Before first talk, I have some housekeeping announcements. First of all, it's about the simultaneous interpretation, which can be accessed on the interpretation icon at the bottom of your Zoom screen.

There's a little globe. You click there and you select the language you want to hear the Congress end. OK, so if you are on a cell phone, you click on the three dots on the side and you have the translation option.

We're going to have a workshop with Professor Fabiana and Professor Leo about unveiling the diaphragm when we will approach several aspects of anatomy and other things,

as well as functions regarding breathing and visceral movement. It's going to last three hours and can be acquired separately. Just getting tested with our production. We are going to provide you a 40 -hour certificate for all of those who participate on the Congress that will be given to you at the Hotmart platform.

And as of Monday, you will have access to the full content of all the talks that we have seen during these four days. Now,

for our first talk with Professor Walt Fritz, seeing the forest through the trees, seeing Fascia under perspective,

treating the person as a whole. Professor Walt is a physical therapist. He has trained with the main myofascial release and manual therapy instructors since 1992 with manual therapy,

additional manual therapy, as well as continued education classes since 1985 to the present days. He still continues his whole history of education,

building the traditional manual model based on tissue and building a more narrative model that is more focused on the patient and based on neurology. Professor Walt,

it's a pleasure to have you here. Welcome. I think that was my introduction. Okay, good day, everyone. I'm going to try and speak slowly enough so the interpreters can understand what I'm saying and hopefully get it to you.

I really do welcome questions, comments, even criticisms of what I might be presenting here in the chat, and I'd be happy to discuss it as long as I can get an English version of that.

that. Thanks so much for inviting me to be a part of the workshop here. It was an interesting email for me to receive initially back in January about to present on myofascial release and my approach to it.

While I'm a bit of a fascial denier if you will, I want to talk about a little bit of that denial.

I want to talk about a little bit of what I've learned in the last decade or so. I want to talk about how we approach manual therapy, how we approach myofascial release, how we approach fascial work in general.

In the United States back in, well when I was much younger, there was a television program called 60 Minutes. It was a news program that was held or broadcast every Sunday evening,

quite popular and it was at the end of every episode. There was a fellow who was given about three minutes to talk. His name was Andy Rooney. Andy was a bit of a grumpy curmudgeon.

He was a bit of a denialist. He was a bit of a skeptic and he was actually wildly popular because he sort of presented things from perspectives that weren't popular.
In a way, maybe because I'm getting to be as old as Andy Rooney was back then, but I kind of see myself in that curmudgeon role here at the World Congress of Fascia because I'm presenting about we may not be treating fascia or at least we may be ignoring important parts of the literature of the research both from the physical sciences as well as the behavior sciences that can explain what happens when we work with somebody, when we touch someone. That really has become the the focus of my profession over the past decade. In the chat I did include a link directly to my website where you can view and download all the references that I'm going to be commenting here and a little bit of explanation throughout the course of this.
And what I'd like to do is not to discredit the fascial research that's been done, that's being done, that will be done in the future. And certainly not to discredit all the good work we're doing.
But what I'm hoping to do is to sort of give a broad overview of what some other people are saying about touch-based interventions such as fascial work.
So a bit about myself first, if you will. I am reading from my copy here, but I'm basically, I became a physical therapist in 1985,
back before evidence-based practice was mandatory, a mandatory part of healthcare at least in the United States. My education was one that certainly introduced evidence,
the research, etc. But we weren't quite held to the same standard that the doctor of physical therapies are held to today with new graduation. And as a result,
I don't think I was really well prepared to understand the evidence that was presented to me, not just in school, but in continuing education afterward. I learned a little bit about fascia in college from someone who had done some malphase release training back before this time,
back in the early 80s. And it was really ironic because our fascial training at the University of Buffalo had to be done with a closed door, with paper taped over the glass on a door.
So other professors didn't see what this one professor was teaching us. Somehow it was the forbidden fruit of manual therapy and a physical therapy.
But it was interesting. It kind of got me interested in that fascial perspective. And it really wasn't until after I graduated that I took a couple satellite conferences, as they were called,
quaintly back in the late 90s, where everybody gathered in one room. And images from a remote conference were sort of streamed in by satellite to people sitting in a room, which is pretty antiquated by today's standards.
But it wasn't until 1992 that I began fascial training, if you will. Malfascia release in the United States is primarily dominated by one model. At least the world that I lived in.
There's certainly models of roping, the more aggressive work, et cetera. But the work that I learned was from physical therapists who had taught tens of thousands from this approach.
And I was pretty gullible. I listened to those lectures. I watched the work being done, and I saw it having effect. So like any good post hoc fallacy,

