Clinical Perspective

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Suggested Citation

Stewart-Seed, E. C. (1979). The Dynamic Approach. *International Journal of Oral Myology*, 5(2), 10-13.

DOI: <https://doi.org/10.52010/ijom.1979.5.2.2>

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The Dynamic Approach

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Per chance, I met an eighty-six year old woman who has worked as a social worker in legal aid for over sixty years. Our Friendship has been both rare and exciting, as she has graciously shared many of her experiences with me. Having spent the benefit of her lifetime effectively relating to people, this woman has taught me a great deal. When I was preparing a short program on myofunctional therapy for a radio station, she suggested that I say, "the sum is better than the total of the individual parts." At first I didn't understand how true this was in my therapy approach, but upon further examination, the meaning of the quote became clear.

You see, to take individual aspects of the therapy program such as motivational techniques, therapy exercises, etc., separately, is not as informative as the sum of the entire process. For this reason, I want to share audio-visual tapes that were filmed last year of my practice. Perhaps by seeing the therapy in action, even though it is not the sum but rather a very small part, you can get a feel for my therapy process.

My exercise program is based on differential diagnosis and treatment planning as taught by Dr. Hanson, Richard Barrett, and Dan Garliner. I really feel that the actual exercises are not drastically different from other comprehensive programs in the United States. I have expanded somewhat to include sub-cortical techniques based on the Rood technique of physical therapy and a few innovations of my own, but the grass roots of my therapy regimen still remain with Dan Garliner, Dr.

Hanson, Richard Barrett, and William Zickafoose. I feel fortunate to have studied under these fine people. I also am deeply grateful to numerous myofunctional therapists in many different states who have shared their therapy techniques with me. Last, but not least, much of my growth as a clinician has been enhanced through immense support, ideas, and encouragement from two very special friends, Bette and Justin McCarthy.

Perhaps it is good that Ulla Albridge persuaded me to share my concepts at this conference. Through analyzing my day to day routine, I have learned a great deal. I have never applied a consciously learned motivational technique or a specific program of behavior modification in my practice. My technique is a function of "doing what comes naturally." I react to the patient's needs as they are presented, but then I have been relating to people in general on this level all of my adult life. Ulla, the coordinator of this conference, observed my therapy in Chicago and labeled the technique "skilled interaction." She thought that I had effectively employed the Thomas Gordon approach. I would have liked to accept credit for being such an assiduous student, but the truth is that I had not even heard of Thomas Gordon.

Because I operate more or less on a subconscious level in my motivational approach, I had to carefully analyze my behavior in order to present it to you today. Do not be mislead. I have read widely on positive mental attitude,

psycho-cybernetics, and numerous psychological approaches designed to understand and/or modify human behavior. In high school, I became fascinated with all types of "self-help" books as I termed them. Human behavior and the understanding of it was to me as three jiggers of bourbon are to an alcoholic. This insatiable quest for more knowledge resulted in visual consumption of hundreds of books and articles on everything from baracuada conditioning to psycho-chemical disorders. So when I say that my motivational approach is based on subconscious or automatic responses, I really should also note that volumes of material have been learned on the conscious level and have been given a great deal of thought over the years in order for my subconscious mind to operate the way it does in therapy.

The following is an attempt to give you my interpretation of the motivational techniques used and the overall philosophy of my approach in myofunctional therapy. Let's call it the "Common Sense" approach and credit Ma and Pa Stewart for its conception. I am sure that not long after I was born, my parents looked at me and said, "You will be very intelligent and of course, you will go to college." They expected me to do well in all endeavors. They believed in me, listened to me at a young age, and most important of all, they trusted me. The whole process of raising me was based on building my self esteem. The attitude at home was that I could accomplish anything I

wanted to accomplish. My parents treated me as though I was their best friend.

Because of this attitude, I wanted to do well. Through my parents thinking so much of me, I developed a great deal of confidence and wanted to succeed to prove them right.

This, as I see it, is my basic approach to each and every patient I treat in my practice. I elevate the patient in my eyes and let him know that I know he or she will succeed in therapy. All the patient has to do is to sincerely want to correct the oral-myofunctional problems. This desire to correct doesn't always come naturally. It is the therapist's responsibility to educate the patient on the importance of correction. Generally, I feel that there is no such thing as an unmotivated patient; there is only the unmotivated therapist. Of course, there are exceptions, but when a patient appears unmotivated to my practice, I simply feel that I have not given that patient enough information.

