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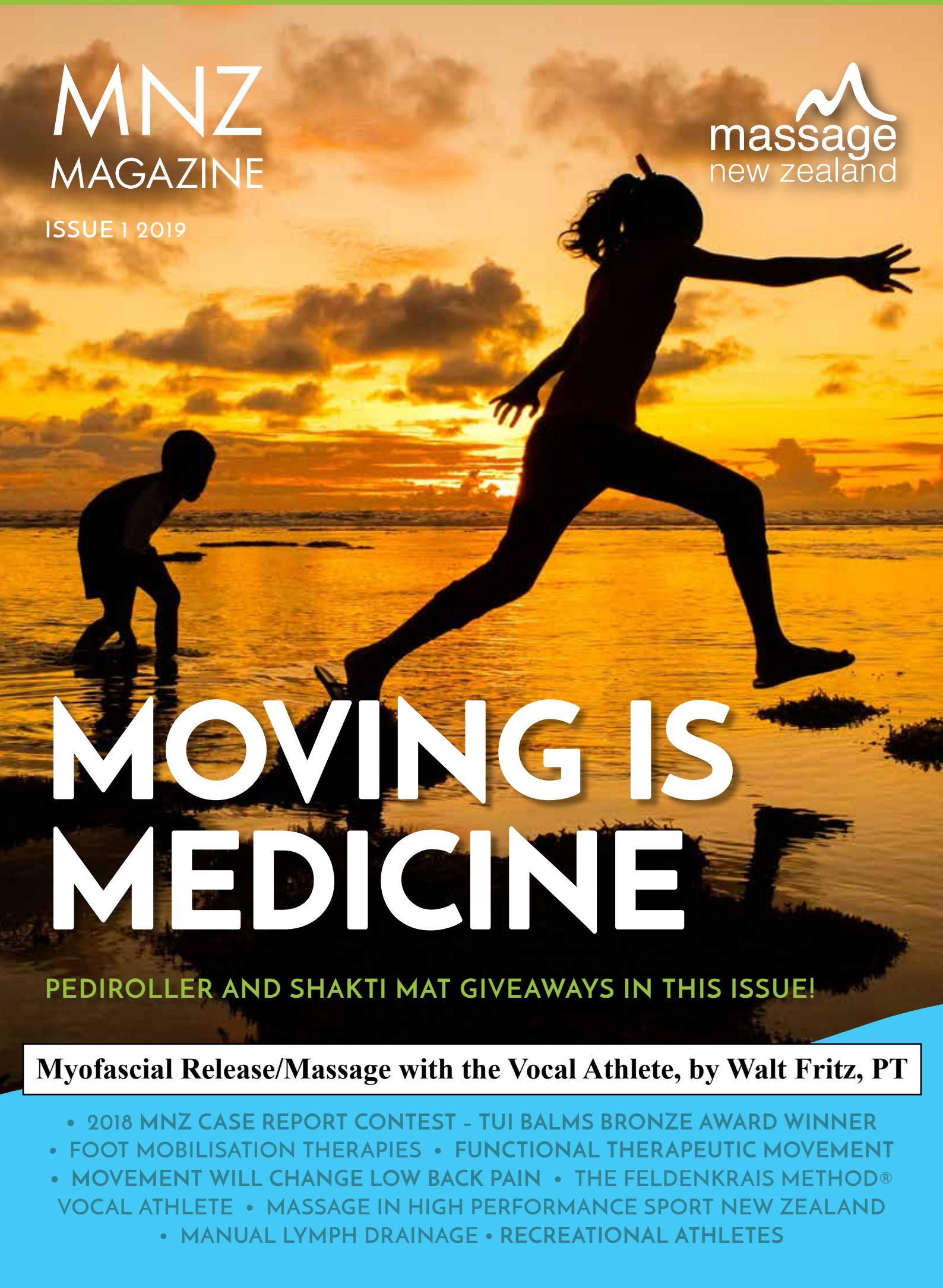

MOVING IS MEDICINE

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MYOFASCIAL RELEASE/MASSAGE WITH THE VOCAL ATHLETE

By Walt Fritz, PT

Massage/manual therapy in sports and movement is typically thought of with regards to performance in traditional sports or athletics, but what about the vocal athlete? Have you ever thought that massage/manual therapy could help these athletes? While not meeting the typical athlete stereotype, singers, and others who use their voice professionally, experience issues of overuse and injury, much like the amateur or professional athlete. They benefit from massage/manual therapy for these issues, as well also benefitting from intervention to improve upon already high-level performance capabilities. Through focused manual therapy intervention, these vocal athletes can significantly benefit from your services, and you may find a unique niche for your services.

I borrow the term, "Vocal Athlete" from a colleague, Marci Daniels Rosenberg, who along with Wendy LeBorgne, wrote the book, "The Vocal Athlete. Application and Technique for the Hybrid Singer"[1]. While the scope of their book reaches well beyond our work, they speak in depth of using manual therapy, myofascial release (MFR) included, with the vocal performer, both for remediation of dysfunction as well as enhancement of existing strengths.

