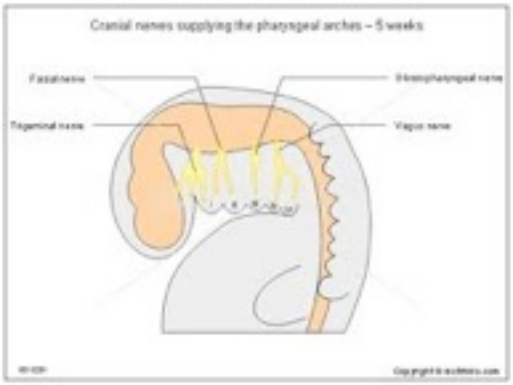
In searching the Internet for information about *tongue tie*, I found little mention of the cause, other than a suspected genetic link in some cases. Unsatisfied with this, I spent some hours studying up a bit with "Dr. Google" on fetal development of the tongue. How relieved I was to discover that the CFT paradigm provides a simple hypothesis for the "why" of this structural disfunction.

A CFT practitioner views the body as one continuous craniosacral fascial web. Restriction anywhere can and does cause symptoms, often several body segments away from the location of the original trauma. In birth trauma, questions arise like what developmental process was in place at the time of the trauma and how will the resulting restriction limit development? We will not know the answer to these questions unless we can document every moment inside the womb. While it would not surprise me if a medical technology surfaces that accomplishes that very thing, for the moment we must rely on our sense of feel and our ability to support the client into her/his healing.

The Baby Day practitioners have found clinically that the tongue and its associated structures are quite complex. They have observed stark differences in strain patterns between the tip and base of the tongue. One area of the tongue may be loaded with fascial strain, while another area of the same tongue is quiet. They have also observed that tongue strain can have a strong connection to deep pelvic fascial pull.

All of that being said, observing the reality of tongue tie, or *Ankyloglossia,* through the lens of the fetal tongue development sequence, many opportunities for restriction become apparent. Tongue development arises primarily from the first 4 *pharyngeal arches*, the bumpy middle section of our folded fetal beginnings.



The tongue does not develop whole, but rather *emerges* from the sides of the mouth. Each side will then fuse together at the midline, making the frenulum a bit like a soft tissue suture, analogous to sutures in the cranium. From each pharyngeal arch derives a section of mouth and throat anatomy. These distinct layers of tissue must slide forward, retract, bend an reposition themselves in a very intricate dance before mouth development is complete. (check out this cool animation, only a few seconds long).

http://php.med.unsw.edu.au/embryology/index.php?title=Quicktime_Development_Animation_-_Tongue

So, consider these hypothetical questions:

- What if a trauma or stress encountered by Mom at the embryonic or fetal stage of development permeates **all** layers of existing tissue?
- What if the resulting strain pattern surrounds each layer, or in the case of tongue tie, each arch, results in an altered outcome at each developmental step?

The onion, we assume, is as small as it will ever be while we are in utero. Since each of those layers will give rise to many structures through a complex sequence of tissue migration and cellular differentiation, it is reasonable to suggest that any strain present could potentially affect the success of both function **and form**. With a structure as complex and multilayered as the mouth and throat, any loss of elasticity (perhaps due to fascial solidification within a strain pattern) could present as a developmental short fall or irregularity.

What does this mean for us as practitioners? It means that 'tongue tie' is not the problem, it is itself a symptom. While clipping the frenulum will often allow for short term positive change with nursing pain, weight gain concerns, temperament and sleep, the true culprit of all of the dysfunction still lurks in the tissue, waiting for the next missed marker to present. This will generally occur weeks months or years after the initial concern. When parents hold off on the clipping and muddle through, the frenulum release can be a wonderful clinical marker to track how much healing has taken place.

Another concern is when there is no medical diagnosis, but the fascial evidence tells the story. A mom will frequently say, "I am having trouble nursing, but my pediatrician says there is nothing wrong." Developing a thorough physical exam that includes checking intra-oral structures (I keep a small flashlight in my offices to get a good look at the back of the throat) is absolutely key to getting the true story from the craniosacral fascial system.

Here are a few suggestions:

- Palpate and search visually for pale ropes of tissue emerging at the midline, not just in the sub-lingual space, but behind the center of the mandible, between and behind where the first two teeth should come in. In some cases, a thick nodule of soft tissue can be found with a direct connection to the frenulum itself. A gentle swing technique holding the nodule and the occiput will allow the release to begin.
- Gently retract the bottom lip away from the jawbone and look for a continuous thick white band of restricted tissue from the lip to inside the mandibular space. When the restriction comes out as far as the bottom lip, the mandible may be in a recessed position ("overbite"?) as though the fascia has created a sling that won't allow proper function of tongue or jaw. A gentle bottom lip pull can trigger healing in those cases.

If you have a professional scope to work within, be careful not to contradict the physician's opinion. Simply speak in terms of what you have found in the tissues, showing evidence of

strain when it presents. Educate parents about the difference between easing a symptom and resolving a cause. Give the parents a glove or finger cot and take them on a tour of their child's strain patterns. Use the *surrogate* techniques when the tissue work and crying create concern for the parent during sessions.

....and as always my CFT colleagues, Breathe, Ground, and Connect!

Christine Holefelder