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Tutorial

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# Issues of Habituation in Oral Myofunctional Therapy

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A "most helpful list" for habituation, in the author's experience, includes a thorough study of *Fundamentals of Orofacial Myology* by Hanson and Barrett, especially Chapter 11 beginning at Phase II, page 287; a video camera; Bill Zickefoose's introduction tape and his swallow charts; dental models; Plak light; Zickefoose and Zimmerman booklets for clients; handouts of therapy procedures for parents; xeroxes from journals as handouts; contracts; charts; lip pressure gauge (as motivation); night posture tape; frequent small quizzes; and lists of reasons for therapy and therapy goals composed by the client.

Key concepts for success in habituation are 1) "early," 2) "self-monitoring," "self-motivation," "choosing," 3) details/data keeping, 4) flexibility, 5) variety, 6) the client as his/her own therapist, and 7) ongoing education for the orofacial myologist.

Set the groundwork for therapy early and carefully, for without this foundation, therapy cannot be successful. Make sure the client and entire family know exactly what to expect. Provide copious information along with the complete picture. Lead the client/family to an awareness of the problem using video tapes, charts and direct observation. Tell the client cheerfully that he/she can easily change with some effort and persistence and time. Be positive but frank about your time frame and do not shorten your program to the detriment of habituation. (Adults finish quickly.) Tell fully what you have to offer. Listen carefully to clients/family. Learn what the client expects from therapy and help modify these expectations, if necessary, to fit reality. Tell what therapy does and does not do. It does not straighten teeth. Know which cases you cannot treat successfully. Help the client formulate realistic long range and short range goals and refer to these frequently during therapy. Clients/families need to choose the therapy actively.

Motivate the client consistently by charting the details of tasks accomplished. Make the work fun; use humor. Utilize peer help. Pace therapy energetically, per session and long-term. Provide structure. Discover effective reward systems suited to the individual. Utilize effective techniques including analogies and demonstrations with a variety of visual, kinesthetic, and auditory approaches. Teach the client very early to self-monitor. Invest extra time in teaching this skill, if necessary. Self-monitoring is critical to success. Move quickly to functional practice.

Determine when the job is done by percentages achieved, charts completed, comparisons of initial video tapes to recent ones, patient and family observations, "squirts while counting backward from 100," "forced tongue thrust" and "sidelong glance" (Hanson and Barrett, page 298), parent "sleep talk," videos made during the therapist's absence from the room, Plak light, etc. According to Winitz, a minimum of 3,000 correct productions are needed in speech correction. This may have implications for OMT. The goal is permanent change.

Debrief at the end of therapy. The client can keep a symbolic cup at bedside, be given list of permanent instructions, be seen at increasingly spaced intervals, and self-monitor. Ask the orthodontic assistant to alert you if tongue thrusting is observed. Keep your door always open.

Let go of your client—not too early, not too late. Clients are responsible for their own therapy. Get feedback for the future. Appreciate your own efforts. Keep yourself motivated. Know your own strengths and weaknesses. Do your best. Call it good.

# Introducing Food Practice

Sylvia Zante, MA

As the therapy for orofacial myofunctional disorders has evolved, increased focus and attention have been given to correct resting postures for the tongue and lips. Current rationale is that long acting resting postures have more influence on tooth position than brief functional activities such as talking or swallowing. Why, then, do we continue to incorporate functional aspects such as swallowing and eating into our programs? These functional activities may possibly work in conjunction with long acting resting postures of the lip and tongue to assist in the creation or maintenance of a malocclusion. They may also be contributing factors in the maintenance of a more forward resting tongue posture.

The interplay of these functional activities justifies their inclusion in the therapy process. Food practice is generally introduced in the second phase of therapy well after the individual has established the new muscle patterns necessary for this task. This second phase is generally easy for most individuals if they have practiced properly in the first phase of therapy. Soft foods such as pudding, yogurt, ice cream, or apple sauce may be introduced initially. Their soft consistency allows for the food to be eaten without chewing. The individual can be focusing total attention on gathering the bolus of food correctly and proper tongue and lip placement. Use of a