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Commentary

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Letters

Let's Take A Rational Look At Myofunctional Therapy

By Andrew J. Hass, D.D.S., M.S.

Dear Editor:

I am responding to the above-mentioned article which was in Volume 3, number 3 issue of the I.J.O.M. The article, which was very well written, provides some good arguments against oral myofunctional therapy. However, it does so with the same lack of information that Dr. Hass criticizes in his article. Many competent orthodontists have negative views on oral myofunctional therapy. With the claims of some therapists and with "short course" experts being turned out nationwide, doing therapy without regard to anatomy and physiology, their comments are somewhat justified. His first statement, "the fact that any controversy exists in regard to myofunctional therapy is indeed surprising," indicates that Dr. Hass may have read a few articles on the subject, but has not dealt with the problem itself. Myofunctional therapy *is* one of the most controversial subjects because of: 1) the lack of controls; 2) lack of standardization in treatment, in training, and in diagnosis. In fact, that is what makes it so controversial that everybody is naming many items the same things. Tongue thrust is not a problem of "position," but one of function.

Dr. Hass defines the normal swallow in two phases. He indicates that in the initiation of the swallow, "the tip of the tongue touches the cinguli of the lower incisor teeth, and not the incisive papilla, as a speech pathologist erroneously imagined some years ago." I believe if Dr. Hass would check the literature, he will find that this statement was given birth in Dr. Straub's early writing. I would however, like for him to document his contention. Such a statement without a well-defined study has limited use.

In most of the literature and studies that I have come across, in the initial phase of swallow the tongue *may* come forward and touch the lingual surface of the anterior teeth. This is considered to be normal behavior (a gathering motion). During the preparation for the second phase, the pharyngeal phase in which the *pressure* is going to be exerted, the tongue tip and the body of the tongue will slide to its ceiling surface (attached to the palatal shelves and rugae) in preparation for this wavelike motion which carries the liquid, bolus or saliva to the pharynx and ultimately to the stomach.

Another statement that Dr. Hass makes in this truly amazing article is that in fifteen years' time this technique has had no demonstrable success. I would like to refer Dr. Hass to the Hansen article in the I.J.O.M. which was also presented at the A.S.H.A. Convention in Washington, D.C., in which studies were shown of the major speech disorders and also studies in tongue thrust. Tongue thrust faired to the highest degree with all of the disorders mentioned. Also, I would be most happy to send him studies on *ethical* oral myofunctional therapy. But that brings up another point. What is effective oral myofunctional therapy?

If Dr. Hass is expecting spontaneous remission of the malocclusion by oral myofunctional therapy, then his assumption would indeed be correct in most cases. Oral myofunctional therapy is given for the purpose of stabilizing the musculature so bone and muscle work together in a favorable environment. It is *not* to correct the malocclusion as he inferred in the article.

Also indicated in this article, was that myofunctional exercise succeeded only in bringing the swallow to the conscious level. If this is true, then the treatment has indeed failed, because in order for something as complex as swallowing to be re-trained or re-programmed, it must be taken to the subconcious level of functioning. He then inferred that this is impossible to do, but I would like him to realize that if this were true, all Speech Pathologists and Physical Therapists in the U.S. would be out of a job. He makes mention that the therapist takes credit for having induced normal dental eruptions. If in fact this is occurring, I agree with him and declare that this is utterly absurd. It is also as absurd for the orthodontist to take such credit, since nature is helping *each* in their systematic treatment for achieving muscle stability, bone support and stability of the occlusion.

In one of his more documented statements in the article, he cites Brodie and Subtelny as indicating there are by far more tongue thrusters evident in the younger population sample than in the mature population sample. I would like to make mention of the fact that 99% of the studies done use children and not adults because they are more accessible. If a subject study were done, which I would be more than happy to do with Dr. Hass, we might find that the incidence does not go down quite as low as he might think.

Another point he mentions is that the elimination of the tongue thrust swallow by means of myofunctional therapy must be characterized by the elimination of the anterior open bite through the use of myofunctional exercise and nothing else. He infers that this has never been demonstrated. First of all, the elimination of the tongue thrust will help stabilize the musculature, and the closing of the vertical dimension of the open bite *may* occur if *time* (and "Mother Nature") per-

mit. Again, moving teeth is not the purpose of myofunctional therapy. That should be the purpose of orthodontics - to straighten the teeth and correct the open bite, and more importantly give occlusal stability to the anterior and posterior segments of the mouth.

Further in the article, Dr. Hass issued a challenge which he said he has issued for fifteen years and hasn't been called on yet. By making a few changes in his working models for a test case, I would be most happy to accept his challenge, first setting valuable and worthwhile treatment goals and setting a definite purpose in the study itself.

During the entire article, he infers the swallow will not and cannot work, because it *can only* be made on the *conscious level*. However, on page 26 of the July edition, paragraph 3, he indicates that *spurs* work beautifully to promote the ideal swallow and "the subconscious" is now aware of the swallow "because of the spurs."

This change on logic and reasoning is not understood. He shows at the end of the article a recent case with pictures. In picture 4-A which he has labeled, he considers this to be the tongue tip in the proper position. In the angulation of the picture in my standards for complete therapy, it does not seem to be stable, nor in position for a lingual palate seal for swallowing. With the cheek retractors in the picture 4-B, the only way that a child could get saliva to the back of the mouth would be through a slurping action, and if in fact this action did occur, this is a patient in relapse and should definitely be *re-treated, not singled out as being completed.*

This response is respectfully made in an attempt to acknowledge the facts that 1) oral myofunctional disorders can be treated professionally; 2) there are a great number of improvements being made in this area; 3) working together in the "team approach" is the proper method; 4) people certifying professionals, i.e. wives, assistants, etc., should not be tolerated.

Regards,

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News and Comments

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