Clinical Perspective

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MOTIVATING THE DIFFICULT OR HANDICAPPED PATIENT

Marjorie Snow, M.A.

We all appreciate the patient whose parents have no problem making or keeping appointments; monitor their child's practice sessions, or actually become involved in each practice session; faithfully deliver this perfect child on time and fully prepared to go on to the next assignment; and at the end of the therapy give you the credit for performing a miracle. Unfortunately, this does not always happen. Given the current priorities of extracurricular activities (dance, gymnastics, scouting, the sport of the season), the working parent with several children and a hectic schedule, frequently finds that, in this juggling act, it is the orofacial myology ball that gets dropped.

Another motivational problem occurs when the patient has physical, mental, or emotional problems which interfere with therapy. When the anticipated progress does not occur, the motivation of the clinician and patient quickly deteriorates unless creative problem solving methods are initiated. It will be the premise of this paper that the orofacial myologist does not sit back on his/her laurels and lament that "there wasn't anything I could do; the patient wasn't motivated!" The most important part of the orofacial myologist's role is to provide the motivation for successful therapy. At the same time, it is essential that we realize that there may be some failures, particularly with patients with significant developmental handicaps. In this situation a realistic therapy goal is more important than a ideal solution.

Motivation may be defined as the reasons or forces that produce given behavior. There are many motivational models but the one that fits health care behaviors well is the Hochbaum, Rosenstock, et al. model (in Taylor, 1986) which states:

1. The individual must believe that they are susceptible to the disease (problem).
2. They must believe that if the disease occurs it could be serious.
3. They must believe that there are actions which can prevent or intercept these conditions.

Once each of these statements has been fully addressed and understood, a sound priority base has been established. At this point it is made clear that "you really oughta wanta" (Mager and Pipe, 1970). If the parent or patient agrees, then the next step is an explanation of the "Triadic Model" (Tharp and Wetzel, 1969), as compared to the traditional psychiatric diadic model. In the triadic model, the patient is identified as the target (person with behaviors to change), the parent or "significant other" is the person responsible for delivering the rein-

forcers, and the orofacial myologist is the consultant. In the diadic model, the patient and clinician interact without including someone in the environment to monitor or reinforce behavior. A working model (Sulzer and Mager, 1972) of the triadic form of behavior change modified for orofacial myology (Snow, 1976) is included in this paper (Figure 1).

FIGURE 1

Breakdown in motivation during therapy is usually the result of boredom, sporadic attendance, or inability to produce the desired behaviors. Today's highly stimulated youth (watch MTV or similar television shows, for example) are unlikely to actively participate in a dry, mechanical, talk marathon where the clinician does all the talking. They need variety, surprises, humor and active participation. Even competition with other patients can be highly motivational if everybody wins. Some examples of motivational techniques will be described for the reader's consideration.

Practice activities can have fun or tasty accompaniments such as squirt guns for squirt swallows; "gum ball squash" uses sugarless gum balls for tongue rest posture reinforcement; board games are used at practice time; place mats with reminder collages can be used at mealtimes; colorful stickers decorate charting forms which are then tacked on a bulletin board with a patient's name prominently displayed; life-saver suckers or pop-sicles brighten tongue tip exercises.

The patient can be encouraged to invent a therapy activity, which is then named after him/her. It is then assigned to other patients so that a healthy competition is set up. A list of tongue twisters can be started and its author identified. If stored on computer disc, it can be added to indefinitely. It gives the patient recognition with others

in therapy. A "hall of fame" poster prominently displayed with full-face pictures of "graduates" of the therapy program gives patients an incentive to be part of the display.

Display pictures of people, cartoon characters, or animals with tongue and lip posture problems. Odie, Reuthford the III, and Funny Freddy (who has the worst malocclusion and tongue thrust any dog ever had) and bears who suck their thumbs or fingers are examples of stuffed animals that can make decorative additions to the pediatric therapy setting. Many 8-10 year olds love those grotesque models of tongues with warts, thumb "suckers" which look like thumbs and are actually suckers, and wax lips to wear while watching TV. Getting down to the level of the patient and laughing with them, but not at them, can be motivational.

Video taping during therapy and then playing the tape back as part of the session is not only motivational, but diagnostic. Behaviors not observed during the session become apparent in the playback. Patients are also more likely to notice non-productive behaviors when they see them on tape. It is also motivating to show progress from the first session to the present. Most children love to see themselves on the TV monitor.

