A Day in the Life of an SLP, at Least Once Using Manual Therapy as an Intervention Strategy — BLOG POST

By Walt Fritz, PT / November 3, 2019

As a physical therapist, I occupy an odd place as a provider of education within the SLP profession. Others have trodden these steps before and will no doubt do so in the future, but being allowed into the role of moving the therapeutic narrative forward is an honor for me. However, as I say quite frequently in each of my seminars, I am only here to meet you, the SLP, at the mid-point of a bridge. I bring to the center of the bridge a manual therapy narrative of impact, handing it to you to move back onto your side of the bridge. Adapt and modify the work I present in ways that have meaning to you and your patients. I make no pretense about knowing the nuances and depth of your education, training, and experience. Still, I am reasonably sure that, in many instances, adding a manual therapeutic style of interaction adds value to the interaction.

How do SLPs incorporate this work into their daily practice? To answer this question, I will present feedback given to me over the past few years from SLPs who have taken my "Foundations in Myofascial Release "Foundations in Manual Therapy: Voice and Swallowing Disorders" seminar (formerly-named "Foundations in Myofascial Release for Neck, Voice and Swallowing Disorders") and put it into use. Understanding the levels of evidence that we accept as "proof" within our respective fields, I agree that anecdotes such as these are low-level proof. Still, they do reflect the experiences and opinions of your peers who have expanded into a broader field of therapeutic vision. The following are unedited stories and reports sent to me.

- *"I have a unique position as an SLP, which I often refer to it as 'Womb to Tomb.' I am fortunate enough to work with the tiniest of humans born extremely premature, to the teen who gets a traumatic brain injury, and even the elderly grandfather that wants one more beer with his son. When making the decision to complete the MFR training, I wasn't quite sure how it would fit into my work life. Selfishly, I was more interested in a personal gain as I am a competitive athlete with a professional strongman competitor boyfriend; thus, I thought it could help us with our aches and pains! But, after finishing this course, the direction of my career has taken off in all the right ways. I never could grasp why PT and OT would manipulate limbs, but we, as SLPs who take just as much anatomy and physiology, run away from physical contact with our patients. I wanted to change the stigma of showing other professions; I can aid their patients. I utilize MFR in my practice both inpatient in the hospital from acute stroke adults to my neonates on ventilators needing fascia manipulation to hold their pacifier intraorally. My outpatient schedule has a waiting list off the charts where I treat chronic cough, voice disorders, and my favorite head and neck resection, including post thyroidectomy to reduce tension at scaring post-surgery, trismus, and tethered oral tissues post-reconstruction. I feel incredibly powerful, being able to help my patients in conjunction with behavioral speech therapy, the manual piece is irreplaceable now that I have touched the surface. I have been trained for not even a year, and I, without a doubt, utilize the principles every single day. It has opened up new doors to a new passion in which I look forward to getting additional education*

on TMJ/trismus as well as taking Walt's Level 2 course." —— Chelsea Zimmerman, M.S., CCC - SLP. University of Nebraska Medical Center Speech-Language Pathologist

- *"I attended the Buffalo course with you back in October. I recently started seeing a 27-year-old diagnosed with vocal cord dysfunction (by referring ENT) with a chief complaint of shortness of breath and inability to take a deep breath. Problem has been ongoing for past 10+ years and able to resolve by forcing herself to yawn. She finally sought treatment when her family became concerned because she was yawning so much and knew she was not getting an adequate feeling breath. Vocal parameters were all within normal limits upon our initial evaluation (except s/z ratio which was <1). No reported vocally abusive behaviors. I have been using some traditional laryngeal control (anterior tone) and diaphgramatic breathing exercises and also complete circumlaryngeal massage. When I added MFR techniques focusing on both 'thoracic outlet,' diaphragm region (love the cross-handed stretch) and cervical region, she began reporting a feeling of being 'wide open' and is now able to take a full breath. I have seen her for four treatments so far and family noticing reduced yawning. Today she made it through a 45-minute session and didn't yawn once." ——- Jordyn Dolce, M.S., CCC-SLP Partners In Rehab, Buffalo, NY*

