TERMINOLOGY CONFUSIONS IN SPEECH-LANGUAGE PATHOLOGY/OROFACIAL MYOLOGY

Most professional groups have a particular vernacular that permits effective and rapid communication among members. In clinical report writing, it is easy to forget that when information is transmitted outside of the group to parents or other professionals, the private vernacular and abbreviations acceptable among group members are not always understood or appreciated by those outside of the group. With a goal of clarifying terminology in the clinical reports of speech-language pathologists and orofacial myologists, some examples of potentially confusing terms often used will be discussed.

EXAMPLE #1: "ORAL-PERIPHERAL EXAM"

The inclusion of this term in a clinical report begs the question: "peripheral to what"? or, "Does this mean that an assessment of the peripheral nervous system was done"? The word ***peripheral*** should be discontinued in describing that an evaluation has been accomplished. Even worse is a written shortened description that a clinician has done an "oral-periph".

The proper description of an examination of the face and oral structures is an ***orofacial examination***. This wording clearly and comprehensively describes what was accomplished. I strongly recommend that the term "oral peripheral" and especially "oral-periph" should be eliminated from all communications, verbal or written, between speech-language pathologists/orofacial myologists, and the public and other professionals. By contrast, an **orofacial** evaluation should be clear to all who read your clinical report.

EXAMPLE #2: "THE ARTICULATORS"

A common wording in many clinical reports of speech-language pathologists/orofacial myologists is that the ***"articulators***" were evaluated. While this term and concept is understood by all SLPs, an articulator in dentistry is a metal apparatus on which dental casts are mounted for study purposes. Consequently, any dentist reading about the *articulators* in a clinical report would presume that the metal device with mounted dental casts is being described. While the use of the qualifying word "speech" is acceptable in some circumstances in clinical reports as in *speech articulators*, the term *orofacial evaluation* encompasses the concept that the speech articulators were evaluated. In my opinion, it is better to either name each "articulator" that has been evaluated, or discontinue all references to having evaluated the "articulators". I vote against naming the articulators in clinical reports. Question: How many professionals from other fields can name the articulators? I rest my case!

EXAMPLE #3: "ARTICULATION"

Many SLPs may assume that the public and other professionals understand the term articulation, or its abbreviation "artic". Not so. By definition (Webster), "articulation" has many meanings, the first of which is: the action of jointing or interrelating; a joint or junction between bones or cartilages in the skeleton of a vertebrate. Way down the list in last place is: "the act or manner of articulating sounds; an articulated utterance or sound".

You did "an artic test"? Great, but please do not report it as such in a clinical report. While references to articulation can be appropriate in clinical reports, the qualifier "speech" is always needed, as in "speech articulation" because of the possible confusion involved without a qualifier. It is a good idea to even use the qualifier when communicating with other SLPs/orofacial myologists as a reminder to do so in case reports sent to outsiders.

EXAMPLE #4: "CARRYOVER"

All SLPs know that carryover is as a part of the speech therapy process, but outsiders would not have a clue about the meaning unless an explanation is included in the report. Use of this term requires an explanation such as the explanation: *carryover* - the incorporation of a corrected sound or word production into general spoken discourse.

There are many reasons why carryover is a problem in speech therapy. An insight from orthodontic treatment is applicable here: during the last stage of orthodontic treatment, it is a common practice with some patients to *over-treat;* that is, if teeth have been retracted with elastics, treatment often continues beyond aligning the jaws in a Class I occlusion. This is done in anticipation that there will be some biological rebound in the retention phase. Another name for biological rebound is *relapse*. Anticipating that relapse, or biological rebound is likely to occur, it is a good idea to over-treat some conditions where the dentition is changed in the horizontal plane.

Speech articulation therapy often is considered successful when a patient is able to produce a sound correctly. Often, therapy stops there instead of making sure that the correction is stable and can be used consistently in spontaneous speech.

"Over-treating" speech errors is not a concept often discussed among SLPs. However, in evaluating why carryover is a problem for many patients, a logical explanation is that the patient was not taken far enough (that is, beyond a normal production) in therapy. An example is the use of *over-exaggerations* in therapy. If opening the mouth widely during therapy creates a strong feedback or self-monitoring cue for the patient, it may carry over more quickly from the therapy training into spontaneous speech.

Obviously, patients are not expected to over-exaggerate mouth movements in their general speech discourse, but the use of exaggerations in therapy may be a way to avoid carryover problems for some patients. The orthodontic concept of "overtreatment" is something to consider and apply to the problem of carryover in speech articulation therapy.

EXAMPLE #5: "ALVEO

When the term *alveolar* is mentioned, most SLPs will immediately think of the area behind the upper central incisors. SLPs should be reminded that all teeth in both dental arches are housed in alveolar bone. The maxillary and mandibular alveolar ridges are processes of bone arising from these bones for the purpose of incorporating teeth into the jaws. Hence, it is proper to specifically identify what part of the alveolar ridge is involved when references to the alveolus are made.

The term "lingual-alveolar" to describe sounds made by a contact of the tongue tip behind the maxillary central incisors is an incomplete descriptive term. In most cases, the tongue tip contact is made on the midline of the hard palate rather than against the palatal surface of the anterior maxillary alveolus. A more specific term to describe /t/, /t/, /n/, and /l/ productions would be *lingual-anterior maxillary hard palate sounds*, or even *lingual-maxillary anterior alveolus sounds*. Granted, the more specific terms are too long and probably unnecessary, but something other than lingual-alveolar is needed when communicating information outside of speech pathology. How about *lingual-incisive papilla sounds*? SLPs should not expect dentists to know what is meant by lingual-alveolar (linguoalveolar) sounds.

SLPs are reminded that all teeth are housed in alveolar bone, or the alveolar ridges, since the currently used inaccurate term lingual-alveolar, can easily lead to confusion among outsiders reading the reports of SLPs and orofacial myologists. 3 The descriptive term " *the spot*" is a creative and e_ective term that is universally known among orofacial myologists; however, the term is foreign to all others without an explanation. When "the spot" is used in clinical reports, an explanation is needed such as "…the *spot* (the incisive papilla area".)

EXAMPLE #6: DIADOCHOKINETIC TESTING

Diadochokinetic testing was originally described and implemented by physicians as a screening tool to identify cerebellar-based problem. The test involves rapid opening and closing movements of a finger and the thumb in a series of rapid finger and thumb contacts and releases. Diadochokinetic testing was later applied by SLPs to the oral structures to assess the neuromotor integrity of the lips, tongue and soft palate. The proper way of describing this useful and important assessment in speech pathology and orofacial myology is to add the quali_er of "oral", as in ***oral diadochokinetic*** testing. The application of this medical screening test to speech-language pathology may motivate physicians to now refer to this test as *digital diadochokinesis*.

SUMMARY

This editorial reminds speech-language pathologists/orofacial myologists to communicate with those outside of the discipline using clearly-understood words and descriptions. Some examples of possibly confusing terms and concepts are discussed.