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Habituation and Hypnosis

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One of the earliest bromides to come out of myofunctional therapy was to the effect that it is no great trick to teach a patient to swallow correctly, but it is nearly impossible to get them to do so automatically. Some authorities have mistaken the extent of the reflexive component involved and decided that the task is totally impossible.[1,5] These people are in error; no reflex directs the oral stage of swallowing, the only location of abnormal function. Some dentists have rejected the retraining concept out of hand because they became convinced that treated cases swallowed correctly only in the presence of the therapist.[10,11,12] This opinion was probably valid, based on the sample of treated cases that they observed. There has been, and unfortunately continues to be, some therapy programs which assume, with some naivete, that once the patient learns the normal procedure, he will then, in some mysterious, unspecified way, supplant a life-long subconscious body function with this strange and unaccustomed method on which he has a most tenuous hold.

These and other ineffective techniques produce results which are hard to live down, and so continue to haunt us at every turn. They can eventually be laid to rest by truly complete therapy programs which do not stop short of thorough habituation of normal function. However, from the beginning to the present, habituation has been a problem for all of us engaged in this work.

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One solution that quickly came to the fore was hypnosis. Fourteen and 15 years ago several articles,[2-9] appeared in various professional journals extolling the efficacy of hypnosis in this service. Entire therapy programs were formulated, consisting of 10 or 15 minutes of explanation on the merits of keeping the teeth closed and lifting or curling back the front of the tongue, followed by a series of hypnotic sessions designed to make these movements a "permanent habit."

I still consider hypnosis to be a worthy modality. In the proper hands, used for logically indicated purposes, it can be a most effective tool. I would recommend its study

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(but not necessarily its usage) by anyone engaged in the modification of human behavior.

However, hypnosis has very definite limitations. It is frequently stated, but less often appreciated, that hypnosis is not magic. It is not witchcraft. We say that, and then go right ahead and expect magical results. In point of fact, one of the more sage observations concerning hypnosis, one frequently rediscovered by authorities in the field, is to the effect that if you know enough about hypnosis, you don't need hypnosis.

I suppose I will never know enough about hypnosis, but I find that I now use the formal induction procedure very rarely in tongue thrust therapy. Good, sound theory requires that several essential pre-conditions be operant before any attempt should be made to achieve an actual hypnotic state. Only in the movies do they swing the gleaming light, force someone under hypnosis, and then work their evil plan. In real life, because of the limitations inherent in hypnosis, certain preliminaries must be assured in order to achieve therapeutic results. And sure enough, once these preconditions are met, hypnosis in its formal state may be second choice.

I would like to set forth four of these preconditions as they apply specifically to myotherapy. Whether or not you ever dabble with hypnosis, these prove to be essential considerations in any program of habituation. These four topics fall very nicely under the headings of What, How, Why, and When.

1. WHAT inquires into *what* manner of swallowing pattern are you trying to habituate? To be successful, the pattern must be truly and totally normal; normal deglutition is efficient, and meets much less subconscious resistance than a distorted or partial concept of swallowing. This normal pattern must be complete in not merely oral, but pharyngeal, facial, labial and dental detail, and must be practiced to the point of effortless execution.

The subconscious mind is very specific and very literal. Thus it has not sense of humor. The dictionary definition of *literal* includes phrases such as "true to the fact," "not exaggerated," and "given to strict construction." If I should ask you at this moment, "Would you like to tell me your name?" being a polite and reasonable person, fully conscious, you would probably murmur your name. Under hypnosis that question would receive a "yes" or "no" answer, with no thought of actually stating your name. It must then be obvious that the subconscious would tend to reject any pattern which was not appropriate to the structures, which was not precise, or less than fully unified into a total, logical pattern of function. *What* you teach makes a difference.

2. HOW switches attention to the patient. Does he really know *how* to swallow correctly? We can only make subconscious what we already know consciously. An example can be seen in the futility of placing a person under hypnosis who has never learned to play the piano, or to speak Spanish, and implant the suggestion that hereafter he will be able to execute these abilities. This is not to say that, having mastered such skills consciously, the person might not then play the piano with greater dexterity, while speaking more fluent Spanish, with the assistance of hypnosis. Nevertheless, with any complex activity, which includes deglutition, the conscious learning must occur first.

Thus the patient should not only be capable of executing a normal swallow, but should also understand each detail of what he is doing, how it works, why he is doing it, and when he can expect to have mastery over it. This means that the clinician is responsible for taking the time to explain such details. It also implies that the therapist must *know* these details.

3. WHY blends the efforts of everyone in the situation. The patient must *desire* the change in function. Even hypnosis cannot bring about behavior that is not basically desired. If you want to be technical, the conscious desire may be subconsciously suppressed which accounts for certain instances of hypnotic behavior; nevertheless, the positive desire must be present before change will occur. Our habits, both good and bad, are acquired because we want them at the time of acquisition. Thus motivation is truly the *sine qua non.* The therapist has but a brief time to instill this desire, the patient must be receptive to the idea, and those about him must be supportive of the effort. The reason *why* the patient is in therapy must have an adequate value.

4. WHEN is frequently a misjudged factor in behavior modification. Time is another controlling influence in tongue thrust correction. Time (at this moment) precludes the full discussion of all ramifications of this consideration. It should be noted, at least, that if subconscious change in swallowing behavior is to be permanent and effective, the change must be completed quickly.

I once believed that I need not aspire to a complete and immediate change. I thought that 51% was a winning percentage, that if a simple majority of swallows were correct, my good friend, time, would eventually and gradually eliminate the remaining instances of tongue thrust since it would be too much trouble to maintain two distinct types. Such thinking proved an illusion. It now seems more realistic to assume that the most motivated of patients would be conscious of perhaps 10% of the overall incidence of routine deglutition. Failing a sudden, dramatic change in subconscious function, it then becomes inevitable that time will bring relapse. Implicit in this concept is the assumption that the clinician will provide the patient with an effective technique by which to render immediate change. Hypnosis, for some patients, tends to be rather cumbersome and slow of foot compared to other available alternatives.

As I stated at the beginning, I still use hypnosis – on occasion. I try to avoid the "Jehovah complex" which many clinicians fall prey to, but on the other hand, I would be sorry to lose my ability to use a valued tool. However, I think that if you have provided the patient with a truly normal and complete pattern of function, if you have taken time to explain this pattern in detail, if the patient fully understands each aspect and is strongly motivated to acquire the new function, if you provide a method by which the change can be made quickly – in other words, if you have really done your job adequately as a therapist – then you don't necessarily need hypnosis.

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