

This is an email which was sent by Pam Marshalla, SLP to the board members of the Oral Motor Institute. In it Pam answers many of the "concerns" related to the issue of EBP (Evidence Based Practice). I think this information is critical for SLPs to read and understand. No two clients are the same and if we are not allowed to be creative then what are we doing? If in therapy you only do what is the result of EBI and you see no changes in your client... what are you supposed to do? Discharge them without trying something you think will work?

The following discussion was the result of an email received from a practicing SLP:

Dear OMI Board Members,

I am now so thoroughly frustrated with the field of speech pathology, I'm tempted to throw in the towel...or should I say throw in the bite blocks? I think the whole question of oral-motor therapy has gotten totally out of hand, and I no longer know what to believe. In this age, from every corner, we are encouraged to use evidence-based practices. Yet, I know that I am not always having luck with evidence-based therapy methods when my young clients have multiple challenges affecting their speech, and it is causing me to lose sleep. If I try your methods, will I be considered a hero or a heretic by a jury of my SLP peers?

Pam's response:

1. This is the first time in the history of our profession where the ideas of the practicing speech-language pathologist have been treated with disdain.

Traditional articulation therapy books written from the 1870's through the 1970's were all written by practicing therapists who shared their clinical experiences, ideas, insights, and hunches. Alexander Graham Bell, Charles Van Riper, Mildred Berry, Jon Eisenson, Hilda Fisher, and etc, etc, etc. ALL of these traditional writers wrote from a clinical perspective, expressing their own clinical experiences.

CLINICAL EXPERIENCE IS THE VERY FOUNDATION OF THIS PROFESSION. The writers of traditional books were very important people-- They were AHA presidents and winners of ASHA's Awards of the Association. Charles Van Riper is the Father of Articulation Therapy, for goodness sake. Alexander Graham Bell is considered one of the most brilliant minds of all times! These people all said that therapy is a process of trial-and-error-- We try this and that to determine, for the particular client at hand, what will work for him. We DO NOT simply apply already proven methods. *We are paid to figure out what will work for the particular client at hand, not to replicate research projects.*

2. I personally am disgusted at the way some in the profession now are throwing out everything that has not been "proven".

In truth, MOST OF WHAT WE DO ON A DAY-TO-DAY BASIC IN THERAPY IS UNPROVEN!!!!!!!

-Where is the "proof" that a mirror helps in articulation therapy? Nowhere. Does that mean that we cannot use mirrors in therapy anymore?

-Where's the "proof" that ideational cues (like the "snake" for /s/, or the "bumble bee" for /z/) help children learn phonemes. Nowhere. Does that mean that we cannot use these methods anymore? I certainly hope not.

-Where is the "proof" that getting kids to sit still and pay attention helps improve articulation? Nowhere. Does that mean that we can no longer ask kids to sit up and listen?

This is the theater of the absurd. The professional speech-language pathologist must be creative and innovative in the application of scientific ideas. That IS what therapy IS.

3. I will be putting a whole section on creativity in my next book on articulation therapy. Here are a few quotes that will appear (references can be found on my list of references on my website:

www.oralmotorinstitute.org). These all come from highly respected professors and clinicians who wrote very well-received textbooks in articulation. Underlining has been added for emphasis:

- 1947: “I rarely use any standard approach because I can always invent a better, more pertinent one for the special person with whom I’m working. Most good clinicians do the same thing” (Van Riper, 1947).
- 1956: “Speech development is best described as a dynamic learning process, not as a ‘still life’ picture. It demands from the learner the energetic and cooperative use of many sensory, ideational, and motor faculties. It demands from the teacher the same kind of dynamism, expressed in his motivation, ingenuity, and intelligent guidance” (Berry and Eisenson, 1956, p. 128).
- 1968: “The skilled practitioner is resourceful in adapting methods to needs ... there is no substitute for creative imagination in planning teaching activities of any kind” (Carrell, 1968, p. 92–102).
- 1971: “The wise clinician will experiment constantly with his case and use what works” (Powers, 1971, p. 894).
- 1981: “Correcting defective articulation is both a science and an art ... No matter how many years of experience you have, you will still find the child who challenges your skills. A speech-language pathologist must continue to be creative and flexible.” (Bosley, 1981, p. 13).
- 1987: “Since what is known about disordered articulation is incomplete and imprecise and since no problems are alike, clinicians must be creative in dealing with individual clients. Such creativity should be based on scientific information ... Perhaps someday research will identify, with greater certainty, which treatment procedures are most effective with which types of clients; however, until that time the speech-language pathologist must make creative use of clinical impressions, judgments, and intuition to strengthen those treatment procedures that have been most productive in the past. In order to be an effective and efficient clinician, one must be a scientist, humanist, and artist” (Weiss, Gordon, and Lillywhite, 1987, p. 178).
- 1993: “**Personally, in actual therapy, I consistently violated all the precepts I promulgated in [my] text. Unto their needs was my motto and to heck with what Van Riper or anyone else says ... I consistently urged my students to develop better methods of their own**” (Van Riper, 1993).
- 1998: “The emphasis placed on the use of experimentally evaluated techniques is not meant to discourage creative clinical work” (Hegde, 1998, p. 48).
- 2007: “Do what’s best for your client! Take risks! Stick your neck out! And, most importantly, don’t be afraid to develop better methods of your own” (Secord, 2007, p. vii).
- 2008: “**Lack of data does not mean that we should do nothing. Using the limited data that are available, along with an analysis of the motor tasks, we can assemble thoughtful paradigms for clinical application**” (Kent, 2008, p. 1).

