Commentary

Letter to the Editor: Thanks for the study of long-term effectiveness of therapy

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Letters to the Editor

Thanks for Study of Long-term Effectiveness of Therapy

A resounding thank you to Clara Mae Rydell and Joyce Harden for their article in the November 1983 *I.J.O.M.* "A Study of Changes in Swallowing Habit Resulting from Tongue Thrust Therapy Recommended by R.H. Barrett." A number of parents have asked me what the percentage of success was with orofacial myology as opposed to a mechanical device encouraging proper swallowing, and now my armament of facts is strengthened by a well-designed study. Tongue thrust therapy is successful, and five years after therapy, 84% should still demonstrate correct tongue function, whereas 0% may do so without intervention. Too, I add my voice to those of the authors in urging study into the effectiveness of mechanical devices placed in the mouth to correct tongue placement and swallowing patterns.

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What Happens If You Don't Do Therapy?

I would like to express my appreciation to Joyce Harden and Clara Mae Rydell for the article "A Study of Changes in Swallowing Habit Resulting from Tongue Thrust Therapy Recommended by R.H. Barrett," which appeared in the November 1983 *I.J.O.M.* This research adds another piece to the puzzle and clarifies the question: "What happens if you don't do therapy?"

Of course I was pleased to see that 100% of the therapy patients had maintained the correct swallow and 88% had maintained the correct resting posture five years after therapy. My own batting average is slightly lower than that, but those figures are certainly realistic and reasonable. What really surprised me and added the most significant new information to our literature were the statistics on the subjects who were diagnosed as tongue thrusters but who refused treatment. Five years later, 100% of the control group were still thrusting and 100% were still using an incorrect resting posture. I really would like a follow-up article providing additional information on this "control" group.

Specifically,

1. What were their ages at initial diagnosis? The article states they had a mean age of 16 years, 5 months; median age 17 years. Five years earlier, they would

have been in the age range of 11 to 12. If swallowing and resting posture are maturational, as some authorities suggest, does that mean that these subjects hadn't "matured" even by their mid-teens?

2. How many of these patients had orthodontic treatment? I would guess that quite a few did since it was most likely the orthodontist who referred them to Mr. Barrett for therapy in the first place. If they had orthodontic treatment and created a favorable oral environment, why didn't the function change? Doesn't form determine function, as some would have us believe?

Again, I am pleased with the results reported in this study. I think it's wonderful that Mr. Barrett has such a high success rate, but I think it's even more significant that those thrusters who weren't treated kept on thrusting. Even without commenting on such orthodontic matters as comparing length of treatment time, changes in occlusion, and relapse between the two groups, the authors made a very good case for the retention of habits, both trained and unchanged.

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Reader Speaks Out for Speech Pathologists

As a speech-language pathologist treating poor orofacial habits, I take issue with the statement that "the professional best prepared to provide these (myofunctional therapy) intervention skills is the dental hygienist," found in Marjorie Snow's article in the November 1983 *I.J.O.M.*, "The Pros and Cons of Myofunctional Therapy: 'Emerging Specialty.'" The field of speech-language pathology has been involved in muscle-function training. Pathologists in the public schools, rehabilitation centers, hospitals, and in private practice have worked with the speech problems associated with tongue thrust for decades, with many intercepting and treating these maladaptive habits. Students in this field also receive enough background and training in their program to work under the supervision of a certified myofunctional therapist. While the habit may be "primarily a dental problem," as Mrs. Snow states, the fact remains that unless there is a concomitant speech problem most people are not sufficiently motivated to change their habits. Hence the habit is frequently a speech problem. The fields of both speech-language