I believed what was told to me about we were impacting fascial restrictions in a unique way that we were taught to use slow, continuous touch versus some of the other styles of fascial work,
which are quite different and were said to be not as effective. I'm still waiting for that study that shows that one form of fascial work is more effective than another. Or maybe one form of body work is being more effective than other.
And I think some of us have trouble really facing that, or I did, let me speak in the eye term. I had really trouble facing that. I was basing all of my work and all the things I said on opinion,
on antidotes. But you know what? I really did fall down the rabbit hole, if you will, of Malfascia release, and I loved it. In 1992, I started taking this work. And I took basically everything that this particular continuum educator had to offer,
so much so that in 1995, I became an instructor. I instructed, I assisted at workshops, you know, dozens and dozens around the world with this particular educator and wrote that forward to a second book that he had written.
And you know what? I was kind of a fascial expert, at least from that really narrow slice of fascia that I was presented with. And then in 2005, I was fortunately or unfortunately drawn into an online discussion on a website called somasimple.
Somasimple .com was populated by manual therapists and others who believe that the effects of our work, manual therapy and otherwise can easily be explained by neurocentric explanations.
And that was kind of troubling to me. It was troubling to me because it's not how I learned the work, it was troubling to me because they were basically discrediting the form of mouth fascia release that I had learned. And so I went on to that website and embarrassed myself to a lot of people who were following along as well as people who were reading it later and embarrassed myself in the way that I was trying to
defend what I now view as the indefensible. I was trying to convince people that we can explain everything from a fascial perspective. We can explain problems from a fascial perspective as well as the ability to touch somebody and primarily engage their fascia.
So that conversation, if you will, that argument went nowhere. I was kicked off the website multiple times basically for bad behavior. And then a lot back on with promises of good behavior that I could never keep.
And basically it kind of died out at the end of 2005. With me not changing my opinion on fascia, and me not changing anybody else's opinion on fascia.
But the following year I chose to leave that fascial community. And I chose also to go back to somewhat simple and start reading what was presented to me back then.
And it was things that I didn't understand at all because it was not within a range of fascial work, fascial research, it was outside that field of behavioral approaches,
of behavioral sciences, of neuroscience, of a lot of things that I really didn't have much knowledge of. I worked hard. I worked hard to understand it.
I still continue to treat, to teach air quotes, myofascial release for many years after that, even though I put a disclaimer in my work, because I really didn't see it possible anymore to be able to say with certainty that when I touch someone,

