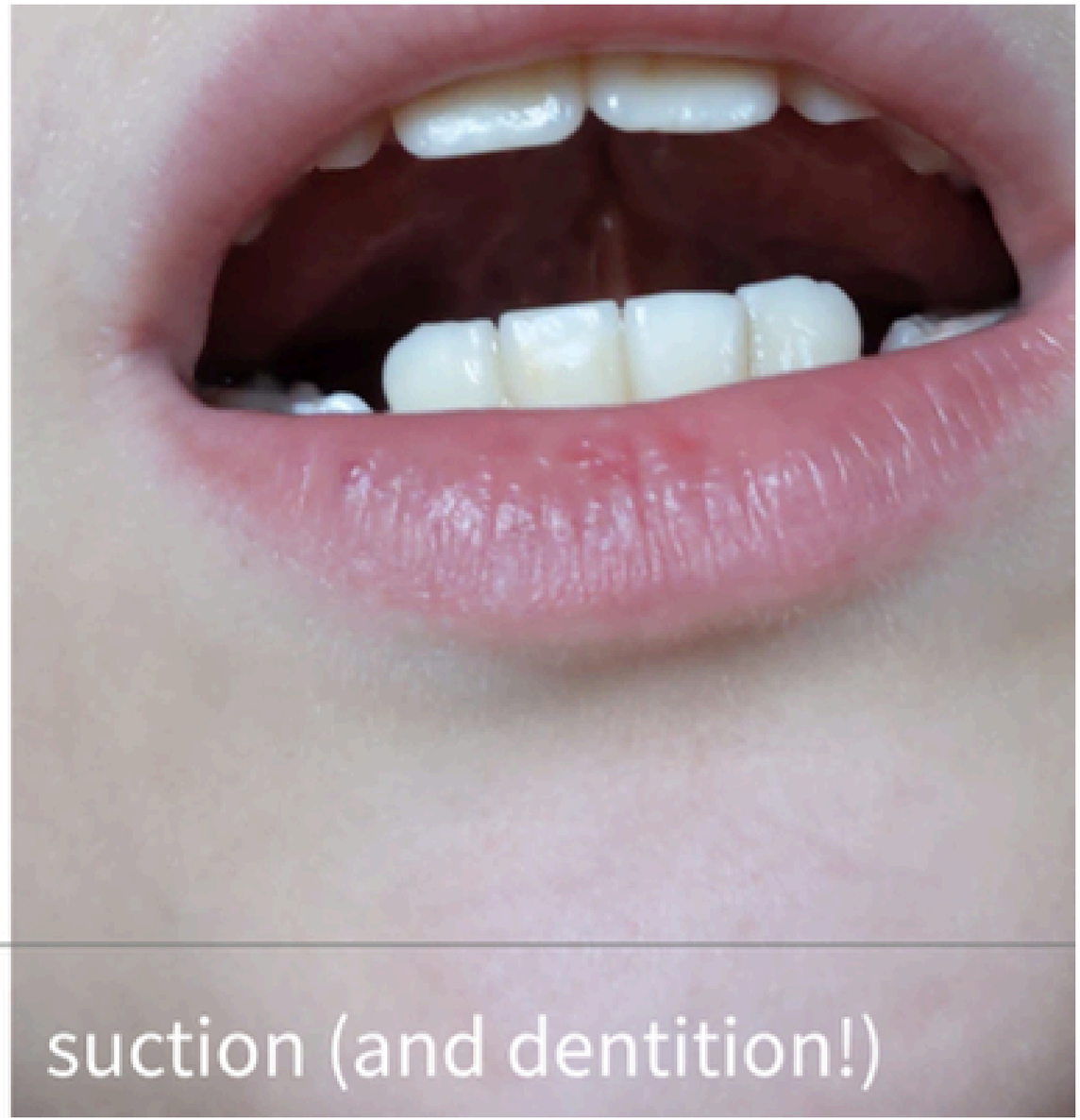
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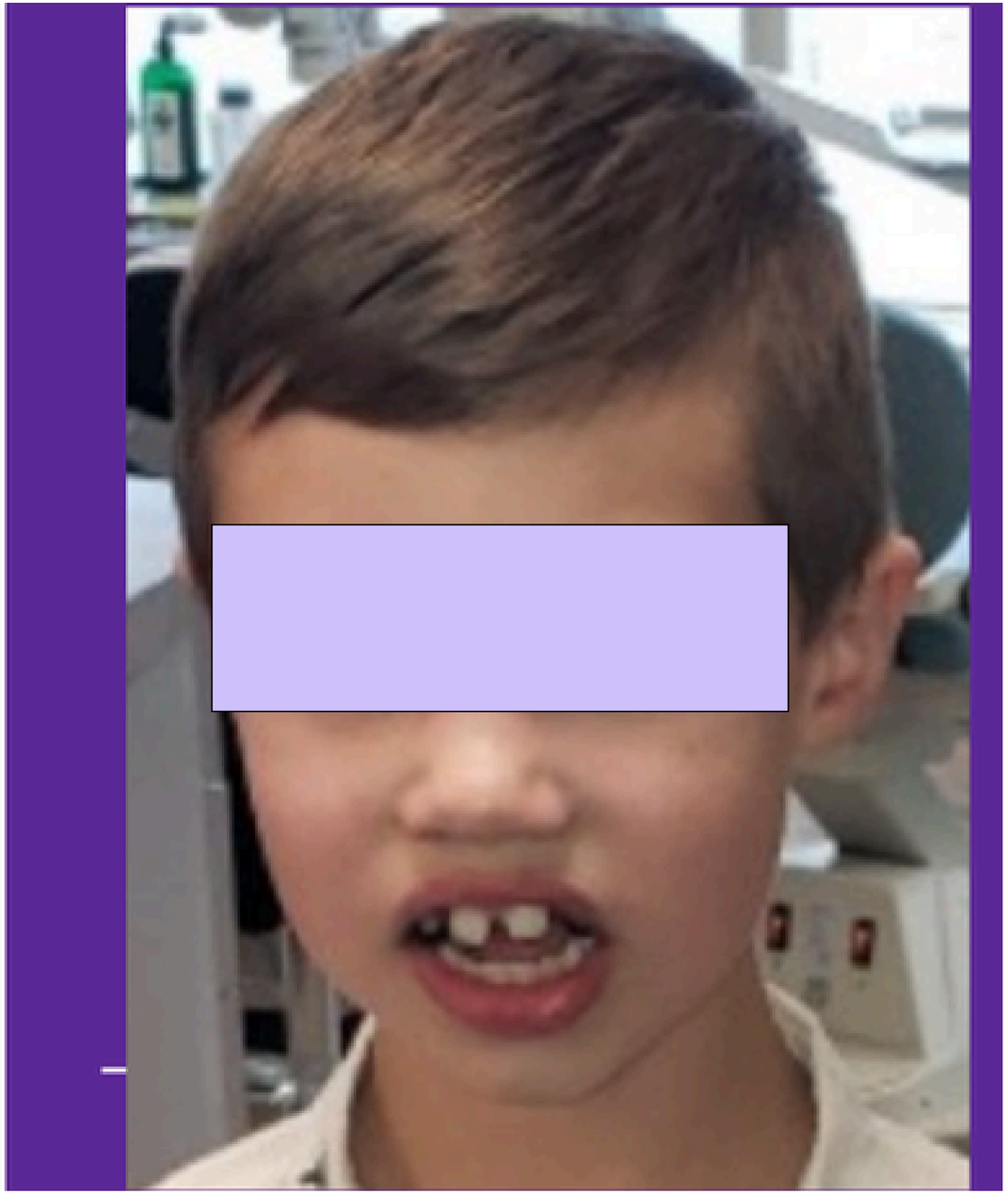




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Yay! He's starting ortho treatment!





