Questions Surrounding Manual Therapy in the Treatment of Voice & Swallowing Disorders — GUEST BLOG POST

By Walt Fritz, PT / May 22, 2021

Being a physical therapist who teaches manual therapy to speech pathologists, there is often a bit of a gulf between our distinct worlds. The specific training for PTs differs from an SLP, but our worlds are not so different. We try to improve function and reduce the negatives. Simple, right? So given the differences in our professions, I wanted to share some common questions that I receive regarding my seminars.

Q: I am a pediatric SLP; do you teach peds-specific techniques?

A: Not really. I teach a method of evaluation and intervention that can (and does) apply across the spectrum of ages and diagnoses. While I have worked in early intervention, home care, developmental disabilities, and private practice, it is only in the context of PT. I believe in passing my work across a bridge to a clinician, allowing them to apply it in the context of their patient population and experience. We speak to specific conditions and populations in each seminar, though no technique that is taught is specific to only one diagnosis.

Q: Do you set out protocols for dysphagia and dysphonia?

A: Somewhat, though the strange thing is that I find myself using the identical technique sequences for both conditions, as well as globus and neck pain-related conditions. We speak to a significant number of protocols spread throughout the evidence to support the classes, and the curious clinician could dive into those studies in an attempt to replicate those protocols. Having worked with these manual therapy techniques for nearly 30 years, I've slimmed down the number that I find helpful and present them to you in the classes, and I use them without regard for the specific diagnosis. If a person presents with an issue in the neck region, I will begin interacting there, relying on a small number of core techniques with nearly infinite variations.

Q: What about evidence, is there any to support the manual therapy you teach?

A: I pride myself in pulling together a deep well of relevant evidence to support the work taught in the classes. Most substantial is the research supporting the use of manual therapy for voice, both dysfunctional voice and normal or performance voice. Manual therapy is well-represented in breathing, oral-motor, tongue-related conditions, and posture as a means of intervention for voice, swallowing, and breathing. There is currently less robust evidence to support manual therapy's role in dysphagia, though studies are out there.

- "Manual Therapy: Integration into a Speech and Swallowing Rehabilitation Program for Head and Neck Cancer"

- "Application of manual Therapy for Dysphagia in Head and Neck Cancer Patients: A Preliminary National Survey of Treatment Trends and Adverse Events"

- "A Novel Manual Therapy Programme During Radiation Therapy for Head and Neck Cancer — Our Clinical Experience with Five Patients"

What should be noted is the evidence-based research provided to support the model of shared decision-making (SDM) used throughout all courses. This model is a stark contrast to the paternalistic model traditionally used in manual therapy. The clinician is seen as the expert and is responsible for all evaluation and treatment decisions. In an SDM model, power is shared more equally throughout the evaluation and treatment process, allowing greater buy-in from the patient.

Q: What is the difference between what you call manual therapy and manual circumlaryngeal treatment, myofascial release, and massage?

A: Beyond the titles, there is less difference than many believe. I use a slow, prolonged input (stretch) that resembles a myofascial release style of work, though I moved on from that title for my work due to the credibility of the perceived target tissues. Manual circumlaryngeal treatment (MCT) is often more aggressive and a quicker type of treatment. While effective, I feel that MCT gives the patient less time to process the stretch and determine relevancy. But that model fits well with paternalistic styles of intervention. Massage seems remote from what I teach and MCT but may not be so different. There is scant evidence to show that one type of work is more effective or impacts other tissues than the next. I encourage clinicians to care less about exactly how they treat but instead care more about how the patient responds to touch. Is the touch/input relevant? Does it connect them to their issues? Does it feel safe and effective, or harmful? I allow my patients to guide me instead of my beliefs.

Q: What about posture? Does it matter?

A: Sort of. In the more general world of physical therapy, poor posture and pain are very weakly linked. But there exists a relatively robust level of evidence to show that postural changes can improve voice, breathing, and swallowing. Addressed in the proper context, posture does matter, but I stop short of stating that someone with no issues of voice, swallowing, or breathing who just so happens to have poor posture must correct the posture to avoid future problems. That is where the evidence falls short. We cover more posture-related issues in my new 2021 Foundations in Manual Therapy Seminar. In the Foundations in Manual Therapy: Voice and Swallowing Disorders seminar, we stick to core concepts relating to breathing, voice, swallowing, globus, oral-motor, and tongue related issues, as well as intervention to the face.

Q: Can a newbie to manual therapy expect to become proficient after just one 2-day class?

A: I believe so. Though an SLP may have less experience applying manual therapy intervention, once some basics are learned and practiced, the work tends to flow quite nicely. The more complicated part is getting up the courage to try the work. Since most patients know little of what an SLP does, it is the clinician who feels awkward, at least to being with. The range of ways SLPs utilize manual therapy varies

from a partial inclusion into every clinical encounter to more sporadic inclusion. I don't view manual therapy as a standalone therapy but should be incorporated into the many effective interventions already in use. Touch is often a substantial contextual bonus for many patients. The affective qualities of touch can be a significant part of the outcomes, which should not be understated.

Q: Isn't it essential to have an accurate diagnosis to determine what exact tissues require intervention?

A: Accurate diagnoses are a must, but that diagnosis will probably not specify a specific tissue as being the at-fault one with any great accuracy. One of the common misconceptions throughout manual therapy is that there is a type or brand of manual therapy that targets individual tissues best. Newer literature points to the tissue not being the target of intervention but instead acting as messengers to higher centers, calling on the brain, CNS, and ANS for change in the periphery. Little credible evidence exists that we can select tissue for intervention that excludes other tissues. One of my favorite sayings is a frequent one passed around in the skeptical manual therapy community: "Treat her patient, not their tissues."

Do you have questions? Feel free to contact me through my website, www.WaltFritz.com. There you will find a slew of podcasts, videos, and articles on the work that I use and teach.

Cheers,

Walt Fritz, PT

Walt Fritz, 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, for ASHA credit.

He now has an online forum for CEUs. You can learn more about his work through articles and videos, along with viewing his introductory and advanced seminars at www.waltfritz.com. Readers can utilize “NiceSpeechLady” as the discount code for 10% off of the course upon checkout.

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