I'm feeling a fascial problem, and I'm able to select that fascial problem and treat it in isolation without treating the human being in front of me.
Without treating and working with that individual's nervous system, their behavioral awarenesses, their own contextual factors, everything.
So many things that I learned, and some of those things I want to share here today. I don't ever envision changing anybody's mind about the relevance of fascia.
Maybe I can get someone out there to question, can we really be sure we're treating fascia when we touch someone? Or is fascia just part of that underlying fabric of the human being that we're working with?
All right. And again, I lived in a tribe. I lived in the myofascial release tribe, and tribal cultures, tribal norms are very difficult to break.
And there's one of the benefits of a tribe is we get a sense of community, of protection and well-being from our tribe. And I'm certain that we can see that in people here for this Fascial Congress.
I certainly saw that in people who were taking my seminars back then. They were looking for the Fascial Answers. And this might not be a popular opinion at all, but I'm not sure that we can treat fascia without including so many more aspects of that.
So let me just catch up on my own list here. In a way, I kind of see a fork in the road, one that maybe needs to be looked at more, that the fascia research that has been done and is being done and will be done is fantastic for understanding a deeper knowledge of the human body,
the how it works. But I see a fork in the road with what we call fascial therapies, fascial therapies. Are we truly with full conviction and understanding?
Are we treating fascial problems? Are we able to select and isolate a person's connective tissue when we do any form of fascial work? Or are we doing what might be called a brand,
a recognizable style of intervention? That generates a lot of arguments and distress when I present concepts like this in social media because we get so embedded into those mindsets that,
oh yeah, when I touch somebody like this, it is treating their fascia, okay? My biggest awareness came is when I took a continuing education training from a woman named Diane Jacobs.
Diane is a Canadian physical therapist, who I include her in that reference list there and you can look her up if you're interested. Diane took a very counterculture way of explaining manual therapy to me and teaching manual therapy to me in that she was doing things with her hands,
which were identical to what I was doing in my last release. And that was really both troubling to me as well as intriguing to me. How is it that someone can explain a complete narrative of manual therapy doing the same things that I do,
but explaining it from a neurology-based perspective, the skin-based cutaneous nerve and neurodynamic perspective. That was troubling to me, but it also got me on this path of where I am today,
all right? My work right now is, since 2013, I've moved to a different population, you might say, than the traditional mouth fascia release and fascily continuing it,

at least for hands-on work. I now teach primarily speech-language pathologists and I teach them a very specific form of work, of manual therapy work, for issues related to voice,
swallowing laryngeal disorders, as well as tongue-related or motor-related things. And again, the irony is, I'm doing with my hands what I was taught back in 1992 with my hands.
It's just my understanding of what might be happening in the people that I work with has shifted dramatically, right? To go back a little bit more, when we look at fascial work,
when we look at fascial perspectives, we're touching people. Are we touching the fascia? Are we primarily engaging the fascia? But we make claims of impacting structure.
But do we approve for that? Not just for fascial work, but for nerve-based work, for laryngeal-based work, all sorts of things. Is that asked me if there's any slides? I do not use slides, I apologize. It's just me,
you're gonna have to look straight at me this whole hour. But the thing is too, when we look at people doing work, they're doing almost the same thing.
Whether we're doing it wet or dry, static or with movement, we're doing remarkably similar things without, but we're doing remarkably similar things,
but calling it all these different titles, all these different sorts of body work, including fascia work, all right? And I think one thing we need to take a look at strongly is this struck me early on in my fascial release training that there was a good amount of evidence presented from that role-thing perspective,
the structural integration perspective, which oddly paralleled the research that was used in my myofascial release training. But yet, the interventions were so dramatically different.
Role-thing, I call it aggressive, other people don't call it aggressive. Role-thing was certainly what is recognizable as a more deep tissue, a quicker, a stronger type of intervention, whereas the work that I was taught was to engage slowly.
and for a long period of time, very, very different interventions, at least visibly, but get both used and continue to use similar explanations for how and why they work.
And I think that should be troubling to some people, but apparently it's not troubling enough. Let me just jump ahead here. I want to talk about some of the concepts that I use now to explain my work.
Some of the people who I use to reference when it comes to this work, some of which you might be aware of, some of which you may not be aware of at all. In my work, in my teaching,
I view the work that I do less about the hands-on work being the therapy, which sounds odd, right? Because we were taught that fascial work is about what we do with our hands to affect the tissues.
I now see this work that I do in the laryngeal region. Possibly it's just a way of communicating to my patient's brain,
central nervous system. There is a colleague of mine in the speech pathology community by the name of Leah Halau. Her references are in the handout that I made available to you.