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Patient #1
18 years old





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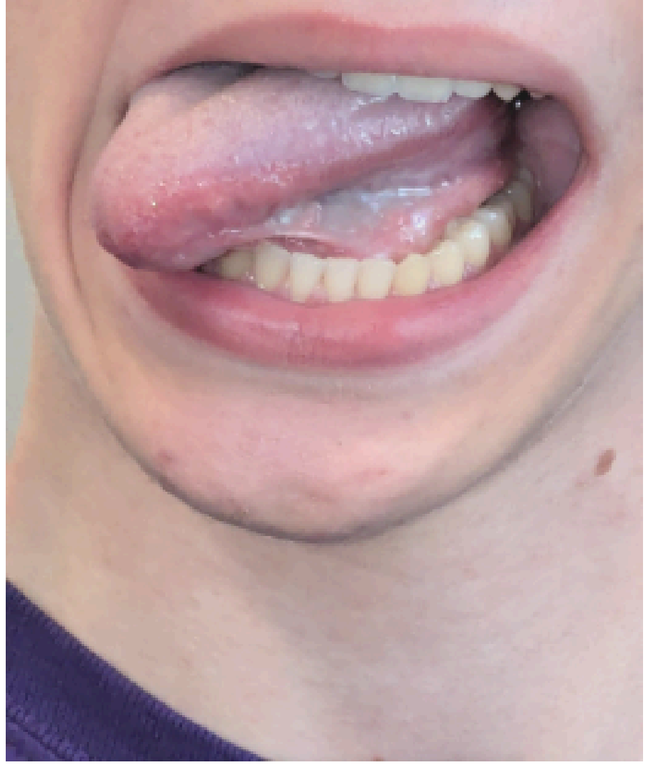




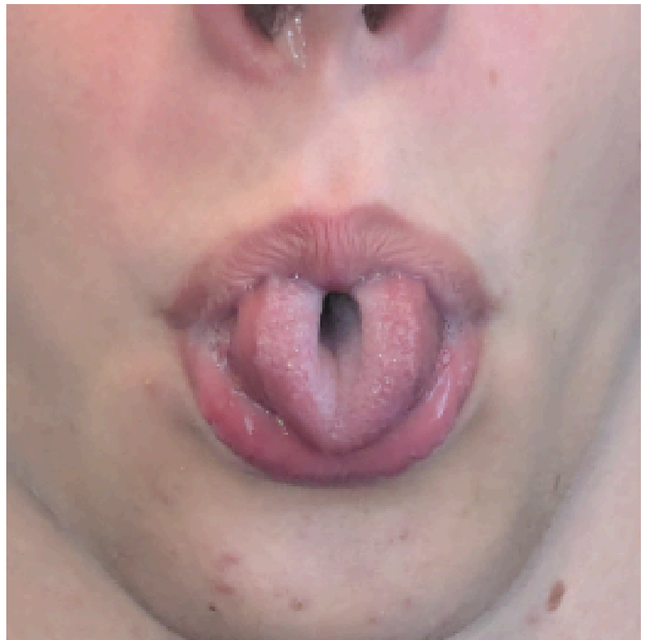
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Patient #2
9 years old





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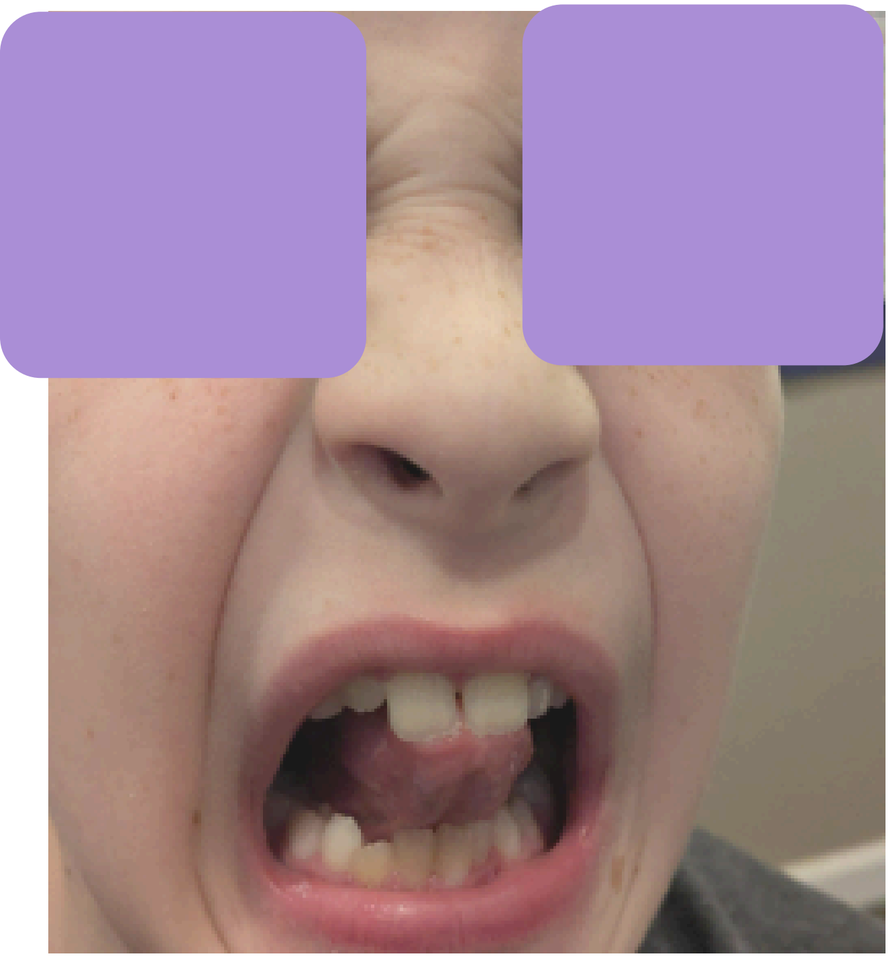


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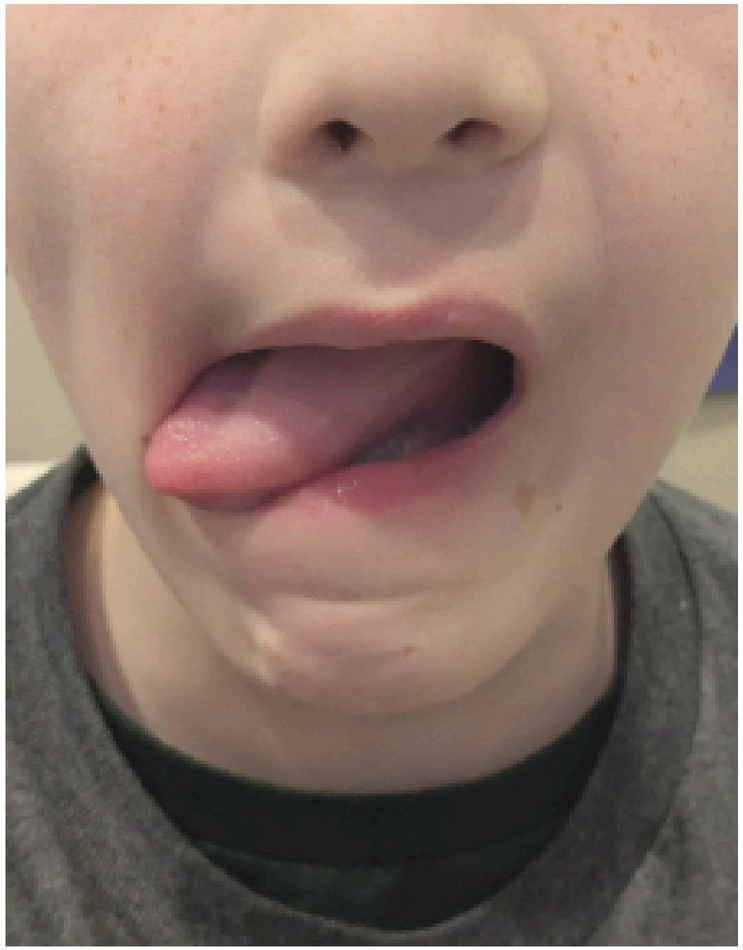




