

# Chapter 1

## The Patient's Runaround

### **What's Inside**

In this chapter you'll learn about the patient's bumpy ride to get help with spasmodic dysphonia. □ Begging for help  
□ Prescription for failure □ Dazzled by high-tech  
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### **Begging for Help**

Patients afflicted with “the strangled voice” or dreaded condition called spastic dysphonia or spasmodic dysphonia are in disbelief. Many actually stay in denial until their voices deteriorate to near muteness. Some can't believe their voices won't go back to normal. Yet no matter what they try, no matter what homespun remedy they follow, their voices basically don't improve on their own. When they're at their wits' end, they finally

knock on the doctor's door. When they do, they encounter the medical paradigm, attributing failed voices to acid reflux or a host of trendy neurological or biochemical explanations.

Ludwig Traube, M.D. (1818-1876), a German internist, first described "a spastic form of nervous hoarseness" in 1871 in a report entitled "Spastisch Form der nervösen Heiserkeit" in *Gesammelte Beiträge Pathologie und Physiologie* 1871; 2: 677-7. In 1875, Johann Schnitzler, M.D. (1835-1893), a Viennese laryngologist, termed the condition "spastic dysphonia." Spastic dysphonia is also called spasmodic dysphonia or SD, but popularly called the strangled voice. I will refer to spastic dysphonia and spasmodic dysphonia interchangeably as such or as SD or as the strangled voice. I find that Spastic Dysphonia occurs when the voice remains constantly spastic. In Spasmodic Dysphonia, the voice is variable in its strangled strain with various circumstances and people. I will define Abductor Spastic Dysphonia and Adductor Spastic and mixed types as SD. Traube attributed the condition he described to psychiatric causes; however, psychiatry does not report a single cure of SD dating back from Traube to the present time.

Spastic and Spasmodic dysphonia while not initially psychiatric *per se* causes its own emotional problems and psychiatric problems. Watching voices helplessly deteriorate is no laughing matter. Take physicians, for example. Without a professional sounding voice they lose credibility—and confidence—with patients and staff. Attorneys are also devastated by spasmodic dysphonia, since speech, voice and, yes, argument plays an essential part of their daily routines. Spasmodic dysphonia is curtains for anyone in the TV or radio fields—that goes without saying. Teachers, college professors, salespeople, homemakers, and others who speak for a living or need their voices to communicate, literally become disabled when their voices fail. Whatever the job or avocation, the human voice plays

a powerful role in everyday life. When disability hits, anxiety and depression—and even possible suicide—may follow close behind.

Depending on the type of job, individuals endure major stress before finally looking for medical help. What's interesting is that individuals with the strangled voice don't rush for medical help because, intuitively, they may not really see their condition as a medical problem. Here we see a divergence of opinion and essential questions regarding spasmodic dysphonia: Namely, is the condition medical or due to incorrect voice usage, a learned behavior? Physicians practicing today's medical paradigm convince patients early on that the strangled voice is an incurable neurological problem.

Without question, the strangled voice is a scary condition, watching otherwise normal individuals turn into vocal misanthropes. The strangled voice may create outward disfigurement in the form of eye spasms, facial spasms, neck and back spasms, which create painful inferences of emotional disturbances for those encountering it. Like the better known problem of stuttering, so, too, patients with the strangled voice stumble, mumble and bumble over simple speech, causing even greater distress to those witnessing the facial contortions and embarrassment firsthand. The person with strangled voice can feel the extreme neck and back tension and see the resultant eye and mouth pressure when viewing themselves.

Spastic Dysphonia is listening to someone painfully choke out the words, barely audible, unintelligible and unable to communicate create terrible first impressions. Putting your best foot forward, making a good presentation, or gaining strategic advantage is virtually impossible for patients suffering with spasmodic dysphonia. Gradually patients wear out. They summon all their energy trying to communicate. But clarity of purpose doesn't correlate with clarity of voice. Without a clear voice, and certainly with a voice that either strangles or breaks up in whispers,

voice tremors, voice breaks, the chances of success in whatever field are greatly diminished.

Faced with conducting business-as-usual or normal everyday conversation with a strangled voice, communication becomes burdensome and traumatic. Spasmodic dysphonia is also called laryngeal stuttering. As do those with strangled voices, stutterers continue to compensate, sometimes developing voice tremors, facial tics, neck or back spasms, and other unusual behavioral manifestations, calling attention to themselves. Contorting one's face, eyes and body, grimacing and otherwise looking badly strained, it's difficult for these patients to go through a normal routine, especially talking on the telephone; they fear using the phone, developing a phone phobia. Eventually the phone voice may drive them to go to doctors looking for help as with stuttering. The SD person like the stutterers usually cannot talk on the phone.

When confronting patients with strangled voices, doctors turn to common treatment bibles like the *Merck Manual*. Under laryngitis, they find many common bromides, like hydration, rest, reflux drugs, acupuncture, antibiotics, allergy shots, post nasal drip medications, deviated septum surgery, sinusitis and much more. When conditions don't improve and patients become progressively desperate, they're typically passed on by primary care doctors to ear, nose and throat specialists, Otolaryngologists, the medical specialists dealing with head and neck problems. For patients with inexplicable conditions like spasmodic dysphonia, going to specialists creates new hopes and raises great expectations.

Specialists hold out hope that this otherwise unresponsive condition has a chance of swift and effective treatment. Patients with the strangled voice have already followed primary care doctors' instructions and received little relief. Finally, they think they're in the hands of someone who truly understands their

condition and can help them. They hope modern medicine can return “normal” voices.

It’s perfectly reasonable for patients to expect from specialists full recovery or at least substantial improvement in their voices. All too many spasmodic dysphonia patients are not diagnosed quickly. Patients go from doctor to doctor. The lucky ones are relieved to be told it’s not in their head assured, “It’s a neurological problem, a dystonia, a disease.” And then the bad news, SD is incurable. Experienced doctors listen for the “squeezed” sound and diagnose the condition as adductor spasmodic dysphonia. If the voice is breathy or breaks up, it’s called the abductor variety. SD can be of mixed types, to involve both adductor and abductor at the same time. Videostroboscopy may help to determine the type of SD, but not always. The clinical ear is key to diagnosing SD. Once diagnosed with SD, patients are typically given reflux drugs, hoping to stop vocal cord irritation, theoretically caused by gastroesophageal reflux disease [GERD].

The medical field believes acid reflux is *de rigueur*—the soup du jour causing deep throat, raspy voices and SD, too. As a clinical voice expert, I estimate that 25% of the population talks with deep throat, raspy voices. The number of people suffering a deep throat, raspy voice is perhaps 75 million people. I listen to voices on the radio, TV, movies, and in person. I hear misuse and abuse of the speaking or singing voice as epidemic. Patients tell me they are assured by medics, “you have acid reflux,” though patients object, saying they don’t, and acid reflux can’t be found, “It’s invisible,” “silent,” or “asymptomatic” patients are told by their doctors. Those who do have acid reflux and take reflux medication for heartburn and indigestion say that reflux drugs did basically nothing for deep throat, raspy voices, and nothing to help the strangled voice. For indigestion and heartburn reflux medications can do wonders but can it do wonders for deep throat, raspy voices? Merck sponsored the 1992 study that found deep throat, raspy voices are due to acid reflux. Merck spent 100

million dollars on heartburn and indigestion on ads. After antacids or reflux drugs don't restore voices, that's when things get interesting. Patients may be given the benefits of high-tech science (Cat Scans, MRIs, videostroboscopy) and other state-of-the-art medicine. SD patients are essentially offered Botox injections in the vocal cords, the muscles creating basic voice. Botox stands for Botulinum toxin, Bo for Botulinum and Tox for Toxin, a friendly sounding name of the deadliest poison known to man. Botox is diluted by the manufacturer Allergan into therapeutic doses, and now touted by Allergan, the maker of Botox, as possibly the next "penicillin." Allergan says that Botox offers patients with spastic vocal cords new hope of getting back voices. The Sunday front-page story in the March 2, 2003 edition of the *New York Times* reported this statement, "Botox is giving those with spastic vocal cords back their voices." In reality, things may turn out to be very different. Patients may get a "Botox voice," but not the normal voice they might have expected.

### **Prescription for Failure**

Living with strangled voices leaves patients desperate for treatments promising relief. Botox spells relief for spasmodic dysphonia or so says the media, medical doctors, speech pathologists and the manufacturer Allergan. The figure may be given to SD patients is that Botox is 99% effective. My extensive clinical experience with SD and numerous reports from SD patients by e-mail, phone calls, letters and patients seen indicate quite clearly that Botox is far from 99% effective. Patients have great expectations before Botox treatment, hoping voices will go back to pre-strangled conditions. Though SD patients may be disinclined to take Botox, a poison, their ENTs and the medical profession basically assure them, Botox is state of the art and treatment of choice. Additionally, patients are assured Botox is "safe and effective" in the short run. But is it? All too many Spasmodic Dysphonia patients who try Botox tell me of serious side effects from Botox shots. Many tell me they tried Botox shots

but they did not get their normal voice back, let alone a voice able to talk with. Medical people may say that Botox shots are bee stings but some patients disagree and say the Botox shot is traumatic.

When patients hear such a high percentage about product efficacy, it sells the undecided and those questioning Botox voice care. Faced with either taking Botox injections or submitting to vocal cord surgery, patients gladly opt for Botox. Others decline Botox knowing it is the world's deadliest poison in diluted form. No one knows the long-term downside effects on the body from cumulative shots.

Dr. Mitchell F. Brin, a neurologist, brought Botox to SD use in 1984. Extrapolating from research that showed Botox successfully treated torticollis [neck spasms] and blepharospasms [eye spasms], Brin thought it only logical Botox should work on spastic vocal cords. On March 10, 3pm, 1991, Dr. Brin noted at a meeting sponsored by Allergan in Irvine, CA before hundreds of people that he wanted to withdraw Botox (botulinum toxin) at the earliest possible time fearing the downside effects on the body. He added that there were other drugs that could replace Botox. The video of the meeting was to be taped and said to be available for purchase. The video of 1991 never was made available.

In 2003, I asked an editor of a national magazine, *ADVANCE*, to confirm or deny Dr. Brin's 1991 statement that he wants to withdraw Botox (botulinum toxin) at the earliest possible time fearing the downside effects on the body. Dr. Brin, thru a nurse or secretary, confirmed the statement adding, it was "dated." Dr. Brin is now a Senior Vice-President Development of Allergan, Inc.

In 1994, the Food and Drug Administration characterized Botox for faces "egregious." Approved in 2003 by the Food and

Drug Administration [FDA] for treating frown lines, Botox has become the rage among physicians seeking wider and wider applications. Botox can now be used for the whole face though not yet approved directly by the FDA. What does Botox do? Botox relieves spasms by paralyzing acetylcholine, a powerful neuromuscular transmitter that causes muscle contractions. Without stimulation, muscles relax, whether they're in the face, eyes, neck, or vocal cords.

Following a medical paradigm, Dr. Brin believes simply paralyzing muscles in the vocal cords should effectively eliminate spasmodic dysphonia spasms for a period of time. Where Dr. Brin miscalculated in the strangled voice was over the simplistic idea that voice production, whether normal or pathological, was based on paralyzing the recurrent laryngeal nerve that activates the thyroarytenoid muscles, which are the vocal cords. Injecting Botox in the vocal folds may often diminish spasms, but doesn't deal with primary cause of the strangled voice. Inside the medical paradigm, spasms in the vocal cords are attributed to dystonia, or, put more simply, uncontrolled neuromuscular activity. Tracing it back to its neurological roots, the medical view insists that renegade activity in the vocal cords is caused by excessive activity in the basal ganglia, a neurological structure near the thalamus, or center of the brain. Initially in 1984, one Botox shot was given in nine months; today patients are receiving 4-10 or more Botox shots per year, each and every year for life.

Dr. Brin insists SD is a gene related and a neurological condition, not a psychiatric problem. Only invasive medical intervention Botox or surgery is appropriate. Dr. Brin does not believe SD is a problem of wrong voice use. I have clinically found neck spasms and eye spasms may be related to wrong voice use.

A high official in a drug enforcement field suffered severe eye spasms along with severe SD. He tried Botox for these conditions only to find it was not productive or fulfilling to him.

After trying several prestigious medical centers with the best ENTs providing Botox shots, he decided to give up Botox and try my program of Direct Voice Rehabilitation (DVR). The outcome for him was extremely satisfying as he found that his eye spasms and his SD both disappeared over a period of a few months by DVR. The patient returned approximately a year later to report that his SD and eye spasms had not returned.

Years back, as the Director of Adult Stutterers at Stanford University, I noticed stutterers had facial spasms including neck spasms. Spasmodic dysphonia patients show similar spasms when trying to talk. The facial and neck spasms of stutterers disappeared when stutterers learned how to talk normally. I found that eye spasms (blepharospasms) and facial and body spasms are reduced in SD cases, too, and eliminated when a normal voice is used. Some SD patients are realizing the connection of their SD voices to spasms of face and body, I am finding. ENTs and neurologists believe facial spasms are part of the dystonia that SD is causing. Those in the medical profession call eye spasms, Meige's Syndrome.

Surgery for spasmodic dysphonia may carry inherent risks, including neurological damage and a variety of post-operative complications, as well as the possible permanent loss of a normal voice. You may get a whisper voice. Surgery may be helpful to some but others may get worse, complicating the picture for possible vocal rehabilitation. Inside the medical paradigm, there are no other options other than reflux drugs, Botox injections or surgery for patients with spasmodic dysphonia. Botox shots, Reflux drugs or surgery for SD do not report a single cure ever.

Operating inside today's medical paradigm, one of the leading theories is that physicians view the strangled voice, as caused by a "focal laryngeal dystonia," or, more specifically, a neurological impairment originating in the basal ganglia of the brain and localizing in the muscles that control the vocal cords.

This theory began in 1960 when Drs. Robe, Brumlik and Moore in *Laryngoscope*, a medical journal, reported that SD might be a hidden neurological condition in some of the ten patients they evaluated. From this brief number they suggested that SD might be related to a dystonia. Prior to 1960, SD was considered to be a psychiatric problem. While neurological explanations remain theoretical and no cures ever, they dictate popular medical treatments for spasmodic dysphonia, including Botox and surgery.

As you can see, within the medical paradigm today there's no room for alternative theories of the cause of SD. Nor is there a choice of the comprehensive non-medical treatment for spasmodic dysphonia known as Direct Voice Rehabilitation, originated and developed by me, which continues to report ongoing cures of medically diagnosed SD. My clinical experiences as a voice and speech pathologist, on staff and faculty as well as a former Director of Voice and Speech Pathology, Outpatient Clinic and a Clinical Assistant Professor, Head and Neck Surgery Division, UCLA Center for the Health Sciences, have given me insights and great success in dealing with various voice problems. Rather than focusing on neurological or biochemical events, I concentrate on retraining incorrect voice habits that I find cause deep throat, raspy voices leading to the strangled voice. My voice approach couldn't be more opposed to prevailing medical theories blaming spasmodic dysphonia on faulty neurology or biochemistry, genes, molecular biology, disease, dystonia, acid reflux, basal ganglia or brain dysfunction, etc., etc.

Since 1970, I went outside the medical box and took a different approach, addressing the underlying theory SD is caused by neurology or faulty biochemistry. I do not clinically find spasmodic dysphonia to be a medical problem. I find that spasmodic dysphonia is simply due to wrong voice use and/or abuse. I question the relevance of other medical theories causing SD. These medical theories include: 1) neurological, 2) dystonia, 3) chemical brain imbalance, 4) dysfunctional basal ganglia, 5) gene related disorder, 6) psychiatric, 7) gastro esophageal reflux disease (GERD), 8)

molecular biology. Medical treatment based on causation from these and other medical theories have never reported a single cure since Dr. Traube in 1871 first described it as “a spastic form of nervous hoarseness”, later to be called Spastic Dysphonia and Spasmodic Dysphonia.

For over 40 years, I have observed that bad voice habits lead to physical stress, strain, fatigue on the lower throat causing exhaustion and negative symptom formation—in a downward cycle I call “Voice Suicide,” a process leading to “voice breakdowns.” The negative symptoms include: sore throat, raspy or hoarse voice, laryngitis, throat clearing, tired weak voice, pain when talking, poor projection, effortful voice, strangled voice, lump in throat, throat tension, deep throat voice, voice strain, voice tremor, back pain, body fatigue, neck muscle, and more. I outline these negative symptoms to wrong voice use in my well-known textbook *Modern Techniques of Vocal Rehabilitation*. Medical theory today makes or relates some of these negative symptoms to acid reflux or a dystonia. The symptoms of acid reflux causing inflammation, edema (inflated or thickened vocal cords), redness for vocal cords and throat are similar to symptoms of voice misuse and abuse. Laryngologists misread and misinterpret acid reflux causing these symptoms when the wrong voice is the essential overriding cause. I see the medical approach as upside down, or, as my former boss and Chairman Dr. Joel Pressman at UCLA Medical Center Head and Neck Division told me, “ass-backwards,” for voice problems in general and I add, for SD in particular. Here’s where things go in opposite directions with current medical thinking. “You got acid reflux” countless people with voice problems are told by their doctors, confusing inflamed, red, or vocal cord edema as caused by acid reflux. These are classical and traditional and routine symptoms of wrong voice use. These doctors are not listening to deep throat, raspy voices to realize that these impaired voices are basically related to deep throat speaking. Strangled strained voices are always focused in the lower throat around the vocal cords and larynx. Doctors do not associate strangled voice simply to deep throat wrong voice talking; the medical profession believes that focus in the lower

throat is caused by a dystonia and cannot be changed. They are terribly wrong; I can change this so-called dystonia focus to a face focus within minutes or seconds for most SD patients. A dystonia means the condition is unchangeable. SD is (a dysphonia), a functional voice problem, you are talking with the wrong voice, and therefore, can be changed.

