

Commentary

Letter: Let's take a rational look at the recurrent Haas article

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Letters

Many practitioners assert that myotherapy should precede orthodontic correction except when the dental arches are so narrow that a correct placement of the tongue is not possible.

As much as this may be true, it is not the entire truth. Abnormal swallowing patterns which cause or contribute to malocclusion appear to primarily affect the functional posture of the mandible. Most deviate swallows have an inadequate vertical dimension and frequently a deviated mandible as well. When patients are taught to swallow with their teeth in habitual occlusion the jaw muscles are trained to maintain the existing mandibular malposture. They may also get excessively stressed. This approach is not optimal.

It is much preferable to establish diagnostically the correct functional relation prior to the initiation of myotherapy and to provide the patient with an orthopedic appliance which guides his jaw into the correct relation every time he swallows.

An abnormal tooth position to be treated by orthodontics can and perhaps should wait for myofunctional correction; a jaw malposture which could be treated via orthognathic therapy, must be handled prior or simultaneously with myotherapy.

Victor Penzer

LET'S TAKE A RATIONAL LOOK AT THE RECURRENT HAAS ARTICLE

R. H. Barrett

Since the first appearance of the article by Haas⁴, the present writer has been filled with an abiding desire to make an appropriate response. It became quickly apparent that this is no easy task. Since this article which claims to be "rational" is in reality, I feel, quite irrational, it becomes difficult to exercise self-control and remain objective, lucid, and reasonably nonaggressive in a line-by-line analysis.

There are several reasons for the present effort: (1) the passage of time seems not to dim the inflammatory influence of this pronouncement, so that further delay would seem futile; (2) copies and reprints continue to be received in my office, heavily punctuated with exclamation points, question marks, underlining and expletives, all requesting some rebuttal but not supplying any; (3) this article typifies some of the recent literature concerning oral myofunctional concepts which are negative in nature, filled with distortions, half-truths, and untruths, yet are eliciting no challenge or refutation from those more knowledgeable in the field. Positive published comment is overdue.

The opening paragraph of the article is as follows:

The fact that any controversy exists in regard to myofunctional therapy is indeed surprising. Consideration of the factors involved—the mechanics of the normal swallow, the mechanics of the deviate swallow, the claims of myofunctional therapy and the evaluation of these claims as sound physiological principles—makes the answer quite clear and facilitates an objective evaluation of myofunctional therapy.

We may heartily agree with almost everything in the statement, the sole reservation being to the all-inclusive referral to "the claims of myofunctional therapy;" Haas appears to be aware of only the extravagant, overly-dramatic, and unrealistic claims of some myofunctional therapists, and since he nowhere specifies that these are oral myotherapists, they may well be dealing with muscles of the pedal extremities.

Following the quoted paragraph, to which we must attribute a connotation quite opposite to that intended by Haas, it is difficult to find any further point of agreement. His lack of knowledge concerning oral anatomy and physiology is quickly apparent, as is his naivete in assuming that "learning to swallow" constitutes the entire field of oral myology. His oversimplified description of the swallowing act is unworthy of professional writing; it is misleading, atypical, and contains an erroneous reference to phonetic placement methodology, plus the added annoyance of a dentist using dental terms improperly. It is a petty matter, but since the incisal papilla does not cut anything, it should not be called the incisive papilla. This minor irritation is aggravated later when "open bite", a term reserved strictly for describing a vertical dimension, is repeatedly misapplied to overjet conditions, a horizontal relationship.

The vexation crests, perhaps, with the flat, doctrinaire assertion that "swallowing is a reflex." If some therapists purportedly working in the area of oral myofunction have made excessive pretensions concerning their accomplishments, some dentists have been equally steadfast and false in taking refuge behind the timeworn and long-disproven concept of the total, global act of deglutition as being reflexive. The entire process of swallowing is too complex to afford even a sensible abridgement here, but one comment that can be made with complete assurance is that the oral stage of deglutition is not bound in a reflex.² A section of the motor center of the human cerebral cortex is specifically assigned to voluntary control of swallowing,^{3,5,6} rendering modification of component elements readily available. We might have hoped by now to have heard the last of "swallowing is a reflex."

To return to an earlier paragraph of the Haas article, the statement is made that "only one type of deviate swallow is considered significant, that which leads to dental open bite." This is supplemented with the comment that no other type is significant, since it would not affect the occlusion. The superficiality of such thinking would be frightening if Haas spoke for a major section of the orthodontic profession. It matters little which classification of types is used, but anyone claiming knowledge in this field should be aware that distinct patterns occur, each involving different muscle pressures, and each exerting a discrete but definite influence on occlusion. The type that results in true open bite is of lesser incidence than several of the others. The tongue that thrusts in the apical region of mandibular incisors, creating a pseudo or "functional" Class III molar relationship, does not lead to an open bite, but is equally real. The type of tongue actions that result in anterior open bite is markedly different than that found in bilateral open bite. In point of fact, one of the more predictable effects of hay rakes or "lingual spurs" is the transmutation of anterior open bite to bilateral open bite. A goodly portion of the present writer's income derives from restoring proper function to posterior lingual and oropharyngeal muscles that have been thrown away by three or four years of suffering the futile discomfort of rakes.