If you haven't heard of a massage therapist working with voice and the vocal athlete, an online search query of "massage voice" or "'myofascial release' voice" provides you with enough hits to keep you busy reading website articles for weeks. Google Scholar reveals evidence speaking to the positive results of using massage therapy for the improvement in voice[3] and you can read about therapists utilising various forms of vocal massage in their practices at links[4-7].

What are the expected outcomes that I seek when applying MFR with the voice patient, and how might that sort of intervention look?

While I teach a seminar that attracts speech-language pathologists/therapists (SLPs/SLTs), as well as MTs, OTs, and PTs who specialise in disorders of the neck, mouth, and upper chest, the percentage of voice patients that I see in my physical therapy practice is small. However, I do see patients referred with dysphonia, which is defined as "difficulty in speaking due to a physical disorder of the mouth, tongue, throat, or vocal cords"[11]. It can be simple hoarseness, acute or chronic, but can be more complex and nuanced and is broken down into many different types. After being correctly diagnosed by a medical specialist, ruling out cancer, etc., it is often treated with Botox injections or therapy by an SLP/SLT. Patients come to me through referral networks that know of my expertise to determine if MFR/manual therapy can help a patient to overcome the disorder or learn management strategies. I have also been fortunate to work with a few performers (vocal athletes) who find the slow, graded, MFR-style stretching helps them reduce vocal strain and fatigue. I frequently see them when they are in town for bursts of sessions, as well as less occasional tune-ups to both improve performance and teach them strategies for dealing with their issues on their own. I know of therapists who travel with big-name performers, providing manual therapy while the artist is touring.

Keeping with the nature of my approach to myofascial release, I work from a patient-directed model which is heavily reliant on finding agreed upon areas of the body that, with palpation, pressure, or stretch, replicates familiar aspects of the patient's issues. Such a patient-directed model contrasts markedly with many models of MFR, manual therapy, and massage that rely more strongly on the therapist's experience and opinions as to what is at fault and what needs intervention. While this often serves the patient and results in positive gains, it can all too easily gloss over patient preferences and experiences, which

makes up a full one-third of the evidence-based model of care that most professions work[8,9]. While my specific MFR treatment which relies on static, lighter holds, massage and manual therapy in general populates the medical literature as being helpful for various issues of not only voice but also swallowing, breathing, jaw dysfunction, and many more conditions.

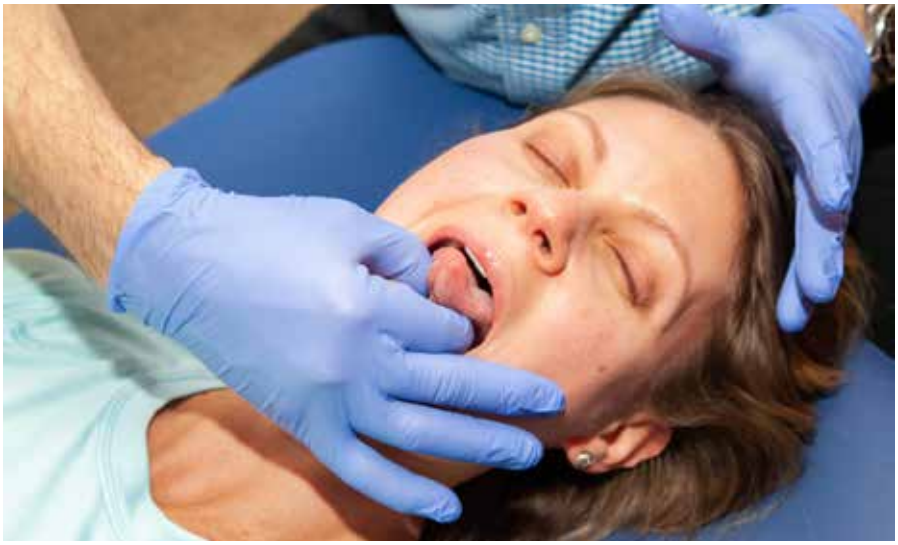
In my work with the vocal athlete, we start with the collection of a full history, which includes a discussion of what the patient hopes to achieve from my services. I look at their medical history, including surgeries, medications, tests, and more, as well as what they have done in the past to help remediate their current situation. Like most of you, I have a large pool of objective testing to pick from that may include a range of motion, functional strength assessment, neurological tests, as well as more specific assessment of the condition. These issues may present as pain, movement difficulty, the perception of weakness, or in the case of the vocal athlete, patterns of strain and fatigue that seem to limit performance.