SD patients are inundated and overwhelmed by theories of cause if not treatment of SD. They do not understand the irrelevance of acid reflux for causing SD, let alone deep throat, raspy voices. They will undergo such treatment believing in medical direction. From the SD patients' perspective, they're looking for a cure, to a voice that is not strangled. A powerful drug, like Botox, is used to paralyze neuromuscular transmitters like acetylcholine believed to be responsible for runaway contractions or spasms. But seeking to arrest spasms in the vocal cords doesn't automatically return patients' strangled voices to normal.

All science looks for cause-effect relationships. In medicine, the goal of etiology, the science of medical cause-and-effects, is to treat causes [underlying medical problems], and to eliminate unwanted effects or symptoms [superficial manifestations]. Symptoms are usually viewed as outward effects. In other words, symptoms don't cause medical conditions—they're an outcome or product of underlying problems. In the case of the strangled voice, the medical profession views faulty neurology or "dystonia" as causing the strangled voice. Botox injections or vocal cord surgery and acid reflux drugs are designed, at least in theory, to palliate underlying pathology and stop uncontrolled vocal cord spasms, and strangled strained voice and speech.

When patients go for medical help they are presented with limited options: Botox and/or surgery, Speech/voice therapy to cope with, not cure ever, spasmodic dysphonia or do nothing and live with the condition. Seldom is made mention of my non-

medical treatment and cure of spasmodic dysphonia known as Direct Voice Rehabilitation—a specialized form of voice behavior modification designed to reverse bad voice habits. Before patients experiment with dangerous surgeries or toxic medications, they should at least know about a noninvasive option like Direct Voice Rehabilitation. Choice of Direct Voice Rehabilitation is not a normal option patients are given for spasmodic dysphonia. They are basically told Botox is the choice of treatment. At a well-known Medical Center, one patient wrote me that there was standing room only in a room full of SD patients to get their Botox shots. And return and return and return endlessly for ongoing Botox shots for life.

The following is an example of one of the many emails I receive on a regular basis regarding SD patients and their ongoing battle with Botox:

“My husband has suffered from SD. He has had three surgeries--a fat injection, implants, and, a few months ago, further injections into his vocal cords. Two different doctors were treating him for vocal cord atrophy. He has been treated with Botox for about 7 years, going every 2-3 months. His voice is worse than ever. He was diagnosed with a "mixed adductor/abductor” and has been told he is a very difficult patient to treat. He has lots of muscle tension in his neck, obviously, from straining to produce sound.

He’s at his wit's end. He has a very demanding job that is made more difficult by this voice problem. He has tried a little voice therapy, though always with people who have no clue what they are dealing with, so he is understandably skeptical of anything that can be construed as voice therapy. He has had doctors tell him that voice therapy will not work.”

In the December, 1999 NSDA *Newsletter*, page 7, Dr. Gerald Berke, Chairman of UCLA Head and Neck Division reports

regarding Botox (botulinum toxin): “...there are some obvious drawbacks. It requires lifelong visits from 4 to 10 times per year for repeat injections. The injections are not inexpensive. The interval between post injection breathiness, good voice, and the return of symptoms may not be very long in some patients. Hypersensitivity and antibody formation have been shown to produce some long term structural changes in muscle cells.”

When patients go to doctors, they expect drugs as the first line of treatment. Treatments that don't involve drugs or surgery lie outside the medical paradigm and the pharmaceutical industry. Alternative therapies or treatments are viewed with deep skepticism by those practicing inside the medical paradigm. That same skepticism easily transfers to patients considering non-medical options but now worried that alternatives lack scientific precision and effectiveness.

Unless patients with the strangled voice surf the Internet or perform their own independent research, it's unlikely they'd even know about my program of Direct Voice Rehabilitation—a proven, non-medical treatment for spasmodic dysphonia with a 35-year track record ongoing cures, recoveries, and improvements.

Today's medical training leaves physicians dubious of non-medical approaches that don't carry the endorsement of the pharmaceutical industry or prestigious medical associations. Only drugs or procedures getting medical approval are viewed as legitimate treatments, irrespective of whether they get results. Differing definitions of medical outcomes also confuse the picture in the treatment of the strangled voice. Whether voices improve or not, the medical outcome is considered effective with reductions in vocal cord spasms. Listening to voices before-and-after Botox or surgery is usually not part of the medical paradigm for assessing results of medical treatment with spasmodic dysphonia.

For all too many patients I see, it's "the Botox voice"—a disfigured shell of the former voice, superimposing vocal cord paralysis on an already strangled voice. Patients submitting to Botox treatments, of course, expect normal voices, not deformed artifacts of their pre-morbid voices. Yet all too often I find following repeated Botox treatments, the voice doesn't snap back as expected.

If the voice does snap back, it is for all too often short periods of time, so short it may be considered a roller coaster ride. Another Botox shot is given and so one may be given a Botox shot every two weeks, or month or on average four to ten times a year, each and every year for life. Does it help? I have encountered SD patients who have had 1, 3, 5, 10, 20, 30, 40, 50 shots without getting a normal voice and sometimes losing their voice. Patients tell a litany of trying Botox shots, once a month with never a return of any voice; some having had 10 shots, and no normal voice to speak of; another 20 Botox shots and no normal voice to talk with. An SD patient tried 17 Botox shots, 16 failed to return a voice, over 4 years. Another tried 45 Botox shots over 15 years and had only a whisper voice from Botox. Asked why she didn't stop, "my doctor told me to continue." Another SD patient had 50 Botox shots and still no voice to speak with. He gave up on his own. Keath Fraser, author of *The Voice Gallery* tried a number of Botox shots for years. He gave up. He reports others trying Botox shots find limited results though they may undergo many shots. Some may get some relief on one of many shots, and others no relief and no normal voice found. Botox is extensively iffy in outcome. Tom had 46 shots over a period of eight years. Not one of those shots gave him any relief. A young lady had a Botox SD shot and reported to her ENT specialist that her hair was falling out, rashes on her body, and that her lip now had a tremor. The ENT assured her it wasn't from the botox shot but from the dystonia. The Reverend Sellers had one Botox shot only to lose his voice for six months. Others tell of losing their voices for weeks and months. Botox shots are well intentioned, humanitarian and compassionate in seeking to help SD patients and other voice problem, but...

A well-known ENT doctor who reports how successful Botox is for his SD patients leaves out his notable failures. Another ENT is quoted in national news as praising his SD successes, ignoring a failed case after two Botox shots left his SD patient with bowed vocal cords, and no voice, only a bare whisper.

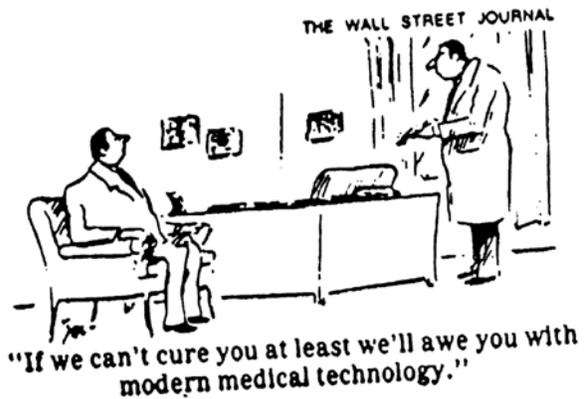
A spasmodic dysphonic patient underwent a surgical procedure for SD only to find she was left with a whisper for a voice. She reports her doctors told her, her vocal cords came together on the vowel “e” ninety to one hundred percent of the time. But when talking, she had no voice to speak with. And on other vowels her vocal cords were not functioning normally. It appears to suggest the patient talk only on “e” vowels? The definition of “success” leaves the patient and the outcome in question. The surgeon’s definition of “success” may impress other physicians, but does it make sense to the patient? Meanwhile other SD patients who underwent surgery tell of the loss or serious impairment of their voices on the Internet and elsewhere. Doctors do not basically report their failures. A famed ENT, when asked about his successes with a new surgical procedure described in a medical journal, told his audience all the successes failed, but assured them, you do not report your failures.

Doctors report their successes, not their failures, it seems. And they report on the “honor system.” That may mean there is no check on their successes. And their failures. What is real?

### **Dazzled by High-Tech**

Another interesting bugaboo for patients seeking treatment for spasmodic dysphonia is their fascination with high-tech procedures. Most patients think “exotic” conditions like the strangled voice can only be treated with the aid of sophisticated computer technology, high-tech equipment, MRI’s, Cat Scans, and more. Pop culture, through TV and film, convey images that high-tech, today’s modern science of medicine has answers for

everything. Without high-tech props like videostroboscopy, phonatory printouts, computer technology, patients become skeptical, lose faith and develop pessimism over treatments. Medical offices and medical centers satisfy the desires of patients for fancy electronic equipment believed essential for effective treatments and successful outcomes.



Diagnosing spasmodic dysphonia in medical offices and centers, patients are often wired to monitors, making the best use of high-tech video equipment, producing elaborate scans and printouts on electrical activity in the voice box. Videostroboscopy, where the vocal cords are actually videotaped with the aid of fibroptic tubes and detailed phonatory work-ups are extensive diagnostic procedures that may take hours—if not days—leading to the diagnosis of spasmodic dysphonia. Yet, experienced clinicians and voice experts, with highly trained clinical ears, can easily diagnose the strangled voice without the use of high-tech contraptions, often in a matter of minutes, even seconds on the phone.

The best of medical hi-technology does not show the laryngeal resonance to be a dystonia. You can palpate laryngeal resonance, you can hear laryngeal resonance pressure, but you can not see laryngeal resonance as far as I can tell. I can help change

excessive laryngeal resonance in seconds or minutes although excessive laryngeal resonance is medically believed to be a dystonia. Using my revolutionary discovery called the C-spot, I am able to refocus the lower throat laryngeal resonance to the face proving quickly, SD is not a dystonia (neurological and not changeable) but a dysphonia (wrong voice use changeable by right voice use). Medicine is baffled and frustrated when SD does not basically show nodes, polyps, contact ulcer or other growths on the vocal cords, or visible pathology to cut out.

No matter how sensitive the diagnostic equipment, the medical paradigm does not prove that underlying neurology or possibly inexplicable molecular events are causing the strangled voice. Within the medical paradigm, it's not permissible to consider alternative explanations for spasmodic dysphonia, including the clinical reality that the condition is due to faulty learning, incorrect voice habits and prolonged "wear-and-tear," not neuropathology. If incorrect voice habits are indeed responsible for spasmodic dysphonia and other common voice problems, then no drug, surgery or high-tech procedure can reverse these conditions.

Specialists using Botox for SD like to give patients detailed graphs proving that the Botox is doing its job. They try to map out the cycle that occurs after Botox injections, including periods of expected muteness or breathiness, then brief cycles of improved voice. All the while, physicians like to identify the effects of Botox as falling into a predictable pattern leading to eventual improvements. But the Botox voice may not fall into a predictable pattern. Patients' Botoxed voices may end in whispers for weeks and months, and still the "normal" voice does not return. Getting the Botox voice may disappoint patients hoping to restore voices to preexisting states, before being afflicted with spasmodic dysphonia. Even after repeated Botox injections, patients still expect voices to return to normal. When the voices don't, the patients are told to be patient. When repeated injections still don't

reestablish normal voices, patients are told it's due to reflux. GERD, Gastroesophageal reflux disease is thought to be one of the leading theories causing spasmodic dysphonia. Patients are often prescribed acid reflux medications prior to or along with Botox shots. I do not find acid reflux causing deep throat, raspy voices leading to SD or that reflux drugs will alter wrong voice talking which leads to deep throat, raspy voices. I report that deep throat, raspy voices are overwhelmingly due to voice misuse and abuse, citing an extensive medical and academic number of studies. (*See my book, Modern Techniques of Vocal Rehabilitation on my bibliography*). SD patients do not find a cure to their failing voices with acid reflux drugs.

No matter how results disappoint, patients typically stay with treatments, sometimes getting ongoing injections before realizing that the Botox has its limitations. But only a small cadre of specialists called Otolaryngologists and some Neurologists actively use Botox to treat the strangled voice. The American Society of Otolaryngology endorses Botox for SD. Together with the National Spasmodic Dysphonia Association (NSDA) and other national and state organizations, they disseminate information about the scientific sophistication and effectiveness of Botox treatments. They endorse Botox as the treatment of choice. Although national and state associations like the American Speech-Language-Hearing Association (ASHA) and the NSDA say they're neutral with respect to treatments for spasmodic dysphonia, they actually promote Botox, wholeheartedly. And the medical profession insists that SD is a hopeless problem, a lifetime death sentence, assuring all patients with SD, that there is only Doctors Gloom and Doom who seek to relieve symptoms, but not cure the problem.

The National Spasmodic Dysphonia Association (NSDA) gets donations of money from Allergan the maker of Botox for its newsletter, website and SD support groups that endorse Botox. Meanwhile, I find even some of the most devoted and dedicated of

SD patients who are associated with the NSDA or officials within the NSDA are abandoning Botox shots, having taken them for years.

Dot Sowerby, President of the NSDA, has been Botoxed for years and years. She was talking with a severely strangled voice when I talked with her by phone. Peggy, who has SD, has also given up on Botox after years of treatment. She is a high official of the NSDA.

David Barton, recently replaced Dot Sowerby as the President of the NSDA. He reports in writing that only three of thirty-seven Botox shots worked for him.

In a highly polished video presentation used by the NSDA, claims are made that highly trained medical specialists determine the precise Botox dosage, and location of injections while treating spasmodic dysphonia. However, according to firsthand reports, both dosage and location of the injections may be more intuitive than scientific. Physicians may use experience and clinical judgment—not high-tech gadgetry per se as described in the NSDA video—to determine dosage and location of injections. That may come as a surprise to many patients sold on the idea that Botox is a high-tech, scientific treatment. It is said by those in medicine that negative outcomes of Botox are due to the doctor's lack of expertise with giving Botox shots. Yet the very best, the elite, and *crème de la crème* give Botox shots. Is it the Botox or the doctor responsible for the iffy Botox outcomes I see and hear? A patient who underwent many Botox shots reports needle placement may be uncertain. His statement is:

“My doctor assured me that the procedure would feel like a bee sting. However, when they told me to lie down on a cold, metal table and hang my head off one end, I began to get very nervous about what Dr. X was preparing to do. He told me, as he held a large needle in front of me that he was going to permanently

rearrange the muscles in my neck. This did not sound too pleasant but he assured me that I would be okay.

“When Dr. X began prodding my neck, it was much more painful than a bee sting. In fact, at that moment, I would have welcomed a bee sting. It hurt so bad I instinctively began yelling and asked him to stop. At first, he sharply addressed me and told me to be quiet. However, the pain was so bad, I could not. It felt like he was going to puncture my throat. I was choking from the needle going into my throat. Finally, after telling him repeatedly to stop, he quit and I tried to regain my composure. The second time after about 10-15 agonizing minutes of this horrific procedure, he then administered the Botox shot. After receiving the shot, Dr. X left, no one said anything to me, and my wife and I just walked out of the hospital. After this first Botox experience, my throat and neck hurt so bad, I could not even look up into the sky for a week. It felt like a prizefighter had punched me in the Adam’s apple.” This patient is not alone.

Another SD patient, trained in mathematics, reports of his Botox experience: “There is no repeatable reference information relative to the placement of the needle. i.e. the clinician takes best guess on where to insert needle into the neck to target cords. Once this location is randomly chosen (the available target area for the placement of Botox is limited to the area within a defined diameter of the throat) the clinician penetrates the skin. Since each of us has different physiology, the placement of the Botox into the cord is random and non repeatable.

“There is no reference to a set of benchmark data that allows the clinician to improve or repeat an injection. I received one good injection; it could not be repeated even with numerous attempts. I believe one of the reasons was that there was no “data” upon which to draw. As an engineer, who is trained in scientific methods, I find this procedure almost comical in its approach.

“There are numerous variables inherent in the process that are not controlled, specifically: the location of skin penetration, the location of penetration of the Cord (from top to bottom), the position of the needle within the diameter of the cord, centered, biased right to left, past center and penetrating the far wall, the rate of injection, too fast and the Botox is not absorbed in cord, and finally, movement by the patient (the cords are not immobilized, the patient does his best to ‘stay still’).

“The signal generator is by its nature a very coarse measurement system. It is used typically as a GO/NO GO gauge. Noise means you have a connection, no noise, no connection. Its use as a guidance system with degree of noise as an indicator of position is not repeatable. At best it tells you that you have contacted some portion of the vocal cord with the needle. Nothing is conveyed about specific location.”

