Policy on Oral Habits

Originating Council
Council on Clinical Affairs

Review Council
Council on Clinical Affairs

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2000

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Purpose

The American Academy of Pediatric Dentistry (AAPD) recognizes that an infant's, child's, or adolescent's well-being can be affected by oral habits and encourages health practitioners to take an individualized approach in the management of these habits.

Methods

This policy was based on a MEDLINE search using the keywords "oral habits", "bruxism", "tongue thrusting", and "self-injurious habits".

Background

Oral habit behaviors include, among others, digit sucking, pacifier sucking, lip sucking and biting, nail-biting, bruxism, self-injurious habits, mouth breathing, and tongue thrust. Nonnutritive sucking behaviors (eg, finger or pacifier sucking) are considered normal in infants and young children and usually are associated with their need to satisfy the urge for contact and security.

Because persistent nonnutritive sucking habits may result in long-term problems, professional evaluation has been recommended for children beyond the age of 3 years, with subsequent intervention to cease the habit initiated if indicated.[1]

Bruxism, defined as the habitual nonfunctional forceful contact between occlusal tooth surfaces, can occur while awake or asleep. The etiology is multifactorial and has been reported to include central factors (eg, emotional stress,[2] parasomnias,[3] traumatic brain injury,[4] neurologic disabilities[5]) and morphologic factors (eg, malocclusion,[6] muscle recruitment[7]). Reported complications include dental attrition, headaches, temporomandibular joint dysfunction, and soreness of the masticatory muscles.[3] Preliminary evidence suggests that juvenile bruxism is a self-limiting condition that does not progress to adult bruxism.[8] The spectrum of bruxism management ranges from patient/parent education, occlusal splints, and psychological techniques to medications.[4,9,10]

Tongue thrusting, an abnormal tongue position and deviation from the normal swallowing pattern, and mouth breathing may be associated with anterior open bite, abnormal speech, and anterior protrusion of the maxillary incisors.[11] Management may consist of simple habit control, myofunctional therapy, habit appliances, orthodontics, and possible surgery.[12,13]

Self-injurious or self-mutilating behavior, repetitive acts that result in physical damage to the individual, is extremely rare in the normal child.[14] However, such behavior has been associated with mental retardation, psychiatric disorders, developmental disabilities, and some syndromes.[15] The spectrum of treatment options for developmentally disabled individuals includes pharmacologic management, behavior modification, and physical restraint.[15] Reported dental treatment modalities include, among others, lip-bumper and occlusal bite appliances, protective padding, and possible extractions.[14] Some habits, such as lip licking and lip pulling, are relatively benign habits in relation to an effect on the dentition.[14] More severe lip and tongue biting habits may be associated with profound neurodisability due to severe brain damage.[16] Management options include monitoring the lesion, odontoplasty, providing a bite-opening appliance, or extracting the teeth.[16]

Oral habits are associated with dentoalveolar and/or skeletal deformation in some patients. The amount of dentoalveolar-skeletal deformation is related to the frequency, duration, direction, and intensity of certain habits and should be assessed by the dentist. Changes that can occur to the dentoalveolar structures may include anterior or posterior open bite, interference of normal tooth position and eruption, alteration of bone growth, and cross bites. The dentist can provide the patient and parent/guardian with information regarding consequences of a habit. Treatment modalities to control habits may include patient/parent counseling, behavior modification techniques, myofunctional therapy, and appliance therapy.

Policy statement

1. The AAPD supports the individualized approach for each child in evaluating oral habits.
2. Where appropriate, the AAPD encourages treatment of oral habits to prevent or intercept possible malocclusion or skeletal dysplasia from occurring.

3. The AAPD supports intervention for bruxism when the habit is of sufficient persistence, duration, or intensity to damage the permanent teeth or cause other complications which affect the child's well-being.

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