Leah has coined a term metatherapy. Metatherapy is, simplistically, therapy that surrounds the therapy. She contacted me after I gave a talk at some grand rounds at the University of Pittsburgh where she's on staff and wanted to talk about the similarity between metatherapy and the way I described my work,
that it's not about what we do right here to peri -laryngeal muscle tension or peri - laryngeal fascial restrictions. What we're doing here is to try and bring my patient's awareness to this area to see if what we're doing feels relevant.
We might be changing muscle tension, we might be changing fascia restrictions, pardon me, but I know I'm gathering my patient's attention. I know I'm calling on their perspectives to possibly create some of the changes that we hear,
see, and feel down here. And what Leah was describing in her work on metapherapy was a simple concept, and I want to explain it really briefly, when a new clinician,
in this case, a speech pathologist, uses an intervention that was taught to them. Something called straw phonation, for instance. Straw phonation is basically speaking, making sound into a straw,
which is seen to have therapeutic effect on the voice, all right? That when someone gets that piece of a treatment, they're sort of taught that it's the treatment that's creating the impact of helping a person's voice quality.
But what Leah was talking about in her research in her papers is it's truly not blowing into a straw or speaking in this straw. It's what we do surrounding that intervention,
what she calls the metapherapy, the therapy that surrounds the therapy. It's what makes a skilled clinician, experienced clinician, have different effects with straw phonation than a new graduate.
And one might speculate that it's possibly why a seasoned fascial clinician, as different outcomes from someone who's learning work for the first time,
now I was taught that the reason I didn't get results in the beginning was because I wasn't doing it properly, that I needed to take more seminars and everything, and all those things certainly helped. But maybe what I was missing were the contextual factors that surround the intervention,
and that's what Leah was talking about in her metapherapy papers. I believe that a lot of the effects from our work is truly what we surrounded with.
Yes, it's about the context that we create of maybe why their fascia is important, why treatment of is important. Maybe it's all true without actually being able to actually treat their fashion.
All right. Can I get a possibly a thumbs up on whether the interpretation is coming through okay? I want to make sure that I'm not speaking too quickly. We doing okay?
I got one thumbs up. Is the translation coming? Okay, good, good. All right. And my goal here is to, great, lots of good okays.
Got it. So I want to talk about some papers, some perspectives, and basically some alternate realities to fashion approaches,
not to say you're wrong or we're wrong, but maybe simply to let us know that there's a lot more to treating a person than thinking about their fashion. A while back,
there was a discussion on social media, and the discussion was surrounding if you, as a clinician, were asked to produce one paper,

one study, one research paper that best summarizes what you believe is a clinician. Why is it that your therapy is helpful to people?
What paper would that be? And it was a really interesting concept. It was an interesting conversation. People were presenting papers and studies and research from all sorts of domains, mostly within their frame of belief.
If it was a fascial person, they were sort of putting out one of the newer fascial papers and talking about that as sort of instrumental in guiding them. So I'm sure if you did this mental game right now,
you could probably picture a study, a book, or something that really epitomizes who you are as a clinician. And basically, it became my turn to present.
And through my own research, through my own writing, through my own lived experiences, there was one paper that I thought was most pivotal. And that was a 1957 paper,
a paper older than me, I was born in 1959, a paper that was written in 1957 by psychotherapist Carl Rogers. Carl Rogers was at the time presenting some fairly controversial concepts in the mental health field.
And what he did was he wrote a paper basically challenging the prevailing mentality at the time, which was that the reason people benefit from mental health therapy is because of the modality that was used,
all right? It was the modality that was the most instrumental in helping a person with their mental health disorder and needs. And when I read that paper,
I couldn't help but notice the similarity to my world for the past 30 plus years of my flesh release, that people thought, people view,
it is the modality, the intervention, the style of work, the teacher of it, the brand, et cetera, that was most instrumental. But what Rogers was saying in this paper, which basically got him ostracized from the mental health community for a while,
was it wasn't the modality that was creating the most impact for the person. It was the relationship that we build with each individual client in the case of Carl Rogers or patient in the case of us.
And to me, when I came upon the paper, that was like, that was an epiphany because it's so well represented my issues with facial approaches, with body work approaches,
and with manual therapy in general, that each one is sort of segregated in this silo of beliefs that this is the best thing out there. This is the reason we help people because I was able to impact their fascia.
I was able to impact their trigger points or their arranging tension or their nerve root, whatever it might be. But all of our interventions have a common denominator,
and the common denominator is that relationship that we build with each individual patient. There's a paper mentioned in the references that I made a build,
much newer paper, by Michiak et al., where Michiak talks a lot about sort of a modernization from a physical therapy perspective of Carl Rogers' original work on the therapeutic pillars of therapeutic relationships.
And I think I know I learn a lot about the impact of my work well beyond the tissue based beliefs when I started going into behavioral sciences in papers such as that and a whole lot of other ones.

