Clinical Perspective

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Galen Peachey (*Boise Speech & Hearing Clinic*)

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HABITUATION IN OROFACIAL MYOFUNCTIONAL THERAPY

Galen Peachey, M.Ed.

*Private Practice in Speech/Language Pathology
with Specialty in Orofacial Myology
Boise Speech & Hearing Clinic, Boise, Idaho*

For the past twenty years I have been working professionally as an independent practitioner in the fields of speech pathology and orofacial myology. During those years over 70% of my caseload has comprised individuals with orofacial myofunctional disorders. Early in my career as an orofacial myologist, I often wondered whether my therapy was truly effective, especially on a long term basis. Perhaps the doubters were right. Maybe we could not alter a subconscious function. Initially, I was apprehensive and had some feelings of guilt about "tongue thrust therapy." It was easy to teach patients to "swallow normally" on a conscious level, but I continually asked myself, "How does the patient swallow when not thinking about it?" "What about long term habituation?" In my search to find answers to these questions, my studies have included behavior modification, autosuggestion, visualization and hypnosis. These studies have led me to create a habituation program utilizing an eclectic approach with techniques from all of the above disciplines. This article will provide the reader with information about this habituation program and hopefully stimulate discussion and research.

The goal of most therapy programs is to establish and habituate a new, and presumably beneficial, function or behavior. In orofacial myofunctional therapy, the major therapeutic goals are to habituate a favorable oral resting posture and swallowing pattern. It is assumed that the clinician possesses the diagnostic and therapeutic knowledge and skills to have already assisted the patient in achieving at a conscious level adequate muscle tone and coordination required to comfortably rest the tongue in the palate and to manage saliva, liquids and solids in an appropriate manner.

I am aware that there are many "Doubting Thomases," particularly among the dental community, who question the value of orofacial myofunctional therapy. They assume that since we subconsciously rest our oral structures in a certain way and swallow reflexively, we are not going to be able to alter those functions on a subconscious or habitual level. I understand their thinking; however, I feel this view is unnecessarily pessimistic. Changing an oral rest posture and swallowing pattern is a challenge but hardly more so than changing speech patterns, as is routinely achieved during speech therapy. To me, **it is normal to be normal!** An open-mouth rest posture and a tongue thrust swallowing pattern may be adaptive, but do not represent normal function. The oral phase of the swallow is an automatic behavior controlled at a subconscious level but is not reflexive and

therefore is amenable to change. One can draw an analogy with the field of speech pathology. Although speech patterns are also habituated patterns of behavior, clinical evidence and research demonstrate that those patterns can be changed.

While there have been many theories suggested for the etiology of orofacial myofunctional disorders (see Barrett & Hanson, 1978), most clinicians now agree that tongue thrust swallowing patterns are usually retained infantile patterns, which are then complicated by altered oral resting postures. If one observes an infant feeding, the contraction of the circumoral muscles and consistent thrusting of the tongue are easily visible. As one spoon feeds cereal, one frequently ends up scraping most of it from the corners of the mouth following the swallow, and then having to put it back in to the baby's mouth! This thrusting swallow pattern is normal for an infant but may become detrimental if it persists beyond early childhood. In most cases, as the child matures, the swallow evolves into a "normal" pattern which accompanies a palatal oral resting posture and assists in normal orofacial structural development. In most cases, it seems that nothing "causes" a tongue thrust, but something interferes with the transition from an infantile swallowing pattern to an adult swallowing pattern. An effective orofacial myology therapy program assists the patient in achieving what is normal in the first place. "Mother-Nature" is on our side; we just have to be good enough diagnosticians to identify that which is interfering with normal function. The therapist may utilize the resources of the dental and medical community in the identification of the interference. Clearly, therapy is inappropriate when the patient lacks the cognitive, physical or structural potential for change. When the patient does have the potential for change, orofacial myofunctional therapy provides the patient with the muscle tone, coordination and skills needed for normal posture and function.

All patients receiving orofacial myofunctional therapy must understand from the very beginning that they are not "going to get rid of their tongue thrust." A major misconception by many of us working with people who have detrimental habits is that "we will help them *get rid* of the habit." We never get *rid* of any habit. Once something is in the "mind," memory and neuropathways are permanently established. The behavior pattern is not going to be erased without trauma or surgery. It is possible, however, to establish and utilize on a habitual level entirely new behavior patterns.