The video used by the NSDA on SD patients tells that the procedure is nothing more than a bee sting, but enough patients report excruciating pain to make me wonder. Others complain about severe post-injection complications, including weakness and respiratory problems, and loss of voice totally leaving them with a whisper voice, or worse. Yet others report that Botox, apparently delivered to precise locations in the vocal fold muscles, causes swallowing problems, and some life threatening breathing impairments; all in all, the process isn't the automated scientific procedure described in an NSDA video that I have seen. Yet being good troopers, desperately seeking help and hoping for the best, most patients with spasmodic dysphonia endure almost any hardship to rid themselves of the condition.

### **Programmed to Fail**

When you think of it, it's far easier or simpler to be told you have neurological condition than counterproductive bad voice habits. Some patients take it personally when told they're been misusing and abusing their voices—though not deliberately. Even

so, getting rid of bad habits takes more work than getting anesthesia, surgery or drugs. If treating spasmodic dysphonia was medical, medicine would have found a cure or effective treatment long ago. But a little attention to history suggests the opposite. For almost 135 years since Traube first described the condition called “nervous hoarseness,” medicine has not been able to crack the mystery of the strangled voice. With almost 135 years of fruitless psychiatric treatments and now over 45 years looking at faulty neurology, medicine still doesn’t have a single cure or reliable treatments.

The Hippocratic Oath sworn to by medical doctors says, do no harm and natural healing. Medical SD care is not conservative as sworn to. It is extremely radical. My approach is conservative and in keeping with the Hippocratic Oath. DVR is safe and effective and can be curative with fully cooperative patients. Botox may not be as effective in the short run as advertised, I find in my clinical practice with SD patients. And in the long run, nobody knows the long-term effects on the body.

From the get-go, patients with spasmodic dysphonia may acquire more than healthy skepticism following years of frustrating experience with conventional medical treatments. Told there are no cures, patients have little reason to believe that a simple, non-invasive approach like my Direct Voice Rehabilitation provides sufficient documentation that cures of SD exist and prevail. It’s also acutely embarrassing to highly trained medical doctors that high-tech procedures and designer drugs can’t cure or consistently improve spasmodic dysphonia. Confined to a paradigm that permits only medically acceptable techniques and procedures, medical specialists’ hands are tied with respect to accepting and using an alternative treatment.

When I found a cure for spasmodic dysphonia, I was struck by its simplicity yet comprehensive way it corrected the patients’ symptoms, voice tremors, spasms of the vocal cords, and other

symptoms stemming from the lower throat voice use. This lower throat voice is the precise pattern leading to the strangled voice and other common voice problems. No medical procedure can basically undo years bad voice habits leading to what I call “Voice Suicide”. This is an insidious process where by the voice literally wears itself out by repetitive voice-use that is forced from the lower throat (laryngeal resonance). I agree with medical specialists treating SD that spasmodic dysphonia is always located in the lower throat. Where medical experts and I diverge is on what causes the voice to drop into the lower throat. Medical experts believe severe vocal spasms are caused by neuropathy in the lower throat, with nerve connections to the basal ganglia in the brain creating a “focal laryngeal dystonia.” I call it a misphonia or dysphonia. A dystonia means you cannot change the problem. A misphonia or dysphonia (wrong voice use) means you can change the problem with meaningful treatment by Direct Voice Rehabilitation. I often report changing the so-called” focal laryngeal dystonia” in the initial consultation. I point out SD is not a dystonia; a dystonia cannot change by non-medical verbal directions. I agree that all SD is a focus or focal placement in the lower throat. I agree only excessive laryngeal resonance is utilized. But the word “dystonia” in the medical definition of SD is where I part company. I find clinically that SD is merely an imbalance of resonance to the lower throat. Only excessive laryngeal resonance is used exclusively by SD patients because of voice misuse and abuse— wrong voice talking— not a dystonia, or medical problem. SD is basically a problem of incorrect pitch and resonance focus, poor breath support, and a wrong voice image and voice identity.

There are three types of resonance: Laryngeal resonance, oral resonance, and nasal resonance. Also there is natural versus forced resonance. All SD patients use only laryngeal resonance exclusively and the attempt to talk forcing this resonance appears to be a dystonia to the medical establishment. Laryngeal

resonance is natural, normal and appropriate but not appropriate used exclusively and forced.

The larynx is located in the lower throat. Therefore, the air passing through the lower throat creates laryngeal resonance; this is normal natural resonance. The SD patients' mistake and blunder is unknowingly pressuring natural laryngeal resonance rather than combining it with balanced oral and nasal resonance in the face. The voice should be placed in the face, emphasizing facial resonance. The facial resonance, oral and nasal, has a noted extent of nasal resonance (not nasality), which gives it energy, ease, and carrying power. In contrast, all SD patients use only forced laryngeal resonance and exclude facial resonance. This focus creates an imbalanced focus of resonance in the lower throat creating the impression to unsophisticated practitioners, it is a dystonia when it is merely a wrong use of voice and focus.

Medically, the throat is called the pharynx. The throat is broken up into three resonance sites. Throat resonance consists of 1/3 laryngeal resonance in the lower throat, 1/3 oral resonance (around the mouth), and 1/3 nasal resonance (around the nose). A good or great voice uses the 2/3 solution, a blend of oral and nasal facial resonance called the mask. Laryngeal resonance is automatic and inherent in all voices. It must not be squeezed or forced. If one uses volume while pressuring laryngeal resonance, it sets off tension and creates an ineffective vocal cord vibration. Wrong pitch, too low or too high contributes to lower throat laryngeal speaking. All good and great voices are placed in the face, not the lower throat. SD patients amplify only the lower throat resonance, not the oral and nasal resonance of the face, which carries 2/3 of the resonance we depend on to carry the voice for effective use. The vocal cords produce a weak sound. This weak sound must be amplified in the face, not the lower throat, to be effective.

The throat is built on a megaphone basis. The narrow portion at the bottom extending outwardly to the face ending at the level of the eyebrows. Using laryngeal resonance (1/3 of the resonance) exclusively is the core of SD being mistaken as a dystonia, I find. The lower throat muscles are called strap muscles. They hold the larynx in place suspended in the lower throat. When these strap muscles are stressed and pressured to tense then the lower throat resonance may be exclusively used and forced.

Henry Kissinger talks from the lower throat. He does not use volume. He uses what is called a glottal fry voice. His voice sounds like he is frying his voice. His pitch is too limited, too restricted to a bass level. He remains raspy but not strangled.

Diane Rehm, the NPR host for years talked in the lower throat, sounding raspy. Over time she crossed the line to spasmodic dysphonia. She attributes her strangled strained voice to Advil and says God is sending her a message, in her book *Finding My Voice*. I have written of my experience with Diane Rehm in two interviews, one in 1985 and another in the middle of the 1990's.

*Finding My Voice - The Whole Story?*

Diane Rehm's book, *Finding My Voice*, has two aspects - finding her voice, her inner self, expressing who she is and also literally, not figuratively, finding her speaking voice. The first part, finding herself, and who she is, is a tale of gradual development and slow realization of herself and what her capabilities are. The second aspect, finding her physical or actual voice, is a different story. She indicates in her book that she has had trouble with her voice for a long time.

*Finding my Voice* by Diane Rehm is a story of a little known voice affliction called Spasmodic Dysphonia (SD). Ms. Rehm tells of the development of her spasmodic dysphonia. She

brings to the public an awareness of this little known condition. Her journey to obtaining a diagnosis of SD had its uplifting aspect - finally she found out what her voice problem was named. Ms. Rehm was relieved to know what her problem was; the problem now was how to deal with it.

She opted for injections of Botox. Botox was her option after she failed to find help by psychiatry, psychotherapy, drugs, and speech therapy.

Diane Rehm interviewed me in 1985 after my book *Change Your Voice, Change Your Life* came out in 1984. At the close of the interview having heard me explain how extensive voice misuse and abuse of the voice is, she inquired about her voice, which was raspy and placed in the lower throat. I told her she was committing voice suicide.

Diane Rehm is an expert interviewer, intellectually stimulating. I was privileged to be back on her radio program a few years ago, talking about my book *Stop Committing Voice Suicide*. My book deals with SD and how deep throat, raspy, SD and other serious voice problems are due to voice misuse and abuse. I explain how Direct Voice Rehabilitation by my non-medical, non-invasive, non-risk approach allows me to achieve ongoing cures, recoveries and improvements of SD, and other voice problems.

I told Ms. Rehm that Direct Voice Rehabilitation (DVR) is not speech therapy (which copes with SD, and has no cures of SD). That DVR is entirely different and has achieved cures of SD. Ms. Rehm's book, *Finding My Voice*, doesn't address DVR or cures of SD.

I believe Ms. Rehm developed SD by misusing her voice for many, many years. She notes that she had voice problems for almost all of the years she has been in broadcasting. Her view is that Advil began the SD, and that God is sending her a message.

My view is that she is not aware of misusing her voice (the pitch and tone focus), and adheres to a voice image that keeps her voice in the lower throat, where all SD patients erroneously focus their voice. She believes SD is a dystonia.; I find it a misphonia or dysphonia. The difference being is that dystonia is neurological (involuntary); a dysphonia is functional misuse and abuse of the voice (voluntary, but unintentional and unknowing).

The concern I have with Diane Rehm's book is that she omits an alternative choice of treatment for those suffering from SD for her readers, listeners and viewers. She appeared on Larry King and Ted Koppel TV programs omitting to tell of cures of SD that she knew of as she interviewed me on NPR radio. Diane Rehm has the Botox voice.

Steven M. Zeitels, MD, from Harvard Medical School was interviewed by Diane Rehm recently on NPR (National Public Radio). Diane Rehm was severely impaired of voice in spite of the fact she is undergoing Botox treatments. It is painful to listen to Ms. Rehm talk. Nonetheless, Zeitels praised Botox as the state of the art and the treatment of choice. Zeitels is referring to the medical treatment of choice, which has no cures, and he says has no cures. I forwarded to Zeitels a list of SD cures by Direct Voice Rehabilitation. **Dr. Zeitels says the medical profession is looking for a permanent cure. I have permanent cures of SD, but they are non-medical cures.**

Robert Kennedy Jr. has severe SD. He has been Botoxed frequently I hear. It is hard to understand or listen to his SD voice. He is on the NSDA masthead with Diane Rehm as an endorser of Botox. He has the Botox voice.

On my website there are a number of cures reported by patients who once had SD and many other types of voice problems, patients who were diagnosed by leading medical doctors and

medical centers. This site also gives information about how DVR works and why it achieves cures.

Henry Fonda dropped into a deep throat voice which he attributed to a faulty pacemaker. His normally focused voice in the face disappeared. He developed a strangled voice, Spasmodic Dysphonia.

Shadoe Stevens, a national syndicated radio and TV personality dropped his bass-baritone voice into the lower throat unknowingly ending up with SD. Shadoe Stevens wrote, *“My voice was becoming strangled. Dr. Cooper’s techniques changed my whole approach to using my voice. It was astoundingly, hilariously simple and logical and it worked.”*

Keith Erickson, a Laker player after achieving fame as a UCLA star under John Wooden, told of his journey into SD doing sports’ casting after his playing days ended.

Fonda, Stevens, and Erikson all found a cure of SD by my DVR program. Basically, I simply helped each celebrity to change the laryngeal or lower throat resonance to facial resonance with diaphragmatic breath control.

**Over 35 years of clinical experience with SD and cures of SD tells me that vocal spasms are caused by prolonged misuse and abuse of the speaking voice. Not medical cause. Not an impairment in the brain. Not a chemical imbalance in the brain. Not a basal ganglia dysfunction. Not reflux acid. Not genes. Not psychiatric problems. Not neurological problems. Not molecular biological cause, not a dystonia.**

Andrew Blitzer, MD and Christy Ludlow, Ph.D. are of the view that SD is a neurological problem. Andrew Blitzer, MD states: “Current methods are treating the symptoms, not the disorder. Botox is the best symptomatic treatment we have at this

moment until we are able to manipulate the brain.” (NSDA Newsletter Vol. 12 No. 2 Oct. 2003). Dr. Blitzer is a close associate of Mitchell F. Brin, MD. They both believe SD is associated with genes as one of the basic causes of SD.

Identical twins were diagnosed with SD at a famous medical center: One with adductor and abductor, the other with adductor. Both tried Botox, which caused one of them to experience life-threatening negative symptoms. Both underwent my intensive DVR program. Both have successfully found fine voices.

Christy Ludlow, Ph.D., Senior Investigator, National Institute of Neurological Disorders and Stroke (NINDS), National Institutes of Health (NIH) states: “It’s going to be extremely important to look at central abnormalities. Focusing on the neuropathology of people who have had spasmodic dysphonia will be critical.” (NSDA Newsletter Vol. 12 No. 2 Oct. 2003)

Autopsies have never proven that patients suffering from spasmodic dysphonia had verifiable damage to the basal ganglia, according to SD literature as far as I can tell.

The medical and academic elite are well-intentioned, humanitarian, compassionate in intent and paradigm. I find they are on the wrong road to cure, never having one cure in 135 years. They are treating SD as a medical problem. As I have reported, my clinical experience proves conclusively SD is not a medical problem. If you seek a palliative fix I have no negatives, and in fact I say, try Botox and see. Try acid reflux drugs and see. Try surgery and see. But be aware that none of these approaches report cures of SD. Botox and acid reflux drugs are symptom oriented only as is surgery. Botox is for life.

Entering non-medical (DVR) treatment, patients need all the positive expectations to improve motivation to get results. Given the impression that only Botox or surgery offer hope, many

patients remain skeptical of non-medical approaches when they should be openly embracing DVR. In order to improve chances of success, patients must be deprogrammed of misconceptions and negative expectations about results from my non-medical approach DVR.

### **Botox and Surgery**

In 1971, in the *Handbook of Speech Pathology and Audiology* edited by Lee Travis, Ph.D., I reported my first cure of SD, one hundred years after Traube's description of what would be later termed spasmodic dysphonia. In my 1973 textbook *Modern Techniques of Vocal Rehabilitation*, I further reported on spasmodic dysphonia and that SD was due to misuse and abuse. I found that speaking incorrectly, namely, projecting the voice from within the lower throat caused SD and the overwhelming number of other failed voices.

My functional analysis of SD and the medical profession's paradigm of SD go in opposite directions. I want to treat the cause of dysfunctional voices: namely, the patients' propensity to drop the speaking voice down into the lower throat and squeeze the voice out with volume. Instead of Botox or surgery, I use a specialized form of voice behavior modification called Direct Voice Rehabilitation to perform, in effect, a "voice lift," to the face where all good and great voices are (the mask) reducing pressure on strained vocal cords, and the lower throat. (I discovered the voice lift in 1962 while on the staff at UCLA Medical Center's Head and Neck Division.) I tell SD patients and others suffering deep throat, raspy and failed voices, to "talk in the face, it is the saving grace." It's face talk and it's nature's simple natural answer of SD and other voice problems.

No matter how much surgery or Botox patients receive, voices don't automatically improve until they're projected out of the "mask," the area of the face between the mouth and bridge of

the nose. The term the “mask” comes from ancient Greek times when male actors talked into a mask, literally to imitate women, as women were not allowed on stage. The term “speaking into the mask,” or “singing in the mask” has identified the secret of correct voice placement or focus. Botox and surgery treat symptoms of vocal strain by relieving spasms, but they don’t reeducate the patient how to find the correct voice. To patients looking for quick fixes, medical voice treatment gives unrealistic expectations: Getting Botox or surgery for SD does not cure this voice problem. It is not the patient but the medical SD voice treatment that is the problem. Acid reflux drugs do not improve deep throat, raspy voices or SD voices from my clinical experience to alter incorrect voice focus or pitch, which essentially is causing laryngitis, SD, or other common voice problems.



My textbook *Modern Techniques of Vocal Rehabilitation* (p.61-62), listed a number of palliative measures used in medical voice care over the years to treat voice problems. The list includes gargles, sprays, lozenges, vaporizers, and steam. These are essentially irrelevant insofar as voice disorders are concerned. The purpose of these measures is only to minimally ease laryngeal and pharyngeal pain created by voice misuse and abuse. They soothe the inflamed area for a short period of time. Some symptoms, such

as hoarseness, may disappear briefly, but they will usually persist despite palliative treatment. These palliatives merely assuage or mask the pain or irritation in the throat, thereby addicting the patient to repeated doses without eliminating the causative factors and enabling the patient to continue using and misusing the voice. Many voice patients report a long history of utilizing these palliative measures, with the essential problem of voice misuse and its attendant laryngeal and pharyngeal discomfort increasing progressively.

As a concomitant for voice rehabilitation, in the early stages of therapy, one or more of these palliative measures for symptom containment and relief may make the patient feel more comfortable and amenable to therapy; however, these measures used in isolation are useless in the containment and elimination of the voice disorder. Voice patients need be made aware of the cause and effect of the symptoms of voice misuse.

Job change or change of occupation is a prescriptive recommendation afforded the voice patient all too often by unsophisticated medical practitioners and supervisory personnel. For those prescribing such an occupational change the underlying belief is that experiencing voice fatigue is natural to some and indicative of inherent voice weakness either of the larynx or of the physical condition of the patient. Occupations that require little or minimal speaking are recommended for these individuals who experience negative voice symptoms. What is really needed is a voice change, not a job change.