This concept of elevating the patient in the therapist's eyes, usually results in the patient wanting to fulfill that image. I try very hard to give one positive comment along with every problem that I mention. To me, building the patient's self-esteem is essential in any program of habit correction. Patients must feel important in their own right and trustworthy to carry out the demands of myofunctional therapy.

In some cases, it is difficult to find a patient trustworthy through observation of his past history in carrying out commitments. In these cases, I tell the patient that he is what I want him to become. In other words, I tell him that he is

conscientious, even if I know that he isn't. Through telling him that I see him that way, he often succeeds in elevating his behavior to fit that image.

I am sure that my parents used this motivational trick on me. But it worked! And I am happy to report that it works in myofunctional therapy.

The following are some examples of areas in which this technique is employed in my practice:

1. Patient is just seated for a diagnostic examination. I ask him to tell me his address, telephone number, birthdate, etc. After his response, I find something honest and positive to say to him. This warms up the therapy room, as parents like nothing more than to hear positive comments about their child. After all, right or wrong, many parents view their children as extensions of themselves. So through complimenting the child, you have just succeeded in complimenting mom and dad at the same time. This is important, as for the next hour I am going to be identifying problems that need to be corrected in therapy. Nobody likes to hear all negative points without positive comments right along with them. It is like the "cat is on the roof" communications story I told in my keynote address yesterday. We, as therapists, have a responsibility to honestly communicate our findings in the diagnostic, which are usually multiple problems. But we can also use our heads when explaining the problems and "cushion the blow."
2. "I just can't find time to practice three times a day" is a common statement from a patient. My

answer would be, "I know that you think you can't find time to practice three times a day, but I am going to work right along with you and show you how you can. When you find out all of the good things that this therapy will do for you, you will find eight times a day to practice. You are very bright and understand that in order to become a baseball player, you have to swing the bat more than once a day. Right? The only way that you can become really good is to practice all the time. Well, myofunctional therapy is like everything else that is worthwhile . . . it takes hard work. Instead of your baseball coach, consider me to be your tongue coach. And the winning hit of the season will be by you when you get your braces off and your teeth do not move out again. That's winning big.

3. Patient is asked to sit down for a diagnostic examination and refuses to obey: Instead of getting stern with the patient, doing a "time out", looking uncomfortable, or expecting the mother to exert some authority, I would say, "Johnny is a very independent young man. That independence can be channeled to make Johnny a super patient in myofunctional therapy. Mrs. Jones (as Johnny is looking around the room), let's get started on background information." After that response, Johnny realizes that he didn't get a rise out of the therapist. So refusal to cooperate is not working. Plus, nobody is paying any attention to him. I would then start explaining the "Super Stars" board and how one works to get on it. "I bet you have been on a lot of "Super Stars" boards,

haven't you Johnny? Johnny might reply, "No, I never even saw one before." The therapist: "That is exciting, Johnny. I am going to work very hard with you to give you a chance to be on this one." I have now given the child something to look forward to in the therapy program. He wanted attention, and now he can get it. Therapist: "Save a school picture and it won't be long before we can put it up. I just know that you will be a super swallower!" I like to use humor in my therapy approach. I describe orthodontics as a way of making sure that your teeth do not protect your shoes from getting wet in the rain.

I describe myofunctional therapy by dumping pens, paper clips, and anything else in sight in one pile on the floor. This is garbage. That represents your bad swallow and resting posture of your muscles. Right now their brain is automatically throwing them garbage or bad swallows because that has been their pattern of swallowing all of their life. Then I explain as I slowly cover up the garbage with white kleenex, that the kleenex represents millions of good swallows which are needed to cover up all of the garbage. The good swallows are called dirt, as layers and layers of dirt are needed to cover up the garbage. After all of the garbage is covered, then their brain will be trained to throw down all good swallows. After covering up all of the garbage (bad swallows) with dirt (good swallows), we see a big beautiful building on top of the dirt. This building is their teeth in good occlusion which is only as strong as the foundation underneath.

I explain that many beautiful buildings have garbage at the base.

What happens is that the buildings cannot take all of the garbage away and do not need to, as they can put layers of dirt on top of the garbage to cover it up. (BUT IT TAKES LOTS OF DIRT!) Then when all of the garbage is covered, the builders can safely build a beautiful building. When people see the building, it is beautiful. Nobody knows that it's foundation is garbage. That is exactly what you are going to do in myofunctional therapy. You are going to cover up all of the garbage with tons of dirt so that you and your orthodontist can build a beautiful building. But you are really lucky. Your building can eat hostess twinkies!