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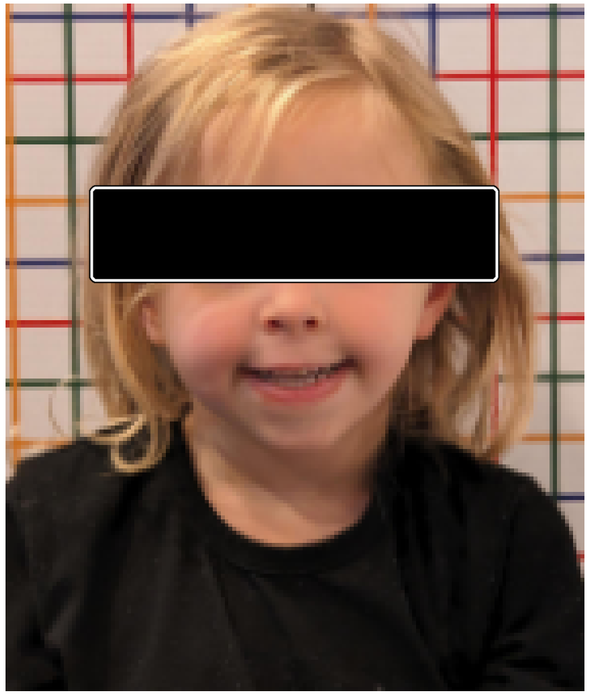
Case Study #1

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Case History

- In developmental Kindergarten program; turns 5 in November
- “weird tongue thrust and positioning with her tongue” previous SLP said
- Snores, wets the bed; can fall asleep easily during the day
- Breathes through her mouth during day and night
- Hard to understand her
- Not making progress in private practice speech mom feels
- Very social, listens “most of the time”, loves learning
- Born at 39 weeks gestation via C-section
- History of pacifier, bottle (no duration shared)
- Messy eater, crumbs all around her area
- Avoids mashed potatoes
- Gets frustrated trying to communicate

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Posture

Team determined:
- [X] *The student can have feet flat on the floor when seated*
- [ ] *The student can adjust pelvis to improve posture*

The student's preferred seated work / listening position:
- [ ] Upright
- [X] Slouched
- [ ] ONE / TWO knee(s) tucked
- [X] Hand supports holding head up
- [ ] Leaning back
- [X] Lean on desk
- [ ] Sitting on a leg
- [ ] Head on desk

Complete the remainder of the evaluation when the student is in ideal seated posture:

- [ ] Forward head position (ear canal is forward of middle of shoulder)
- [X] Neutral head position (ear canal is centered on middle of shoulder)

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Oral Rest Posture

- [x] Lips are open wide
- [ ] Lips are closed
- [ ] Tongue rests with tip up
- [x] Tongue rests low in mouth
- [ ] Tongue rests interdentally
- [ ] Tongue protrudes between lips
- [x] Tongue presses against UPPER / LOWER teeth

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Breathing

- [ ] Nasal
- [x] Mouth
- [ ] Mixed Nasal-Mouth
- [ ] Silent
- [x] Audible at rest
- [x] Fast, shallow
- [ ] Slow, deep
- [x] Able to pass 3 minute nasal breathing test
- [ ] Unable to pass 3 minute nasal breathing test

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Lips

- [ ] Close without mentalis strain
- [x] Close with mentalis strain
- [ ] Normal
- [x] Dry/chapped
- [ ] Short upper lip
- [ ] Poor lip closure /p, b, m/

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Unable to visualize tonsils

Palates & Throat

- [ ] Tonsils are less than 50% of airway
- [ ] Tonsils are more than 50% of airway
- [ ] Soft Palate has normal color (not blueish, no ridges suggestive of submucosal cleft)
- [x] Tongue can fit within the palate
- [ ] Tongue unable to fit within palate
- [ ] High
- [ ] Narrow: ANTERIORLY / THROUGHOUT

Tongue appears adequate to fit within palate

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Unable to elevate tongue without stabilizing the tip

(such as opening her mouth, then lifting her tip)

Tongue Range of Motion

Tongue to the Tip: *Keeping a wide open mouth, ask student to elevate their tongue to aim toward The Spot (or behind the front teeth)*

- [x] Tongue can elevate at least 50%
- [ ] Tongue elevates less than 50%

- [x] Floor of the mouth is engaged

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not able to fully assess today, appears adequate

(also see Palates & Throat section if the tongue fits in the palate: if it overflows onto molars >7mm, the tongue cannot stabilize between molars for speech sounds)

Lingual Palatal Suction: *Ask the student to create a lingual palatal suction (LPS), then open wide, but maintainging a strong suction)*

held briefly

- [ ] Unable to create a LPS
- [x] LPS is weak
- [x] LPS can be held with good range of motion (2 fingers width)
- [ ] LPS requires excessive jaw closure to obtain suction (<2 fingers width)

- [ ] Tongue splays onto occlusal surface of teeth _____%
  - *if 7mm or more, orthodontic expansion may be necessary to allow space for tongue to position and stabilize for connected speech

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Sweep the Molars: *Necessary for oral hygiene. Ask the student to sweep their molars. Support motor skills to determine it is not the causing failure, but truly is a lack of range of motion.*