Unfortunately, far too many individuals heed the dictum of job change and become voice hermits. One patient remained at home, seldom answering the telephone, because she was advised that continued voice rest was the only answer to her voice problem. She no longer assisted her husband in the store and the personality effect was severe. Another patient gave up a lecturing career and

became a researcher because he was advised to use his voice minimally to avoid voice fatigue.

Vacation and bed rest are two other palliative measures that are medically recommended. Those prescribing such measures presume that the patient is mentally or physically fatigued and in need of rest or an environmental change. The inadequacy of these measures is proven time and time again as these patients re-experience the voice symptoms and voice disorder once they return to normal activity. Some are not free of the voice symptoms even during the rest or vacation. The pressure of the environment may not be the basic cause of these voice symptoms. Temporary voice effect from tensions is experienced by most, but the effect need not be lasting if the patient has voice knowledge and ability in correct voice usage.

Patients should not be asked to change their personality because of voice misuse. If a patient is outgoing and dynamic, he should not be told to speak less or to be quiet in order to save his voice. Containment of the personality is not only unrealistic, but it is also unfair to the patient. Patients also should not be told simply to speak in a relaxed manner, because what usually happens is that the patient drops the pitch to the lower throat with a low pitch, uses little volume, and in the process further misuses the voice.

Regarding palliative measures, Guthrie (1940) reports that local treatments are secondary and subsidiary to orthophonic or re-educative methods. Not atypical is the patient with functional misphonia who was given twenty-five different medication, including Librium®, sulfa, Polycillin®, tetracycline, atrophine, and ACTH as well as ultrasonic medcolator treatments for hoarseness and laryngitis over a period of years by two laryngologists. The patient in this case was markedly hoarse and had secured no relief from the administration of such medication over this protracted period of time. This patient's functional misphonia was eliminated by voice rehabilitation. Douglas (1950,

p. 383), a medical specialist, writes (*Modern Techniques of Vocal Rehabilitation pages 62-63*):

The patient is alarmingly frequent who has been treated for hoarseness supposedly due to sinusitis, deviated nasal septum, enlarged palatine tonsils, infected or noninfected, for one or two years prior to seeking other medical advice, when his symptoms have either failed to have been alleviated or have progressed.

Not infrequently, the patient is seen to have a uvulectomy or wholesale dental extractions performed in an attempt to treat the hoarseness or laryngeal sensations.

Tarneaud (1947, p. 14) concurs: “The patients often receive wrongly and unsuccessfully treatment for chronic laryngitis, whereas, only phoniatic treatment—considering the somatic and psychological etiology—is promising.” (*Modern Techniques of Vocal Rehabilitation page 63*).

Palliative measures are not curative measures. They do not eliminate; they merely alleviate. They are misleading to the patient and contributory to the continued voice disorder and personality effect that accrues to a patient with a voice disorder. Palliative measures, nonetheless, continue to be the pervasive measures prescribed by most medical personnel and accepted by most individuals experiencing voice disorders. (*Modern Techniques of Vocal Rehabilitation page 63*).

Nowadays I add reflux drugs and Botox to the list of palliative measures. There are fads and fashions in medical voice care. In 1913, Paraffin was the Botox of its day. It was injected into the vocal cords to close impaired vocal cords. Dr. Brunning’s paraffin implant was not successful. Over the years other implants have been tried including Teflon, silicone, bone, stints, gel foam, and of late collagen as the state of the art and treatment of choice for impaired vocal cords. Pete Wilson, the former Governor of California was surgically treated with stents in his vocal cords, resulting in a further impairment of his troubled voice. Two

surgeries later the stents were removed. Mr. Wilson's failing voice apparently was not served well by the implants. He was forced to drop out of the Presidential campaign. Implants come and go. Dr. Goode of Stanford Medical Center's ENT Division wrote that leeches were used to treat laryngitis in the 18<sup>th</sup> Century.

A story that the BBC Evening Show ran on April 20, 2004, says "Doctors in the US are offering cosmetic surgery for people who want to sound as young as they look with a so-called 'voice-lift'. Like the rest of the body, the vocal chords grow weaker with age as talking, shouting and singing take their toll. People can make their voices sound younger by exercise, but some require surgery to help the vocal chords to close. When the two vocal chords close together they produce sound. For about \$17,500 (about £10,000) doctors will insert implants through an incision in the neck or inject fat, collagen or a bone-making substance called hydroxyl appetite through the mouth. After resting for a couple of weeks, the patient can speak with less effort in a firmer tone, says *The Times*. Among those interested in the procedure are radio announcers, actors, politicians, sales personnel and corporate executives."

Steven M. Zeitels, MD, Director, Eugene B. Casey, Chair of Laryngeal Surgery at Harvard Medical School, is a leading proponent of implants, along with Botox, into the vocal folds to treat voice disorders. The medical community, from my experience also seeks to make common voice problems into diseases caused by acid reflux.

Zeitels in Otolaryngology-Head and Neck Surgery Clinic Online, April 2002, Volume 126, Number 4 p.8 says, "It has been recommended that botulinum toxin injection be used for recalcitrant granuloma cases. We have used this treatment and found it to be effective in selected cases," says Zeitels. Botulinum toxin paralyzes the vocal cords. It does not address the issue of whether the voice is changed for the better, or whether the patient

can talk more efficiently. It simply addresses the remission of contact ulcer or granuloma of the vocal cords. So when the term “effective” is used, it may identify drastic and draconic medical intervention with Botulinum toxin that can be achieved without Botulinum toxin—with simple voice rest. Once the Botox wears off and the individual starts talking again without a paralyzed Botoxed vocal cord, the contact ulcer and granuloma may flair up again, because the cause of these conditions is overwhelmingly not acid reflux but voice misuse and/or abuse, I find.

Jackson defined the condition of contact ulcer in 1928; however, Virchow referred to a condition similar to contact ulcer as “pachydermis laryngis” in 1858. Contact ulcer is a lesion which occurs on one or both of the medial surfaces of the arytenoid cartilages. In incipient contact ulcer, edema inflammation, and/or redness is present. As the contact ulcer develops, the interarytenoid area consists of “an area of exposed necrotic cartilage surrounded by a rim of raised granulation tissue” as, described by Cooper and Nahum (1967, p. 41).

According to these authors (1967, p. 42), contact ulcer develops in three stages, the first stage being incipient contact ulcer:

The first stage is manifested by fatigue and hoarseness which occur at the end of the day or after periods of voice stress. The amount of trauma required to produce the symptoms gradually decreases. Voice rest, usually at night or on weekends or vacations, results in recovery and loss of the symptoms, but they recur more frequently as time goes on. Examination discloses minimal edema and redness of the interarytenoid area and is seen only when the patient has recently abused his voice. With rest the appearance returns to normal.

In the second stage there is continual hoarseness, fatigue, and occasional pain on speaking or swallowing, and rest affords

only temporary relief. Examination show severe inflammation with early loss of the mucoperichondrium covering of the opposing arytenoid surfaces.

In the third stage there is severe constant hoarseness, fatigue, pain on swallowing or talking, and little relief with the mere rest. Examination shows a denudation of the opposing cartilaginous surfaces and a surrounding rim of granulation tissue.

Since contact ulcer of the larynx is due mainly to voice misuse and abuse, a major approach to the treatment is voice rehabilitation. This disorder was initially treated by voice rehabilitation by Peacher (1947c). Some authors have maintained that emotional tension is the central cause of the contact ulcer. Arnold (1966, p. 80) postulates: "Contact ulcer is a psychosomatic disease resulting from emotional tension." Peacher (1961), in a follow-up of 70 cases, notes that superficial psychotherapy was adequate for most patients; only a small number required psychotherapy. A review of this author's patients confirms Peacher's findings regarding psychotherapy. However, voice psychotherapy was vital for all contact ulcer patients seen.

Jackson and Jackson (1935a) find that a number of contact ulcer patients dated the onset of their laryngeal symptoms from a cold or influenza. Holinger and Johnston (1960) also note that 26 patients out of 92 attributed the onset of the symptoms to an acute upper respiratory condition.

Jackson and Jackson (1935a) warn that the condition is usually overlooked. Cooper and Nahum (1967) recommend that the physician watch for the patient who is in the incipient or first stage of contact ulcer. They (p.42) continue:

Patients in the early stages are the easiest to treat and good results can be obtained relatively early, which prevents the long-term problems associated with advanced cases.

Three different pathological conditions of contact ulcer have been encountered. The first type is incipient contact ulcer, which is treated by voice rehabilitation alone. The second type is the benign contact ulcer granuloma and/or fossa which is the type that prevails most frequently. The granuloma may be treated by surgery prior to voice rehabilitation; the fossa is usually treated by voice rehabilitation alone. The third type is the contact ulcer granuloma, which has undergone malignant degeneration. This type is diagnosed by biopsy and treated by surgery and/or radiation followed possibly by voice rehabilitation.

The treatment of contact ulcer by voice rehabilitation affords excellent results. The usual duration of therapy falls within six to twelve months for a resolution of the lesion. A shorter period of time may eliminate the problem in some cases. The contact ulcer patient is almost invariably at the basal or near basal pitch of voice. The tone focus is usually in the laryngopharynx. Poor voice hygiene often accompanies the voice misuse, adding to or initiating the condition itself. Therapy for this condition is the same as has been described.

In my textbook *Modern Techniques of Vocal Rehabilitation*, 1973, of the 49 patients completing therapy for Contact Ulcers by Direct Voice Rehabilitation, my success ratio was 87.5%.

I have seen approximately 200 Contact Ulcer Granuloma Cases to date, and my success ratio is excellent (90+).

### **Spinning Bad Results**

Putting a positive spin on Botox treatment, patients are told—or at the least infer—that more injections increase chances of recovery. Injections may cost around \$500, \$1,000, \$2,000, \$3,000, \$4,000 depending on where they're given. Patients may automatically submit to more injections than necessary. Not only is Botox costly, but no one currently knows its long-term health

risks from repeated exposure. Without getting meaningful results on strangled voices, patients may be told that they simply need more Botox to get results.

Putting fibroptic tubes into the larynx and videotaping the vocal cords gives some reassurance to patients otherwise dissatisfied with the results. Telling patients they measured less spasms provide little consolation when voices may still be squeezed and disordered, or lost.

A young lady suffering with severe SD, abductor type, the type that is contraindicated to be Botoxed for vocal cords (that means not to be given Botox) was injected with Botox for approximately three years, once every three to four months. She told her ENT that her voice did not return, that the placement of the needle was traumatic, and that the spasms of her voice had not been eliminated. The ENT advised her to have Botox shots every month rather than every three or four months despite the fact that none of the Botox shots worked for her. She was not of the view that the cost of the Botox shots, which ran \$3000.00 per shot, was the motivating factor for her Botox shots that never worked. Another of her doctors advised her to give up the Botox shots, which she did.

### **Wrap Up**

Patients are inherently vulnerable, desperately seeking help for spasmodic dysphonia. When running to the doctor, they hope to find effective treatments but find themselves confronting the medical paradigm today that insists the strangled voice is a product of faulty neurology called a “dystonia.” So powerful are medical beliefs that proven treatments—like my Direct Voice Rehabilitation—rarely are even given to patients as a legitimate option. Without knowledge about voice dysfunction and the essential factors of voice rehabilitation, most patients readily

submit to medical treatments, including reflux drugs, Botox and surgery.

Believing strongly in medical treatment, physicians inadvertently—though sometimes deliberately—disparage alternative treatments. Patients have no way of assessing pros and cons of legitimate therapy, and, instead, frequently submit to Botox or surgery. Despite dicey results, patients stay with medical treatments, believing that alternatives are based on junk science or may indeed be risky or ineffective.

Beyond competing paradigms, there's a legitimate controversy over the etiology of the strangled voice. Nearly one hundred years of misguided psychiatric explanations have now given way to a new generation of neurology and molecular biology. But judging by the inconsistent results of prevailing medical treatments, the medical approach may be still barking up the wrong tree. I found with my thirty-five years of helping to cure the strangled voice, (spasmodic dysphonia), and my forty-five years of clinical voice experience with other common voice problems that poor voice habits were leading to mechanical voice breakdowns.

If spasmodic dysphonia is indeed caused by speaking incorrectly, no medication or surgery can correct the dysfunction. Botox has its applications, but treating spastic vocal cords may not be its most effective use. Though the main effect of Botox is only temporary, long-term adverse side effects remain unknown. Current trends in medical voice treatment have increased the frequency of Botox injections. While Botox has less risk than surgery, its use may have little value to the vast majority of patients suffering from spasmodic dysphonia or other voice problems to a cure.

No matter how optimistic, medical practitioners can't tell patients they'll benefit from Botox without verifying results.

Patients with the strangled voice have only one benchmark for determining success: Actual ongoing improvements in voice. With physicians measuring vocal cord spasms, patients must rely on themselves and others to judge whether treatments are working. If voices don't improve meaningfully, patients need to explore more productive options.

### **Talking Points**

- Only Direct Voice Rehabilitation has reported ongoing cures of SD for over 35 years.
- There has never been a medical cure of spasmodic dysphonia.
- The medical paradigm today believes spasmodic dysphonia is neurological, and a medical problem.
- I find SD is not a medical paradigm, not neurological nor a dystonia but is caused by voice misuse and abuse and is a dysphonia (non-medical problem).
- Botox and surgery create high expectations for recovery.
- Botox and surgery yield inconsistent results.
- Patients expect and want hardcore science and high-tech treatments for SD from medicine yet none have been shown to actually work to a cure.
- Patients are programmed to doubt an alternative DVR to medical treatments.
- Results of treatment must be measured by listening to patients' voices. Do the voices remain normal and lasting?

- Botox and Reflux drugs are simply hopefully palliative.
- Implants, such as collagen, bone, gels, silicone, Teflon, stents, cadaver skin, etc., are intended to be a medical voice lift when a natural voice lift by DVR is available and overwhelmingly effective.

# Chapter 2

## When Paradigms Fail

### **What's Inside**

In this chapter you'll find how paradigms govern today's voice business and sometimes block discoveries and breakthroughs.

- State-of-the-art-medicine
- Serendipitous discoveries
- Good deeds don't go unpunished
- Old news is no news
- Cure is a dirty word
- Barking up the wrong tree
- Wrap up

### **State-of-the-Art Medicine**

From the days of Herodotus in ancient Greece [460-380 BC], medicine relied heavily on pure science to find cause-effect relationships. Exploring biology, physics, mathematics, and, yes, philosophy, medicine sought to extricate itself from a society mired in myth, witchcraft and demonology. Whether in science or religion, the world-view is set by prevailing paradigms—encompassing structures determining the nature of reality.

Paradigms control thinking, establish basic facts and influence perceptions of the outside world. For those seeking new explanations—whether in science or religion—they must go outside the box [paradigm] for new discoveries and breakthroughs.

Even the history of religion attempts to consolidate a pantheistic [multi-god] universe to a more modern monotheistic [one-God] framework. All systems of thought—whether secular or religious—rely on prevailing paradigms to dictate reality. Seeking more scientifically based theories helped physicians find reliable ways of treating illness. The history of treating SD is no exception. After chasing psychiatric explanations for nearly 100 years, the medical voice field now looks to neurological cause. But ultimately, when paradigms fail they must accept reality and change models to better explain cause-effect relationships.

From ancient Roman times, scientists worked with glass to improve magnification, both long distance and short. Once astronomers developed improved ways to look into the heavens, physicists and biologists found more accurate ways of studying matter and the human body. Microscopes really took off in the seventeenth century with a Dutch glassmaker Anton Van Leewenhoek generally credited with inventing the first scientific microscope in 1670. By looking beneath the surface, scientists believed they could more accurately explain inexplicable events.

Today's modern medicine continues the tradition of developing more powerful microscopes, cracking genetic codes and ultimately reducing disease to mysterious molecules—much the way the pre-Socratic Greeks believed understanding “atoms” were the keys to understanding the world. “The future of treating SD,” said Christy Ludlow, Ph.D., Senior Investigator, NINDS, National Institutes of Health “is in molecular biology,” perpetuating the same old thinking and medical tradition: All medical problems have their answer in genetic codes and molecular biology. Today's medical paradigm seeks answers by

automatically assuming that every known problem stems from faulty biology or has its roots in biochemistry.

One hundred years of psychiatric theories of the strangled voice ended in 1960 when Robe, Brumlik and Moore linked the condition to faulty neurology. Since then, today's research has fixated on finding the neurological basis to SD. State-of-the-art diagnostic techniques hinge on measuring neuromuscular activity in the vicinity of the brain and larynx. Over thirty-five years ago I stepped outside the medical box and began examining different variables—non-medical factors related to voice, including, pitch, tone focus, rate, volume, mid-section breath support and vocal image. Yet, the medical field has remained true to its prevailing paradigm, considering only medical and biological causes to explain SD.

Only recently have acid reflux drugs or acid-blockers, become the latest trend in treating of SD. Less toxic than Botox, reflux drugs like Prilosec are now quite popular with doctors treating a wide range of common voice problems, including spasmodic dysphonia. It's now routine practice for physicians to prescribe these drugs. In my clinical practice I do not find that reflux drugs cure the strangled voice or other voice problems. I find almost all voice patients report reflux drugs have little effect on disabled voices, yet they dutifully follow medical advice, believing, as they do with Botox, that deteriorated voices will find a quick fix solution.