Food for thought...

Reminder: Evidence comes from the LAB, the CLINIC, and the CLIENT (i.e., not just the lab!)

Respectfully-
Pam M.

Pam Marshalla, MA, CCC
Speech-Language Pathologist
Founder and Co-chair Oral Motor Institute
www.oralmotorinstitute.org

Later in the discussion Donna Ridley, SLP added some very interesting thoughts:

From Donna:

Thank you, for reviving an important question. I believe your heartfelt plea for a discussion expresses the dilemma in our profession as a whole, and what our future is, (or is not)...

Part of it ('it' being the belief that evidence-based practice includes only techniques/methods/programs which have been proven effective by research) arises from our particular profession.

Part of it has arisen more broadly from the same 'trends' in medicine and education, and in our culture at large.

In public schools, teachers have become (or are supposed to function as) technicians. They are only allowed to teach 'approved' material, texts, and use 'approved' methods. This is less true in private schools (which generally have better achievement levels), but it is a pressure there too.

In medicine, this trend is increasing too. Having the results of a large body of research helps greatly in narrowing down the possibilities of both diagnosis and treatment options. But ... if I have a rare brain tumor, do I want my neurosurgeon to recite the 'list' of approved treatments, or do I want a physician who will THINK, and perhaps say "well, it's a long shot, but we might try X, it has not been tried on someone like you, but I believe it might work *because* ___." ??? It is the 'because' part that I am interested in.

Our culture supposedly values 'thinking outside the box', but at the same time, some are excoriated for actually doing that.

If SLPs were just to apply techniques/methods/programs from an approved 'list', there would be no need for anyone more experienced than anyone else, because the SLP could simply google an approved list of methods, and pull up related DVDs that demonstrate these.

At the risk of repeating, I am going to echo Pam Marshalla's statements, particularly, this one:

We DO NOT simply apply already proven methods. *We are paid to figure out what will work for the particular client at hand, not to replicate research projects.*

I actually think this 'battle' is more about EBP than it is about 'oral motor'...

I'm glad I got in this profession in 'the old days' when clinicians were ADMIRERD and sought out for their experience and on the spot improvisation, when 'the usual' wasn't working. It is so different from today's world, yes??

I apologize if this seems to be preaching to the choir. But...we need to remember, and spread the word, that we are teachers, healers, and thinkers. When I do articulation therapy, I do whatever it takes to get the client to be able to hear, feel, see, experience, and perform the actual targeted position and movement. The end goal is functional, usable speech. But sometimes we need to practice the

position, before we can do the movement. I know it's been said that practicing tongue holds (tongue tip held up on the alveolar ridge) is 'not speech'. I wonder if Mikhail Baryshnikov would say that practicing fifth position is unnecessary and 'unrelated' to actual dancing...

Donna Ridley, M.Ed., CCC-SLP

Speech-Language Pathologist

www.donna-ridley-slp.com

This last entry is a page from one of PamMarshalla's classes in which she talks about EBI:

Evidence-Based practice (EBP)

1. Dollaghan, C. A. (2007) *The handbook for evidence-based practice in communication disorders*. Baltimore: Brook.

Dollaghan says that and EBP is the conscientious, explicit, and judicious integration of best available:

1. *External* evidence from systematic research (LAB)
2. *Internal* evidence from clinical practice (CLINIC)
3. Evidence concerning the preferences of a fully-informed patient (CLIENT)

2. Asha Definition – www.asha.org

ASHA's logo for EBP reflects the same idea. An EBP integrates information from the LAB, CLINIC, and CLIENT. The following logo is copied from the ASHA website:



3. Justice, Laura (2008) "Evidence-Based Terminology" Laura, Editor, *AJSLP*, 17, 4, November 2008.

Justice contrasts EBP with “empirically validated treatments” (a treatment that has been validated by empirical research). She wrote: “...one’s use of an empirically validated treatment is not the same as engaging in EBP” (p. 324). Using EBP, the clinician “systematically gathers and integrates information (i.e., evidence) from a variety of resources, including **scientific evidence**, **prior knowledge**, and **client preferences**, to arrive at a decision” (p. 324).

4. Sacket, D., & Richardson, W.S., & Rosenberg, W., & Haynes, R.B. (1997) *Evidence-Based Medicine: How to Practice and Teach EBM*. Edinburgh: Churchill Livingstone.

“Evidence-based medicine is not ‘cook book’ medicine ... It requires a bottom-up approach that integrates the best **external evidence** with individual **clinical expertise** and **patient choice** ... External clinical evidence [i.e., research] can inform, but can never replace, individual clinical expertise” (Sacket et al, 1997, p. 3-4).