Habituation occurs with the establishment of new neuromuscular pathways and memory in the brain. These new pathways are as real as the tracks that are seen across a field where there has been repetitive travel. To illustrate: Clap your own hands together (as in applauding) and notice which is the striking hand and which is the receiving hand. Now reverse the striking and receiving hand and see how uncomfortable this simple act feels. This is a good example of an habitual muscle function directed by the neuromuscular pathways. We have the ability to consciously override these pathways but when we do not think about it, or make a conscious effort, the subconscious habit takes over and "we do it the old way." We do not "get rid of a habit." We establish and employ a new habit. The new habit of resting the tongue on the roof of the mouth is incompatible with resting the tongue on the floor of the mouth; resting with the lips closed is incompatible with a lips parted posture. Similarly, the new habit of swallowing without constricting the lips suppresses the tendency to constrict the lips when swallowing. Understanding of these concepts helps patients to guard against relapse — because they understand the old habit is still in the mind. It becomes easier for patients to understand the necessity of repetition and application. Orofacial myofunctional therapy must be an educational process. It is the therapist's role to ensure that the application of repetition is appropriate for the age and maturity of the patient. We must be creative and imaginative while still being goal oriented.

It is helpful for the patient to understand the four phases of habit change:

1. **Unconscious Incompetence.** The person has a problem but is not aware of it or its consequences. (The patient is typically unaware that the tongue is resting against or between the teeth).
2. **Conscious Incompetence.** The person is aware of the problem, however does not know how to deal with it. (The patient is aware and tries to make some habitual changes but is unsuccessful.)
3. **Conscious Competence.** The person is aware of the problem and has the skills and knowledge to deal with it but only on a *conscious* level. (Therapy has provided the muscle readiness and knowledge but the person must think about the act.) Traditionally many programs have ended here!
4. **Unconscious Competence.** The person has the skills and knowledge and now uses these skills without thought, on a subconscious level. (Patient has established and habitually employs new oral postures and behaviors.)

The critical importance of habituation is underscored by my colleague, Joe Zimmerman, who says, "As retention is the problem in orthodontics, habituation becomes the problem in myofunctional therapy." Habituation training must begin with the first therapy session and continue throughout the program. The emphasis of the first session is an overview of the entire therapy program and the establishment of both short and long term goals. The therapist guides the patient toward recognition of the habituation of normal oral resting posture and swallowing function as the final outcome. The initial phases of

the therapy are directed toward increasing oral awareness and normalizing muscle tone and function of the orofacial musculature (*conscious competence*). It is important to emphasize during each therapy session that the ultimate goal is to habituate the desired oral patterns (*unconscious competence*). An effective exercise to use in the third or fourth session of the therapy program is to ask the patient to write out the therapy goal/sub-goals as s/he understands them. This exercise is useful to determine if the patient and the therapist are working toward the same end, encourages the patient to become self-directed, allows the patient to become involved in the monitoring process and provides a tool for patient self-evaluation. These goals are periodically reviewed by patient and clinician throughout the therapy program.

Therapist familiarity with principles of behavior modification, visualization, autosuggestion and mental imagery enhances the habituation process. Only rarely is hypnotherapy appropriate with orofacial myofunctional patients. However, some selected principles of hypnotherapy can provide a better understanding of the process of habituation. The better that patients are at mentally *seeing* themselves as having achieved their therapy goals, the faster and more successful the habituation process. Our role is to assist the patient in *seeing* the desired results, helping to remove obstacles, establish routines and reinforce the desired behaviors.

An excellent technique for mental imagery is to ask the patient to close his/her eyes and visualize the desired end results. It is best to begin a visualization process with examples with which the patient is both comfortable and familiar. Patients can close their eyes and *see* a room in their home that is comfortable and then describe this room in detail. Once this is accomplished, this same procedure can be used for one or two more physical settings, with the therapist asking for more detail each time. The next step is to have the patient *imagine* any physical setting that s/he *makes up* in his/her own mind. Once the patient has a mental picture, s/he is asked to describe the *pretend* picture in as much detail as possible. This exercise allows the patient to understand how to create mental pictures. The next step is to have the patient mentally *see* him/herself as s/he will look in the future, following therapy. With eyes closed, the patient describes oral resting posture as well as desired dental occlusion. The procedure is motivating to the patient and also facilitates the establishment of subconscious awareness. Once the patient can easily visualize future results it is helpful to ask him/her to *see* these results in his/her mind every night as s/he is going to sleep.

Autosuggestion is a beneficial adjunct in habit acquisition. We constantly influence our own behavior with *self-talk*. The patient is made aware of the power of positive and negative *self-talk*. Some self-talk phrases that are negative include: "I can't do that;" "I always do it wrong;" "I'm no good at..." Positive self-talk phrases, or affirmations include: "I've always been able to do things easily;" "I learn new skills quickly;" "I do most things very well;" "I have a good memory."