With medicine fixated on faulty neurology, it's easy see how drugs designed to affect the nerves become the treatment of choice. Acid-blocking drugs, of course, have only tenuous effect on faulty neurology by reducing Gastro-Esophageal Reflux Disease [GERD], a condition apparently, at least according to medical voice specialists, irritating the nerves and causing spasms—or that's how the theory goes. Clinically, I find reflux has little to do with the problem voice, speaking or singing. Reflux

drugs, while fashionable, don't address key variables associated with dysfunctional voices.

Harking back to scientists of yesteryear, the continued search for genes and molecules hasn't yielded much fruit in the treatment of SD. Staying inside the medical box, physicians can't see beyond the medical paradigm, continuing to go back to old explanations, regardless of whether they apply or get results. In the case of the strangled voice, medical practitioners continue to rely on biological explanations when the condition shows scant signs of faulty neurology. When paradigms fail, inside the box thinkers continue to play with the same old facts and push inside-the-box theories. When misinformation treatments and explanations fail, the traditional paradigm typically attacks new explanations, hoping that the old ways still apply. Only after endless repeated failure may the door swing ajar to go outside the old paradigm.

### **Serendipitous Discoveries**

I have always been moved by challenge. When I was not quite eight years old, my father died, leaving my mother without any income. She started working in a factory. I ran the streets of the Bronx. I hated school until I was almost 16 years old. Then I discovered reading and the library. After that I couldn't stop reading everything I could find.

I hadn't intended to go to college, but my friends suggested I go with them to take the college exams for City College and Brooklyn College; they could miss school and have a ball. I did, and passed both exams. But there was no money for college. Although the city colleges were free to all who passed the exam, my mother insisted on a letter from the bursar saying that there were no fees for anything. At college, I spent many hours a day, studying in the library, trying to keep up and stay in college.

Raised in the Bronx, I entered Brooklyn College with such a thin, nasal voice that my shame and embarrassment kept me withdrawn and barely noticed. I was disinclined to talk in class. I decided to go out for the debate team to learn to talk in public. The coach, Professor Larson, told me I was the worst speaker that Larson had ever known. Setting back in his swivel chair, Larson said, "There are only four years to improve, Cooper. Go out for the wrestling team."

Seeing my inability to face an audience with eye contact, with my shaking knees, and my looking at the ceiling warranted public training in appearances before the public. Since Larson could see how terrified I was talking with him and others in debate, he suggested I go out for stage acting and the chorus. Recognizing my insecurity in debate, two professors suggested I lower my voice to improve my stature and confidence. With my new deep voice, my social life blossomed, opening up new unexpected doors. Gaining experience in standing before the public and losing my stage fright, which was markedly debilitating to me, I became the best speaker on the debate team, helped by my proud deep voice. Honored by the team itself, I was given the Sigma Delta Rho award. I never accepted the honor of Sigma Delta Rho, telling Larson, "I do not need recognition from others; I need it from myself. And I have that recognition." This debate team experience has stayed with me throughout my life: I was indifferent to what others thought of me. I persisted in what I wanted to do.

I majored in Political Science and History. It was not what I had in mind. There was too much uncertainty about what was fact or fiction. I turned to the speech field midway through college and then the field of speech pathology in graduate school, believing these fields were more factual. I later realized that the speech pathology field was based partially on misleading theories, such as making misused voices into diseases.

After graduating from Brooklyn College in 1952, I had a brief stint in broadcasting. Then in late 1952 I volunteered for the Army, spending two years in the Service. At Camp Gordon, the Signal Corp headquarters, I learned how to send and receive Morse code. I was made aware of my keen ability to differentiate code sounds; I graduated second in my class. I was FBI cleared and was assigned to the Pentagon. Shortly after, I was sent to Germany to serve in the American Forces Network. I wondered why my voice was tiring on the air. I visited ENT doctors who found nothing but inflamed vocal cords. Allergy, I was told over and over. I felt a foreign substance in my throat; nothing was found.

After my discharge from the Service, my “Cinderella” voice started to unravel, becoming strained, hoarse and raspy, eventually deteriorating into a situational strangled voice. When my voice was failing, I consulted 12 different doctors, all of whom had different treatments, advice and bromides, genes, post nasal drip, allergy, and cancer. A gastroentologist told me, “Your hoarse voice indicates you have cancer, but I can’t find it.” None helped. One thing was for sure: My new image wouldn’t let me return to my old thin, nasal voice. Finally, I went to the 13<sup>th</sup> doctor, Friedrich Brodnitz, M.D.; this laryngologist mentioned that I was talking wrong. Brodnitz used the “chewing approach” to change the voice. You were to chew on sounds as though eating. It worked but was impractical. People were not taken with you talking to them and chewing on sound. It didn’t work. Brodnitz wrote that a quiet hour would take care of my voice image; I found that Brodnitz underestimated the strength, intensity and durability of the voice image. “Get into the field of speech pathology,” Brodnitz advised. My troubled voice was opening another world to me, as had Brooklyn College for my mind.

I then trotted off to graduate school at Indiana University (with my deteriorating voice), continuing my studies in the field of speech; I combined this major with a minor in the field of speech pathology, with an emphasis on voice production. Immersing

myself in voice literature, I began the slow process of uncovering the key variables and dynamics responsible for voice problems. I took a course in “Voice Science,” where I learned about the anatomy and physiology of the larynx. But this knowledge did not help my voice. I was not interested in stuttering, but was assigned courses in stuttering (causes and treatment). I studied with Dean Williams, Ph.D., who was a protégé of Wendell Johnson, Ph.D. of the University of Iowa. (Johnson’s contribution to stuttering was that it was due to a wrong image of speech and bad speech habits.)

After finishing my Masters at Indiana University in 1957, I applied for an assistanceship at Stanford University to work with Dr. Virgil Anderson, a quiet but brilliant professor of voice training. Dr. Anderson was on sabbatical when I arrived in September 1957.

### **Little Peggy**

I had just arrived at Stanford when I was given a case involving five-year-old “Little Peggy.” Prior to my first meeting with the youngster and her mother, I was called in to visit with Tom, the supervisor of the speech clinic. He briefed me on Little Peggy, then handed me two volumes containing information on her background and medical history. “The child is autistic,” the supervisor told me reflecting two volumes verified that diagnosis supported in the view by psychiatrists and neurologists.

In my initial meeting with Little Peggy and her mother, I noticed that the mother would say something to her daughter and Peggy would respond with animated antics. For example, if the mother said, “No, I don’t want you to do that,” Peggy would stomp her feet, gesture, and twist her face but not talk.

Even with my slight background on autism while getting my Master’s degree, I did not believe the youngster was autistic. Children with autism have a problem concentrating meaningfully

with others, and responding socially. Little Peggy was responding, but not verbally or orally.

I told my clinical supervisor what had happened.

“Do you think you’re smarter than all the neurologists and psychiatrists?” he replied.

No, I was simply informing the director about what I had seen, using my own sense and mind.

“You’d better not take that tact,” he told me.

My feeling was that Little Peggy was faking it. The little girl and I met three times a week, and neither of us spoke or made a sound. I simply sat with her in the speech therapy room and read a newspaper while she sat on the floor. At the end of the month I wrote my report to my clinical supervisor, “No progress,” I noted.

Tom called me into his office and asked what was taking place during my session with Little Peggy. “Is that all you are going to report?” he asked.

“Yes,” I replied.

“What are you doing besides reading the newspaper?”

“That’s it. I read the newspaper.”

“Don’t you work with her? Play games?”

“No.”

The supervisor was not taken with my approach, which admittedly was unorthodox and, to say the least, unbecoming of a speech pathologist working clinically with a child. I told him again I thought she was faking it.

The next few months went by and I continued to read a newspaper while Little Peggy sat on the floor, doing nothing. Two weeks into the third month, as I was reading and ignoring my patient, I suddenly heard a clear voice say, “I don’t like you. You don’t play games with me.” Her speech was perfect.

I put aside the newspaper and turned on a tape recorder. Peggy stopped talking and thumbed her nose at me, then twitched her lips and face.

When I told my supervisor what had happened, he said, “You know you’re losing your marbles. And you have a good shot

at losing your scholarship. You're not professional in what you're doing."

"Then maybe I'm in the wrong field," I said.

It was about two weeks later that Little Peggy talked again. This time she let go with a tirade of words, telling what she thought of me. At my fingertips was a high quality Tandberg tape recorder. I taped her at length, then dismissed the child and went down the hallway to my supervisor's doorway. I caught my supervisor's eye. I was just about to go inside when I had a sinking feeling. What if the recorder hadn't picked up her words? What if the tape was blank? I could see his shrug and facial grimace. I went back to my office and checked the tape. Peggy's voice was there, loud and clear. She ranted on at me for not playing games as others did with her, and she spoke unkindly about me because I wouldn't do things her way. I went from chump to champ.

In my original application to Stanford, I had written a five page letter to Anderson about my frustration at finding help for my failing voice though I had seen twelve medical doctors and speech pathologists; this was partly why I was accepted at Stanford. I was unaware that Dr. Anderson was impressed with my working with Dr. Dean Williams. I did not know that Dr. Anderson was interested in a new approach to stuttering that Johnson had developed, namely, that stuttering was not gene related or neurological or chemical in cause but was caused by misconception of what is normal in speech. Dr. Wendall Johnson's approach was sweeping the country.

I was appointed to be the Director of Adult Stutterers at Stanford University by Dr. Anderson. At the end of the year Dr. Anderson told me that I had done one of the best jobs in the history of Stanford's Stuttering Group. I gave full credit for my outstanding results with stuttering to Drs. Dean Williams and Wendall Johnson. I had turned the stutterers' group into a debating society with the stutterers talking with normal speech to such an extent that Dr. Anderson, who had dropped in to hear the group,

thought he was in the wrong place as they were speaking normally. Transcripts of three hours twice a week and recordings to hear themselves in meeting were an innovation I found helped stutterers self-monitor themselves to deal with their speech problem.

Asked why I got such excellent results, I responded, "I use my eyes, ears, and mind." I found that stuttering was due to a wrong image of speech, not a problem of genes, or dystonia.

Dr. Anderson offered me a sizable increase in stipend and money for filming the Stutterers' Group the next year. One qualification only, "you have to wear a tie and tweed jacket." I wouldn't do it. I left Stanford and went to UCLA where I was given a scholarship, after taking the Graduate Record Exam.

The first day I arrived at UCLA I met with Dr. Elise Hahn, the Chairperson of the Speech Pathology Division. She beckoned me to come in to her office and motioned me to sit down. I stood. She gestured me to sit down again. I sat. "You are going to work for Dr. Jack Pressman of the Head and Neck Division," she told me. I explained I wanted to get my Ph.D. as soon as possible and that I didn't want to work except taking all of the courses that she had told me I needed to make it to the Ph.D. Her response was simple. "Your chances of getting a Ph.D. is nil to zero," she said, "if you don't take the job." Dr. Hahn had made an offer that I couldn't refuse. Dr. Hahn added, "Dr. Pressman wants success with his voice patients. He has not been getting success."

Since I had studied with Dr. Anderson, Dr. Pressman and Dr. Hahn believed I was knowledgeable in voice rehabilitation.

Hahn told me that I had fifteen minutes to get to see Dr. Pressman in his office at the Medical Center. "It will take you ten minutes to walk there and five minutes to figure out where to go. Dr. Pressman is expecting you in fifteen minutes." She smiled at me as I was leaving.

A dark-suited gentleman motioned to me to follow him once I was outside Dr. Hahn's office. His name was Professor Charles W. Lomas. I was dressed in a freshly pressed shirt and slacks. He was dressed in a suit, a white shirt and a tie. I wore a sweater and an open collar. He motioned me to his office a few doors away from Dr. Hahn's office. He gestured for me to sit down. I stood. He gestured again for me to sit down. I sat down. "Do you want your Ph.D.?" he asked. "Yes, of course," I replied. "Here we wear a suit and a tie," he said flatly and firmly. "Any questions?" he added. I shrugged. He motioned me out. The encounter with Professor Lomas took one minute. I had fourteen minutes to get to meet Dr. Pressman.

Dr. Pressman's secretary checked with him to make sure he wanted to see me. Once in his office he gestured with his forefinger very rapidly, motioning me to sit down. I stood. He motioned me again and I sat down. The exchange was brief and to the point. "Bring me success, not theories." He paused. "Any questions?" he asked. He motioned me out with his forefinger. The meeting with Dr. Pressman took less than one minute.

I proceeded to give Dr. Pressman success over the eight years with him. He voiced his delight in memos to me on cures of various voice problems.

Had Dr. Pressman and the staff and faculty known Dr Anderson's voice training was only for improving the normal voice, he might not have been so insistent in hiring me twenty hours a week to work for the Head and Neck staff. I turned Anderson's voice variables of pitch and tone focus from the lower throat to the upper throat and into the face that he used for normal voices into use for abnormal or failed voices. It worked marvelously.

While searching the archives in the medical library for a possible Ph.D. topic during 1962-1963, I stumbled on behavior

modification. The concept was sweeping the mental health field during the late-50's. I didn't know how, but wondered if voice behavior modification could be specialized to treat common voice disorders.

I also stumbled on other buried kernels in the archives. A 1945 study by Professor A. B. Williamson, who treated 72 patients afflicted with hoarseness and chronic laryngitis, found that 69 out of 72 patients were speaking below their optimal pitch level. He stated; "The most common principal cause of hoarse-voice was the throat tension resulting from the effort to speak at a level far below optimal." Meanwhile, Georgiana Peacher, Ph.D., by studying 16 patients, noted that in 1947, in her dissertation, that contact ulcer granuloma was curable by a change in pitch. Prior to this finding, contact ulcer granuloma was considered incurable. The studies opened a new vista in treating voice patients. Prior to Dr. Peacher's cure of contact ulcer granuloma, patients with this condition who could afford a trip around the world were told to use perhaps ten words a day in their year long journey.

In 1961, Georgiana M. Peacher, Ph.D. published "Vocal Therapy for Contact Ulcer of the Larynx. A Follow-Up of 70 Patients," in *Laryngoscope*, 71, 37-47. This study indicated the success of vocal therapy for contact ulcer and the not so beneficial results of surgery for contact ulcer.

A Head and Neck Division ENT professor sent me a case, which was contra-indicated (not advisable to do surgery.) The patient's name that was a jawbreaker and then some. "Call me, 'Russian,' he said "ahem," interjecting after each phrase or sentence. Russian talked with a guttural deep throat voice. He had severe pain when talking.

"Vat I have? Ahem," asking me to read his chart. "You have a contact ulcer of the larynx," I told him. "Vat means that?" ahemmed he asked. "You are squeezing your voice from the lower throat," I explained. "Vat they not do surgery? Ahem," he

asked. “Because it isn’t what is best or appropriate for you,” I told him. “It might only make the pain more severe and ongoing,” I added. “Vat you want me to do? Ahem,” he asked. After each question or sentence, he said “ahem.”

I had never heard that manner of speech before, but became accustomed to it working with him for some weeks. Hearing Russian, I tried to have him raise the pitch of his voice, which would help him talk in the face where nature wanted him to talk, where all good and great voices are. Russian couldn’t get it.

“Vat means that? Ahem,” he asked when I took him to a piano in the medical lounge to use the piano. The piano was the way to find the right pitch of voice. Russian couldn’t match the piano pitch range with his speech. Then a eureka moment struck, the moment of truth. I realized that when Russian said “ahem” he talked at the right range and his voice went to the face where I asked him to speak.

“Vat means the ahem, Ahem,” he said. And when he said the ahem his pitch rose four to five notes, each and every time, like clockwork.

“Do you feel the ‘ahem’?” I asked.

“Vat ahem, Ahem,” and saying the “ahem,” his voice was in the face.

I played back the conversation we had with Russian hearing the ahem; Russian could feel the resonance in the face, away from the laryngeal resonance in the lower throat where Russian normally talked.

“That is vat you want me to talk on?” “Ahem,” he said. I nodded. Russian did it. Before long, Russian’s guttural painful voice was gone. When seen in the head and neck division, the granuloma, a growth between the arytenoid cartilages was healed. The ENTs at the Head and Neck Division said Russian was fine.

“Vat you not tell me to talk on the “ahem” to begin with, Ahem,” Russian asked.

I told him, “I discovered the ahem because of you.” “Then I should get discount, no?” he said ahemming to me. He had a

point. My Chairman, Dr. Pressman asked me, “was it true that you discovered the “ahem” technique to focus the voice in the face?” I assured him, “yes.” I never heard if Russian got a discount. One thing was certain. Without Russian, I never would have discovered a miraculous amazing way to help countless voice cases find a natural voice lift and effective voice quickly. I found you can “ahem” through the day and people love to hear you because they believe you are validating their listening. And who doesn’t want to get heard, and listened to. Meanwhile you are practicing on what is the right voice to talk with and help you get the right focus of your voice in the face, with people not realizing you are practicing on them, to get your effective voice. Emile Froeshels, the ENT doctor who discovered the “chewing” approach that produced the natural face-lift had given me the idea to extend the natural voice lift that would save troubled voices. I simply made Froeshels’ great discovery to a practical and acceptable user friendly method to carry over the natural right voice throughout the day talking in public and having everyone believe you are listening and validating what you say as you practice using your right voice.