So you might consider reading some of this paper, understanding that when we touch, maybe we're not touching a person's tissue. Maybe we're creating a unique awareness and link to their sense of awareness,
sensation, connecting with their past experiences to see if it connects them to their present day experience. And some of that comes to these behavioral based papers.
I'm guessing most people here are relatively familiar with concepts relating to neurodynamic technique. The question that was put into the chat,
I apologize, I cannot read that. If someone's able to translate that for me, I would like to address it if it's something that needs to be addressed. Neurodynamic effects basically, you know,
I mean, they came forward in the early 90s, Michael Schachbach, David Butler and more, talked about sort of an alternate reality of manual therapy that maybe it's not the tissues themselves,
maybe it's the nerve that the motor sensory motor nerve that's giving problem. And they talked about simplistic ways of defining and identifying nerve tunnel syndromes as well as very specifically saying you know for an older nerve if you do things like this you can both diagnose the problem as well as intervene on it by adding nerve flossing nerve guards etc.
It's certainly an interesting perspective especially when presented from Diane Jacobs again that that Canadian physiotherapist I mentioned when taking her look at neurodynamic technique because Diane speculates in an in a rather unique model that when we do manual therapy the only thing we can be certain of is that we're touching skin and short of having a scalpel I think most of us could agree that when we touch somebody
we are only able to touch their skin. Diane has come up with sort of a narrative an explanation that works from that concept of the simplicity of the skin or the complexity of the skin if you will to say that quite possibly when we do a lateral skin shear a lateral skin stretch it's quite possible that the primary means of communication from peripheral to central is via cutaneous to peripheral to central nerves and
that in and of itself could be impactful enough to create at least some of the changes when we do what we think to be fascial work. Now it doesn't say again we're not saying that we're not impacting fascia but we're definitely impacting skin and skin is richly innervated with cutaneous nerves with a lot of receptors that I'm going to talk about in just a minute which possibly could be at least an alternate explanation
for why we're getting the effects that we are getting and maybe among some researchers some clinicians some academicians possibly a more plausible model right so neurodynamic technique is a good possibility that whenever we touch somebody in a fascia -based way we're also engaging their peripheral nervous system their autonomic nervous system their central nervous system,
and including their brain. It's a pretty quick three nerve, two synaptic junction or root from the skin anywhere in the body to the brain.
That's fast action. Can our brain begin to create some of the changes that we attribute to fascial changes? That's an interesting question.

And I don't know that there's a lot of hard fast evidence out there yet, but I think it is plausible. Let's talk a little bit about peripheral receptors for a moment.
I'm sure most of you are familiar with Robert Schlepp's seminal papers on fascial plasticity from 2003. Talking about the neurobiological explanations for fascia work,
and I know Robert has done a lot of excellent writing before, during that time, and since then, including shifting some of the narrative from the things we think we're doing from a mechanical level,
literally at that tissue level, to understanding it's a bottom up, top down type of approach. And in that 2003 paper, I think it was in part one of the fascial plasticity paper,
Robert talks about many of the peripheral mechanoreceptors that are present in the fascia and the connective tissue and the joints, et cetera, that we potentially are impacting when we do fascial work,
including raffinis. Raffinis were an interesting one for me. Raffini mechanoreceptors react and respond to the exact same stimulus that I provide with that fascily-based work,
that I don't call fascily-based work anymore, but the work that I do, I mean, I'm literally holding and stretching in a prolonged lateral skin stretch or a lateral tissue stretch.
Now Schlepp talks about that as having a secondary, raffini mechanoreceptor stimulation as having a secondary effect of reduction in sympathetic dominance.
That's a pretty interesting direct response to stimulation of a specific class of macanoreceptor. I thought that it was interesting and I see we all speak from biases and I'm not certainly not criticizing Robert's work at all because I think his work is fabulous,
but I did notice that in his paper, he talks about ruffinium's location in the fascia, in the et cetera, et cetera, but doesn't really mention that they're extremely plentiful in the skin.
There's another conundrum, if you will, because maybe when we do lateral skin stretching or a lateral stretching, maybe we are stimulating down at the deeper level within the fascia to cause a ruffinium macanoreceptor to take note and send something up to the brain to be more aware,
but we have to recognize that there are alternate and equally plausible explanations out there and the fact that ruffinium macanoreceptors exist in skin as well as connective tissue sort of blurs that line.
How can we know that it's all about the fascia, right? In my work, continuous touch was hugely important.
I can't speak to other forms of training around the world because I know it goes by a lot of different names, a lot of beliefs, et cetera, but the way I was taught was we needed to hold a stretch,
hold a release for a certain amount of time. Back in the '90s, it was 90 to 120 seconds 'cause it was said that that's what it takes to affect ground substance and for the piezoelectric effect to commit.