To quote Bob Moawad of the United Learning Institute: "Humans rarely, if ever, exceed their own expectations."

Because many of us use only negative self-talk we have low expectations. If we see ourselves as failures, we will certainly fulfill our expectations! The patient is encouraged to identify past successes and failures and feelings of competence and incompetence regarding various life skills. Discussion can then focus on how *self-talk* perpetuates either success or failure attitudes and behavior. When the patient understands the principles of autosuggestion and how it influences action we have another tool for habituation.

The patient can be assisted in writing a script to be memorized and used for autosuggestion. The script is most effective when it contains concepts which are therapy goal oriented as well as concepts which are personally important to the patient. This script is written with positive affirmations and goals only. This is most effective when short and to the point so it can be easily memorized. An example of a typical script is as follows:

"Because it is important to me, I always rest with my tongue on the spot, my teeth in very light contact and my lips closed. I do this because correct mouth posture helps me swallow correctly, it is healthier and makes me look attractive. I always swallow with my tongue on the spot, my teeth lightly together and my lips closed. Saliva, liquids and solids are sucked back and easily swallowed with the back of my tongue and throat. All of my swallows feel like this." (Patient now swallows softly.)

The patient is then instructed to repeat the script each night when entering the sleep state. This time is recommended because as we enter sleep, the conscious mind becomes less active, and the subconscious mind is subjected to our conscious thoughts. To keep the mind from wandering to other thoughts it is helpful to instruct the patient to first think about script and then count from 100

down to 90, then think about script, count from 90-80, script, count, etc. Habits are stored in the subconscious mind and this exercise is a powerful means of direct communication between the conscious and subconscious.

A beneficial extension of autosuggestion is the use of audio cassette tape recordings. A tape can be prepared by the patient, the therapist, or one can use a prerecorded script. The tape should be recorded with a list of positive affirmations related to all the orofacial myofunctional therapy goals. It is well known that when we are relaxed, our subconscious mind is more receptive to suggestions. With this knowledge, it is important when preparing an audio tape that the first section should include some relaxation suggestions. Once the relaxation procedure is complete, the patient should be exposed to positive affirmations consistent with therapy goals. When recording these affirmations it is essential to word them as positive rather than negative suggestions. The following are a few of the positive affirmations with which patients identify and readily accept:

"I am the one person responsible for my success." "I am improving each and every day." "I continue to work on my correct oral resting posture each and every day." "I think about the correct swallowing of the first 3, 4 or 5 bites of every meal." "I do all my exercises because I continually want to improve." "I think about my mouth posture each time the phone rings."

In summary, habituation of normal oral resting posture and swallowing function must be the final result of orofacial myofunctional therapy. Habituation starts with goal setting at the initial visit, is augmented by purposeful repetitive exercises, and maintained by the activation of neuropathways to establish new but normal oral postures and functions.

SELECTED BIBLIOGRAPHY

- Barrett, R.H., & Hanson, M.L. (1978). *Oral myofunctional disorders*. St. Louis: Mosby
- Custer, D. (1983). *The miracle of mind power*, Glendale, CA: Westwood Publishing.
- Elman, D. (1981). *Hypnotherapy*, Glendale, CA: Westwood Publishing.
- Emery, S. (1978). *Actualization: You don't have to rehearse to be yourself*. Garden City, NY: Dolphin Books.
- Helmstetter, S. (1986). *What do you say when you talk to yourself*. Scottsdale, AZ: Grindle Press.
- Maltz, M. (1965). *Psychocybernetics*. New York, NY: Simon & Schuster.
- Martin, J.R. (1978). *Success through self-hypnosis*. Salt Lake City, UT: The Psychology Center for Self Improvement.
- Moawad, B. (1980). *Unlocking your potential* (Audio Tapes). Tacoma, WA: United Learning Institute.
- Swartz, D. (1965). *The magic of thinking big*. Hollywood, CA: Wilshire Book.
- Tebbetts, C. (1985). *Self hypnosis*. Glendale, CA: Westwood Publishing.
- Waitley, D. (1979). *The psychology of winning* (Audio Tapes). NY: Berkley Books.
- Zilbergeld, B. & Lazarus, A. (1987). *Mind Power*. Boston, MA: Little, Brown & Co.
- Zimmerman, J.B. (1976). The habituation stage in myofunctional therapy. *The International Journal of Oral Myology*, 2(4), p.99.