Clinical Perspective

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The Habituation Stage in Myofunctional Therapy

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Myofunctional therapy like any other profession in its embryonic stage has experienced many "growing pains" throughout its brief existence. Today, myofunctional therapy is still a very controversial topic in most dental and speech therapy circles. In the author's opinion, these controversies are a very healthy part of the growth of this profession, as they are providing the necessary catalyst for the needed research in this field. Dissent is the necessary ingredient to progress.

Some of these controversies have been self-inflicted by those who were ignorant that their actions would later become the major diet of those who were in opposition to their philosophies. That is, when "tongue thrust therapy" first made its debut, many orthodontists, dentists and speech therapists were left with the impression that all one had to do to correct such a problem was to teach the patient how to swallow, or in some instances, merely to tell the patient where the tip of the tongue should be during deglutition.

Most therapists at that time conducted therapy using the same premise. They became experts in teaching individuals how to swallow correctly. It was through ignorance, not intent, that most therapists were spending little of their time and effort in assisting the patient in the habituation of that newly learned pattern of deglutition. The author would be first to admit his mistakes in this regard.

Meanwhile, many orthodontists tried "tongue thrust therapy" and found it unsuccessful. Hence, one of the "growing pains" mentioned earlier had been inflicted. The controversy of the **value** of the therapy had been unintentionally launched by the active proponents of the concept.

The author feels that teaching a patient a good, conscious normal swallowing pattern is the easiest part of therapy (providing the patient has normal muscle control). However, habituating this newly learned pattern of deglutition is the most difficult and time-consuming task. As retention is the problem in orthodontics, habituation becomes the problem in myofunctional therapy.

The entire therapeutic process is enhanced if both the myofunctional therapist and the patient understand fully the objectives of therapy. The design of the lesson plans should clearly reflect those objectives. The broad objectives in therapy are: (1) to teach the

skill of normal deglutition, (2) to effectively establish a routine within the framework of the individual patient's life-style, (3) to develop an awareness within the patient of the musculature involved, (4) to tone the musculature so that it can more easily accept the new responsibilities imposed upon it, (5) to educate the patient as to the specific objectives of each assigned exercise and (6) to assist the patient in making the newly learned pattern of deglutition habitual.

A good analogy of the therapeutic process might be the ascent of a mountain. At the bottom of that therapeutic mountain is old habit. At the top or summit of the mountain is a very high awareness level. An attempt is made to maintain a certain level of awareness during the habituation stage in treatment. A concern of both the therapist and the patient is that once the ascent has begun, one has to be cautious not to "slide" back to his old ways. The therapist is aware of the paths to take on this mountain and is instrumental in guiding the patient to the summit and eventually to habituation. The therapist must recognize that each patient will experience individual "ups" and "downs," and must attempt to keep these "slides" at a minimum. This can be more easily accomplished if the reason(s) for the slides are identified early.

As it is important for both the therapist and the patient to understand the objectives of treatment, it is equally important that both also understand the "enemies" to the therapeutic process. These "enemies" if left unchecked can be responsible for the destruction of the habituation stage in myofunctional therapy.

The first such enemy needs no introduction as most therapists are fully aware of this culprit. It is lack of motivation. If this enemy is encouraged, the onus is on the therapist to try to motivate the patient. The therapist can accept part of the responsibility but certainly cannot accept all responsibility. How then do you motivate?? The author feels that one can assist in this endeavor by taking the time to educate the patient as to the concern about the problem. The patient should be informed that the problem could have a negative impact on his mental and dental health later in life.

A second "enemy" is discouragement. In a program as intensive as myofunctional therapy, discouragement will enter in from time to time. If the patient is made aware of this enemy, he can identify the problem in the early stages. Once identified, the therapist can take necessary steps to minimize its involvement.

A third "enemy" is frustration. A certain amount of frustration is necessary for any learning to take place. That is, the patient has been informed that he has a problem and having a problem in itself is frustrating. Of course, this kind of frustration is positive as it is part of the catalyst for motivation. The therapist must be cautious not to assign too much as this can lead to too much frustration. This excessive frustration can be damaging and can be responsible for the destruction of the therapeutic process.

A fourth "enemy" is forgetting. If a patient forgets to do that which has been assigned, it is obvious that this can hinder the therapeutic ascent mentioned earlier. The author's philosophy is not to look for what the patient has forgotten to do, but rather to notice what the patient has done. If what has been done is not enough, then the topic of forgetting should be discussed. If after the discussion the forgetting continues, the therapist should feel justified in questioning the patient's motivation level. Each patient is entitled to his forgets, however when forgetting becomes too frequent the problem must be rectified if possible.

A fifth "enemy" is boredom. The patient can become bored with the program and with the exercises. This occurs particularly if the program is not varied. If the same lesson plans

or exercises are assigned over and over again, the introduction of this enemy can be swift. To minimize boredom, a varied program is suggested.

The sixth "enemy" is over-confidence. This usually occurs in the latter stages of treatment. The patient feels that the newly learned swallowing pattern is habitual prior to its habituation. The patient's efforts reflect this overconfidence and regression ensues.

The last "enemy" is the most devastating. The author refers to it as the "killer" to the therapeutic process. This "killer" is dishonesty. If the patient is dishonest about the assignments the entire process has been undermined. At the beginning of treatment it must be pointed out that the entire program is based on trust and honesty. The therapist will be honest with the patient, and the patient must be honest with the therapist. This bond of mutual trust becomes the foundation on which the new habit is to be constructed.

If an individual patient is having difficulty in therapy, the first step in alleviating the enemy(ies) involved is to admit to their presence. Once identified, corrective measures can be undertaken to enhance the habituation stage in myofunctional therapy.

Zimmerman, Joseph B., "Current Concepts in myofunctional Therapy. **The Bulletin**. Pacific Coast Society of Orthodontics. vol. 50, no. 2, pp. 20-22, May, 1975.

Self-describing Questionnaire

You are invited to complete this questionnaire. Mark each question with a number from 0 to 10. The higher the number, the more accurately you feel describes the characteristics of your therapy "consciousness." (For example, if the characteristic therapy "consciousness" describes your ability to educate patients, you might write in a "10"; if the characteristic is your ability to motivate patients, you might write in a "4", etc.) Because each characteristic has multiple definitions, use the therapy "consciousness" example that is provided.

Do you consider yourself:

1. **An Expert?** (If you consider yourself an expert when answering to the controversies of myofunctional therapy, mark in a high number.)_____
2. **An Educator?** (If you educate your patients to the objectives of myofunctional therapy, mark in a high number.)_____
- If you design your therapy lesson plans to reflect the objectives of the therapeutic process, mark in a high number.)_____
3. **An Establisher?** (If you are an establisher of habituation, and awariness to the objectives of your myofunctional therapy program, mark in a high number.)_____
4. **A Motivator?** (If you are a patient motivator, mark in a high number.)_____
5. **A Mitigator of Discouragement?** (If you can minimize the discouragement your patients will encounter during myofunctional therapy, mark in a high number.)_____
6. **A Mitigator of Frustration?** (If you can minimize the frustration your patients will encounter during myofunctional therapy, mark in a high number)_____
7. **A Positive Reinforcer?** (If you can minimize your patients frustration and perhaps even boredom when striving for correction and habituation, mark in a high number.)_____
8. **A Builder of trust?** (If you establish a mutual trust with your patients, mark in a high number.)_____

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