The One Where We Tackle Misconceptions on Orofacial Myology

An Open letter to *The Informed SLP*

The opinion piece by The Informed SLP (TISLP) only highlights studies showing no benefits of orofacial myofunctional therapy without acknowledging mixed or moderately positive evidence.

It has come to our attention that our recently published paper in the International Journal of Orofacial Myology and Myofunctional Therapy, Effectiveness of Orofacial Myofunctional Therapy for Speech Sound Disorders in Children: A Systematic Review (Merkel-Walsh et al., 2025) was cited in an editorial opinion piece by The Informed SLP titled "*The One Where They Tackle Orofacial Myology*." While we appreciate the ongoing dialogue around orofacial myofunctional therapy (OMT), it is important to address how selective citation can lead to misinterpretation of scientific findings, especially in a field already mired in complexity and debate. The opinion piece by The Informed SLP (TISLP) only highlights studies showing no benefits of orofacial myofunctional therapy without acknowledging mixed or moderately positive evidence.

TISLP's editorial, "Orofacial Myofunctional Therapy: What is it, what's it For, does it Work, and Should You Be Getting Trained?" presents an overview of OMT that significantly misrepresents critical aspects of the field and disregards the breadth of its current evidence base. It narrowly frames outcomes within traditional speech-language pathology roles, omitting research supporting OMT's impact on sleep, airway health, and dental development. The editorial adopts a defensive stance toward traditional scope of practice rather than embracing the interdisciplinary collaboration and evolving scientific evidence that defines modern orofacial myology. Contrary to the implication that orofacial myology is a novel or emerging trend, the field has been well-established for over fifty

years, with a strong foundation of international research, clinical application, and interprofessional integration.

It is essential to address concerns about selective citation and mischaracterization of scientific findings. We as expert clinicians and researchers with a deep understanding of orofacial myology, appreciate respect for all pillars of evidence including patient reported outcomes which drive the clinical interest in orofacial myology. We would like to take the opportunity to clarify a few critical points that were either mischaracterized or omitted in TISLP's analysis.

OMT is not simply an "alternative" therapy; it is an individualized, evidence-informed intervention. It targets the muscles of the jaw, tongue, lip, cheek, and pharynx, as well as breathing mechanics, oral resting posture, mastication, oral-speech motor coordination, and more.

Clarifying Misconceptions About Orofacial Myology

Orofacial Myofunctional Disorders include "dysfunction of the lips, jaw, tongue, and/or oropharynx that interferes with normal growth, development, or function of other oral structures, the consequence of a sequence of events or lack of intervention at critical periods that result in malocclusion and suboptimal facial development" (D'Onofrio, 2019, p.1).OMDs occur across the lifespan, are the nexus of function and structure where the diagnosis considers the interaction of how atypical movement patterns result in structural changes and how structural anomalies impact functional skills (Merkel-Walsh, 2020).

OMT, used as a treatment modality to treat OMDs, is not an unregulated, alternative therapy, but an evidence-informed, interdisciplinary practice that complements the scope of speech-language pathology. It is inaccurate and potentially offensive to suggest that "any health practitioner" can learn and apply OMT. In many states, such as New Jersey (Chapter 44C, Audiology and Speech-Language Pathology Bylaws, 13:44C-7.2), orofacial myofunctional disorders (OMDs) are explicitly recognized within the licensed scope of speech-language pathologists. Furthermore, ASHA standards for accreditation (CAA, Standard 3.1-4B) require training in orofacial myology for graduate students in speech-language pathology programs.

The TISLP editorial unfortunately omits the broader domains impacted by OMDs which includes breathing, sleeping, eating, swallowing, speaking, orofacial structural integrity, and the interdisciplinary collaboration required to address them. Professionals such as chiropractors, dentists, physicians, orthodontists, lactation consultants, occupational and physical therapists, and sleep specialists each treat different aspects of OMDs, with SLPs playing a central role in functional therapy. Each professional uses modalities within their specific scope of practice such as a frenectomy for ankyloglossia (oral surgeon) or myofascial release for jaw pain (physical therapist); however, while these licensed/certified professionals treat OMDs, they are not necessarily using OMT as a therapeutic intervention, specifically.