It was 1962 when I had developed my “a-hem” or “um-hum” technique for finding the optimal pitch level and balanced tone focus. The patient says “um-hum” using a rising inflection with his lips closed, as if he were spontaneously and sincerely agreeing with what was said. When produced correctly, the patient will feel vibration around the mouth and nose, where, according to Robert West, Ph.D., all good and great voices are found. (Dr. West was one the principal founders of the American Speech and Hearing Association, now known as the American Speech-Language-Hearing Association). This technique is one of the foundations of my DVR. This approach to locate the optimal pitch of voice replaced the prevailing use of the piano. The “um-hum” technique, if produced correctly, locates the correct pitch level and proper tone focus can result in a normal quality of voice in seconds.

At UCLA Medical Center Head and Neck Division under the supportive arm of the famous Dr. Joel Pressman and with Hans von Leden, MD, a renowned laryngologist, I became intrigued by voice disorders and all the voice patients. I refined my techniques, working with a wide variety of voice disorders, including patients in post-operative recovery from voice surgery. Incorporating Dr. Anderson's variables of pitch, tone focus, rate, volume and diaphragmatic breathing (which Dr. Anderson had used with non-pathological voice cases), I applied the key factors of pitch and tone focus directly to pathological voice disorders. I earned a reputation of getting exceptional results with almost all voice problems and especially difficult cases.

Two proposal studies for my dissertation had been rejected. I had taken a two-week course with Dr. Nathaniel Levin at Miami University Medical Center, author of *Voice and Speech Disorders: Medical Aspects* in esophageal voice training. (Dr. Pressman had arranged for me and for my wife Marcia, a MA in Speech Pathology from Stanford University, to attend.) At the close of the two-week course in order to obtain certification, everyone in the course was required to write a paper on some topic. I had no topic in mind. Dr. Levin asked me, "Have you seen an interesting case at UCLA Medical Center?" I mentioned a young boy of 12 who had biopsied papillomatosis of the vocal cords diagnosed by the Head and Neck Division. The growth disappeared after my program of DVR. I knew nothing of papillomatosis of the vocal cords being incurable. Dr. Levin said, "Write it up." I did and then proposed a clinical study of vocal cord papillomatosis as a doctoral dissertation. Dr. Pressman assured me "papillomatosis was hopeless." There were no cures by any medical intervention. Ullman in 1923 had done a study on ten cases of papillomatosis. He found the condition was due to a virus. Ullman's position became the prevailing medical view despite the medical findings of Scott and Ferguson, and Paul Hollinger, who criticized Ullman's study as flawed. I asked Dr. Pressman to help me fulfill the Ph.D. requirement for original research. "Okay," he said. "Go

ahead.” Dr. Pressman had the Head and Neck Division check out 34 biopsied cases of vocal cord papillomatosis. Nine cases were agreeable to undergo the study. Dr. John Snidecor set up the clinical study. Nobbi Isshiki, MD, later to become world famous for his thyroplasty surgical procedure, handled the spectrographic analysis. Papillomata of the vocal cords is a serious organic growth, a premalignancy that could lead to cancer of the vocal cords.

In my 1964 doctoral dissertation, I found prolonged deep throat speaking was contributing to voice stress, strain, fatigue and, eventually, pre-malignant organic growths on the vocal cords. I changed the pitch, tone focus, and breath support (all wrongly used) of these patients. Following three months of DVR three times per week, five out of the eight patients had a reduction or an elimination of the condition. Dr. Pressman was unbelieving. He was aware the faculty and staff of the Head and Neck Division had reviewed the vocal cord papillomatosis before and after. “It is an amazing finding,” Dr. Pressman told me. Dr. Pressman asked me to apply for a grant. “But chief, you said it was pointless.” Dr. Pressman sighed and waved me out of his office. “Do it.”

That study was peer-reviewed and published in the *Journal of Speech, Language and Hearing* in 1971. It also involved the extraordinary concern of the President of the American Speech-Language-Hearing Association (ASHA) to undertake an investigation involving the success of the study. ASHA contacted the Head and Neck Division to verify that medical doctors had indeed checked out the vocal cords before DVR and after DVR to verify the reduction or elimination of the papillomatosis on the vocal cords. Also for documentation the papillomatosis had been biopsied; it was biopsied papillomatosis. The Head and Neck Division confirmed the amazing findings. The publication was a *landmark study*. A patient in that UCLA study sought me out 25 years later to thank me for my help in directing him to a normal voice by DVR; he had had no papillomatosis since 1964.

Years later, another patient, Paul, a chief salesman for a well known drug company appeared on my public TV program, *Change Your Voice, Change Your Life* reporting that my program of DVR had resulted in full recovery, a cure, of his voice from biopsied papillomatosis (a premalignancy of the vocal cords of the vocal folds. Paul had undergone surgical procedures on the vocal folds, but the growths were reoccurring. A five-year follow-up of his progress by DVR found him to be without further vocal fold problems. Paul's voice was clear and normal in contrast to the severe hoarseness he once had, and his impaired ability to project his voice. His tired inefficient voice was gone.

Another patient had biopsied vocal cord leukoplakia, a premalignancy of the vocal cords like papillomatosis and keratosis, surgically removed but the growths were returning. I worked with the patient. The growths regressed and disappeared. The ENT doctor commented "sensational."

Letter from former patient diagnosed with biopsied Squamous Papilloma of the vocal cords.

*To whom it may concern:*

*During the late 1970's, I was diagnosed as having a squamous papilloma of the vocal cords. My speech was shot and for several years I had several surgeries all to no avail, talking caused pain and fatigue.*

*Eventually I saw Dr. Morton Cooper. I retrained my speaking through his coaching and repetition. Today occasionally when my voice becomes tired I go back to the old method and in a day or two I'm once again okay by practicing Dr. Cooper's methods.*

*Sincerely,*

*Lawrence Spira, MD*

After obtaining my Ph.D. in 1964 at UCLA, I remained at the UCLA Medical Center as Director, Voice and Speech Clinic,

Outpatient Clinic and Clinical Assistant Professor, Head and Neck Surgery Division.

Following the thinking of Professor Williamson and Dr. Peacher, I found that the pitch of voice was usually too low in most cases of functional and organic dysphonias, but not all. I reported my findings at the American Speech-Language-Hearing Association (ASHA) and the California Speech-Language-Hearing Association (CSHA) over the years. The theory at that time was to usually lower the pitch. I was called a “high-pitch pusher” by some. Later, I described my successes with various types of dysphonias in my chapter in Dr. Lee Travis’ *Handbook of Speech Pathology and Audiology*, and in my textbook, *Modern Techniques of Vocal Rehabilitation*; my view of lowering the pitch or raising the pitch, as needed, was shown to be perfectly correct.

I have found that most voice disorders (functional misphonias or dysphonias) that I treated were caused by wrong voice use, which created the voice problems. While I was formulating my theory of “Voice Suicide” at UCLA, Hans Selye was busy revolutionizing medicine with his stress model of disease. Unlike earlier psychosomatic views, Selye’s stress theory held that prolonged “wear-and-tear” on targeted organ systems caused (a) alarm and mobilization, (b) resistance and (c) exhaustion. Unbeknownst to me, I was coincidentally paralleling Selye's findings with my voice breakdown findings. I developed my “Voice Suicide” model indicating that normal voices deteriorate from poor alignment of essential voice variables—wrong pitch, incorrect tone focus, poor breath support and inappropriate volume. With repeated clinical cases over forty-five years, I consistently found that patients’ voices didn’t deteriorate because of faulty neurology, biochemistry or psychiatric problems, but through sustained “wear-and-tear” or voice misuse and abuse due to poor voice habits.

Of all the challenges in working with voices disorders, I became intrigued by a condition then called spastic dysphonia

(strangled voice), one of the most dreaded, and least understood voice and speech disorders. Speech pathologists and Ear, Nose and Throat Doctors were taught to fear these patients, believing they were somehow afflicted with a serious mental disorder. A century of psychiatric care did not report a single cure. Deso A. Weiss, MD, a psychiatrist and voice doctor wrote in *Functional Dysphonia* (1971) that SD was hopeless and that anyone reporting any inroads on SD was making an Olympic achievement. I responded to the challenge.

Then, I made an unexpected discovery. I was treating a female patient with severe spastic dysphonia. She basically represented the prevailing view of psychiatrists that spastic dysphonia was a psychiatric problem untreatable to a cure. Since patients were told to lower the pitch of voices for spastic dysphonia to keep them calm and contained, it had never occurred to me not to lower the pitch of voice. I advised her to lower the pitch of her voice. I also told her her SD condition was incurable. Only palliative measures were possible. I was still thinking inside the box instead of outside the box. When she returned to treatment after the weekend, I was astonished that her strangled voice was gone and she had a perfectly clear voice. But, instead of lowering her voice, she misunderstood my original instruction and raised the pitch. By serendipity, I found that raising the pitch and tone focus lifted the strangled voice out of the lower throat, placing her voice into the mask, the area from the lips to the bridge of the nose. By chance, serendipity, I realized the truth about SD. **SD responded to a change of pitch with a clear normal voice.**

I asked for advice from Friedrich Brodnitz, M.D., an ENT specialist who had directed me to the field of speech pathology. "What I should do regarding the revelation that an SD patient could talk at will with a normal voice if given an appropriate pitch level?" Brodnitz's advise was simple: 1) Gather a series of cured SD cases, 2) Follow them up to verify that they remained cured, 3) Then publish. I did exactly as Brodnitz suggested. I gathered a series of SD patients who had recovered by undergoing my DVR

program. I reported my findings (which were peer-reviewed) in the *International Association of Logopedics and Phoniatrics* in 1980. Ironically another top medical doctor at UCLA whom I helped to achieve a normal voice, told me exactly what Brodnitz told me. “Do not publish until you have enough cases to verify your view that SD is recoverable and curable by DVR, else you will ruin your career.”

Dr. Jack Pressman, Chairman of the Head and Neck Division, died of cancer. I had served on his staff and faculty for eight years. He wrote of my service “To Morton Cooper, the best speech pathologist I know.” Yet, the new Chair assured me in his first faculty meeting that my view of pitch was all wrong. I knew it was time to move on. I left the UCLA Medical Center soon after.

By using my “um-hum” technique, I was now able to give patients with spastic dysphonia the natural “voice lift” needed to deal with SD. My natural “voice lift,” which had improved and cured many common other voice problems, helped the strangled voices. By getting a natural “voice lift,” to the face or mask, the patient takes stress and strain off the vocal cords, eliminating many inexplicable symptoms masquerading and mimicking neurological medical cause, namely a dystonia. But, more dramatically, my voice techniques eliminated the need for high-risk surgery. In some patients with SD, I found “organic” problems, including nodes, polyps, contact ulcers, bowed vocal cords, etc. in addition to spasms of the vocal cords. This was thought to be an unusual finding, but not to me. It fit my paradigm of misuse and abuse of the voice. **These growths on the vocal cords responded to DVR with a high success ratio (see *Modern Techniques of Vocal Rehabilitation* (1973) and an article in the *Journal of Speech and Hearing Disorders* entitled “Spectrographic Analysis of Fundamental Frequency and Hoarseness Before and After Vocal Rehabilitation”), which showed a 98% success ratio for 155 voice cases including many types of voice disorders (1974).** I followed these voices for three months to seven years to verify

the successful outcomes renamed. I realized that these benign growths were part and parcel of voice misuse and abuse as was SD.

Earlier I had written in my book, *Modern Techniques of Vocal Rehabilitation, 1973* (pages 13-15), the following explanation of the development of different voice disorders:

“The theoretical foundation of the development of premalignant growths, such as keratosis, leukoplakia, and papillomata, to malignant growths is posited by this author as follows: (1) The misuse and abuse of the speaking voice creates inflammation and irritation of the vocal folds without organic damage. This irritation and inflammation may be acute, but with repeated damage to the folds by continued voice misuse and abuse, along with other irritants such as smoking, the inflammation and irritation become chronic and move into the next stage. (2) Thickening or edema of the folds takes place. This stage may also be acute or chronic. The thickening, or hyperplasia, in time with continued voice misuse and abuse, turns to metaplasia. (3) Benign growths such as nodules, polyps, and contact ulcers may follow continued voice misuse; the growths may then progress into the premalignant growths, such as leukoplakia, keratosis, and papillomata. Or the premalignant growths may develop directly from the metaplasia, circumventing the benign growth stage. These premalignant growths remain within the acute or chronic stage before moving on to malignancy. It is posited that this stage is reversible or can be stagnated by voice rehabilitation plus the cessation of other irritants, such as smoking. (4) Malignant growths occur on the vocal folds.”

All the stages described do not occur in each individual; some stages progress more rapidly than others (again with individual variation), and some stages remain more static than others. Knowledge of such stage development would be helpful, if not vital, in determining when voice misuse and abuse must cease, if such a factor is contributory and pertinent to the onset and development of vocal fold cancer.

Jackson and Jackson (1939, p. 210) write: "The location of 85 percent of cancers on the most abused part of the larynx, the middle third of the cord, renders it logical, even if not probable, that vocal abuse is one cause of cancer of the larynx." Cavanaugh (1923) says that laryngeal irritation predisposes to malignancy. Tucker (1935 and 1937) finds that chronic irritation may be one factor in the change from benign growths to malignant growths. Mitchell (1943, p. 250) says: "Benign tumors cannot be overlooked as a factor in the production of cancer." Froeschels (1943, p. 129) writes: "The pressure of one vocal cord against the other in production of the *coup de glotte* may even favor a malignant growth in a predisposed person." Wallner (1954, p. 260) reports: "Speaking with chronically inflamed vocal cords may lead to voice strain that results in the formation of polyps or of polypoid degeneration. The prolonged irritation of the mucosa may cause keratosis or even malignancy."

Pietrantonio and Fior (1958), in studying 200 unselected patients with cancer of the larynx, have found that 14 percent of their cases suffered from voice strain. They feel that these findings indicated that voice strain was important in the genesis of cancer of the larynx. Luse (1965) has reviewed the occupations of 491 laryngectomees prior to surgery. Their occupations had involved trauma of the vocal folds from pulling, pushing, lifting, or from vocal abuse. Many of the patients had had to talk in noise on their jobs.

Vocal misuse and abuse are linked with papilloma, leukoplakia, and hyperkeratosis. Brewer and Briess (1960a, p. 462) write:

Screamers, speakers, or singers nodes have long been reckoned as the wages of voice strain, yet many swollen vocal cords without other evidences of inflammation, polyps, papillomas in the adult, contact ulcers, hyperkeratoses, and leukoplakia, as well as localized edemas and inflammatory areas, can now be traced to specific intrinsic laryngeal muscle dysfunction for their etiology.

Kernan (1937) notes the relationship between voice strain and hemotoma, which lead to papilloma. Cracovaner (1965) writes that if causal factors such as cigarette smoking, alcohol, and vocal abuse are eliminated, hyperkeratotic and leukoplakia lesions may be reversed. Cooper (1971a) reports the results of a three-month program of vocal rehabilitation for eight patients with biopsied papillomas of the vocal folds. In four of the eight subjects, laryngologists found that slight to extreme reductions had occurred in the size of the lesions.

In summary, the results of vocal misuse and abuse are variable. They depend upon the circumstances, the degree and extent of the misuse, and the external and internal needs of or demands upon the individual.

Controlled research is limited in isolating the variables that may produce cancer of the vocal folds through the stages previously described, with vocal misuse and abuse contributing to all stages. The premalignant conditions of the vocal folds—leukoplakia, keratosis, and papillomata—must be studied as to the effect and results of vocal rehabilitation, as it eliminates the vocal misuse and abuse.

### **VOICE MISUSE IS NOT DUE TO OVERUSE OR EXCESSIVE USE OF THE SPEAKING VOICE**

Vocal misuse and abuse are often either confused with overuse of the voice or thought to be synonymous with vocal overuse, as mentioned by Ash and Schwartz (1944) (vocal misuse or excessive use) and Withers and Dawson (1960) (vocal misuse or overuse). Vocal misuse and overuse (or excessive use) are two separate entities. Although overuse or excessive use of the voice is usually listed as a leading cause of voice disorders, in reality, misuse and abuse should be cited as basic causes.

Overuse of the speaking voice does not occur at any time unless the speaking voice is misused and/or abused. If vocal misuse and abuse are transpiring, any use is overuse. There is no overuse of the speaking voice if the speaking voice is properly

used. Overuse is a factor only when vocal rest is essential for healing following a surgical procedure, when the individual has a cold or upper respiratory infection which has adversely affected the vocal folds, or when the vocal parameters (pitch, tone focus, breath support) are influenced by a severe mental or physical condition. The term overuse is a misnomer. Voice disorders are not due to *overuse* of the voice; they are due to *misuse and abuse* of the voice. A voice well used is essentially never overused. (*Modern Techniques of Vocal Rehabilitation* pages 15-16).

My view and identification of poor voice habits, namely, deep throat speaking, as the cause of most common functional voice problems, including all spastic dysphonia. I identified organic manifestations as symptoms [effects] as primary from wrong voice use and not medical cause. I found once the medical paradigm commits to neurological causation, it also commits to an invasive solution, either surgery or Botox, and of late, Reflux acid drugs.