 Able to sweep molars

 Unable to sweep molars

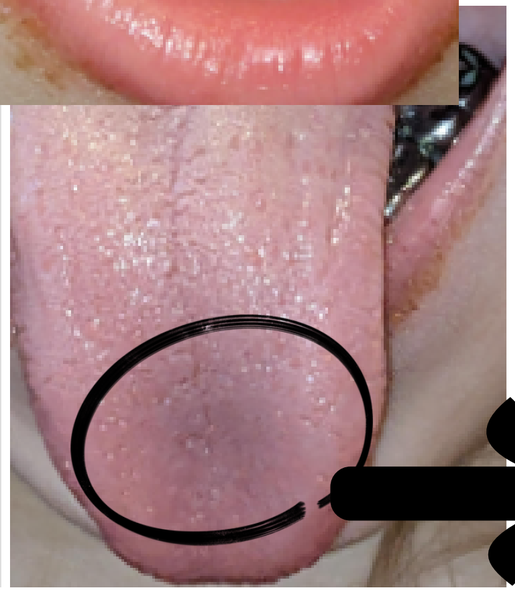
appears to be a motoric challenge

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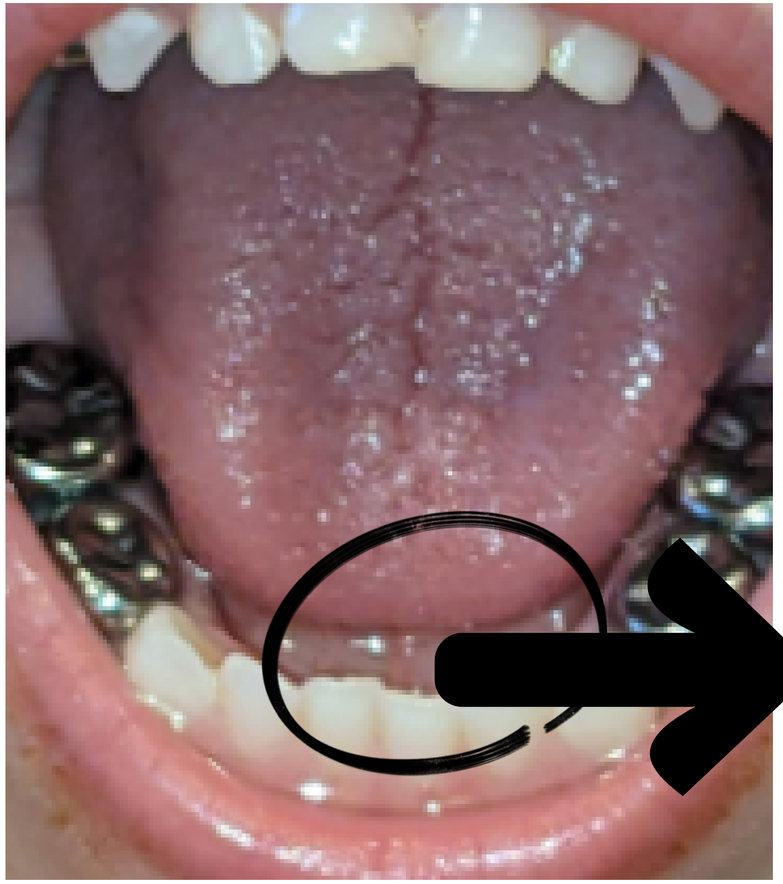








Appears to have a dimple from tension under tongue



Lingual frenulum

Tongue Appearance

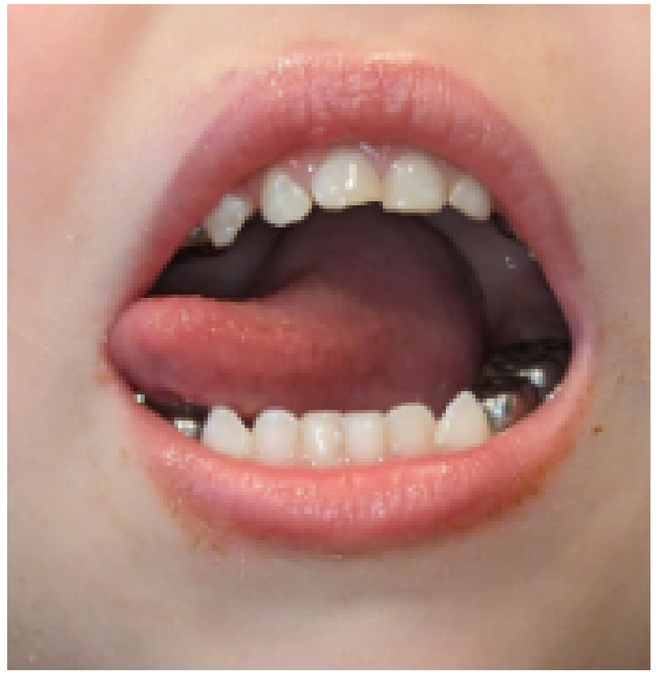
- [ ] Lingual frenulum is SHORT / HIGH INSERTION (>50%)
- [x] Pink
- [ ] Coated
- [ ] Pull at tongue tip
- [x] Midline tension
- [x] Lingual frenulum tense, visible at rest

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The only other lingual movements she could demonstrate



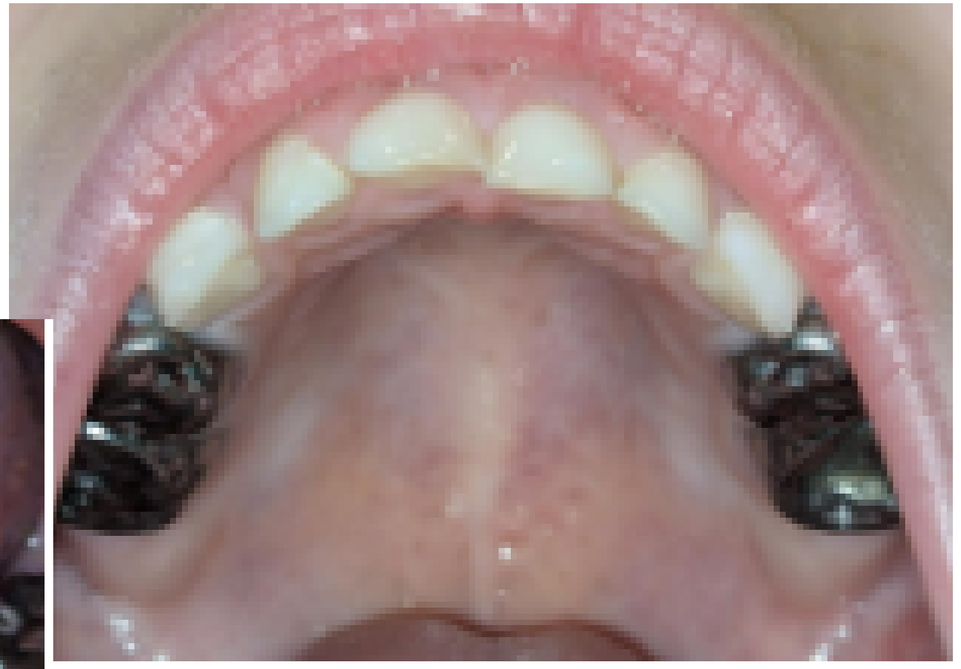




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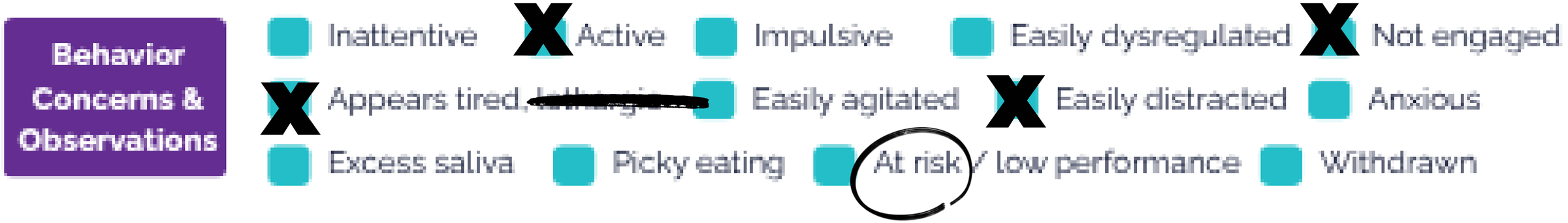


Dental

- [x] Dental wear is not observed
- [ ] Dental wear is PRESENT SIGNIFICANT
- [ ] Diastema: MAXILLA / MANDIBLE
- [ ] Occlusion appears healthy
- [x] Occlusion concern: OVERJET/RECESSED JAW OPENBITE CLASS III (underbite) CROSSBITE

end to end (top teeth and bottom teeth "match") with open bite

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Speech-Language

- [ ] Delayed language
- [x] Speech sound disorder
- [ ] Stutter / Dysfluent
- [ ] Voice disorder or hoarse quality observed
- [x] Mumbles / Unclear
- [x] Hyponasal
- [ ] Hypernasal
- [x] Dentition appears to be affecting articulation
- [x] Tongue mobility and range of motion appears to be affecting articulation in connected speech

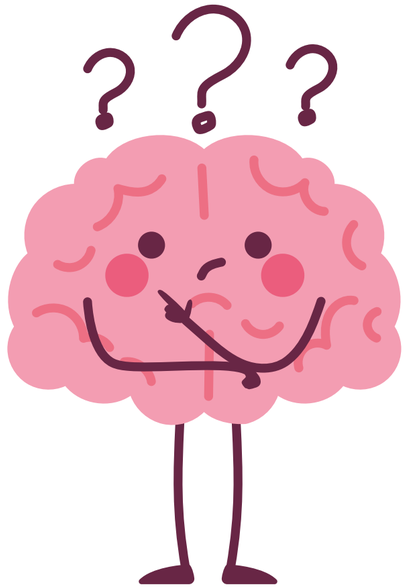
- "t, d" dentalized
- "s, z" interdental
- "l" substituted
- "sh" interdental
- "ch" interdental
- "j" interdental
- "r"distorted, substituted
- "p, b" labiodental
- "th" substituted

hyponasal - congested today; unclear if it's an allergy or cold, or lack of nasal breathing

Connected speech is highly unintelligible to an unfamiliar listener

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What would you do?