Haas then states that "the only proof which is acceptable for absence of tongue thrust is tooth to tooth or tooth to tissue contact during swallowing. That is, when teeth are in contact no open bite exists anteriorly or buccally." Ignoring the fact that he has thereby made two disparate statements, one point that should be shouted throughout the land is that oral myofunctional therapy should never be proposed as a substitute for orthodontic treatment. The oral myologist does not move teeth; the dentist (and Nature) move teeth. Oral myofunctional therapy should facilitate and expedite orthodontic treatment, and ideally should be conducted with dental cooperation, but any spontaneous correction of tooth relationships should only be considered to represent a secondary physiological reaction of the body to the normalization of function. While such improvement of occlusion is frequently found, this should not be the purpose of either therapy or spurs.

Haas next decries the lack of publication of even one scientifically documented study showing even minimal success resulting from myofunctional therapy. He is somewhat justified in this, and all of us in the field must share the blame for not conducting and publishing more of such studies. However, his amazement that we still exist after these many years of non-publication is hardly justified; we have been fully occupied in demonstrating our proficiency on a daily basis to the local dentists with whom we work, men who have taken the trouble to investigate our procedures, who constantly monitor our results, and who are far too intelligent to persist in such folly if they found no permanent value in our services. Many of these dentists originally turned to oral myofunctional therapy after repeated disappointment in the efficacy of lingual spurs, or in revulsion from the sadistic concept inherent in such devices.

The accusing finger of Haas points next at the therapists who claim responsibility for the occlusal improvement which occurs naturally as a result of growth and development, i.e., clinicians who provide therapy for six- and seven-year-old patients. Again without stopping to belabor the statement that "the influence on the teeth changes from lingual to labial," a sentence which is simply devoid of meaning as written, we can only suggest that Haas become acquainted with the International Association of Oral Myology. This is the only organization with a meaningful certification process by which to verify the proficiency of clinicians, and a Code of Ethics by which to maintain these standards. The I.A.O.M. is a young organization, and perhaps to date it has had less impact on the eastern half of the United States than elsewhere, but it is the position of I.A.O.M. that oral myofunctional therapy (or hay rakes) should not be considered for any patient until permanent incisors are fully erupted. The caseload of the present writer extends from 8 to 40 years of age as a rule, with an average age above 12 years. In a recent run of 50 patients, there were 30, or 60%, who had passed their eighteenth birthday; admittedly, this was a somewhat unusual number of adults. But I am not attempting to "dupe" Dr. Haas when I demonstrate some closure of an open bite, too frequently in orthodontic relapse patients, and I cannot dispel a collective resentment by all I.A.O.M. members at being lumped in with the fanatical fringe of our profession who rely on maturation or trick photography to substantiate exaggerated claims. Dentistry has its advertising dentists.

Haas speaks of a challenge that he has been issuing to myofunctional therapists since 1960 or before, daring them to show 10 cases of open bite that closed spontaneously within one year following therapy (note that he allows himself three years plus orthodontic treatment to close the bite when the rake is used.) It is to be regretted that Haas was so secretive with his challenge. Only a limited number of us were working in this field in 1960, and I never heard of Haas or his challenge until 1975. The arrogance of Haas surely peaks with his statement, "I contend that of the 10 cases, not one will show a remission of the open bite. The percentage of success would be zero." While still rejecting tooth movement as my primary

responsibility, I would have been delighted to show Haas 10 times 10 cases that met his criteria, even in 1960. I have published a few such cases; ^{1,2} perhaps I have been remiss in not offering more. Since 1961 I have invited dentists to survey my finished cases, to make thorough investigation of the results of my work. This invitation has been accepted on several occasions, and the results have invariably shown a high ratio of success. However, I have felt a strong distaste for the use of mere intraoral photographs, taken from uncalibrated angles, as evidence of the efficacy of oral myofunctional therapy. More extensive records should be utilized, records not readily available to the oral myologist in the usual setting. The therapist develops techniques; only in the dental school can properly controlled research be conducted to evaluate those techniques. The dental schools have been extremely laggard.

Haas should feel some shame in justifying his use of rakes by claiming that he is merely following a procedure used by Angle. It is inconceivable that a person of Edward Angle's nature would employ such a cruel and barbarous device—which Haas self-serving terms a "subtle" reminder. I have read most of Angle's writing, and have spoken with two men who knew him personally. Nowhere have I found any indication that Angle used lingual spurs. He never recognized the tongue as a problem, except in regard to size. He attributed all difficulties to the "pernicious" habit of mouth breathing, an idea which gains in validity the deeper one probes into oral dysfunction, and a concept which seems to have eduded Haas entirely.

It is quite true that sharp mechanical appliances, designed to inflict pain as a punishment for tongue thrusting, have been periodically re-invented by various dentists since approximately 1920⁷. (Angle's last book appeared in 1908). Had the coercion upon which these devices depend been adequate to the task, and if they really had proven the best and most logical solution, oral myofunctional therapy probably would have ended with Rogers 50 years ago, before it even began in its present form. Many dentists, including Straub, tried and rejected hay rakes.

Oral myologists did not press their services upon the dental profession; there were no oral myologists. Dentistry sought out therapists. The mistake was made in accepting totally unqualified people, in assuming that because someone was a "speech therapist" they would know something about tongue thrust. Unfortunately, that was not true then, and probably never will be true. However, the sadly deficient therapy which resulted from some of those early efforts has propagated to the point that it is now possible for people with no shred of professional background, or even a day of college behind them, to take a five-day course and bill themselves as oral myologists. Until dentistry becomes a bit more discriminating in selecting its ancillary personnel, it should not complain of poor results.

Haas concludes with the description of a child who was the product of two years of myofunctional therapy. Since it is not possible for effective therapy to extend over a two-year period, he has selected, in effect, an untreated patient. We cannot deny the above-described host of unqualified people claiming to be oral myologists, any more than Haas can deny the legion of incompetents holding dental degrees.

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