Now, since I've left the fascial community, I understand there's a lot more research on mechanofreinstruction, why it might be important for us to hang out longer than 90 to 120 seconds,
and in some cases up to five minutes is being recommended now, which, you know what, that's what I did anyway. I was always holding for what observers would think was ridiculous lengths of time.
How can you hold a stretch for 10 or 15 minutes? And it's like, well, it's easy. I was taught that that's necessary. And even when I let go of thinking about those as accurate beliefs,
I still saw value in continuous touch. Why is it that continuous touch could be impactful beyond what we think we're doing with the tissue? There was a very interesting study done in 2000,
sorry, 2017 by a lead researcher by the last name of Sarah Telley. Sarah Telley's name is probably well known to some of you. The title of this particular paper was the effect of continuous touch on brain functional connectivity is modified by the operator's tactile attention.
Well, that's a long title, right? The paper is in the references. It was a paper, if you can envision for a moment, what they wanted to do was to figure out, well,
they knew that touch, well, they knew that people have the ability to self -regulate through C -tactyl apharen stimulation with interoceptive properties,
right? That was a known concept. And it's one that I think is a real fascinating one from the perspective of touch. But what Sarah Telley wanted to know was, would those same fibers,
in a sense, translate out anything from clinician to patient without words, is touch sufficient to essentially activate parts of the patient's brain connectivity?
So what Sarah Telley did was they basically laid a patient on the table and they wired their heads so that they can figure out what part of this person's brain is active right now, right? And then I think they had some sort of a wall which prevented the patient who was laying on a table from seeing the clinician who was standing down at the patient's ankle,
right? They had two groups there. there. What they were doing, what they did with one group is they put headphones around the clinician and they were being bombarded with random noise.
Under the assumption that that noise would keep the clinician's attention away from the patient, that they wouldn't be able to attend to their touch at the patient's ankle.
The other group had no headphones. They were simply asked to touch the person's ankle, not in a way that they were doing anything, but just touch that person's ankle and put their attention into that touch.
And what they were watching in those two groups was what happened up there, what happened in the patient's activation, the connectivity, the functional aspects of their brain. What changed?
And to summarize briefly, in the patient who was being touched by the clinicians whose brain was being blasted with random noise, very little change. There was little change in brain activation patterns as measured by the measuring devices.

But in the other group where the clinician was able to attend to touch, what they saw was a gradual increase in essentially awakening of the attention centers of the brain that peaked at 15 minutes.

Now, it would be easy for me to cherry pick and to exaggerate a bit to say that study validates my need and my reason for holding a stretch for 10 or 15 minutes.

It doesn't say that. That's not what the study is about. What they saw in this study was that basically the patient's brain attention peaked at 15 minutes and then slowly went back.

I do think that might be some of the reasons, though, why my prolonged touch had impacts that might be in addition to some of those tissue-based narratives that some of us know about,

or maybe in replacing some of those tissue-based narratives. It's not like irrefutable proof that the reason that long touch is impactful isn't occurring at the tissue level,

it's occurring at the brain level, it's not saying that at all. But hopefully, if you've never heard of this study, never heard of these concepts, it's enough to sort of wake that part of your curiosity up to say,

"Well, what else does it play?" There were another couple of studies done-- - Five minutes. Five minutes. Five minutes left? - Yes. - Okay. All right, so I'm gonna move on quickly then because I don't,

I got some other things here. Another researcher who I had not known was part of this conference, Joel Bialoski. Joel's papers have considerably influenced the way that I look at my work.

