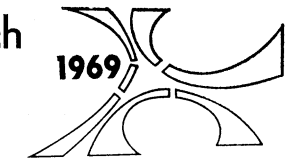
Contraindications for Speech Therapy for Cleft Palate Speakers



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First I should like to state that children with palatal problems in our facility, the Department of Otolaryngology and Maxillofacial Surgery at the University of Iowa, are evaluated individually by all disciplines to determine the procedure best suited to the patients' needs. For some patients this may be done one step at a time; for others, long term planning may be outlined with re-evaluations scheduled at each stage if multiple procedures are indicated. I state this since we feel very strongly that there are no blanket rules governing the treatment for these children. We cannot fit them into neat little compartments simply on the basis of the physical findings.

Now the question posed is when *not* to encourage speech therapy. There are three main areas which we consider.

I. Speech therapy is contraindicated when the preschool child needs language development primarily, not articulation therapy. Children who are corrected at the early communication level may not continue to progress in overall language skills. We therefore recommend, as a rule, that parents use the same language stimulation advanced for a noncleft child. We encourage the families to promote verbal response regardless of intelligibility, and, hopefully, by school age the child with a palatal problem will have attained the same level of vocabulary and sentence structure as his or her peers. It has been our conviction that at this level this is the more important skill since speech therapy can be introduced with equal effectiveness for ultimate habilitation after the child has adjusted to the school situation.

II. Speech therapy is contraindicated if there is evidence of psychological reaction to the speech deviation. Again we feel very strongly that additional pressure to perform speechwise in any way different may only aggravate the present psychological reaction. This is particularly true if the prognosis for achievement of velopharyngeal closure is poor.

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Children with palatal incompetence with normal intelligence can function in every way as well as their peers if they are permitted to communicate in their own way.

When a child is reacting to his speech deviation this is an indication that there has been a lack of acceptance of the articulation pattern by a member or members of his environment. This should not be compounded by initiating speech therapy. In so doing, the child is repeatedly reminded that his way of communicating is not pleasing and his natural reaction is usually to minimize the amount of verbal output. If the family or teachers are determined to try to alter an existing articulation pattern it may even be sufficiently painful to a speech deviant to start a nonfluency pattern.

III. Speech therapy is contraindicated if there is documented evidence of velopharyngeal incompetence which is scheduled for remediation.

The adequacy of the palatal function is judged by the surgeon, a speech pathologist, manometer ratios, and radiographic examination. If there is agreement that the present physiological structure is inadequate for good closure of the pharyngeal port, surgical or prosthetic correction is scheduled and speech therapy is deferred until the recommended procedure is completed.

There must be diagnostic evidence that the speech problem is related to the palatal incompetence and that it is not a complex articulation problem.

One of the problems in making such a decision is that there are many patients with cleft palates who also have functional articulation problems. These are sometimes presumed to be secondary to the palatal deviation. There is no reason not to have speech therapy for any of the many speech problems which may not be related to the palatal function provided there is no attempt to correct sounds requiring oral pressure if there is inadequate closure of the velopharyngeal port.

I repeat, it is always essential to have adequate speech evaluation prior to initiating any speech therapy.

I am sure all of you can cite individual cases where children have developed amazingly intelligible speech despite poor velopharyngeal approximation. These are exceptional cases and it is not advisable on the basis of these individual accomplishments to recommend speech therapy routinely.

In the case of the individual with poor closure who eventually attains acceptable speech without prosthetic or surgical management, we frequently find by radiographic analysis that the child has developed a Passavant's pad. It is our contention that this may be developed by that particular client with or without formal speech therapy.

In conclusion it should be stated that there are contraindications to speech therapy: a) If there is a need for good language structure *first.*

b) If the patient exhibits psychological reaction to the existing speech pattern. c) If there is documented evidence of lack of ability to attain closure of the velopharyngeal port the patient should not be subjected to speech therapy.

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