

Oral-Facial Evaluation for Speech-Language Pathologists

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Contents

<i>Foreword by Raymond D. Kent, PhD</i>	<i>vii</i>
<i>Introduction: About Oral-Facial Evaluation for Speech-Language Pathologists</i>	<i>ix</i>
<i>Acknowledgments</i>	<i>xxii</i>

Part I. Before the Procedures	1
1 Getting Started	3
Part II. Gathering Client-Centered Evidence	15
2 Instructions for Routine Oral-Facial Evaluation Procedures	17
3 Instructions for Discretionary Clinical Observations	65
4 Suggested Adaptations for Examinees With Special Needs	99
Part III. Interpreting and Managing the Evidence	127
5 Interpreting the Findings	129
6 Documenting the Findings	165
<i>Appendix A. Recording Forms</i>	211
<i>Appendix B. Equipment and Supplies</i>	373
<i>Appendix C. Optional Rapid Review of Relevant Anatomy and Physiology</i>	377
<i>Appendix D. Summary of Relevant Cranial Nerves</i>	417
<i>Glossary</i>	421
<i>References</i>	427
<i>Index</i>	435

Foreword

The orofacial examination (OFE), also known as the oral peripheral examination or speech mechanism examination, is one of the earliest components of clinical education in speech-language pathology. It is also one of the first examinations typically administered to a child or adult with a suspected problem of articulation, resonance, voice, or swallowing. Early instruction in this examination usually gives the student some basic pointers on how to conduct the examination, what to look for, and how to write a brief report summarizing the observations. The instruction is seldom deep or detailed because the student is just learning about the anatomic and motoric complexity of this system and has not been exposed to the array of clinical issues that can arise. This early clinical experience with the OFE is an essential introduction, but students who continue to learn the knowledge and skills required for independent professional practice become aware that the initial exposure to the OFE merely opens the door to a wider set of clinical observations and decision making. It is one thing to perform the examination on a typically developing child who is compliant in all facets of the examination but quite another thing to perform this examination on a child with a cleft palate or other craniofacial anomaly, an adult with a facial paralysis resulting from stroke, or an individual with autism. The OFE is not a cut-and-dry, one-size-fits-all procedure. Rather, it is an adaptive inquiry into a system that has numerous vulnerabilities and complex interactions.

The OFE broadly applied to the practice of speech-language pathology is multifaceted and multilayered. With experience, clinicians can and should go far beyond the basic principles typically learned in a first course. But this knowledge is personal and is usually won with substantial time in the clinic. Commonly, a curriculum addresses this

need by incorporating extensions and elaborations of the OFE in various courses such as craniofacial disorders, speech sound disorders, voice disorders, neurogenic disorders, and birth-to-3. Although this approach is satisfactory for some purposes, it can fail to show the integrated nature of the OFE in its diverse clinical application. The OFE is a longstanding basic procedure in speech-language pathology, but it appears that it is often taught and practiced in a nonstandardized and fragmented way. That circumstance is about to change.

Oral-Facial Evaluation for Speech-Language Pathologists takes several significant steps toward a systematic and reasoned OFE. The first two chapters define the basic problems and guide the reader through the routine process of the examination. Methods of the examination are clearly tied to purpose and conclusions. Subsequent chapters consider the manifold issues of the OFE in relation to discretionary observations, adaptations for individuals with special needs, interpreting findings, and documenting findings. In this way, the book unfolds into an expanding coverage of the OFE that meets diverse needs in speech-language pathology. Illustrations, tabled summaries, a glossary, and companion videos make this a book that is highly informative in an inviting and supportive format.

This book consolidates clinical expertise to guide readers through an effective examination of the structural and functional integrity of a complex system in individuals with a variety of communication disorders. Author Barbara Johnson-Root has given the field of speech-language pathology an unparalleled resource in the logic and methods of the OFE. Her book is a *tour de force* that will be consulted repeatedly by clinicians with various levels of experience. *Oral-Facial Evaluation for Speech-Language Pathologists* is a milestone in the literature on clinical methods.

—Raymond D. Kent, PhD
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1

Getting Started

Qualifications for Examiners

Independent Inspections: Practicing Professionals and Clinical Fellows

When performing an oral-facial inspection independently, at minimum, qualified examiners are required to (1) have earned a master's degree in speech-language pathology or equivalent discipline from a program that is accredited by the Council on Academic Accreditation (CAA) or in the process of obtaining the accreditation *and* (2) either hold the American Speech-Language-Hearing Association's (ASHA's) Certificate of Clinical Competence (CCC) or are in the process of earning it. Individuals who hold the appropriate master's degree but for some reason do not maintain the ASHA CCC should at the very least maintain either a license to practice speech-language pathology in their state or a teaching certificate specific to the speech-language discipline.