Joel has laid out in a brilliant way, in his 2009 and 2018 papers, the multifactorial aspect that touch creates in our patients.

And I think that's important, especially when we're locked into, it's all about the tissues. A hugely important paper as well as researcher. Another one was done, and again, all these papers are in that handout by Jerry,

G-E-R-I, in a paper called Manual Therapy, Exploiting the Role of Human Touch. Jerry had a line, I quote from this paper that I think it's so important,

it's at the top of my Facebook page, that clinicians should remember that manual techniques are not tools to fix the person's body. Rather, they provide the opportunity to communicate with the patient's brain similar to words.

And if anything can sort of embody how I now view my manual therapy slash mouth-to-early type of touch, it's that my touch is a way to communicate with the patient's brain,

and not simply to try and remedy a peripheral problem, right? Paper by Cole, KOLB, The Evolution of Magnotherapy Education, what are we waiting for?

It's a very easy, quick two-page article that talks about, essentially, we know so much. Why do we continue to teach tissue-based narratives as the sole quality that creates change?

To me, again, that's huge. One more set of studies, and I'm going to let this go. Laryngeal manipulation in this other world, speech pathologists, laryngeal manipulation,

which is basically grabbing hold of the larynx and doing a aggressive lateral manipulation to try and reduce local tension, was seen back in 1980 to be effective for voice disorders.
When they were thinking that the problem was too much tension right here in the peri-laryngeal muscles, and by manipulating them, you were able to reduce that tension to allow the person to speak easier,
better with clear quality. Well, if you go from 1980 through the '90s through the 2000s, and you started reading literature, research papers on laryngeal manipulation for these voice disorders,
people were still speaking in those, "There's too much tension right here," and when we do this, we're breaking up that tension, allowing the larynx to move better in an upward and downward motion necessary for speech,

seeing it as all a local effect. But then, things started to change in the 2000s and 2010s, and there were two studies released, one in 2017 by Spangler,
one in 2019 by Nelson Roy, and this is, to me, the embodiment of where our research needs to go. They had a person with a voice disorder.
They had a script that they put her in an MRI machine, and they had her read that script, and her voice patterns followed the traditional laryngeal problems that they see with something called muscle tension dysphonia.

And it was shown on the MRI to be essentially dysregulated brain activity. They pulled her out of the machine. They did the equivalent of an hour of manual therapy to the laryngeal region to try and reduce the tone and repost your the larynx in a lowered plane.
And then they slid her back in the MRI 'cause she was able to produce a clearer speech. They slid her back in the MRI and they had to read that same script again. And what they saw recorded on that second set of MRI images was a very different activation pattern in this person's brain.
That paper doesn't prove that it's not here, it's here. But to me, it is the embodiment that it is the human being that the problem exists in.
And it's the human being we're treating even though we might think we're treating the fascia. I think I got to most of my points here.
There's a few papers in that reference guide there that we didn't cover. I make myself available for follow-up if people have questions of any sort,
whether it's reaching out to me on social media, grabbing me via email at my website, which is waltfritz.com. And I hope that this has not been too confrontational for all of you and maybe it was helpful.
So thanks for listening. Are there any questions? I see a number in ways that I can't read. Are there any questions?
Yes. - Can you understand the English from the translation? - Yes, but I'm not seeing the translation. I'm only seeing the original language being,
I must not have said something up properly on my chat wall. So were there any specific questions that you might be able to ask me that were not answered?