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Reporting Your Findings

A model. An idea.
Always use your independent clinical judgment when evaluating a student and determining eligibility.
Strictly follow your state and local educational agency procedures.



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IEP:

Student presents with speech sound errors for “r, th, l, s, z”, and distortions for “sh, ch, j”. In connected speech, she is likely to use her lips and lower teeth to produce “p, b” (labiodental productions). Her upper teeth are observed to be in contact with her lower teeth at rest (“end to end”) with some space between them (an open bite). This likely contributes to her incorrect articulation placement for “s, z” (which she uses with her tongue between her teeth), and her “t, d” (which she makes with her tongue pressing against her upper front teeth. She appears to have adequate space for her tongue to stabilize on her upper molars for her sound productions. This will be necessary to support her productions of “sh, ch, j, s, z, r”. At this point, Student demonstrates significant weakness of her tongue to move independently; she needs to stabilize it on the roof of her mouth (her palate) when she lifts it, and she has slight jaw movement to the right when she moves her tongue in that direction. When she lifts her tongue, significant floor of the mouth engagement is observed, indicating additional muscles are activating to support this tongue movement. She is able to lift her tongue to suction into the palate (lingual palatal suction), however it is weak and can only remain there for 1 second. She appears to have motor challenges moving her tongue to sweep her teeth - necessary for oral hygiene. A slight dimple is observed about 15mm from the tip of her tongue, suggesting a pull from the tissue under the tongue. Though Student is quite clear in single word utterances, she is 25% intelligible in connected speech with an unfamiliar listener. She appears to have difficulty coordinating movement between the speech sounds, which may be due to a limited range of motion. This is informational data the family may wish to share with her medical/dental provider(s).

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Mouth breathing due to:

- enlarged tonsils?
- sick?
- allergies?
- ENT visit history?
- low resting tongue

Would you write about the mouth breathing in the IEP describing her:

- Behavior?
- Academics?
- Speech?

Would mouth breathing be a goal?

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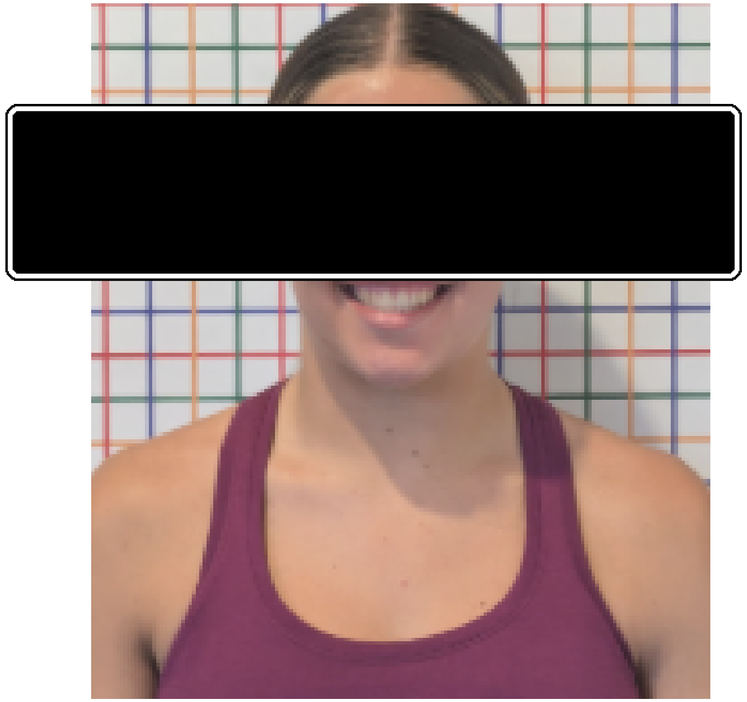
Case Study #2

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Case History

- Entering 9th grade, has been in school-based speech since 2 years old
- Family has done in-home therapy, and taken her to speech therapy after school on and off over the years
- Twin; no concerns with delivery
- Gets pulled weekly for /r/ to play Jeopardy
- Therapist says to elevate and retract her tongue; she tells the therapist she cannot do it. She's polite and tries to please.
- All A student. Highly motivated, in several extracurricular activities
- Social, loves learning
- Is difficult for family, friends to understand her
- Shy; speaks softly
- Jaw tires from talking a lot; tension in the back of her neck and shoulders

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Posture

Team determined:
- [x] *The student can have feet flat on the floor when seated*
- [ ] *The student can adjust pelvis to improve posture*

The student's preferred seated work / listening position:
- [x] Upright
- [ ] Slouched
- [ ] ONE / TWO knee(s) tucked
- [ ] Hand supports holding head up
- [ ] Leaning back
- [ ] Lean on desk
- [ ] Sitting on a leg
- [ ] Head on desk

Complete the remainder of the evaluation when the student is in ideal seated posture:

- [ ] Forward head position (ear canal is forward of middle of shoulder)
- [x] Neutral head position (ear canal is centered on middle of shoulder)

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- “crease” at the mentalis showing she’s working to close her lips.
- shorter upper lip?



Oral Rest Posture

- [x] Lips are open wide
- [ ] Lips are closed
- [ ] Tongue rests with tip up
- [x] Tongue rests low in mouth
- [ ] Tongue rests interdentally
- [ ] Tongue protrudes between lips
- [x] Tongue presses against UPPER / LOWER teeth

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Breathing

- [ ] Nasal
- [x] Mouth
- [ ] Mixed Nasal-Mouth

Midthoracic

- [x] Silent
- [ ] Audible at rest

- [x] Fast, shallow
- [ ] Slow, deep

- [x] Able to pass 3 minute nasal breathing test
- [ ] Unable to pass 3 minute nasal breathing test

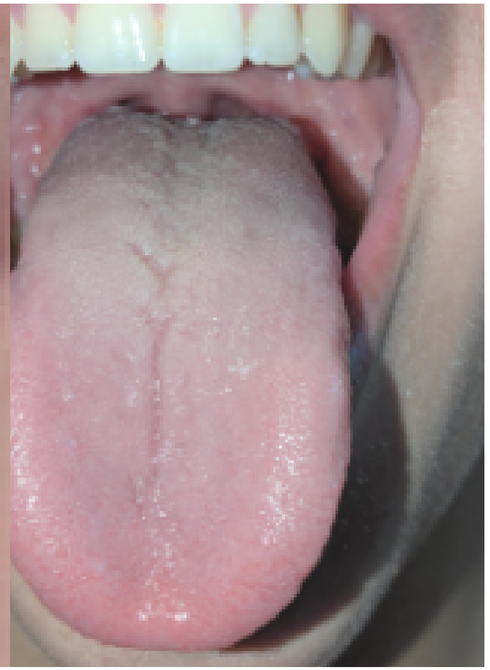
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Lips