Supervised Inspections: Student Clinicians

Students in clinical practicum earning clock hours in preparation for the CCC also may perform the oral-facial evaluation but only under the direct supervision of a qualified examiner who holds the ASHA CCC and meets the criteria for supervision under the guidelines of the student's accredited academic program. Furthermore, nothing prevents students who

are learning about the procedures from cautiously practicing them on volunteers such as friends and relatives, provided that examinees knowledgeably consent to the inspection and the outcomes are not tendered as clinical results. In fact, practice inspections are encouraged so that students may become thoroughly familiar with the procedures and forms, while also arriving at an operative grasp of the range of normal appearances for structure and function to be encountered clinically at a later time.

Special Comments for Examiners

Newer Service Providers and Students

If you are a relatively new practitioner or a student of speech-language pathology, be assured that this manual grew out of a need expressed by individuals in your current position. The manual's structure and detail are intended to put into your hands a well-organized plan that tactically guides you through the oral-facial inspection process, so as to increase your confidence to competently evaluate a broad array of oral-facial mechanisms for structure and function.

As you grow in proficiency through experience, the need for extensive structure and detailed explanations will diminish. Yet, especially where some of the less common discretionary clinical observations and special populations are concerned, this tool is likely to continue to serve as a useful resource for years to come.

Academics and Clinical Supervisors

Preclinical Academic Teaching

Ideally, the oral-facial evaluation is introduced to students before they begin supervised clinical practice. In some programs, classroom-based exposure to oral-facial inspection is one of the first academic activities requiring students to synthesize large amounts of information learned in prerequisite coursework for the purpose of clinical decision making. Many students find this challenging, although most are relieved to at last try their hand at the practical problem solving that will eventually define their professional future.

It is at the first exposure to oral-facial inspection that full use of the manual yields the most benefit. Once a professor or supervisor lays the foundation by fully exploiting this highly structured and informative resource, students can and should practice the procedures on one another so that they become thoroughly familiar with them while also becoming acquainted with a range of normal appearances that they will inevitably view and judge later in professional practice.

Also, informal practice opportunities afford occasion to observe the few variations and anomalies that willing peers may be amenable to share, such as the occasional high palatal arch, dental misalignment or malocclusion, minor palatal fistulus, tongue-thrust swallow, or even repaired craniofacial anomaly. Although the irregularities that peers typically bring to the actual practice session are most often subclinical in nature, the opportunity to view them prior to clinical practice is invaluable.

The fundamental worth that the manual brings to your course lies in its breadth and depth. That is, the content not only scopes a wide range of possible conditions but also details procedures for identifying these idiosyncrasies, while also commenting on potential for relevance to clinical decision making.

Practicum Supervision

Supervising a student clinician's early experiences with oral-facial inspection presents many challenges. None are insurmountable, but rising above them requires supervisory vigilance as well as a generous

amount of supervisory support. Less experienced clinical supervisors may find oral-facial inspection somewhat more challenging than other supervisory activities; for that reason, the comments that follow are intended to support the supervisory process on an as-needed basis.

Fundamentally, clinical supervisors serve two roles. The first and foremost is to ensure that the client receives competently delivered clinical services; the second interfaces with the first, and that is to strategically exploit teaching opportunities that benefit the student clinician. All parts of the evaluation process demand attentiveness in both of these areas, and oral-facial inspection is no exception.

With the goal of fulfilling these two intertwining supervisory roles, we strongly recommend not only being in the diagnostic room with the student and client for the entire oral-facial evaluation but also being *fully prepared* to participate in the inspection alongside the student clinician. Letting the student know in advance that this will be the case is only fair. Furthermore, expect that properly prepared students normally welcome the support since they are already cognizant that some clinical observations require more experience than they bring to the diagnostic room.

