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Commentary

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Proposal That American Speech-Language-Hearing Association Modify Its Policy Statement Regarding the Treatment of Tongue Thrust

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December 12, 1980

Chairman, Resolutions Commiteee
American Speech-Language-Hearing Association
10801 Rockville Pike
Rockville, Maryland 20852

Dear Sir/Madam:

Over six years ago the Joint Committee on Speech Pathology-Audiology and Dentistry published a statement which questioned the validity and efficacy of treatment for tongue thrust. The Statement was subsequently incorporated into a policy statement by the American Speech and Hearing Association, and later by the American Dental Association and the American Association of Orthodontics.

A few years before the publication of the policy statement, a group of speech pathologists, members of the American Speech and Hearing Association, who were engaged in the treatment of oral myofunctional disorders had formed a professional organization, now known as the International Association of Orofacial Myology. The purpose of this organization was to upgrade the quality of therapy for the disorders treated, and to encourage and sponsor research which would investigate interrelationships among speech, dental occlusion, and oral habits. This organization has, for several years, published the International Journal of Oral Myology. We formed this new organization only after consulting with the Executive Secretary of ASHA, who stated in his written response that he saw no conflict between the purposes of ASHA and IAOM.

We who formed the new organization were painfully aware of the negative opinions regarding oral myofunctional treatment being engendered among many speech pathologists and orthodontists, due principally to inadequate training being offered by certain opportunists in the Eastern part of the United States to laymen, to dental personnel with limited backgrounds and knowledge. Three- and four-day courses were providing people with certificates "authorizing" them to provide therapy. As a result, patients received ineffectual therapy from clinicians who made unwarranted claims about the results of their work.

The disrepute into which such therapy fell was inevitable, and ASHA appropriately expressed its concern through adoption of the Joint Committee Statement. When the statement was published, some of us reacted by publishing articles and letters in *JSHD* and *ASHA*, but we tried to keep from being too reactionary. Most of us in Western United States found that, although our referral sources were aware of the positions of their professional associations regarding the treatment of tongue thrust, their own experience with alternatives to therapy for patients with tongue thrust (alternatives were ignoring the problem or treating it with appliances) had proven unsatisfactory, whereas they had, for several years achieved positive results from oral myofunctional therapy. In my own part-time private practice, I continued to see my waiting list lengthen, and I continued to receive more and more referrals from dental specialists.

Recently, six years after the publication of the Statement, the Dean of the College of Humanities of the University of Utah, spurred on by a colleague of mine in our own Department, issued a "decree," stating that if I were to continue treating patients with tongue thrust, I would have to have each patient or parent sign a release form, which he called a "Statement of Informed Consent." This statement declared that the patient had read the policy statement of ASHA, which warned against the validity of such treatment, and that if, having read the statement, the patient *still* wanted to receive the therapy, he agreed to disassociate the University, the College, and the Department from such therapy.

In keeping with the purposes of ASHA's policy, I have continued to provide therapy for oral myofunctional disorders. I am keeping thorough records on my patients, for research purposes. In addition, I have conducted research on the efficacy of therapy (see Christensen-Hanson article, enclosed, accepted for near-future publication in *JSHD*), and am now completing a 14-year longitudinal study on 61 subjects, who are now 18 years old. Now I am concerned, because if my patients have to read the statement the Dean has prepared, there is no possibility of their retaining the motivation to succeed in therapy, or the confidence in the therapy itself, that are so necessary for the success of my treatment. Imagine what it would be like if every stutterer, every voice patient you saw would have to first sign a similar statement about the efficacy of your treatment. The result is going to be, in my own practice, that any objective evaluation of the efficacy of my therapy for oral myofunctional disorders is going to be impossible. When you take away the patient's confidence in the treatment, you place an insurmountable obstacle in the path of progress.