- [ ] Close without mentalis strain
- [x] Close with mentalis strain
- [ ] Normal
- [x] Dry/chapped
- [ ] Short upper lip
- [ ] Poor lip closure /p, b, m/

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Could also indicate unable to visualize, or try “ah - ah - ah” to lower tongue root for better view attempt

Palates & Throat

- [x] Tonsils are less than 50% of airway
- [ ] Tonsils are more than 50% of airway
- [x] Soft Palate has normal color (not blueish, no ridges suggestive of submucosal cleft)
- [x] Tongue can fit within the palate
- [ ] Tongue unable to fit within palate
  - [ ] High
  - [ ] Narrow: ANTERIORLY / THROUGHOUT

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Tongue Range of Motion

Tongue to the Tip: *Keeping a wide open mouth, ask student to elevate their tongue to aim toward The Spot (or behind the front teeth)*

- [x] Tongue can elevate at least 50%
- [ ] Tongue elevates less than 50%

severe -nearly onto occlusal surface with elevation

- [x] Floor of the mouth is engaged

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severe floor of the mouth compensation -nearly onto occlusal surface with elevation

Lingual Palatal Suction: *Ask the student to create a lingual palatal suction (LPS), then open wide, but maintainging a strong suction)*

- [ ] Unable to create a LPS
- [x] LPS is weak
- [ ] LPS can be held with good range of motion (2 fingers width)
- [ ] LPS requires excessive jaw closure to obtain suction (<2 fingers width)

??? appears so; can continue to evaluate as tongue strengthens

- [ ] Tongue splays onto occlusal surface of teeth _____%
  *if 7mm or more, orthodontic expansion may be necessary to allow space for tongue to position and stabilize for connected speech

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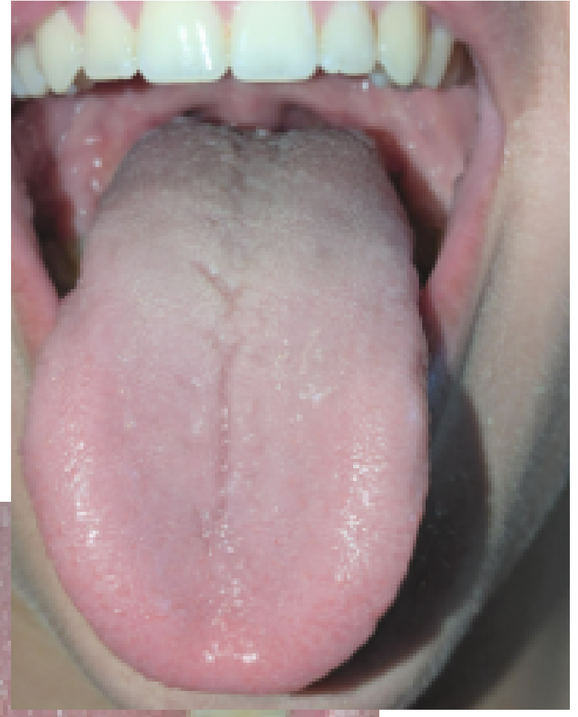
Sweep the Molars: *Necessary for oral hygiene. Ask the student to sweep their molars. Support motor skills to determine it is not the causing failure, but truly is a lack of range of motion.*



hurts bilaterally with stretch, especially stretching to left side

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Tongue Appearance

- [ ] Lingual frenulum is SHORT / HIGH INSERTION (>50%)
- [x] Pink
- [ ] Coated
- [x] Pull at tongue tip
- [x] Midline tension
- [ ] Lingual frenulum tense, visible at rest

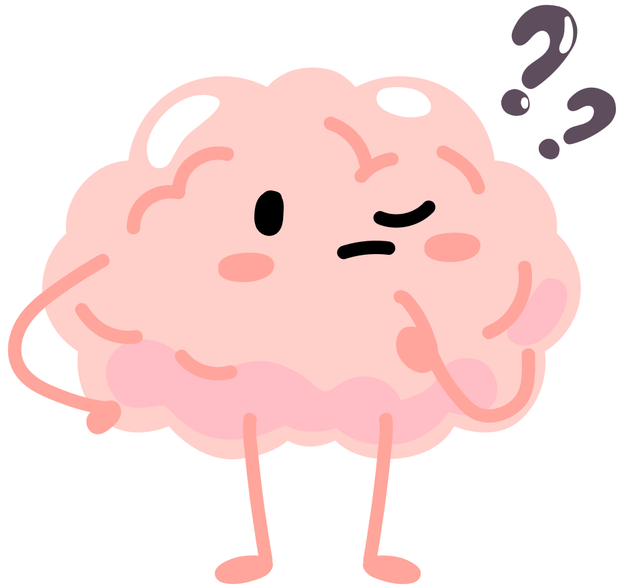
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Other “fun” pictures



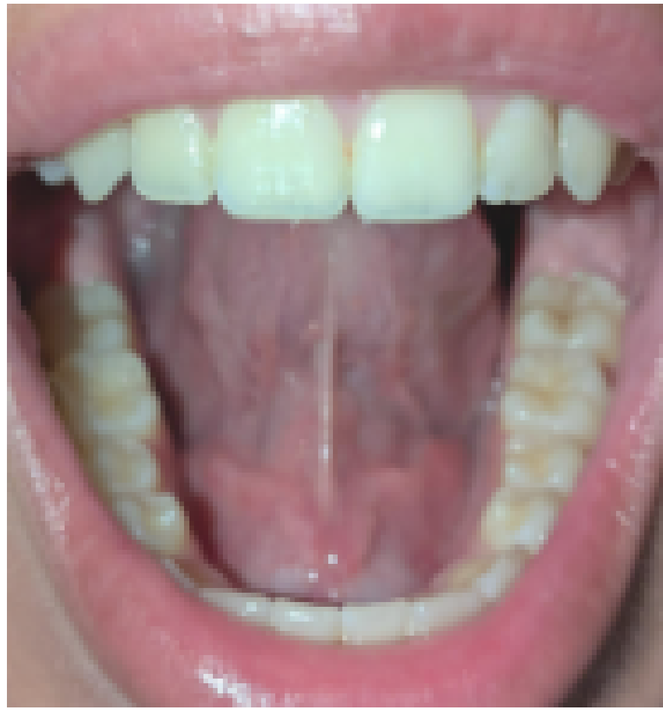




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Dental

- Dental wear is not observed
- Dental wear is PRESENT SIGNIFICANT
- Diastema: MAXILLA / MANDIBLE
- [X] Occlusion appears healthy
- Occlusion concern: OVERJET/RECESSED JAW OPENBITE CLASS III (underbite) CROSSBITE