I got the point across and we had fun at the same time. Word gets around fast. New patients often mention these stories when they come for a diagnostic appointment. That makes therapy fun.

I enjoy using humor in my therapy approach to make a point. Patients are collecting cartoons regarding oral-myofunctional problems. The most recent cartoon read: "I finally got my husband to stop biting his nails." A friend said, "How? He bit for years." The woman replied, "I hid his teeth."

Patients know that nail biting causes a fronting of the tongue against the teeth, thus putting pressure on the teeth that could cause damage. So the fact that the husband had false teeth drove home the point.

Patients are taught to value good occlusion. I rent office space from a group of periodontists and endodontists. My patients have access to educational films on prevention, perio, endo, and myofunctional therapy. I am constantly amazed by what they absorb while waiting for their

therapy. I take time to answer their questions regarding periodontal problems because I feel that "knowledge is power" is true in most areas of life, but has really paid off in myofunctional therapy.

I try to give accurate appraisals of where my patients are at in therapy and where they have to go to be corrected. Children, as well as adults, need structure to stock with the demands of therapy. I expect a great deal from my patients, but I feel that I give a great deal back in return. Mutual respect is the common denominator in my therapy program.

I could speak indefinitely on the value of the aforementioned approach in dealing with patients. The positive interaction patterns established in myofunctional therapy carry over in all areas of the patient's life. So many really positive changes have been observed in patients as therapy progresses. Often grades in school reflect this teaching of a positive self-concept. As I was writing this speech, a junior high school patient called me at ten o'clock at night hoping that I would still be working. She called to tell me that she won first place in a state contest science project. Guess what her science project was on? Myo, of course. She did a study at school on fifty boys and fifty girls to see if tongue thrust was related to malocclusion. She took lip pressure, broke the lip seal while feeling the hyoid bone move for the swallow, and recorded her findings. By the way, her research findings showed a positive correlation between tongue thrust and malocclusion. New year, she will probably solve the function vs form dichotomy! To me, that is motivation.

I would like to use the remaining

time to answer some commonly asked questions, some of which are:

1. What is the best way to refer patients to a myofunctional therapist?

Key Word: Positively!

2. What is the best way to set up and conduct a diagnostic appointment?

Key ideas:

- A. informative and pleasant on telephone
- B. be firm about time slot reserved—establish respect for your time
- C. make each patient feel special
- D. assess much more than muscle function
- E. let patient talk—he will tell you what is wrong
- F. compliment referring practitioner
- G. build self-esteem as soon as possible
- H. assess parents relationship to each other and to child
- I. learn ways to predict failure
- J. be selective
- K. don't miss any related oral habits
- L. one good comment about child for every problem mentioned
- M. be thorough in differential diagnosis to avoid unnecessary exercises
- N. be professional in dress, speech, and attitudes

3. What are some habituation techniques?

- A. hold seminars for parents monthly
- B. habituation at home
 - 1. 26 card game
 - 2. 3 goofs and you are taped for 15 minutes alias: "You snooze . . . You lose!"
 - 3. Nickel game
 - 4. 100 point bonanza free ticket to bowl, skate, etc.
 - 5. stickers (reminders) family members wear
- C. Habituation at school
 - 1. call teacher and enlist support
 - 2. x on finger
 - 3. push up 1 elastic all day long
 - 4. time charts and reminders (time charts that are not mutilated are not acceptable)
- D. Motivation in the office to habituate
 - 1. piggy back ride
 - 2. Super Stars Board
 - 3. tongue olympics
 - 4. for little boys in the hate girl stage: A kiss if they don't practice
 - 5. Building motivation through stories:
 - a. Spanish mackerel and baracuada
 - b. Glen Cunningham
 - c. quitters never win and winners never quit
 - 6. ultimate reward: swallowing dinner with therapist

4. What do you do when a patient does not practice as you recommend?

- A. give more information
- B. parent conference
- C. What is patient-therapist rapport?
- D. Any big problems at school or home?
- E. If no recourse . . . give a child a vacation no anger . . . door is always open when you are ready to come back
- F. Let patient know there is something to lose

5. When do you decide that you are finished?

- A. I don't. Still seeing patients two times a year from seven years ago.
- B. When occlusion is stable and has been without retention for one year
- C. When patient moves out of United States
- D. When growth and development is finished
- E. When patient feels he is and has proven to me skill in muscle awareness

6. In which cases do you recommend appliances (functional) with myo?

- A. Molar to molar openbite in ortho and myo oral screen to inhibit or intercept tongue thrust; vestibular screen to reinforce nasal breathing and lip closed posture