My discovery that wrong voice placement and wrong pitch, breath support, and voice image—not underlying neurology—caused SD and other voice disorders dented the medical paradigm, insisting that anything other than neurological and biochemistry cause can't be trusted. Years after my SD patient at UCLA Medical Center misunderstood my advice, defied prevailing wisdom and improved her strangled voice by raising the pitch, the medical paradigm for SD still hasn't included my direct functional approach to voice care. As Thomas Kuhn points out in his book *The Structure of Scientific Revolutions*, the paradigm doesn't take lightly anomalies or "exceptions to the rule." But important breakthroughs can't be ignored indefinitely. Kuhn blueprinted the course of normal science by which new discoveries make their way through the tortuous path toward eventual acceptance. According to Kuhn, when confronted with new ideas, old paradigms close ranks, try to disprove new workable theories and positive

outcomes, find creative ways to slam the door and hang on to the old ways.

### **Good Deeds Don't Go Unpunished**

I find the voice experts and scientists operating outside the prevailing paradigm pay a Draconian price for independent thinking. While many think that science encourages creativity and independent thinking, the paradigm doesn't show much tolerance. Sigmund Freud, a Viennese neurologist, stepped out of the box in 1900 when he published his blasphemous work, *The Interpretation of Dreams*, officially abandoning the prevailing medical paradigm to explain and treat common types of mental illness. Freud abandoned the established medical paradigm not out of disloyalty but because it couldn't explain or treat everyday psychiatric problems.

Freud faced ostracism and criticism from the medical establishment for daring to be different. Today's voice field, dominated by neurology and biochemistry, has little tolerance for alternative ideas that dispute the prevailing SD medical model.

My view of SD involving forced laryngeal resonance, a problem that occurs when bad habits push the voice into the lower throat. Spastic dysphonia is a constant strangled strain without remission. Spasmodic dysphonia has remissions. Both types I find have spastic vocal cords. Forced laryngeal resonance causes stress, strain, fatigue, exhaustion and eventual symptom formation leading to SD. There's nothing mysterious about my blueprint for voice breakdowns. It parallels the Nobel Prize winning work of Dr. Hans Selye's "Stress" model of disease. Like Selye, I view persistent and sustained wear-and-tear causing mechanical breakdowns and benign, premalignant and malignant (at times) organic growths on the vocal cords.

Under the medical paradigm excessive and exclusive laryngeal resonance for SD is regarded as evidence of dystonia, or neuropathology causing uncontrolled spasms in the larynx. I find that the SD voice is due to ongoing prolonged forced laryngeal resonance, placing the voice entirely and incorrectly in the lower throat—a process that eventually functionally wears out the voice and the body, too. In my experience, surgery or medication does not reverse years of bad habits eventually causing voice breakdowns.

My approach to SD hasn't received a warm reception in conventional medical and academic circles. Getting cures, recoveries and significant improvements with direct voice behavior modification proved to me that SD could not be due to faulty neurology in the vocal cords. You can't trick the brain or reverse neurological damage. Today's medical model views SD as caused by neurological damage in the brain's basal ganglia, transmitting runaway signals to the vocal cords causing uncontrolled spasms. If this were really true, patients couldn't and wouldn't respond to my DVR. I help relax the focal laryngeal resonance by placing a balance of the oral and focal resonance relieving and then eliminating the pressure on the laryngeal resonance. All voices have laryngeal resonance. It is natural and normal. It becomes pathological when stressed and used solely as the resonance of "choice" appearing to be a dystonia when it is merely a functional mechanical misphonia or dysphonia.

Viewing the strangled voice (SD) as a focal laryngeal dystonia, medical specialists readily prescribe Botox as state-of-the-art treatment. Botox is designed to paralyze acetylcholine, a neuromuscular transmitter substance responsible for muscle contractions. According to medical theories, stopping spasms should restore voices back to normal.

"Botox is giving patients with spastic vocal cords back their voices" according to a claim made by Donald G. McNeil Jr.

in the *New York Times* front page on March 2, 2003. No appropriate source or documentation was given to verify or support this unqualified statement. I contacted Mr. McNeil who presented an irrelevant source in the *Annals of Otolaryngology, Rhinology, and Laryngology* in 2002 to “document” his statement in the *New York Times*.

I quote McNeil’s documentation:

“The purpose of this study was to determine whether paced electrical stimulation of the posterior cricoarytenoid muscle with an implantable device could restore ventilation in a patient with bilateral vocal fold paralysis without disturbing voice. In the first US case of a multi-institutional study, this patient was implanted with an Itrel II stimulator (Medtronic, Inc). In monthly postoperative sessions over an 18-month period, an effective stimulus paradigm was derived, the magnitude of stimulated vocal fold abduction and ventilation was measured, and perceptual judgments of voice quality were made. After identification of optimum parameters, posterior cricoarytenoid muscle stimulation produced moderately large vocal fold abduction of 4mm, but only marginal improvement in mouth ventilation, with no change in voice quality. After adductor muscle blockade with botulinum toxin, the patient’s voice improved with increased phonatory airflow, but ventilation through the passive airway was still inadequate. However, by combining these two therapeutic strategies, dynamic abduction increased to 7mm, ventilation through the mouth surpassed that through the tracheotomy (allowing decannulation), and voice quality was restored to normal.”

This document has nothing to do with the statement “Botox is giving those with spastic vocal cords back their voices.” This is an exceptional case involving bilateral cord paralysis which only a handful of SD cases have.

Botox gives patients a “Botox voice,” superimposing vocal cord paralysis on top of squeezed voices. As Botox degrades and

no longer blocks acetylcholine, there's a brief window during which the voice may briefly improve. In reality Botox voices all too often and too quickly revert back, requiring more Botox injections.

My DVR offers a prognosis of permanent cure for patients with the strangled voice by retraining counterproductive voice habits. But because I have stepped outside the medical paradigm, my approach is dismissed as “alternative treatments,” a buzzword used to disparage non-medical therapies. Frequently, my approach is dismissed as “voice therapy,” which is a collection of dubious techniques that have a poor track record and no cures with the strangled voice. In truth, my DVR bears no resemblance to conventional speech or voice therapy.

Some years ago after successfully treating a case of spastic dysphonia referred by a Beverly Hills ENT doctor, I met for breakfast with the specialist. Expecting to get praised for a job well done, the doctor sent a very different message. Though impressed with the outcome, the specialist told me he could no longer refer SD patients. I asked whether there was something wrong. When finally pressed, he admitted to me, he couldn't afford to refer more patients. Meaning if patients were to get a recovery by DVR, it might be interfering with physicians earning a living on treating chronic conditions. I was flabbergasted. At a meeting designed to share cases, compare notes and develop an ongoing referral relationship, I found that “good deeds don't go unpunished.”

As we've seen, the history of scientific discovery isn't always a happy scenario of replacing the old with the new when a better model comes around. Paradigms—and those adherents working inside the box—don't take lightly to change, frequently attacking anomalies that threaten revolution. My inadvertent, yet inescapable, discovery of DVR at UCLA Medical Center represents the kind of unwanted anomaly that the medical

paradigm finds increasingly annoying in the face of ongoing improvements, recoveries and cures by non-medical intervention, DVR. No paradigm should prevent responsible clinicians from developing new ways of helping patients.

### **Old News is No News**

Thirty-five years of cures of spastic dysphonia, now called SD, my DVR has become old news to Christy Ludlow, Ph.D., at the National Institutes of Health, Neurology Section. “Dr. Cooper has nothing new to report,” said Dr. Ludlow in 2003, recently, insisting that spastic vocal cords are caused by brain injury or disease, neurological damage or molecular biology. Working inside the medical paradigm, Dr. Ludlow believes Botox is the only legitimate treatment for SD, despite knowing of my approach. She says she won’t pay attention until I produce Phase 1, Phase 2 and Phase 3 clinical trials requiring scientific scrutiny by the FDA. But my Direct Voice Rehabilitation isn’t a drug treatment qualifying for FDA approval. It’s a non-toxic, non-invasive form of voice behavior modification. SD is not a medical problem, I maintain, and there is no clinical basis to make it a medical problem or a disease.

Lynn Payer’s book *Disease Mongers* explains extensively and in detail how medical societies make non-medical problems into medical problems and medical diseases. She calls such activity “disease mongering.” I find that SD has been turned into a disease. If it is a disease, a dystonia, how is it possible to report ongoing cures of a “disease” or “dystonia”?

I have numerous clinical case studies with before-and-after voice recordings and patient’s personal statements attesting to lasting cures covering over thirty-five years of SD with DVR. Before-and-after clinical case studies—not experimental research—are the most powerful proof that treatments work and produce results. Ignoring my results simply on the basis that my

cases haven't been subjected to experimental, "scientific" proof defies logic and common sense but deprives patients of effective treatment nevertheless. Recent revelations published by the *Los Angeles Times*, by Pulitzer-winning David Willman on the NIH, demonstrate that "scientific" proof doesn't tell the whole story. My work isn't funded by pharmaceutical companies, invested in a positive outcome to get drugs to market and augment sales. In regarding SD therapy, Dr. Deso Weiss the famed psychiatrist and voice doctor noted in his book *Functional Dysphonia*: "In therapy we only ask whether it works. Scientific explanations change anyway with the further development of our basic knowledge, but (therapeutic) factors remain."

Investigative reports into the drug industry by the *New York Times* and the *Los Angeles Times*, which won David Willman a Pulitzer, indicate that pharmaceutical companies have a vested interest in the outcome of research. Take the drug Rezulin for example. Researchers supported by the drug maker proved in numerous "scientific" studies that the drug was safe and effective. Yet, independent studies warned that the drug had dangerous liver toxicity. When it came time for Food and Drug Administration approval, the drug maker, Parke-Davis/Warner-Lambert, lobbied the FDA to gain approval, despite substantial evidence of liver toxicity. Rezulin was declared "safe and effective" by the FDA for several years. After numerous deaths and injuries—and an avalanche of lawsuits—the FDA finally withdrew its approval in 1997.

What's instructive here is that Parke-Davis/Warner Lambert sponsored umpteen "scientific" studies proving with scientific precision that Rezulin was safe and effective. It took massive exposure by lawsuits and investigative journalists at the *New York Times* and the *Los Angeles Times* to pressure the FDA to finally withdraw approval. When bureaucrats ask for scientific studies it's frequently used to discredit otherwise valid approaches. Instead of winning accolades in the voice field, my non-toxic non-

medical cures of SD have earned scorn, ridicule and ostracism by the medical profession and by the American Speech-Language-Hearing Association (ASHA). Growing concerns about scientific research indicates that 96% of drug studies are sponsored by the drug companies seeking FDA approval and brisk product sales. With those types of conflicts-of-interest and lobbying, it's no wonder drugs like Rezulin get approved, causing injuries and deaths.

Recent revelations on Wall Street about stock analysts—those specialists issuing “objective” buy-sell ratings a various stocks—actually working for the investment banking houses that bring companies public, have forced new laws to reassure the investment community. In the case of drug treatments, the same lack of objectivity rules the process by which breakthrough therapies gain FDA approval and make it to market. Treatments like my DVR spur little interest to publicly traded drug companies actively seeking to augment the drug sales. Whether questioning the validity of Wall Street analysts or pharmaceutical companies, consumers should keep in mind what may drive some free enterprise.

Publicly traded drug companies like to support non-profit organizations connected with various causes, especially popular diseases. The American Cancer Society gets generous contributions from companies selling chemotherapy drugs. That same involvement goes for any and all non-profit organizations affiliated with high publicity diseases such as diabetes, muscular dystrophy, arthritis, and, yes, SD. Allergan, the maker of Botox, gives donations to the National Spasmodic Dysphonic Association, a non-profit national support organization chartered to advance knowledge, research and treatment of the strangled voice.

In exchange for sponsoring non-profit organizations, drug makers get their message out, helping to promote products and increase sales. It's no wonder that pharmaceutical companies

sponsor all kinds of continuing education events for physicians and allied health professionals. Corporate involvement in non-profit organizations crosses the line when drug companies impose their will and set agendas for independently-minded non-profits. Take the National Spasmodic Dysphonic Association (NSDA). Officially, they claim that they don't endorse any treatments, yet their meetings, proceedings and activities center around the use of Botox for SD.

Christy Ludlow, Ph.D., sits on the masthead of the NSDA that gets donations of money from Allergan, the maker of Botox. She is involved in deciding who gets grants for research on SD cause and treatment. She was sponsored by Allergan in the 2003 March presentation on cause and treatment of SD. My cures of SD by DVR are not allowed in the national Allergan sponsored meetings. Only those who have no cures of SD are invited in to Allergan sponsored SD meetings. In 1982, Christy Ludlow wrote: "Many cases of dysphonia have a neurological basis with involvement of either a unilateral recurrent laryngeal nerve or, less frequently, a superior laryngeal nerve paresis." Christy Ludlow Chapter 1 *Proceedings of the Conference on the Assessment of Vocal Pathology*, ASHA Reports Number 11.

My response to her:

"In 1982 you wrote that voice problems are often related to neurological cause. I do not agree with you. I find the overwhelming number of voice problems as well as SD are caused by functional voice misuse, not neurological cause. It seems to me, Dr. Ludlow, that you are obligated to afford a diversity of views, not a subjective view. Your association with the NSDA, your close ties to it, and your close ties to the neurological point of view on voice problems should not blind you to a different paradigm on the cause of SD."

I find that when alternative treatments that don't use Botox, like my DVR are raised, medical and drug companies don't disseminate information because it doesn't meet their views. Yet

those same medical and scientific standards used by drug companies are compromised by heavy support and funding for drug research which may be a conflict of interest and bias. Most patients suffering from debilitating conditions like SD welcome information about alternatives to reflux drugs, Botox and surgery. Politics play a role on Wall Street, but shouldn't slam the door on new and effective SD treatments. Here's where the prevailing paradigm clearly interferes with the natural course of scientific discovery. If money and turf weren't a factor, then more information would flow freely to non-profit organizations chartered to disseminate fair and balanced information.

Three recent books on the influence of the drug industry of medicine present a very dark picture of how the drug industry and the medical profession have morphed and become one, all too often. A book titled *On the Take* by Jerome Kassirer M.D., tells of the loss of medical independence in the treatment of our healthcare due to drug companies marketing and advertising their respective drugs. Dr. Kassirer was the former editor of *The New England Journal of Medicine* for eight years. Another book by John Abramson, MD. called, *Overdosed America: The Broken Promise of American Medicine* tells a similar and frightening story of how the medical profession has been inundated and overrun by the drug industry in the treatment of our healthcare. A third book is by Marcia Angell, M.D., entitled *The Truth About the Drug Companies, How They Deceive Us and What to Do About It*. Dr. Angell was the former editor in chief of *The New England Journal of Medicine*. These books are telling of the serious implications that do not bode well for the future in our general healthcare because of the advertising and marketing of drugs, which ignore the serious side effects, biasing drugs for general health without providing the full outcomes of drug studies.

In writing about paradigms, Thomas Kuhn in *The Structure of Scientific Revolutions* never understood political and economic influences affecting scientific discovery and normal time-lags for

new theories. With a preponderance of favorable results, you'd expect that discoveries like DVR would find its way toward acceptance in the medical community. Today's business marketplace assures that some discoveries—no matter how beneficial or significant—may never see the light of day because they don't correspond with powerful financial interests. Publicly traded drug companies don't want non-medical treatments interfering with their business models; they throw roadblocks in the way of competing treatments. You'd think that responsible science invite trial-and-error approaches into the mainstream when they prove positive results. Yet working against breakthroughs are not only hubris but powerful political and financial and interests, unwilling to surrender turf, market share and, yes, credibility.

### **Cure is a Dirty Word**

I published the following statement in an ad in the California Speech-Language-Hearing Association Magazine in January/February 2002. “The medical profession, the American Speech-Language-Hearing Association (ASHA), and the National SD Association (NSDA) guarantee that SD is incurable.”

Within all official medical circles, SD is considered incurable: That position is taken by all major non-profit associations in the field of laryngology and my field of speech pathology. The California Speech-Language-Hearing Association (CSHA) banned my ads that reported cures of SD because I dared to challenge the prevailing view that SD is an incurable dystonia.

Because I voiced a position and paradigm that ran counter to the medical paradigm, Lisa Cabiale O'Connor, the President of CSHA, cancelled my contract for ongoing ads and point blank wrote that “*The message we have tried to send is this-- we will not place ads that are written challenging other people or putting down their work on the same disorder ...*” Those individuals I challenge are guaranteeing there are no cures for SD.

O'Connor further stated in writing that she had one secret letter, and three additional calls, upon which she based her cancellation of my written contract. She banned further ads because of "four disgruntled members" whom she did not want to lose because it would diminish the number of members in CSHA from approximately 5500 by four members.

In writing I asked O'Connor who the four disgruntled members were, what they said, and could I see the secret letter privy to only O'Connor, as it was that letter apparently upon which she based her cancellation of my contract. Her response was that the secret letter was privy only to her and that it was a personal letter, though she made a professional announcement on behalf of CSHA as its President on a personal private letter to her alone.

President O'Connor meanwhile notes on May 25, 2002, "In short, the ad needs to focus on the product you are selling which appears to me to be unique and, for many, an effective way to address a particular voice problem." However, cures are demonized. I'm selling a new paradigm and she doesn't like it. I can use the word "effective" but not cures. Effective doesn't trouble the medical-drug establishment. Cures do.