Ideally, the student performs the inspection completely and with reasonable efficiency without mediation, while you serve as a coexaminer so as to ensure a thorough and competent appraisal. To increase the likelihood of an uninterrupted procedure from start to finish, we recommend meeting with the student *prior to* the day of the clinical evaluation. The aim of the pre-session meeting is threefold. First, together with the student, look over the equipment and materials that the student plans to bring to the examination room, confirming that the student has amassed a full array of supplies that meet specs detailed in Appendix B. Second, give the student an opportunity to rehearse selected procedures in your presence, so that you may anticipate his or her style and even add to his or her understanding if necessary. Third, the preassessment meeting is an excellent time to help the student prepare in advance for discretionary procedures that may be anticipated based on preliminary case history intake. Taking the time to do these things prior to the session is very likely to save time during the session, while also

increasing the student's confidence to perform an oral-facial evaluation on a person who has legitimate communication needs.

It is entirely possible that some clinical teaching may be needed when in the presence of the examinee. The student should be aware of this possibility so as not to feel blindsided in the event of a necessary interruption that is intended to benefit both the examinee and the student. For example, a student clinician may naïvely perform a part of the inspection in a way that is unlikely to yield the needed information; you may observe and point out a structural or functional irregularity that the student needs to see; an unanticipated discretionary clinical observation may need to be performed; or change in protocol may become evident while already engaged with the examinee in the examination room.

In anticipation of the possible need for intermediation, always let the student know in advance that the inspection should be considered a team effort, that the student is responsible to perform the procedures, that you will intervene if needed, and that you will coinspect so as to ensure that all noteworthy irregularities are noted. Go to the session prepared to work with the student as a team member. That is, wash your hands and don the gloves before the inspection begins and position yourself so as to maximize opportunity for co-observations. If it becomes necessary to demonstrate, reinstruct, or point out a feature, then politely request permission to provide input at that time thereby reducing opportunity for the student to feel undermined. Even if a student performs the activities very poorly or appears unprepared, a problem that hopefully hardly ever occurs, keep in mind that during the session, your concerns about a student's preparation or aptitude should not come across in any way so as to maintain focus on client needs and avoid potential for awkwardness.

Experienced Practitioners

As an experienced practitioner, you have most likely adopted a working set of oral-facial inspection procedures and at the very least are familiar with the process well enough to benefit from published checklists that can serve to remind you to do things that through years of practice you already know

how to do. You may have even developed your own checklist or protocol, or it is even possible that you smoothly execute the inspection from memory.

Certainly, those who specialize in a particular area do not need the amount of structure and detail provided herein, especially when evaluating cases that lie entirely within their area of expertise. Yet in deciding whether this manual is applicable to your practice, consider the benefit of having handy access to discretionary clinical observations that lie outside your area of expertise, information on serving individuals with special needs, detailed and orderly recording forms, and ready access to a well-ordered teaching tool when mentoring students and newer clinicians.

Suitable Populations

General Guidelines for Deciding Which Examinees Should Receive an Inspection

An Appropriate Activity for Most

As a general rule, if an examinee's communication goals include speech and the person is able to tolerate the procedures and follow the instructions, that person is more often than not able to participate in a meaningful inspection using the resources provided in *Oral-Facial Evaluation for Speech-Language Pathologists*. Although adaptations may be needed for selected special populations, the manual takes this into account by providing various suggestions that are applicable to a variety of exceptional groups. Be encouraged to consult Chapter 4 if necessary whenever working with persons whose needs are discussed in that section.

For the Few Who Are Not Able to Tolerate the Oral-Facial Evaluation

It is exceptionally rare to find a person who has potential to use spoken language who also is not able to participate in most of the activities shown in the manual, giving consideration to special needs and age-related limitations accounted for in Chapter 4. Yet, in some settings, the clientele may include

an abundance of individuals who are not capable of participation due to reasons that may include multiple concomitant disabling conditions, serious illness, deteriorating health, profound physical or cognitive limitations, or other deleterious state. For individuals who cannot participate, whether and how to complete a meaningful inspection is a clinical decision that relies on professional judgment.

Consider the Examinees' Speech Sound System

Since the manual focuses on considering a person's capacity to produce speech, potential to form specific speech sounds enters the discussion repeatedly from start to finish. The sound system of reference throughout the manual is American English, unless denoted otherwise.

Many aspects described herein may be reasonably applied to other languages. Nonetheless, exercise caution if using this manual to inspect a person's capacity to produce specific features of a language other than American English, especially if the features of interest are not part of the American English speech sound system.

