Dear Editor:

What is sauce for the goose is sauce for the gander.

It was with some regret that I read the Position Statement that appeared in the May issue of ASHA on Tongue Thrust.

As a long time member of ASHA who, not only has been seriously concerned with the problem of orofacial soft tissue behavior and myofunctional therapy, but also concerned about the problems that ASHA must ultimately face because of the dearth of scientific evidence relating to the effectiveness of speech and language therapy in all areas of Speech Pathology, this statement came as a surprise that myofunctional therapy would be selected out for criticism by ASHA when this kind of a critique has never been done in any other area.

What acceptable body of research does ASHA offer to support claims of significant, stable, long-term changes as a result of therapy with individuals having phonatory, articulatory, fluency or language disorders?

It seems that the same position paper could be offered in these areas—and by the standards demanded of this position paper—Speech pathologists would have little, if any, grounds for therapy in any area of Speech Pathology.

I think that ASHA has opened a Pandora's box which ultimately may be a very fine thing for the profession.

Speech therapists are doing therapy with very young children for all sorts of so-called language and learning disabilities; they are giving children in kindergarten through second grade articulation therapy for immature [r], [l], and [s] sounds; they are in cerebral palsy clinics giving therapy for dysarthria; they are in schools for the deaf teaching speech and lip reading; they are in classes and in institutions for the mentally retarded doing so-called language therapy; they are in nursing homes giving speech therapy to feeble old people waiting to die.

All of this at tremendous expense to society. Yet in each of these areas there does not seem to be, at least I have not been able to discover, sufficient classical scientific research supporting the effectiveness of the therapy that is being offered and thereby justifying it in the eyes of society.

It seems that in order to be consistent, ASHA should offer the same position paper merely substituting the words Dysphonia, Aphasia, Dysfluency, Dyslalia, etc. for Tongue Thrust and the word speech for Myofunctional where appropriate and see if the position statement does not make as much sense in these other areas.

The interpretation of the Joint Committee's statement on "Tongue Thrust" by the Ethical Practice Board is very difficult for this writer to understand.

Speech pathologists are recommended not to engage in clinical management procedures for tongue thrust because there is no real evidence that is valid but in the next breath are counseled that if they do engage in these highly questionable, unsubstantiating procedures of therapy, they are not violating the ethical code.

I fail to see how ASHA can have it both ways. Perhaps I am not understanding correctly and, if so, would appreciate more elucidation and illumination in this area where I see darkly.

I have been engaged in the study of orofacial behavior for over fifteen years. I have studied this behavior in literally thousands of individuals. I firmly believe and have demonstrated pragmatically and clinically to my own satisfaction that Tongue Thrust therapy in which I include all of the basic upper gut functions—sucking, swallowing, chewing,

breathing, hard food orientation, etc.—is not only effective but essential for successful therapy with dyslalia and dysarthria.

Insofar as malocclusion is concerned, there are many orthodontists and pedodontists, acknowledged by their peers as outstanding clinicians, who routinely prescribe Tongue Thrust therapy in conjunction with orthodontic or preventive pedodonture because they are observing positive clinical effects as a result of this therapy which would not otherwise be obtained.

If Speech Pathologists refuse to cooperate with these specialists, they (the specialists) will be forced to resort to other personnel and professionals for this service.

It is perhaps appropriate here to reiterate the words of Edwin W. Martin, Director of the Bureau of Education for the Handicapped, in a paper presented at the 1974 ASHA convention.

In discussing the evaluation of speech and hearing services as part of the subject of "accountability", Martin feels "that speech and hearing specialists have failed to give sufficient scientific attention to the basic questions of the effectiveness of our services. It does not seem to be a subject that has attracted our academic leaders and scientists. We study many esoteric phenomena but our *basic reason for existing* has seldom had the benefit of careful longitudinal analysis."

A basic evaluation of all our services seems to be long overdue. To paraphrase Martin we are in the service dispensing business and our very existence depends on the public's believing these services are valuable.

What scientific evidence do we have as to effectiveness of speech and hearing services? Generally, in my opinion, so called tongue thrust therapy would probably compare most favorably with that for other disorders, if not much better.

Again I repeat—What is sauce for the goose is sauce for the gander—and to my fellow speech and hearing professionals who are critical of my efforts and the efforts of the International Association of Oral Myology, I ask—"Why beholdest thou the mote that is in thy brother's eye, but considerest not the beam that is in thine own eye?"

Sincerely,

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