- I will do my best in English. - Okay. - We have a question from Eliane Maros. A question about the intervention from the lettings.
If can work on immunological diseases like essential tremor of the speech? The answer would be in the literature there's rather slim evidence for that.
All right, at least when it comes to a broad term like that. Essential tremors of the voice also known as dystonia, vocal dystonia, has been mentioned in some of the manual therapy literature.
I would have to dive deep into my literature. If anybody has specific questions on that, send me an email and I'll see if I can find any papers. There was an interesting paper though on Parkinsonians dysarthria.
Dysarthria is the four ability to form words, right? Often a side effect of Parkinson's disease and what it just a fabulous paper by Adaris and Von P.
Kark that what they did was they used neurodynamic technique to the nerves of the face that are seen to be involved with Parkinsonians dysarthria and showed how again manual therapy could be explained from different perspectives.
The concept of doing specific nerve tunnel releases, tunnel stretches for those conditions. Muntubei,
I have another question. I would do both the question in Portuguese and after that in English for you to understand. So just to repeat the question from Elianimados,
I have a question from Elianimados. The question is the larynx intervention adopts to the immunological diseases like just the speech tremor.
You just answer that question, okay? So let's go to the next one with Maria Silva though the stretching of the face for five minutes, couldn't that stimulate the myofraboblases taking two fibrosis?
- This stretch of the fascia for more than five minutes cannot, can stimulate more myofraboblases leading to fibrosis. - I think that's an interesting philosophical question.
I have never looked at it from that perspective and I've never seen any research that says we could be creating more of a problem rather than helping a problem.
Let me sort of segue sideways for a moment because there's a paper on fibrosis when it comes to radiation treatment for cancers, all right?
That fibrotic changes are often a runaway nonstop problem for people who've undergone radiation fibrotic treatment especially with this population that I'm dealing with,
the head and neck cancer, okay? But there's some interesting evidence by Christianus and I did not put this paper on the references but I can easily share this with you.
Christianus talked about, there is early evidence to show that various sorts of touch - based intervention can diminish the progression of fibrotic changes in a positive way that the kind of work we're talking about here,

sustained touch, could be impactful in reducing the negative effects of runaway inflation or inflation, not inflation, inflammation when it comes to fibrotic changes.
That does not answer your question about the prolonged time with the fibroblasts, I think, but I don't have an answer to that one. Would I dare comment on acupuncture and fashion?

Nope, I'm not gonna comment on that one at all. I don't dare go there because I just think there's a lot of, there's so many rabbit holes that we exist in and we find ways to explain and rationalize the work from so many different perspectives and I've seen some of the papers and talked about acupuncture and fascia fascia.
And I think it's interesting work and I think it probably will bear out in terms of future research. I just, whether it's acupuncture and fascia, fascia work and fascia, trigger point and fascia,
I think it's just so important to remember that we're treating a human being and not an acupuncture murder, not a fascia restriction. And as soon as I touch somebody and as soon as they feel my touch,
safe, unsafe, appropriate, inappropriate, that while I might be impacting the fascia, I also know I just did something to alert them to create awareness.
And that brain, that central nervous system, could independently of mechanical changes to the tissue, could be sufficient to create some, if not all the changes that we think we're doing at a peripheral level.
- (speaks in foreign language) Any other questions? Yes, we have (speaks in foreign language) - Could be that touch could be replaced by a material such as a ball or an elastic band or a piece of metal.
- The question from Andrea Ikea de Garcia. Do you believe that the touch can be substitute for another material like a rubber ball? - Absolutely,
I don't, I, okay. I gotta go back to 1990. I was taught that human touch is the most important aspect that we can't replicate my fascia release with a ball,
with a tool, with taping, et cetera. And you know what, I love using my hands, but now I do use tools. I work over people's clothing. I sometimes work over their hands to give them a sense of control of safety,
of boundary. I absolutely think that we can do this work through any kind of these mediums. Are we, again, I'm gonna go back to the question. question. Are we able to select fascia for treatment,
whether it's with our hands or a ball or anything else? I think that is what my whole skeptical approach boils down to. I'm not certain that we can never be certain that when I touch somebody here,
I can find a problem in their fascia, only fascia, and I can treat a problem only in their fascia with that touch. That's my primary goal for presenting this talk today,
is we're treating a human and not their tissue. (speaking in foreign language) Thank you very much.
- Very good, thank you so much for your answers. - Thank you for your answers. It was such an enlightenment from our perspective of fascia body work,
because we, most of the times try to translate what's happening inside the human body. Like stretch weights,
like narrow visions. And I think your presentation just gave us a whole new vision about fascia body work.
- Yeah, I'm not saying that any of us, myself included, have to stop thinking it's about the fascia. - Yes.