Oral-Facial Inspection for Persons Requesting Services to Address Language Difference

The scope of practice for speech-language pathologists continues to include services for individuals who choose speech therapy as a method for reducing the effect of a dialect or accent, apart from communication disorder. For the vast majority of these examinees, oral-facial inspection yields unremarkable findings. Yet, to verify that all parts are structurally and functionally sound, as well as confirm that no physical hindrance stands in the way of the person's communication goals, the routine oral-facial inspection is included in the protocol for all kinds of comprehensive communication evaluations (see Table 0–1). Of course, if remarkable findings are discovered, they should be treated as they would for any other person receiving oral-facial inspection.

Revisiting Oral-Facial Inspection for an Examinee Who Was Previously Evaluated

Most oral-facial evaluations are incorporated into the comprehensive diagnostic process that precedes decisions about plan of care. Occasionally, a clinically significant feature is missed during the preliminary inspection, and it becomes necessary to revisit oral-facial inspection as part of a therapy program even though the oral-facial region was already examined. When this happens, it is only necessary to revisit the parts of the inspection that may shed light on the problems the person experiences from a plan-of-care perspective (Box 1–1).

Amount of Time to Allow for Oral-Facial Inspection

Three principal factors strongly influence the amount of time needed to administer *Oral-Facial Evaluation for Speech-Language Pathologists*. They are examiner experience level, whether Routine Clinical Observation 1 (i.e., conversational speech sample, facial region inspection, breathing observations) is completed prior to the inspection as part of another assessment goal, and whether discretionary clinical observations are needed.

Examiner Experience Level

Undoubtedly, skilled practitioners have the advantage of immense familiarity with both oral-facial inspection practices and oral geography. Armed only with a barebones checklist and vivid internal visual and auditory models of both normal and aberrant findings, as well as having completed a conversational speech sample, facial region inspection, and breathing observations while interviewing or testing in other areas, many experienced clinicians can complete a basic routine inspection within 5 to 10 minutes under exemplary circumstances. On the other hand, students and less experienced clinicians require additional time to competently perform a simple routine inspection.

Box 1–1. Clinical Examples: A Portion of Oral-Facial Inspection Was Revisited After Treatment Commenced

Clinical Example 1

The author strongly suspected serious tongue-tip immobility for a 4-year-old child who had received speech therapy for a few months with another service provider. The diagnostic report clearly stated that the oral-facial mechanism had been inspected and that all parts were structurally and functionally adequate for speech, and the therapy progress report indicated difficulty making therapy gains but gave no indication of concerns with tongue agility. Yet, the child's speech and oral posture convincingly suggested tongue immobility.

As a result, a partial oral-facial inspection to evaluate tongue mobility was inserted into a treatment session, and it revealed exceptionally short lingual frenum, heart-shaped tongue tip, and failure to elevate the tongue tip beyond the cutting edge of the mandibular incisors. Once ankyloglossia was medically diagnosed and addressed, and the tongue was strengthened after a lifetime of inactivity, consistent and maintainable therapy gains began.

Clinical Example 2

An adolescent who had been a long-term recipient of speech therapy to remediate a set of consonants requiring lingual precision had worked with a

few clinical service providers on a semester-by-semester basis. Gains in therapy were slow and characterized by loss of progress between sessions and considerable relapse during semester breaks.

When attempting to achieve tongue position for target phonemes, the client's jaw consistently moved with the tongue, possibly interfering with ease of the lingual movements. Wondering if freedom of movement would be enhanced by relieving the burden of carrying the jaw along with the tongue for articulation, the portions of the oral-facial inspection that investigate differentiated tongue movements were performed in a diagnostic therapy session.

This revealed difficulty with moving the tongue independently of the jaw for both speech and nonspeech activities, even with modeling and clinical teaching. As a result, a goal was added to explore whether treatment evidence supported the idea that increasing tongue independence would improve articulation. In this case, it did.

Summary

In these examples, only the portions of the oral-facial inspection that addressed newly emerging clinical questions were administered upon reinspection. Typically, this is an acceptable approach when taking a second look at someone whose oral-facial mechanism was already examined.

Whether Conversational Speech Sample, Facial Region Inspection, and Breathing Observations Are Completed Prior to the Inspection

Since the oral-facial inspection is usually completed at the end of an assessment session that comprises

a range of procedures (see Table 0–1), many opportunities to complete these observations occur well in advance of the formal oral-facial inspection, and experienced clinicians take advantage of them. Thus, whenever this happens, the amount of time needed for oral-facial inspection can be reduced considerably.