If the patient is enjoying therapy and making progress, appointment attendance problems are minimized, unless the reason for non-compliance is beyond the patient's control. In these cases, it is necessary to take a look at the Triadic Model and consider reinforcement for the mediator who is usually the parent responsible for making and keeping appointments. Some kind of individualized reward may need to be established with the parent, contingent upon desired behavior. An example would be a book of coupons, made up by the orofacial myologist, which could be cashed in by the mediator for such rewards as a night out with friends, dinner out with their spouse, help around the house from the patient, and other ideas generated by the three of you.

Motivation of handicapped patients is based primarily on facilitating some small approximation of success and then immediately reinforcing the behavior. The behavioral techniques most effective are shaping, breaking a behavior into small approximations, and modeling, demonstrating the desired behavior in a way that the patient can imitate (Rimm and Masters, 1974). One of the motivational techniques that can be used is the token economy. See Figure II. The behaviors, and the point value attached to those behaviors, can be adjusted to fit the individual situation. The reinforcement menu (rewards assigned to the points) can also change on a daily or weekly basis. This system is most effective when visible tokens such as poker chips, dry beans, buttons, etc. are given on a daily basis, and put in a glass receptacle where the patient can watch them accumulate. The most common reason for breakdown in a token economy system is failure on the part of the mediator to deliver the rewards. If this cannot be managed, then the orofacial myologist should work directly with the patient to ensure that desirable behavior receives reinforcement.

In addition to the behavioral techniques detailed above, one may consider paradoxical therapy which is sometimes called negative practice. This method is

FIGURE II
OROFACIAL MYOLOGY CLINIC
TOKEN ECONOMY FORMS

FOR:

TOTAL POINTS = 70 per week (10 per day)

FIRST PRIZE = 65 - 70 points

SECOND PRIZE = 60-64 points

NO PRIZE BELOW 60 POINTS

ADDED DUTIES FOR BELOW 55 POINTS

BEHAVIORS WITH POINT VALUE:

1. Practice twice a day = 2 points.
2. Brushing teeth twice a day = 2 points.
3. Flossing teeth once a day = 1 point.
4. Doing assignments other than practice (i.e., charting, wearing oral shield, etc.) = 2 points.
5. Lip closure all day = 2 points (minus ½ point for each time apart).
6. No nail biting all day = 1 point (minus ½ point for each time seen doing it).

*THESE BEHAVIORS WILL BE REFERRED TO BY NUMBER ON THE CHART BELOW.

BEHAVIOR NUMBER	WEEK ONE POINTS FOR						
	1	2	3	4	5	6	
MONDAY							=
TUESDAY							=
WEDNESDAY							=
THURSDAY							=
FRIDAY							=
SATURDAY							=
SUNDAY							=
WEEKLY TOTAL							=

based on the behavioral principle of extinction where the patient is isolated from any feedback. In negative practice, the patient is asked to perform the undesired behavior continuously in an environment of isolation. An example would be asking a child with a thumb sucking habit to sit on one special chair in an out-of-the-way place. Only in this setting would he/she be allowed to suck the thumb, which must be done continuously for a predetermined period of time. It is essential that there be no reinforcers in the area if this is to be effective.

The successful orofacial myologist is creative and able to problem-solve on an individual basis as the situation arises. For some people this seems to be a natural talent, but anyone can improve these skills with practice. Two books which can assist in developing these skills are *A Whack on the Side of the Head* (van Oech, 1981) and *A Kick in the Seat of the Pants* (van Oech, 1986). The challenge of motivating a highly intelligent patient with a combination of creativity, innovative problem solving, and humor, makes therapy enjoyable for the patient and the clinician. The patient with physical, cognitive or emo-

tional handicaps often presents a greater challenge, but worthwhile change in behaviors can often be achieved with a team effort.

Motivating the patient is the task of the orofacial myologist. There are many behavioral techniques available which aid motivation. The suggested model is triadic, in which the three most important components are the target (patient), mediator (parent or "significant other") and the orofacial myologist. Breakdown in

motivation is usually the result of the mediator's failure to deliver the contingency management of the target behaviors. This implies reinforcement of desired behaviors and the elimination of reinforcement for undesired behaviors. The orofacial myologist skilled in the triadic model can use creative problem-solving methods to increase patient motivation and cooperation thus increasing the chance of a successful therapy outcome.

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