CLINICIAN'S CORNER

Suggestions for Combatting Digit Sucking
As Offered by Members at the 1982 I.A.O.M. Convention

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Those present at an early meeting of the I.A.O.M. conference were asked to share any ideas or techniques that had worked well for them in eliminating finger and thumb sucking habits. The following suggestions were compiled, edited, and offered as a reference for those therapists who work with digit sucking problems. The names of the members who offered the suggestions are included.

Most of the information submitted referred to the Barrett and Hanson text, *Oral Myfunctional Disorders,* as the nucleus of their therapy techniques. Quoting from Chapter 16, page 235: "There are four specific elements that the child should incorporate into a daily routine. He is to (1) suck on a piece of paraffin during period of inactivity, (2) sleep with an elastic bandage on his arm, (3) have a piece of adhesive tape on the tastiest finger, (4) keep score daily on his successes and failures." Barrett and Hanson have other important suggestions regarding counseling with the family and the client. It would be valuable for parents, clients, and teachers to be made aware of the suggestions in the book. They are the most positive and succinct I found anywhere.

The following suggestions are either incorporated into the Barrett and Hanson regimen or used independently. They are listed in alphabetical order according to the members who submitted them:

1. *From Cheryl Barron* – The three most important things I cover are (1) commitment on the part of the patient; (2) removal of guilt and elevation of self-esteem; (3) willingness of parent to give the child the special extra attention during the beginning of the treatment. I establish a ritual to be observed then, as soon as possible, remove all aids, so as not to establish dependency. The aids I use are merely to alert the patient to the fact that he is about to suck his thumb. Preferably they will even wake him up if he starts to do it in his sleep, hence the ace bandage. He must then decide to do it or not do it. I ask the patient what feels good about sucking – is it the mouth that feels good, or is it the digit? If it is the digit, I ask him to give it a nice affectionate squeeze when he needs to suck it. If it is the mouth, I have him suck a piece of wax if he feels he wants to.

2. *From Roberta Buckley* – First, a clever reward that has worked well as a motivator: when I first see the patient, if the thumb is really noticeably calloused and swollen, I make a quick thumb or finger impression, but I do not tell the client what it is for, only that they will see the results upon completion of therapy. I use a small juice can filled with impression material. The client is asked to push the digit way up into the material (otherwise there is just a strange protrusion not recognizable as a thumb or finger). Pour the impression up with stone and make a stone base. After the habit is successfully corrected, and the patient is feeling proud of himself, then I present the "dumb thumb" trophy, sometimes with a dollar bill folded like a fan tied onto it. It brings in humor and provides a learning experience as we compare the "new" thumb with the old one. The second technique I use is to make sure the patients call me at least once each day. This really seems to help reinforce the therapy and establish a close relationship with the patient.

3. *From Leilani Greenly* – After the client agrees that stopping makes sense, I make bulky "bootees" with ties that go around the wrist. I embroider a beautiful smile or "I love you" and give two or three of the bootees to the client so they can be washed. This is worn at night, and a chart is checked in the morning if it is dry and unchewed. For daytime use, I ask the parent to lovingly stroke the child's cheek and pull the thumb out, giving a hug when it is pulled out willingly. Sometimes just pointing a finger and throwing a kiss as a reminder to pull it out will do. This gives the parent something to do that makes him/her feel good as well as making the child feel good instead of angry and frustrated.

From Dorothy Baruch's book *New Ways of Discipline* – Dr. Baruch suggest that the parents take a good look at the methods of sabotage they are allowing when children drag blankets around and suck their thumbs. She suggests rap session for groups of parents where mutual discussion and support serve as a reward for parents who have really confronted the problem and dealt with it.

4. *From Geri Hicks* – Use adhesive tape to affix the thumb to the forefinger at night. This is done for at least

a two-week period with the parent checking after that time allowing a trial night or two with the tape off. The clinician should call after one week and praise the patient lavishly even if the tape has been left on only for one night. Call again in another week and schedule an office re-check in one month.

I usually divide the habit into three stages: (1) wakeful sucking; (2) drowsy pre-sleep sucking; and (3) deep sleep sucking. I work on one stage at a time, either #1 or #3, and verbally permit #2 until the others are eliminated. Results have been excellent and the patients are less intimidated than if total immediate elimination of the habit were required.

5. *From Gladys Jann* – Group discussion sessions with the parents of thumb suckers is recommended. These sessions should be loosely structured and include the oral habits of adults, the rationale for objections to the habits, and any other pertinent information they wish to discuss. All sorts of revealing material comes out of the discussion such as displacement, projection, and substitutions.

6. *From Susan Lee* – I use play dough shaped in the palm of my hand to represent the palate. I tell the patient that the roof of the mouth can get pushed out of shape every time the thumb pushes against it. This is demonstrated against the play dough. I then tell them that the younger they are, the more damage they can do, and that they need to stop the habit NOW. I use the Barrett and Hanson technique with this.

7. *From Richard Liddell* – A fourteen year old girl was motivated to stop finger-tip sucking and nail biting by using an ace bandage on her arm at the elbow. This was effective as a pre-act indicator.

8. *From Marjorie Pals* – Clients call the office and leave the message "I was the boss" or "I was not the boss" each day. The calls should be made early in the day or late in the day so as not to interrupt sessions. I encourage children to use complete sentences and their best speech when calling in on the Code-a-phone. For example, they are requested to state their name, the date, and "I was boss" or "I was not the boss" and finish with "have a nice day, good-bye". Another technique that I have used was to have a sixteen year old girl, upon my invitation, bring her blanket to me for safe keeping until she discontinued her thumb sucking.

9. *From Lynn Sherman* – Two techniques which work well are as follows: (1) Charting which monitors each activity and/or location where sucking occurs, morning, afternoon, evening, and night. This way the patient has many opportunities to succeed immediately and the motivation level remains high. (2) The patients are encouraged to suck on wax for one hour before bedtime and while watching TV.

10. *From Marge Snow* – Ask the child to name another child that they thoroughly dislike (usually the class bully). Then explain "habit" as a subconscious entity that says, "Suck your thumb! Come on suck it now!" Name "habit" the same as the disliked class bully (or sometimes a not-so-nice teacher), and set up a competition between the subconscious and the child. The "habit" says "go" and the child says "no". This is always used as an adjunct to the Barrett and Hanson regimen.

11. *From Betty Wommack* – Have the child make a chart picturing situations where he is sucking his thumb. He gives himself a star for each place he did not suck his thumb – such as watching TV, just sitting around, in the car, at school, in bed, etc.

12. *From Joe Zimmerman* – Educating the parents and the patient to the nature of the problem and building the patient's confidence that the problem can, indeed, be overcome are essential to any therapy program. Also guiding the parent(s) to notice when the thumb is *out* of the mouth and not just when it is *in* the mouth.

My thanks to those who offered suggestions. Maybe there will be more forthcoming from those who were not at the conference.