- *"62 y.o with diagnosis of melanoma of left neck, treatment with radical neck dissection, 36 radiation treatments. Referred to SLP 8 months post-radiation with complaints of severe neck tightness and pain, impacting voice and swallowing. Treatment: Myofascial release, along with traditional voice exercises and swallowing comfort strategies. 8 sessions of MFR completed over 12 weeks (patient traveling 2 hours for treatment), focusing on jaw bilaterally, anterior and lateral neck, base of skull (supine and sitting). Most sessions lasted 25-30 min. I worked on the lateral and posterior cervical region mostly and once we had achieved functional change in those areas we moved into treating the hyoid and supra hyoid areas. Results: -Subjective improvement in tightness – immediately after session – 75% better. After 8 session and self-treatment at home, patient maintaining improved sensation 80%, using traditional massage biweekly to aid in neck and back treatment. Swallow function: EAT 10 score improved from 31/40 at start of care to 6/30 at discharge (normal is 3). Patient reports improved ease and control of swallowing and improved comfort with pills. Voice: VHI-10 – 36 start of care to 7 at discharge. MPT – 6 sec. at start of care to 17 sec. at discharge." —— - Andrea H. Storie M.S., CCC-SLP. Pendleton, SC*

- *"I have personally found that voice patients do not relate to their symptoms during MFR, much of which is tension-based, as many of them don't really have physical symptoms (like pain) other than vocal hoarseness or change. I find that personally, MFR is a good precursor to doing vocal exercises, but it has been difficult to really achieve any sort of vocal improvement during the MFR itself. Patients become more aware of the degree of tension they were carrying following a successful session of MFR when they can feel the difference before and after. This really helps the vocal exercises to be more effective, especially if they use neck/chest tension to drive their voice, which likely is a primary feature of their disorder. Many of my voice patients enjoy the infra-hyoid region MFR done before vocal exercises, which are easily trained for patients to do on themselves as part of a HEP." ——- Marja Rowberry M.A., CCC-SLP. Swedish Covenant Hospital Chicago, IL*

- *"Patient is a 41 female who had surgery to remove a cyst from behind her left tonsil, which included a tonsillectomy, partial glossectomy, and partial pharyngectomy in June of 2016. This left her with scarring of on the left side from her anterior faucial pillar to the base of tongue. Within a few months patient was able to tolerate regular food but expressed that "some food would get stuck" in her pharynx. A videofluoroscopic swallow study (VFSS) showed residue in the left vallecula on hard*

solids. My first interaction with her was in September of 2016 when she came to the University clinic after her primary physician requested a swallow evaluation and therapy. She had recently had a repeat VFSS, which did not show any significant, changes. Following our initial assessment, our therapy consisted of teaching her compensatory strategies to allow the material to clear the pharynx. She did really well using head turn to the left resulting in no noticeable residue in the pharynx. We also did some basic stretching exercises but these really had not made a difference for her. She came every other week for this and did the stretching at home too. In February of 2017, the patient expressed that she really wanted to not have to use the compensatory strategies and that she would like for the issues to just go away. Soon after that, I took Walt's class in Chicago in April of 2017 and expressed to my patient that I was going to learn some things that I hoped would help her. During the class, I had my patient on my mind a lot and was very interested to learn everything that I could to help her. Following the class, I was very eager to get to work on her and I scheduled a session with her in the neighboring PT clinic where I had use of a high/low table, having practiced on one of the graduate student clinicians before the session. During the first session, we targeted all of the areas surrounding the hyoid as well as the tongue, left faucial pillar, and left palatal areas. Immediately after I noticed an improvement in her voice and the way she articulated her speech. We did some food trials and she expressed that the 'food didn't get stuck as much.' At the following session a week later, my patient said that the improvements lasted for 2 days and then she went back to having problems. After the second session, the improvements lasted about 3 days. A few weeks ago we began teaching her how to do some of the techniques herself, which she tried anytime she felt like she was having problems again and the effects would last for a few days. During our most recent session, she said that she feels that there is some "permanent" improvement and each week seems a little better. I hope it continues to a point where she fells 'back to normal.' We'll see what happens!" ——- Karen Geist, SLP. Sycamore, IL

- *"Success story! A 58 yo male LTC, s/p multiple CVAs, quadriplegic, aphonic, NPO on PEG feedings for 2+ years. He recently declined further and I picked him up for secretion management as his swallow was quickly diminishing. Tactile and thermal stimulation were ineffective and he's not a candidate for e-stim. I tried Walt's release of anterior cervical region (transverse process) on and off for about 20+ min and the patient initiated 6 dry swallows!! They were delayed and incomplete, frequently resulting in coughing, but pharyngeal swallows nonetheless! The best part was the smile on my patient's face. Can't wait to see him for the next session! Thanks Walt!!!" ——- Magdalena Banas, Philadelphia, PA*