OMT is not simply an "alternative" therapy; it is an individualized, evidence-informed intervention. It targets the muscles of the jaw, tongue, lip, cheek, and pharynx, as well as breathing mechanics, oral resting posture, mastication, oral-speech motor coordination, and more. Both ASHA and the American Dental Hygienists' Association recognize its relevance under the scope of SLPs and RDHs. As with other specialty methodology such as PROMPT or LSVT, properly trained clinicians use OMT based on patient need, clinical training and expertise within a goal-based treatment plan.

Variability in techniques across practitioners is expected, just as it is across other areas of speech pathology such as articulation, AAC, fluency, and voice therapies. Such variability does not negate the legitimacy of OMT, but reflects the individualized, complex needs of patients with OMDs. Further research is certainly warranted, but this is true across many areas of speech-language pathology.

Clarifying Our Paper's Findings

Scientific integrity requires more than just citing evidence, it requires representing it in its entirety. TISLP's opinion piece treats lack of strong RCTs as "proof" that OMT does not work, without recognizing that most therapy modalities often start with lower levels of evidence such as case and cohort studies, before stronger evidence evolves. The fact that we could conduct a systematic review shows that researchers are in fact recognizing connections between OMDs and

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speech sound disorders, but this is a very challenging correlation to explore.

The review excerpt shared in the article highlights one aspect of our conclusion that "no conclusive evidence supports OMT as a standalone effective treatment for SSDs." By isolating a single quote from our paper without presenting the broader context or acknowledging the nuanced findings across our study, the article presents a skewed interpretation. Since TISLP strives to support SLPs in the critical analysis of research and interpretation of data, we were surprised by the potential bias reflected in the technical analysis of our paper. Selecting only phrases that support the authors' opinion can be misleading for clinicians trying to make evidence-based decisions and this contributes to the ongoing polarization of those who specialize in OMDs within the field of speech pathology.

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As clinicians, we consider the improvements observed in our patients when utilizing OMT as a part of a treatment approach for individuals presenting with OMDs. However, we consistently combine OMT with phonetic placement techniques, PROMPT, and other evidence-based methods appropriate for treating organic speech sound disorders (SSDs). Therefore, it was not surprising that OMT alone did not yield positive results as a standalone modality in our paper. This does not invalidate clinical knowledge and /or other levels of evidence where OMT did have positive outcomes for speech improvements.

If there is one standalone quote that we would have selected for the "Orofacial myofunctional therapy: What is it, what's it for, does it work, and should you be getting trained?" article, it would be: "It is important to note that OMT should only be considered as a potential therapy modality in situations where an organic SSD is present, an OMD has been identified and is impacting the client's ability to make gains with traditional articulation therapy alone." This gives a much clearer picture of when and why OMT is implemented in therapy, to treat the root cause of the SSD, such as atypical oral resting posture, mouth breathing and/or inadequate muscle strength or endurance.

We welcome critical examination but expect it to be conducted with the intellectual honesty and professional respect that clinical science demands.

An Invitation for Collaboration, Communication and Continuing Pursuit of Research

The complexity of OMDs and OMT warrants careful, nuanced discussion rather than reductive characterizations. We urge TISLP to engage responsibly with research by representing studies in their entirety rather than through isolated excerpts that reinforce editorial bias.

We welcome critical examination but expect it to be conducted with the intellectual honesty and professional respect that clinical science demands. We remain committed to advancing research in this area and invite open, evidence-based dialogue with researchers, clinicians, and professional organizations alike.

We encourage readers, practitioners, and educators to engage with the full review to better understand the limitations and possibilities that exist within the current research landscape. The question isn't whether OMT is a monolith or a magic bullet, it's whether we, as professionals, are open to understanding its evolving science, its potential within our scope, and the real-world outcomes it can offer patients. Rather than dismissing OMT due to its complexity, let's engage with it critically, collaboratively, and with the nuance it deserves.

We invite SLPs and organizations like TISLP, to engage in constructive dialogue with physicians, subject matter experts, researchers, and interdisciplinary providers who specialize in OMDs to build a clearer, more unified understanding of this important clinical topic.

Respectfully,

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Orofacial Myofunctional Disorders reference list available by scanning QR code: