Clinical Perspective

The "difficult" patient and tongue thrust

Laurence S. Pitcher

Follow this and additional works at: https://ijom.iaom.com/journal

The journal in which this article appears is hosted on Digital Commons, an Elsevier platform.

Suggested Citation

This work is licensed under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License.

The views expressed in this article are those of the authors and do not necessarily reflect the policies or positions of the International Association of Orofacial Myology (IAOM). Identification of specific products, programs, or equipment does not constitute or imply endorsement by the authors or the IAOM.
The "Difficult" Patient and Tongue Thrust

Laurence S. Pitcher, D.D.S.
Colorado Springs, Colorado

Day in and day out we dentists attempt to provide service that is many-faceted. One of the most basic and difficult tasks is working with our hands in the patient's mouth, trying to do the best technical work possible. Often, even with careful diagnosis, considered with knowledge, expertise and ability, the execution of our plan falls short of our goal because of the simple fact that we are physically unable to do a good job in that patient's mouth. "A problem patient!" "Apprehensive!" "Nervous!" "Scared to death!" "An odd ball!" "Drives me crazy!" All of these terms and more, at times, describe the patient we would rather hide from than work on. Even though the meaning of the term "tongue thrust" seems to be somewhat in question, I shall use it to describe in general terms a condition which causes one of the primary problems with which we have to deal in our profession.

Over the past years I have been piecing together bits of information and have come up with what is to me a revelation in dealing with difficult patients. I have found why a great many patients react the way they do and I now have the understanding needed to modify the behavior of both the patient and myself. This article is based entirely on personal experience and observation.

In reviewing the literature on tongue thrust, all that I have read has pertained to malocclusion, tooth position or malposition, speech difficulties and in general the cause and effect relationship of the individual to tongue thrust. I firmly believe another equally important problem of the tongue thruster relates to a patient management problem which is of concern to treatment-oriented dentists.

This concept first came to my attention a few years ago when a 35-year-old man sought emergency treatment. An abscessed lower left second molar needed immediate attention. I elected to open the tooth for drainage initially, with root canal therapy to follow later. The patient agreed to this and I prepared to give a mandibular block injection.

At this time beads of sweat broke out on the patient's forehead and upper lip and he became quite agitated. He raised both hands and said, "Now wait a minute! I am not afraid of shots but I don't react well to anesthetic in the mouth." I asked the usual questions about anesthetic allergy and he replied, "No, that is not what I mean. I get choked and have even on occasion thrown up when work was being done!" When I suggested proceeding without anesthesia he said "No, I can't tolerate pain either. I guess I am just a big problem."

After this initial appointment I readily agreed. We got the tooth opened, but with much difficulty for both of us.

This patient had an extensive history of dental treatment, including a crown and many multiple surface fillings. After some discussion, he admitted that he considered himself a terrible patient and was genuinely ashamed and embarrassed by his inability to cooperate. In all other regards he was an intelligent, interesting person, held a good job, had a wife and several children and lived in a happy home.

After some months of dental treatment, it became apparent his evaluation of himself as a bad patient was quite accurate. He was extremely nervous when work was being done, a gagger, had excessive saliva, his tongue was all over the place, and he constantly interrupted my work with the complaint he needed to spit, rinse, swallow, or some other excuse. The root canal therapy was done by a colleague who tried nitrous oxide to help sedate the patient. The patient threw up, blew the rubber dam off, made quite a mess, and felt terrible about it.

What was his problem? I didn't know then, but after carrying out a number of procedures on him, things began to fall into place. A common denominator appeared.

Certain patients have unique problems that are directly related to the tongue-thrust swallowing pattern, I believe. As a direct, though subconscious, reaction to these problems the patient is forced to be a difficult patient, unconsciously and virtually uncontrollably! This varies in degree from patient to patient depending on the severity of tongue thrust, personality, previous dental history, etc., but there is to some degree a common denominator of apprehension. Conversely, in many apprehensive patients, the common denominator is tongue thrust.

My intention is not to discuss the causes of tongue thrust but only how it manifests itself in the difficult patient in the dental office, and what we can do to alleviate the problem to better allow us to do our job with the least amount of discomfort to the patient and trauma to ourselves.

To swallow, most patients with a tongue-thrust type of swallow pattern must, or perhaps subconsciously feel they must, extend the tongue forward into actual contact with the anterior teeth (upper primarily, but often both upper and lower), and close their mouth, or at least purse their lips together before they can initiate their sucking type of swallow. Most tongue thrusters I have seen can swallow in a reasonably normal manner but it is usually uncomfortable for them to do so and often takes extra effort.

The conflict with operative dentistry is obvious. With fingers, drills, matrix bands, cotton rolls, etc., how can the mouth be closed and the swallow be effected in these people? This can also be complicated by the recumbent position used in sit-down and four-handed dentistry. Also, with water-cooled drills spraying water as work proceeds, even with modern evacuating equipment the swallow...
reflex is repeatedly triggered. Saliva flow and the swallow reflex is much more active in tongue thrust patients than in "normal" patients and this compounds the problem. A subconscious, uncontrollable, or only partially controllable reflex or series of reactions enters the picture as work is being done on the tongue-thrust patient. The subconscious says to the patient: "Look, with this guy's hands and all that gear in your mouth, along with all the water, cotton, etc., there is no way you are going to be able to swallow. It follows, buddy, that if you can't swallow you are going to choke to death or drown in your own saliva and that, my friend, is fatal! Since you don't want to die here, you had better hit the panic button, gag, start pulling things out of your mouth, or do something!"

Clearly, when this subconscious information filters through to the conscious, it is greatly attenuated, but the sweat on the forehead and upper lip and the apprehension, fear and nervousness are very real and visible manifestations of a very deep problem. It is an uncontrollable fear of death, just as inexplicable to them as acrophobia or claustrophobia might be. For this reason these people, if not in evident panic, are at least apprehensive during dental procedures and must have a look in their eyes the dentist has seen all too often before.

One course the prudent dentist who has not recognized the basic problem might use would be to apply a rubber dam for operative procedures. This would control the usually hyperactive tongue, the copious salivation, and the water spray from the dental handpiece. At least this controls things for the dentist.

How about the patient? Swallowing with the mouth closed and the lips together is impossible with a rubber dam and clamp in place. Though the water spray is controlled there is still saliva to swallow. This means the patient must struggle to control his swallow pattern and attempt to swallow with the mouth open. Some can do it, some cannot. Few can do it with comfort, especially if they do not know why they are in distress in the first place.

Again, the inability to swallow comfortably, combined with the subconscious necrophobia, sets in motion the sweat, apprehension, fear and uncontrollable symptoms that we frequently encounter in tongue-thrust patients. This deep-rooted dread of the possibility of choking to death creates difficulty for the patient and for us. Unless the cause of this problem is brought into the open, both dentist and patient may be fighting to continue stalemated in the struggle to accomplish dental treatment.

The dentist who has been in practice for a period of time can almost recognize these patients in the reception room and might say to himself, "Oh boy, here comes a bad one." or "I'll bet she would be bad news to have to work on." He may not know why he senses this but if my theory is correct there are visual clues that are tipping him off. Tongue thrusters usually have a characteristic appearance. They often have spaced anterior teeth, usually upper but sometimes lower. They frequently have prominent premolar areas and a full-appearing mouth with the face often rounded, especially in the middle third. I have found some tongue-thrust patients who do not fit this visual pattern, but if there is doubt, they can easily be identified in the chair.

If it appears that a patient may be a problem and tongue thrust might be at the root of it, I simply have them swallow for me and observe them performing this simple act. Struggling to swallow, the tongue pressing forward against the teeth, forced closure of the mouth and/or pursing of the lips tell me what I need to know. If there is still any doubt, I have them attempt to swallow with the mouth open. Most can, but it is usually a struggle. Also, I often simply ask the patient if he has difficulties during dental procedures and if he considers himself a problem patient. Patients usually have a very accurate estimation of themselves and their ability to tolerate dental treatment.

Now, assuming that we have identified the problem patient and suspect tongue thrust, what do we do about it? I have adopted the policy of telling these people the situation as I see it. Here, I might note, not all tongue thrusters are bad or troublesome patients. Discussion is necessary only with those who are, have been or perhaps will be, problem patients. I explain to them about tongue thrust and have them swallow once or twice. Usually, without much prompting, they see that they do indeed have this swallowing pattern. Then I go into some detail about patients I have had in the past and describe their behavior, including breaking into the uncontrollable sweat, fear of choking, reluctance to have dental treatment, putting off needed dentistry, gagging and discomfort during treatment, unexplainable apprehension before and during treatment, and finally, knowing they are a problem for all concerned but not knowing why. They usually agree that some or all of these symptoms apply to them.

I do not try to tell these patients why they have the tongue-thrust pattern, nor try to cure them of the habit. I explain simply that I will try to make them aware of why their fear may relate to the tongue thrust and then attempt to demonstrate how we both can better work with the difficulty. I explain that I believe it is actually a subconscious fear of choking or suffocating, triggered by a difficulty or inability to swallow that causes the outward symptoms. I then see if they can swallow with their mouth open. Again, most can.

Putting all of this together I say that since they now know what their problem is, and that they know that I also understand it, it can be a great help in future treatment. I mention that they may signal me by raising their hand and I will stop what I am doing at any time and let them clear and swallow. I also suggest that they try to swallow with their mouth open to help keep their own saliva under control and tell them that I will watch closely for signs of distress and fluid build-up in the mouth and will let them clear and swallow as needed. In actual fact, I let them swallow and clear much more often than a "normal" patient.

So far, none of my 50 problem patients were aware that they had a tongue thrust or even knew what a tongue thrust was. They all knew that they were problem patients and were apprehensive to a greater or lesser degree, but none had any idea why. After an explanation, most have felt
that this began to clarify the picture of themselves as dental patients for the first time. One patient had even thought she might be deranged because of the problems she created in every dental office she had been to and I am sure some of her dentists were ready to agree with her.

Without exception, the patient who has listened to my story and has fit the pattern has been a better patient to deal with. The most important factor in the change in attitude of the patient, I am firmly convinced, is that for the first time the patient knows what is causing the problem and, armed with that knowledge, can begin to cope with the fear, apprehension, and often misery he has had to live with. It also has been a great help to me because I have been able to understand why some patients act the way they do and with this understanding I am able to work with them and their problem rather than fight against it.

Even tongue thrust patients who have not experienced operative dentistry can be a problem. Trying to do a prophylaxis on patients whose lips are tight, especially with the lower lip pushing the fingers away, is difficult. Taking bitewing radiographs on a patient who is trying to push the film packet out of the mouth with the tongue is a frustration to us all. Gagging, of course, during any procedure makes it difficult if not impossible.

Since my “discovery” I have found much more often than I ever would have expected that the thrust pattern is the significant factor in a problem situation. In the past I had associated tongue thrust only with the malocclusion-speech aspect of patient behavior but now tongue thrust is of equal concern in patient management problems. Because of this approach my ability to manage these patients and my attitude towards them and to some degree my attitude towards dentistry in general has improved immensely.

Not all “bad” patients have tongue thrust as the root of their difficulty and not all tongue thrusters are problem patients. However, if one analyzes difficult patients for the tongue thrust swallowing pattern, many will be found. It will help in dealing with these patients when both the dentist and the patient discover the root of the problem.

By knowing why certain patients react the way they do, the dentist can modify his technic. Otherwise difficult-to-impossible procedures can be accomplished, perhaps not with ease, but certainly without many of the previous difficulties.

I suggest making a mental note of difficult patients and, the next time they come in for treatment, checking them out as outlined. It is surprising what may be discovered. Take the time to explain why they may have these fears. Outline to them the swallowing difficulty they may have. Explain to them that since you both now may know what the real problem is perhaps you both can work to overcome it. Be compassionate with them and let them swallow, rinse, and spit more often than you would a “normal” patient. The dividend of this small investment in understanding and time will be most rewarding. As a fringe benefit, your attitude toward these otherwise difficult or impossible people will become one of compassion rather than animosity and you will find that you too will feel better and are better able to cope with them.