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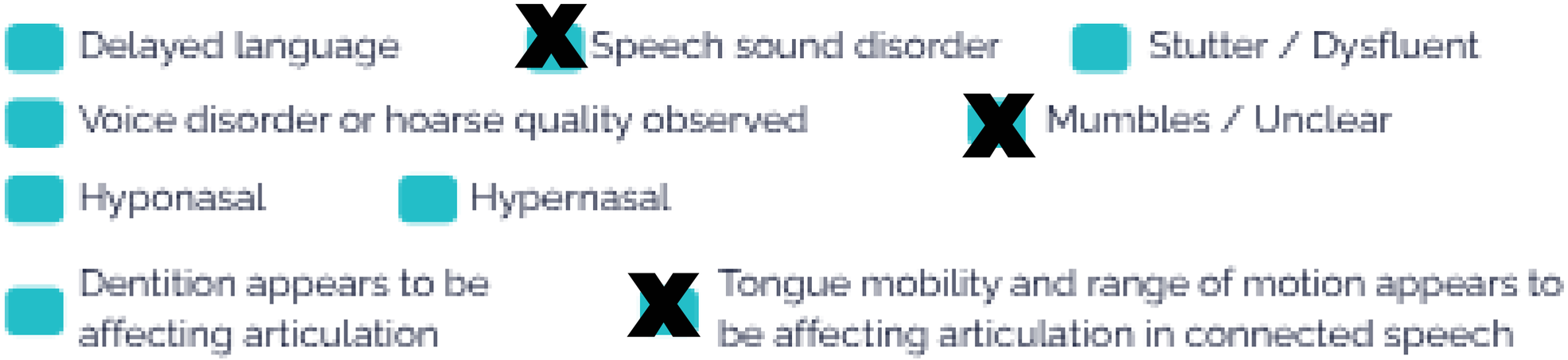


Ideal student! Works very hard to avoid talking - uses as few words as possible; avoids words with R. She indicated she has scripted some responses to common questions to avoid using R.

(SLP sidenote: She shared in Spanish, her teacher marked her down for not rolling her R's, pronunciation errors. Very anxious to continue Spanish with new teacher this year. Avoids telling her parents these uncomfortable communication situations.)

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Speech-Language

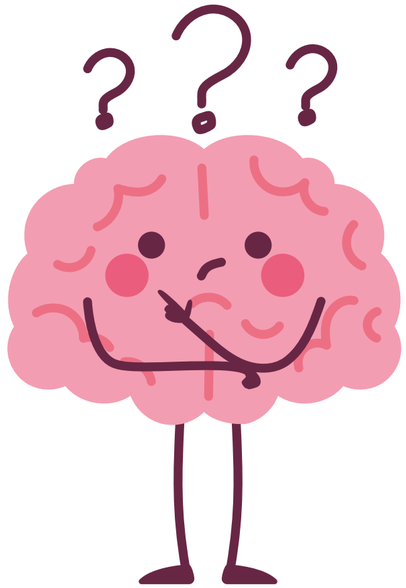


- "t, d" dentalized
- "n" dentalized
- "l" interdental
- "s, z" lateralized
- "r"distorted, substituted

Student reports she is unable to elevate, retract, and widen tongue to stabilize on her molars. She is very clear about what she is supposed to do. She can hear a correct prodution.

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What would you do?



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Reporting Your Findings

A model. An idea.
Always use your independent clinical judgment when evaluating a student and determining eligibility.
Strictly follow your state and local educational agency procedures.



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IDEA Eligibility:

1. **Is there a disability? Yes:** According to articulation norms by McLeod & Crowe (2020), /r/ should develop by 5 years of age. Student is unable to produce the /r/ in isolation; she uses a lateralized /s, z/ and uses an incorrect placement for “t, d, n, l”. She can discriminate between correct and incorrect productions by a clinician. Student is 95% intelligible by a familiar listener when context is known, and 60% by an unfamiliar listener with an unknown context. Student demonstrates a low tongue resting posture, which contributes to her mouth breathing. Mentalis strain is observed as she closes her lips. Her palate appears adequate for her tongue to rest within it to stabilize her tongue for producing speech sounds, however she reports she is unable to widen her tongue once it is elevated and retracted. She has been in speech therapy services for 12 years with the parents reporting additional outside services 4 of these years with various clinicians and clinics. Student demonstrates a severe floor of the mouth compensation to elevate her tongue to the point the floor of the mouth nearly overflows onto the occlusal surface. She can create a lingual palatal suction, however it is very weak, and again has a severe floor of the mouth compensation to elevate her tongue into this position. She is able to sweep her molars (necessary for oral hygiene), however she reports a stretch, especially when she sweeps her left molars. She is often perceived to speak unclearly (“mumble”), which is consistent with a limited range of motion her tongue has to move so quickly between the precise points of articulation in connected speech. Her tongue’s mobility and range of motion appear to have a significant impact on her ability to produce /r/ in isolation, as well as “connected speech.

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IDEA Eligibility #2:

Is there and adverse educational impact? Yes: In an interview with the SLP on (date), student stated she avoids using R words and scripts answers to common questions she receives, such as how her sport is doing, how her day is, or her class schedule. All of her classroom teachers reported she is very unlikely to participate in class. If she has a question she might approach the teacher after class once the peers have left the room.
Student has all A's on her report card and reports having a close group of friends.

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IDEA Eligibility #3:

Is there a need for specially designed instruction? No: Given the student has received speech therapy services targeting her articulation since she was 2 years old (12 years of school-based services), and the parents have reported providing therapy services intermitently over 4 years at various clinics, continuing articulation therapy does not appear clinically indicated at thsi time. Student appears to have a significant range of motion and mobility challenge with her tongue, and therapy cannot alter the observed and reported structural limitations without medical intervention. Based on the data collected, this appears to be an anatomical basis for her challenges, and further therapy would likely result in a continued lack of progress. The information gathered through this report are informational data the family may consider sharing with Student's medical and/or dental provider(s).



Check wording your administrator will support

ASHA Ethics Principle I, Rules K, L



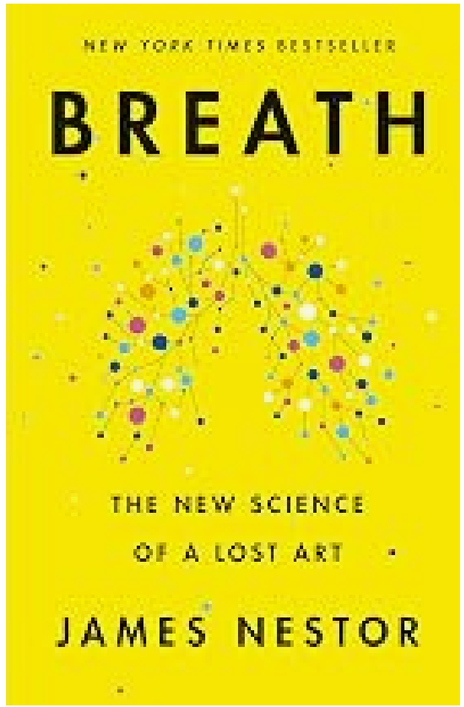
1. *Individuals who hold the Certificate of Clinical Competence shall evaluate the effectiveness of services provided, technology employed, and products dispensed, and they shall provide services or dispense products only when benefit can reasonably be expected.*
2. *Individuals who hold the Certificate of Clinical Competence shall use independent and evidence-based clinical judgment, keeping paramount the best interests of those being served.*