Next comes the hands-on assessment, which in the case of the MFR-style work that I use and teach involves lightly placing hands on the area of patient concern, which is one point where my approach diverges from others. While many have been taught more far-reaching narratives of causation, with the belief that nothing can be sustained unless, for instance, the feet are leveled, the pelvis is balanced, the core is strengthened, the posture is improved, or C1 is in proper placement, I try to see all of those beliefs as recipes vs. fact. This statement might be seen as insulting, given the typical reports of outstanding outcomes utilising such disparate causation narratives, but if each one was true, then no other narrative would come close to having successful outcomes. The "facts' that many of us were taught are most probably recipes and stories that we tell ourselves and in turn, our patients. My original MFR training taught that we were to "find the pain, look elsewhere for the cause" as if we can ever really know what the cause is. In my MFR family of origin, the cause was invariably identified as a fascial restriction; one that no one else had found, which gets slippery when the concept of fascial restrictions has never been shown to

be true, much less all of the other aspects of so-called fascial evaluation and treatment. I make many enemies in the MFR, massage, and manual therapy circles by questioning what we have been taught, but I am quite comfortable in this role. I speak to this concept at length both in my seminars as well as on my blog.

While all of the above may matter and can be used successfully, the primary aspect of evaluation I rely on is palpation to connect/replicate an aspect of familiarity to the patient's condition. Throwing more cold water on our beliefs and training, palpation itself has quite poor inter and intra-rater reliability, when it comes to locating what we think we are locating. For instance, my palpatory training in myofascial release consisted of me feeling tightness and claiming it to be a fascial restriction. However, the next therapist might palpate the same area and claim it to be a trigger point (or spasm, knot, etc.). I have a few appropriate references in the extensive bibliography I make available to support my seminar that speak to such palpation reliability issues[13]. While I acknowledge the limitations of palpation, I still use it extensively, but hopefully in a less rigid context. My goal with palpation is not to locate and define the problem, but to begin a conversation about relevance with my patient.

I continue to trust much of what I was taught and from the years of experience, as I am seeking areas of apparent tightness, density, or overall grumpiness through my palpation, but once I feel like I may be on to something, I turn the dialogue away from what I have found and toward my patient and what they are feeling. I try not to sell them that the tightness, density, or grumpiness is the problem; instead, I ask them what they are feeling. Ideally my palpation, whether mild pressure, stretch, or other stimulation, begins to replicate familiar aspects of the condition they are seeking my help with, whether a mild exacerbation or even a lessening of the symptom. "What do you feel" is one of my favorite open-ended questions, as it gives them a chance to respond with no sense of being guided. Once they tell me what they feel, I'll ask, "Is that a familiar feeling? If so, in what way? When do you feel that?" If my findings do not connect with a familiar sensation, I'll move on. If I can replicate aspects of their experience, I ask a series of additional questions, starting with two 0-10 questions. First, I ask the very familiar, "0-10, how much (fill in the blank with the sensation that they reported) are you feeling right now?" After they respond, I'll ask, "0-10, what number will you stop me? What number would be too much?" These two questions hopefully determine if I am near provocation, regarding symptoms intensity. If my pressures/stretching is replicating familiar feelings that are well within the range of acceptable, I'll ask what is often a difficult question, "Does my stretch feel like it might be helpful?" Many might be unable to answer that questions with certainty. If so, I'll turn the question around and ask, "Is there anything about my stretch that



feels like it might be harmful?" If so, I'll stop immediately. Once we establish that my stretch feels safe and potentially helpful, in traditional MFR fashion, I'll simply hold a light stretch or pressure until symptoms shift, change or dissipate. My hands-on technique is much like the traditional/historical type of MFR treatment, but my interview style is far-removed from what is usually used.

Working with the vocal athlete often involves having them "perform" during treatment. I'll ask them to move (perform) when working with dysfunction, as I am hoping that my touch introduces a sense of greater ease of vocalisation or movement, as well as with attempts at performance enhancement. One joy of teaching this work to speech and voice professionals is the excitement when the therapist who is acting as my demonstration model, who may be a performer themselves, notes changes in their vocal tone, range, or pitch from my touch during and after the course of a short intervention. In much the same manner that I work with actual patients, I'll immediately have them put their hands in the areas we just worked and ask them to try to replicate the felt-sense of the sustained stretching to give them tools to help themselves. My goal is to give them a locus of control over their situation. No matter the disorder, I'll always follow with functional movement, which can include what might be seen as traditional exercises or, more commonly, functional movement as well as self-stretch using principles found in evaluation and treatment. In the two videos linked below [10,12], you can see a bit of how my intervention progresses, from evaluation through to treatment.

If working with the vocal athlete interests you, I hope you'll consider joining me in Auckland 17-18 August 2019, where I'll be teaching my Foundations in Myofascial Release Seminar for Neck, Voice, and Swallowing Disorders. You can find more information at www.FoundationsinMFR.com.

AUTHOR BIO

Walt Fritz, PT owns the Pain Relief Center in Rochester, NY, USA and travels worldwide to teach his science-informed version of MFR, Foundations in Myofascial Release Seminars. His audiences include massage therapists, speech-language pathologists, voice professionals, physical therapists, and occupational therapists. You can learn more at **www.FoundationsinMFR.com** and his accompanying blog, **http://www.waltfritzseminars.com/blog/**

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