- *"Pt is a 72 y.o. female; PMH includ/es malignant neoplasm of the mouth s/p Erbitux and 33 XRT treatments in 2010, tongue/neck resection in 2016, and osteoradionecrosis (ORN) after tooth abscess with jaw numbness in 2017. After reconstructive surgery, pt experienced lower facial weakness and numbness due to nonfunctioning right marginal mandibular branch of the facial nerve. After surgery, pt was seen for speech therapy at the local hospital to address dysarthria and dysphagia for several months, she noted regularly keeping up with 'popsicle sticks' exercise for trismus, however, continued to experience decreased opening of the jaw. She was received for speech therapy in spring of 2018 for articulation therapy to improve intelligibility and saliva control, with secondary complaint of laryngeal strain discovered only during initial evaluation. Treatment: Introduced Myofascial Release Therapy (along with traditional voice therapy exercises) for 5 sessions. Manual therapy was performed for 25-35 minutes, with 2 sessions of instruction and review of self-administration over 10 weeks at grossly 1-2 week intervals. Sustained engagement of mechanical pressure and opposing stretch to hyolaryngeal, suprahyoid/BOT, R side SCM and strap muscles, intraoral tongue, and intraoral as well as external jaw stretches/exercises were performed;*

areas of focus per session were determined based on patient feedback. Results and Observations: The patient noted decreased mechanosensitivity to mechanical pressure over course of therapy. During hyolaryngeal stretch, pt had reported increased sensation in R jaw region where she typically felt numbness. She viewed this as positive despite only temporary improvement. The patient reported immediate and long-term benefit across sessions: she noticed overall 'loosening' and 'opening up' of neck, throat, and tongue with improved phonation and reduced strain when speaking, as well as decreased 'tightness' of skin and tissues surrounding site of surgery and XRT. By the end of therapy, she noted suprahyoid and hyolaryngeal tissues felt 'softer' and were noticeably more pliable. The patient reported MFR therapy to be the most beneficial therapy addressed during sessions (despite her primary reason for seeking speech therapy for articulation!), reducing tightness and discomfort of surgery/XRT site, improving voice quality, and reducing laryngeal strain. She 'wished she had known about MFR therapy a long time ago.'" ——- Jessica Schwartz, M.S., CCC-SLP, Bethlehem, PA

I teach a very style of manual therapy that conflicts with many pre-conceived notions of what is at fault or what is the primary target of intervention. Manual therapy, which includes massage, myofascial release, manual circumlaryngeal treatment, and others, often cites issues within the tissues. While a compelling and straightforward narrative, it is incomplete. Roy (2019) shows us that while it is tempting to point to muscle tension as both causative as well as the primary tissue of impact with manual circumlaryngeal treatment, a deeper look shows that the brain carries more weight as a potential driver of muscle tension as well as a motivator for impact and change from our manual therapy interventions. (1) These views are slowly becoming accepted in the broader field of manual therapy, including physical therapy, and through research such as Roy's, this field is leading the way. My work is not always easily assimilated, as some are seeking a strict protocol to work through as I teach a more extemporaneous approach, though one not out of synch with current behavioral approaches. I believe in a therapeutic partnership, not a therapist-in-power relationship, one that requires the patient to play a more significant role in decision-making. This approach is not always easy to adjust to, but once done, it makes for what I feel is a more meaningful relationship.

Thanks to the SLPs who agreed to share their feedback with me, and now, with you.

Walt Fritz, PT

"Foundations in Manual Therapy: Voice and Swallowing Disorders" (formerly-named "Foundations in Myofascial Release for Neck, Voice and Swallowing Disorders")

Walt Fritz, a guest nicespeechlady.com blog contributor, is a physical therapist in the Rochester, NY area who has been using manual therapy as a primary intervention since 1992. He has been an educator since 1995, and his work has evolved from “myofascial release” into a more accurate term: “manual therapy.” He teaches his Foundations in Manual Therapy: Voice and Swallowing Disorders seminars to a variety of health professionals, including SLPs, across the globe. You can learn more about his work through articles and videos, along with viewing his introductory and advanced seminars at www.waltfritz.com. Coursework that Fritz teaches are ASHA-approved seminars for speech-language pathologists.

1. Exploring the Neural Bases of Primary Muscle Tension Dysphonia: A Case Study Using Functional Magnetic Resonance Imaging. Roy, Nelson et al. Journal of Voice, Volume 33, Issue 2, 183 – 194.

Disclosure: Foundations in Manual Therapy: Voice and Swallowing Disorders is a sponsoring advertiser of nicespeechlady.com.