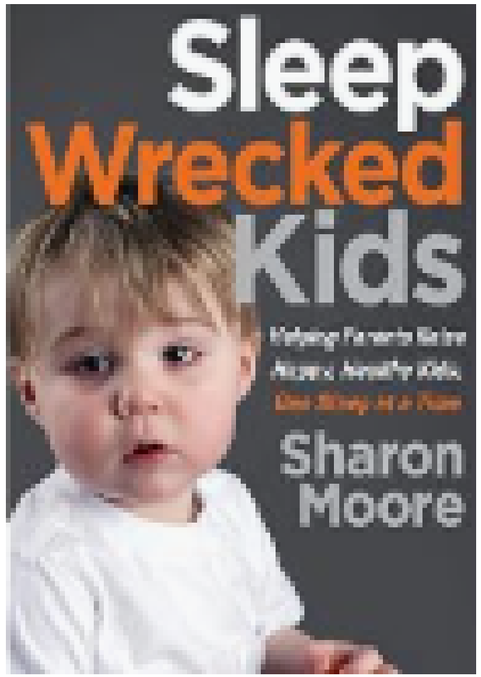
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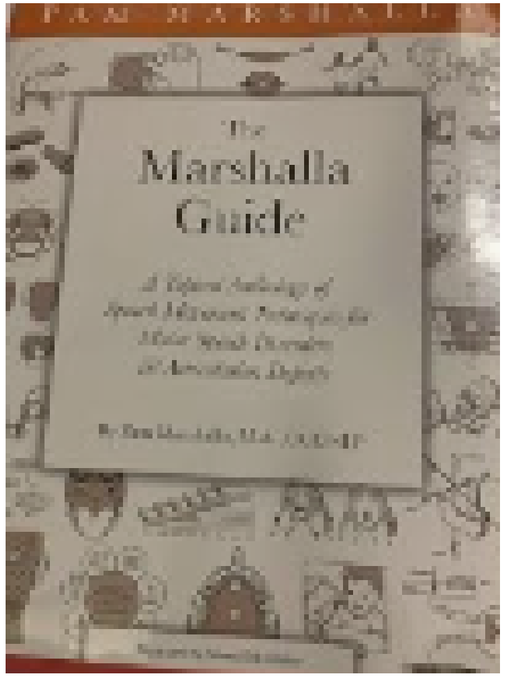
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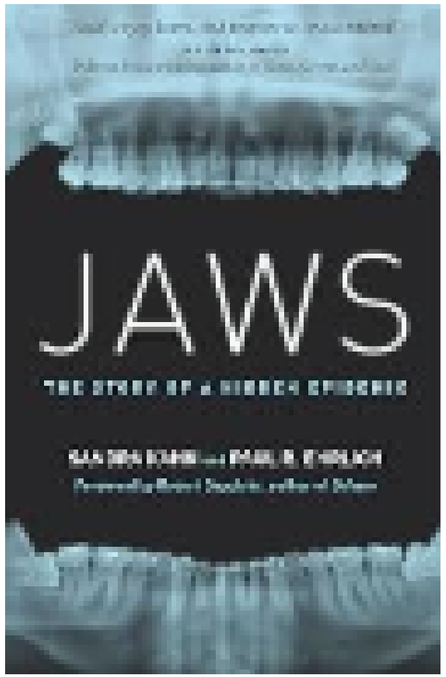
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Nerdy Facebook & Online Groups



Oromyofunctional Study Group

Private group · 22.8K members



The SLP's Myofunctional Therapy Study Group

Private group · 1.4K members

THE ORAL MOTOR INSTITUTE

FOR THE SCIENCE OF ORAL MOTOR TREATMENT

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Myofunctional Disorder Specialization Training



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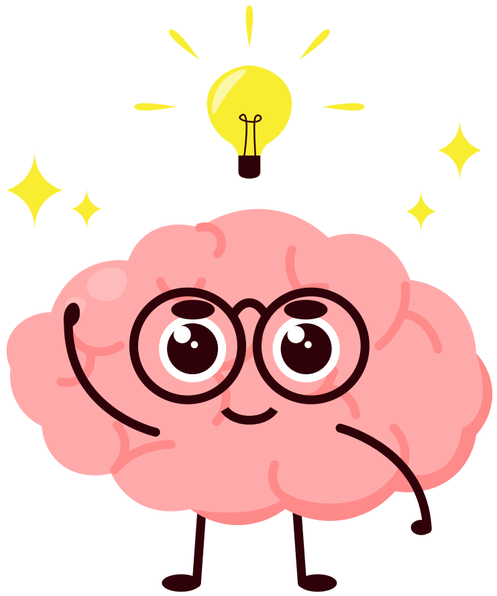
Kristie Gatto
KristieGatto.com

Amanda Chastain
GOMAP infant and toddler feeding
https://www.tsnky.org/courses

*there are no “cheap” alternatives to do it correctly

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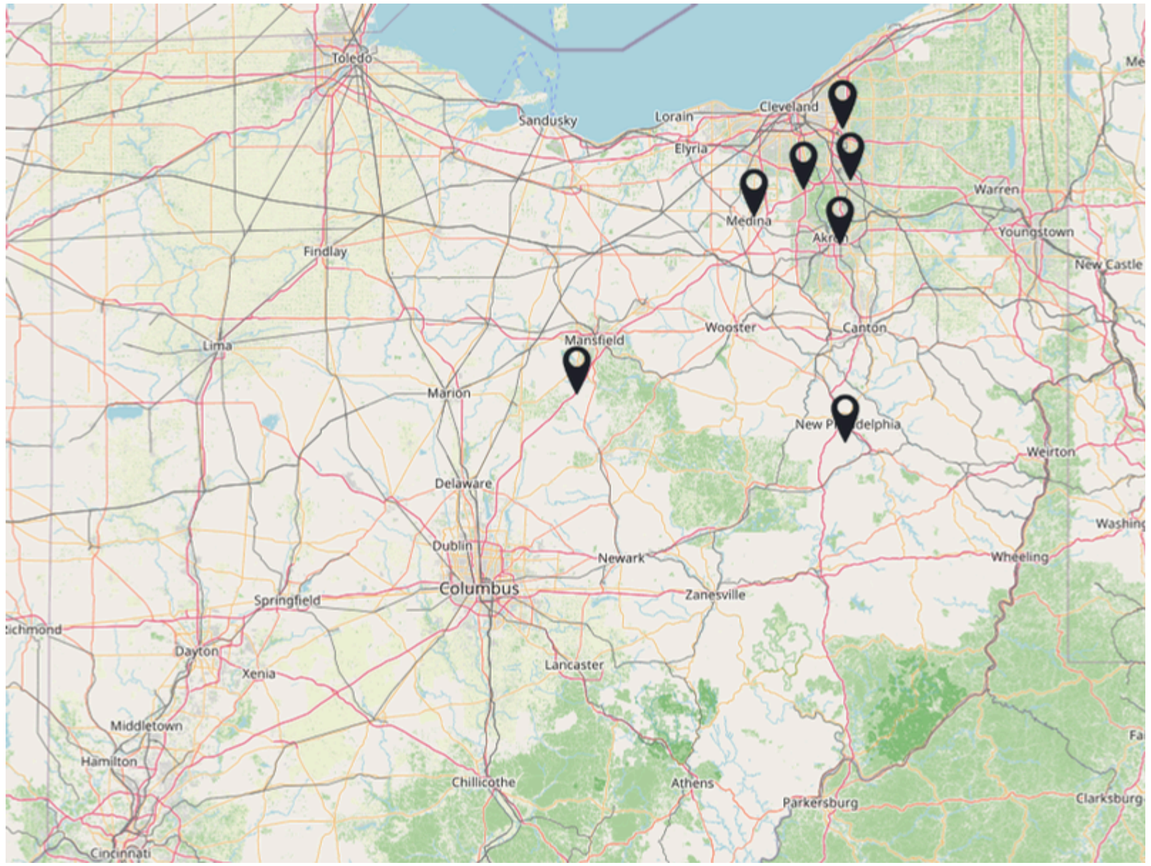
You do not need certification with our SLP Scope of Practice!



- Certification can be necessary for other professions to practice independently (per state license)
- It will take about a year of regular use to become comfortable and fluent with your initial training
- You need to jump in tomorrow and start playing with it (or it gets overwhelming and you won't touch it. Start with yourself or a family member!)
- Several great mentors available to coach you!
- Field changes quickly as collaboration improves across related professions; you find your collaboration team as you grow
- Follow ethical guidelines, as always, in your practice

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thank you!

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