So whereas the purposes of the ASHA policy statement were noble and proper, in my opinion and in the opinions of all of us ASHA members who provide therapy for oral myofunctional disorders, those purposes are not being realized, nor are they likely to be in the future. Our efforts since the publication of the Statement to secure private or governmental grants for conducting the recommended research have all failed. When agencies have a choice between directing their funds to areas which professionals are in agreement have highest priorities for research, and directing them to an area apparently of questionable worth, the choice is easy. The final year of my longitudinal research project, the first six years of which was federally funded 14 years ago, I have had to conduct at my own expense.

I do not deny the controversial nature of the topic of tongue thrust. I do maintain that if its treatment were

consistently ineffectual, or that if it were in reality not a valid behavior for treatment, little controversy would, in fact, exist, and referring orthodontists would not have persisted for 20 years in insisting that their patients with tongue thrust receive treatment for it before any orthodontic treatment would be initiated. The existence of the controversy is due to many factors, among which is the great variety of training and expertise of those who administer the therapy. I also contend that no one could read the extensive literature on the topic and deny that there is substantial evidence supportive of the existence of an identifiable behavior of the oral musculature, and a significant relationship between that behavior and the existence of sibilant defects.

Before giving further evidence of my pathological lack of inhibitor function by prolonging this letter as long as I would like to, let me state my proposal: I propose that ASHA's policy statement be revised so as to more effectively encourage research without placing a stigma on the administration of those therapies that need to be objectively evaluated.

As support for that proposal, and before I word it in the prescribed language, I want to call your attention to an article I wrote for the IJOM a few years ago, "The Joint Committee's Statement of Oral Myofunctional Disorders," IJOM, January, 1976. Below, I am writing a summary of the points I made in that article. They are pertinent to your consideration of the nature and results of the ASHA policy statement.

In addition, I have included abstracts of several articles dealing with oral myofunctional disorders. Most of them have been published since 1974. Many are supportive of therapy for tongue thrust, and provide evidence for that support. I hope you will take time to examine them.

SUMMARY OF THE January, 1976 article:

I have excerpted statements from the Joint Committee Statement, and replied to those statements. I list each portion of the larger Statement and follow it with my reply.

1. The validity of the diagnostic label of tongue thrust is questionable.

ANSWER: Several independent incidence studies have obtained strikingly similar results regarding the incidence of tongue thrust at various ages. It is a behavior that is consistently identifiable, among separate studies, and among judges within research projects.

2. The contention that myofunctional therapy produces significant consistent changes in oral form or function has not been documented adequately.

ANSWER: (1) The purpose of therapy, as practiced by the great majority of clinicians, is *not* to bring about changes in oral *form.* We neither aspire to that goal, nor make claims to that result.

(2) Several studies, some of which are reprinted and enclosed, have definitively demonstrated changes in oral *function* as a result of therapy.

3. There is insufficient scientific evidence to permit differentiation between normal and abnormal patterns of deglutition, particularly as such patterns might relate to occlusion and/or speech.

ANSWER: (1) Reliability coefficients of 0.90 and higher are consistently reported by trained observers on independent judgements of the same swallows.

(2) The type of tongue behavior during swallowing consistently reflects the type of malocclusion. Several studies by orthodontists have found strong relationships between type of occlusion and tongue behavior during swallowing.

(3) Several studies have found significant relationships between tongue thrust and speech defects, some regarding the coexistence of the two problems in given children, and others regarding improvements in the one being accompanied by improvements in the other.

4. There is unsatisfactory evidence to support the belief that any patterns of movements defined as tongue thrust by any criteria suggested to date should be considered abnormal, detrimental, or representative of a syndrome.

ANSWER: (1) If "normalcy" is that which more than 50% of the population does, tongue thrust becomes abnormal, according to several incidence studies, after the age of five, and gets progressively more abnormal during the next few years.

(2) It is *certain* that more research is needed to determine whether harmful effects result from tongue thrusting. There is considerable *clinical* evidence that this is the case.

