PREFACE

Some form of clefting occurs once in every 500 to 1000 live births, depending on the studies cited (Brogan and Woodings, 1976; Fogh-Anderson, 1942; 1961; Ivy, 1957; Tretsven, 1963; Weatherley-White et al., 1972), and is one of the most frequently encountered major correctible birth defects. Yet, speech-language pathologists would see relatively few such cases if it were not for the fact that the data are seriously underestimated when we take into account the numbers of children who have speech problems associated with velopharyngeal incompetence from other structural deficits such as submucous cleft palate (Calnan, 1954), congenitally large pharynx (Calnan, 1971a), occult submucous cleft palate (Croft et al., 1978; Kaplan, 1975), or congenital palatopharyngeal incompetence (Blackfield et al., 1962; Calnan, 1956, 1971a and 1971b; Chaco and Yules, 1969; Croft et al., 1978; Fara and Weatherley-White, 1977; Gibb, 1958; and Randall et al., 1960). This latter category overlaps with those previously listed, and some authors have chosen to identify velopharyngeal incompetence arising from causes other than clefts as congenital palatopharyngeal incompetence.

Since the communication problems associated with velopharyngeal incompetence, regardless of cause, are similar, all of us serving as speech-language pathologists are likely to see more children in the course of our professional lives than the prevalence rates for clefts alone would suggest. Thus it is essential that we be fully informed about the diagnosis and treatment of velopharyngeal incompetence and that we learn early in our careers that speech therapy is very often not an appropriate solution even in the presence of marked communication disorders. Unfortunately, centers specializing in the clinical management of such patients continue to see children and adults who have had years of unrewarding, frustrating, and expensive speech therapy administered without diagnosis of the responsible condition. Such therapy is doomed to failure and calls upon us as a

profession to take aggressive steps to rectify this situation.

It is the purpose of this issue of *Seminars* to discuss current methods of diagnosing and treating communication disorders associated with palatal clefting and related disorders. The philosophy underlying the individual articles is that communication is so intimately tied to human development that all aspects of that process must be taken into account in the management of speech and language problems, including those having their origins in the anatomy and physiology of the vocal tract. Thus, we will discuss how intelligence, ability to learn, emotional status, language, hearing, and speech are influenced by the presence of a cleft and how we as speech pathologists can function most effectively and most efficiently to eliminate or minimize the resulting communication deficits.

Information about clefts and related anomalies has expanded rapidly in the past two decades as new instrumentation has become available to permit the scientific study of the velopharyngeal valve, as understanding of language and speech acquisition and development has improved, as greater objectivity in selecting surgical and dental techniques has become possible, as new insights into the efficacy of speech therapy have emerged, and as the theoretical constructs underlying systems of therapy have been elucidated. This is an exciting time to be interacting with the many other professional people who join together to provide the superb care that is possible in 1986. It is our hope that the readers of this issue of *Seminars* will capture that excitement and will work in major ways to ensure that patients everywhere have access to the best and most sensitive services that well-informed speech-language pathologists are capable of providing.

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