(3) Tongue Thrust is *not* a syndrome. We who administer the treatment have recognized for many years that it is a *behavior,* involving the pushing and/or resting of the tongue against the anterior teeth.

5. The few suitably controlled studies that have incorporated valid and reliable diagnostic criteria and appropriate quantitative assessments of therapy have demonstrated no effects on patterns of deglutition or oral structure.

ANSWER: I vehemently challenge that statement! I *know* the literature on tongue thrust, and I know of no studies that fit the above description and find those results. Certainly studies by Case and by Overstake are well-controlled, well carried out, and demonstrate definite changes in swallowing patterns. More recently, a study by Christensen and Hanson, soon to be published in *JSHD,* demonstrated definite modification of swallowing behavior in six-year-olds, along with facilitation of lisp correction, as a result of therapy for tongue thrust. Several studies done five years post-treatment have demonstrated retention of proper swallow habits, and retention of corrected occlusion (orthodontically corrected). The entire field of speech-language pathology was, until the past two or three years, embarrassingly devoid of long-term research to measure retention of corrected speech patterns.

I have no confidence in my ability to word "whereas" and "be it resolved" statements, but I will try:

WHEREAS the acceptance by the American Speech and Hearing Association of the Joint Committee on Speech Pathology-Audiology and Dentistry six years ago was announced in order to encourage research into the validity and efficacy of the treatment of tongue thrust, but in fact has had the opposite result; and

WHEREAS the stigma placed on such therapy on ASHA's endorsement of the statement has cast such serious doubts regarding the therapy that motivation of many patients has been seriously dampened; and

WHEREAS many strongly supportive members of ASHA persist in doing the therapy, because of their own convictions of its efficacy, and because their referring orthodontists likewise persist in their convictions of its efficacy, but are experiencing the deprecation of some colleagues and administrators because of their continued activity in this area; and

WHEREAS the wording of the Joint Committee Statement did not, and currently does not, accurately reflect the goals or claims of most clinicians who engage in oral myofunctional therapy; and

WHEREAS the scope of oral myofunctional disorders is extensive, encompassing sucking, biting, and chewing habits, tensions resulting from postural anomalies, and bruxism, and although the Statement is directed primarily toward tongue thrust, the other habits treated are, by association, relegated to a status of dubious merit; and

WHEREAS supporters of, or clinicians active in, the provision of such therapy were not represented on the original Joint Committee, hence their points of view were not adequately presented; and

WHEREAS the Joint Committee, which at the present time does include a member who is strongly supportive of therapy for oral myofunctional disorders, is apparently threatened with extinction;

BE IT RESOLVED THAT the American Speech-Language-Hearing Association modify their policy statement regarding the treatment of tongue thrust to read as follows:

The American Speech-Language-Hearing Association encourages research which would contribute information to answers for the following questions:

1. Is "tongue thrust" a consistently identifiable behavior?
2. Are there any significant relationships between oral myofunctional disorders and dental malocclusions?
3. Are there any significant relationships between oral myofunctional disorders and speech disorders?
4. When articulation disorders and abnormal oral vegetative behaviors co-occur in the same individual, what are the relative efficacies of various possible approaches to the remediation of those abnormalities?
5. Does oral myofunctional therapy:
   a. Reduce the time required for orthodontic treatment in patients with whom such therapy is deemed "successful?"
   b. Positively affect the likelihood of retention of orthodontically corrected dental occlusion?

The Association encourages objectivity in the diagnosis and treatment of oral myofunctional disorders, and discourages any affirmations by practitioners regarding any changes in oral form resulting from such treatment, in the absence of data to support those claims.

Thank you for your attention to this lengthy set of materials. I welcome your scrutiny of the revised statement, and appreciate your consideration of my proposal. I would be happy to travel anywhere in the U.S., at any time, to discuss it with you, at my own expense, of course.

Sincerely,
Marvin Hanson, PhD