Itemizing a litany of excuses, Lisa Cabiale O'Connor, insists that my clinical findings don't meet her standards required for product claims—the same complaint echoed by Christy Ludlow, Ph.D., with the National Institutes of Health. Yet physicians using Botox—and professional associations supporting its use—have no problem to disseminating the results of treatment 99% effective and 99% safe, making claims that are neither supported by scientific fact nor confirmed by clinical examination. Calling Botox treatments "effective" satisfies the current CSHA leadership, ignoring the basic questions that should ask effective for what and for whom? Botox shots for SD are a lifetime annuity and full employment act for those kind enough to be providing this service.

Yet, I continue to offer compelling before-and-after clinical case studies and testimonials, attesting to dramatic cures by DVR of SD. In 2001, in *ASHA Leader*, a news journal that goes to approximately 116,000 plus members of speech pathologists and audiologists ran a report by a Dr. Stephen McFarlane in which he said that SD is incurable, SD is a dystonia, and Botox is the treatment of choice. I responded in the *CSHA Magazine* that SD is curable, presented a number of cures of SD including cures of SD patients involving the top medical centers and top medical doctors in the country, underscoring the fact that SD is not a dystonia, but is a dysphonia. I did not oppose Botox as a treatment for SD but presented the view that Botox is one of the treatments, not the only treatment for SD and that patients with SD deserved a choice of treatment that allows them to look to a possible cure of SD rather than a lifetime pattern of Botox for life.

While local, statewide and national organizations are committed to opposing non-medical cures of SD, patients and speech pathologists are unable to get satisfactory information about the success of DVR in curing the strangled voice and other hopeless voice problems including papillomatosis, unilateral cord paralysis, bowed vocal cords, etc. Maintaining the illusion that SD is incurable perpetuates an industry of medical and non-medical practitioners and drug makers committed to the strangled voice as a chronic disorder. No medical paradigm or association of like-minded practitioners should deliberately block access to exciting discoveries and breakthroughs in treatment for the strangled voice or other so-called hopeless voice disorders.

Is Spasmodic Dysphonia really Spasmodic Dysphonia (SD)? Or is SD Muscle Tension Disorder (MTD)? When I achieve cures of SD, suddenly the medically diagnosed SD is not SD. The top ENTs and neurologists at UCLA Medical Center, Mayo Clinic, Cedars Sinai, USC, Scripps, Vanderbilt, etc., and ENTs in private practice have diagnosed the SD cases I have seen and helped to a cure or recovery. If all these elite physicians are

deemed incompetent to diagnose SD as SD, something is very wrong.

### **Barking up the Wrong Tree**

Paradigms have the unique feature of setting agendas and restricting research in areas that don't go with its status quo program. Once the program is set, it's hard to deviate from the conventions set by the model. In the case of SD, the medical paradigm forces researchers and practitioners to view the strangled voice as an indisputable neurological condition.

In my book *Modern Techniques of Vocal Rehabilitation* in 1973, I made it clear that spasmodic dystonia was a functional laryngeal dysphonia or misphonia, or, more simply, a problem of incorrect voice use.

Trying to disseminate my findings in professional journals, best selling books and at professional meetings, I tried to get the word out that serious voice disorders were not due to faulty neurology but instead to bad voice habits and commitment mechanical breakdowns. In 1980, I published in the *International Association of Logopedics and Phoniatrics Journal* reporting cures and recoveries from SD. In this report, I noted the severe problems of surgery for SD. **Fourteen years later ASHA confirmed my earlier concern about surgery for SD, with 2/3 worse after surgery.**

Since the popularity of Botox in the mid 1980's, not to mention today's acid reflux blocking drugs used to treat gastroesophageal reflux disease [GERD], has the voice field been chasing neurological and biochemical causes of the strangled voice. Viewing spasms as caused by neurological "storms," arresting mini-seizures in the vocal cords became the focus of treatment. Either with surgery or presently with Botox, laryngologists still don't adopt the bigger picture, looking at voice

misuse and abuse. Honing in only on faulty neurology, the medical paradigm can't switch gears to include the critical factors of what I call "Voice Suicide," a cycle that may eventually lead to SD.

### **Wrap Up**

More than thirty-five years ago, I found the primary cause of SD was the inadvertent voice misuse and abuse of resonance (tone focus), pitch placement, and breath support. No sophisticated medication or high-tech surgery can reverse years of bad habits, causing disabling wear-and-tear on the vocal apparatus.

Paradigms are designed to govern the orderly process of research, discovery, breakthroughs and practical applications. But when paradigms get it wrong, focus on extraneous variables and yield disappointing results, as in the field of treating the strangled voice, it's time to incorporate a new paradigm that helps to get the patient the help they need.

My DVR paradigm, based on voice behavior modification, indicates that faulty patterns of behavior can be unlearned and correct voice behavior relearned. Looking at patients with SD, I noticed that all SD patients speak in the lower throat focus, verifying the medical position. Only the medical view characterizes SD as a dystonia, a hopeless neurological condition beyond change and a cure. I characterize the lower throat voice as a dys-ponia or mis-ponia, a wrong use of voice answerable and responsive to a right use of voice use and focus. This lower throat voice focus creates a predicable pattern of deterioration that may lead to vocal cord spasms and tremors from vocal stress, strain, fatigue, exhaustion, symptom formation and eventual voice breakdowns.

My discovery that the wrong pitch, tone focus, mid-section breath support, voice image and voice identity sabotaged the speaking voice led to my revolutionary voice behavior modification treatment known as Direct Voice Rehabilitation

(DVR). My DVR treatment approach bears little resemblance to conventional voice or speech therapy.

Powerful influences stemming from the nature of paradigms and corporate pressure in medical voice care have kept my DVR from becoming a legitimate option to conventional medical treatments. Dominance by the Botox industry makes otherwise important discoveries difficult to disseminate. With control of the voice industry now in the hands of publicly traded drug companies, non-medical cures like DVR are low on the food chain. Universities, impressive medical journals, scientific meetings, non-profit trade associations and, yes, prestigious broadcast and print media organizations may receive generous support from the drug industry perpetuating this trend. More than only paradigms, powerful economic and political currents now decide how breakthroughs gain eventual acceptance.

Publicly traded drug companies, medical practices closely aligned, and non-profit organizations used as marketing tools oppose non-medical approaches that don't use their commodities. My non-medical treatment of the strangled voice doesn't increase the bottom line of industries seeking to promulgate the chronic use of Botox, reflux drugs and surgery. Though modern medicine insists that SD is a neurological and biological disorder, over thirty-five years of my clinical practice with SD proves otherwise. Before the medical paradigm sees the light, patients can expect drugs, psychiatry and surgery as the first line of treatment for SD and no cures.

#### **Talking Points**

- Cure of SD is a dirty word.
- Faulty neurology isn't the cause of SD.
- I discovered the answer to SD by accident in 1968.

- Speaking and/or singing incorrectly and using bad voice habits cause SD.
- Failed medical paradigms don't readily accept and even block access to new discoveries and breakthroughs.
- Powerful political and corporate influences suppress non-medical cures.
- SD is treated as a chronic lifetime condition with 4-10 Botox shots or more a year, each and every year for life.
- Cures of the spasmodic voice by non-medical care is regarded as unacceptable.
- The SD voice is not a medical problem. Medicine has not one single cure of the condition since Traube in 1871 described the condition as "a spastic form of nervous hoarseness."
- I have ongoing cures and recoveries of all types of SD for over thirty-five years by Direct Voice Rehabilitation.

## Chapter 3

# History Repeats Itself

### What's Inside

In this chapter you'll learn how history, paradigms and publicly traded drug companies keep the voice field in the dark. □ Early medical explanations □ Changing times, same old answers □ Looking for new molecules □ Common sense, no longer common □ Drug companies call the voice shots □ Doomed to repeat □ Wrap up.

### Early Medical Explanations

When Ludwig Traube, M.D., first described the puzzling condition of “a spastic form of nervous hoarseness” in 1871, little was known about the disorder that robbed people of their voices. In the late 19th century, neurology began offering modern medicine new explanations for previously inexplicable conditions. During this time, the Swiss psychiatrist Emil Kraepelin began

categorizing various forms of mental illness into a coherent system, forming the nucleus of modern psychiatry. Back in 1871, a 22-year old named Sigmund Freud was just completing medical school, following exciting new developments in the field of neurology. Little did anyone know, Freud would abandon neurology and 100 years later, the voice field would embrace neurology.

Before modern medicine, patients with peculiar symptoms like the strangled voice were viewed as demonically possessed, exorcized and sometimes burned at the stake. With neurology, more humane medical treatment of the mentally ill in psychiatric hospitals began. Instead of shackling, beating or isolating patients, doctors finally looked at underlying neurological explanations to account for peculiar behavior. It was in this humanistic atmosphere or “enlightenment” toward the mentally ill that Traube tried to explain “nervous hoarseness,” a bizarre disorder in which voices became strangled beyond recognition.

With neurology and psychiatry in their incipient stages, Traube postulated that the strangled voice was a psychiatric condition somewhat akin to conversions hysteria, described by a Viennese psychiatrist named Joseph Breuer. Breuer, a mentor of Freud’s, studied the effects of hypnosis—known then as Mesmerism, named after a physician named Anton Mesmer [1734-1815] studied “animal magnetism”—the mysterious process affecting medical symptoms. In this context, Traube humanely attributed psychiatric causation to “nervous hoarseness,” not realizing then that psychiatric symptoms were secondary symptoms, not primary causes.

Sending the speech field on a 90-year goose chase, Dr. Traube was well intentioned, preferring to link the strangled voice to psychiatric problems, rather than demonology, witchcraft and sorcery. For nearly a century, patients suffering with spasmodic dysphonia were referred to various head doctors for psychotropic

medications and psychotherapy. Back in Traube's day, Freud abandoned the prevailing neurology paradigm, infuriating the medical community still seeking to explain all psychiatric syndromes through neuroscience. In the late 1800s, psychiatric explanations were actually considered more sophisticated than neurological ones. Freud actually ended his project for Scientific Psychology, an ambitious, but failed, attempt to use neurology to account for all mental illness. By 1900, Freud published his book *Interpretation of Dreams*, established "psychoanalysis".

It wasn't until 1960 that Drs. Robe, Brumlik and Moore switched gears, deciding that faulty neurology might be responsible for the strangled voice. With 90 years of psychiatric failure, attributing spasmodic dysphonia to neurological problems seemed like an advance. Rejecting psychiatry de-stigmatized spasmodic dysphonia, putting a purely medical focus on the condition. Yet more than twenty years of surgery by Herbert Dedo, MD., from the 1970's on, still didn't produce a single cure.

Botox was introduced in 1984. This drug has had a checkered track record for treating spasmodic dysphonia. While Botox creates great expectations—especially among unsuspecting patients suffering with the strangled voice—few of its many promises are redeemed. Most true believers of the neurological theory of spasmodic dysphonia insist that Botox relieves spastic vocal cords. I find clinically from emails, calls, letters, and my clinical practice, few patients, looking to recover healthy voices, are satisfied with an outcome that only includes high-tech analysis without carefully listening to post-Botox voices.

Listening to voices, especially voices of SD patients has become a dirty word in medical circles, because success is measured by reductions in vocal cord spasms but not in achieving lasting improvements per se in actual voices. I point out cured and natural voices come from talking in the mask, the area above the lips up to the bridge of the nose. Nasal resonance—not nasality—

is the hallmark of good and great voices. No matter how many surgeries or how much Botox, voices won't lastingly improve until bad voice habits are broken and new ways of speaking take hold.

When an Austrian botanist named Johann Gregor Mendel [1822-1884] formulated his "gene theory," it gave remarkable insight into the nature of disease. Only recently biochemist-entrepreneur J. Craig Venter [1946-] mapped the human genome, the entire genetic blueprint of human beings—giving yet new hope for possible genetic cures of currently unknown and incurable diseases. Around the time of Mendel, a French chemist named Louis Pasteur introduced the "germ" theory of disease, establishing microbes and bacteria as a primary cause of many illnesses. Two medical doctors in the Pasteur Institute at the close of the 19<sup>th</sup> Century finally solved the age-old mystery of the bubonic plague or "black death," which nearly wiped out Europe during the Middle Ages. In 1345 when the Bubonic Plague was to claim 25 million victims, the French King asked that his three leading physicians explain to him why the Bubonic Plague or Black Death prevailed. The physicians asked that they be given time to consider the answer and the French King granted that request. They returned and explained that—the stars were coming together in the galaxy as the cause for the Bubonic Plague. (*American Scholar*) Over the next five hundred years this plague was to claim additional millions of victims until the medical community found the answer to the plague, rats.

### **Changing times, same old answers**

According to Dr. Mitchell F. Brin, as reported by Jane E. Brody, Health Writer in the *New York Times* March 11, 1992, several "well designed" clinical studies show that Botox injections restore normal or near-normal speech for 3-4 months, about 80% of the time. The terms "normal" or "near-normal" speech have not been defined. In addition, my experience with SD patients does not confirm the 80% figure. The figure 99% safe and effective has been bandied about for years, a figure that patients tell me doctors

tell them. Many SD patients I have treated have gotten limited meaningful voice improvement, or in cases, have actually gotten worse, from Botox or vocal cord surgery. Dr. Herb Dedo, a famed ENT at The Medical Center at the University of California, San Francisco has characterized Botox for spastic vocal cords (SD) as a roller coaster ride.

Advocates of Botox admit that the treatment dissipates over time requiring repeat injections once in every 2, 4 or 6 weeks in some cases now averaging between 4-10 shots or more a year. To my knowledge, the manufacturer Allergan has not advanced convincing research proving that Botox is safe for long-term use. Full-page ads, costing millions, ran in the *New York Times*, *Wall Street Journal* and *Los Angeles Times* by Allergan, attempting to address safety concerns when Allergan was warned by the FDA to curtail its Botox facial ads, claims of safety and effectiveness were the issue.

### **Looking for New Molecules**

Christy Ludlow, Ph.D., with the National Institutes of Health suggests that the future of spasmodic dysphonia lies in molecular biology. Her statements perpetuate the idea that the strangled voice is primarily a neurological or biochemical problem. Ignoring my lifelong clinical experience and published results, Dr. Ludlow insists that Botox effectively treats adductor [squeezed] spasmodic dysphonia. I provide compelling before-and-after testimonials regarding the effectiveness of DVR, yet I was told by an ASHA reviewer my video on cures of spasmodic dysphonia lacks professional quality and is not appropriate for members of ASHA. The objection to the video quality is begging the point; the video is to demonstrate cures, not to please the aesthetic taste of the reviewer. In my opinion, my cures of SD are extremely appropriate to ASHA, especially since I am the only doctor in ASHA reporting cures. In a new video and DVD of SD, I have included additional patients with cures of SD.

ASHA in its news magazine officially in 1993 reported there are no cures of SD. From 1994 through 2006 ASHA's official website insists SD is incurable, a dystonia and Botox the treatment of choice. In 2006, ASHA reaffirmed its position that SD is incurable and that botox is the treatment of choice, and now links itself to the Dystonia Medical Research Foundation as it had to the NSDA. Both the NSDA and the Dystonia Medical Research Foundation receive grants from Allergan; the NSDA newsletter and its website and SD support groups are generously funded by Allergan.

It's no accident that Allergan sponsors research into the benefits of Botox, suggesting that molecular or toxic approaches hold the answers for effective treatment. But if my "Voice Suicide" model is correct, namely, that "stress-breakdown"—not faulty biological or neurology—causes spasmodic dysphonia and a host of other common voice problems, then new molecular solutions or high-tech surgeries won't work. Take the popular acid reflux drug Prilosec, for instance. As mentioned in Chapter 1, Merck sponsored the original study with James A. Koufman, ENT in 1992 arguing that acid reflux causes deep throat, raspy voices. The outcome of Merck's study gave impetus to the medical view that acid reflux causes deep throat, raspy voices. The medical view also believes that strangled voices or spasmodic dysphonia is associated with, related to, or caused by acid reflux. Acid reflux drugs are now widely prescribed for voice problems, irrespective of whether they're correlated with laryngitis, hoarseness or any other common voice problem. I clinically do not find acid reflux drugs help eliminate deep throat, raspy voices, or SD. I have extensive documentation to support my clinical findings that acid reflux is normally not involved in deep throat, raspy, or strangled voices. A voice case now and then may be caused by acid reflux, but not widespread involvement in troubled voices. Were acid reflux to be causing SD, why don't those in medicine prescribing reflux drugs report a single cure of SD ever?

Before patients with strangled voices submit to Botox, it's not uncommon to receive healthy doses of acid reflux drugs and various medications. Here again, the search is for new molecules or drugs designed to treat failing voices. When voices fail, it's easier to blame it on reflux and various unproven theories, than to recognize patients have often engaged in years of voice misuse and abuse. Modern medicine promises effective treatments based on high-tech surgeries or drugs, not, as I have found, on principles of voice stress and voice behavior modification. That, of course, begs the questions about etiology, or the presumed causation of most common voice problems.

Assuming that drugs like Botox affect faulty voice neurology doesn't in the slightest way suggest that they're effective in treating the cause of spasmodic dysphonia. Like most muscle leg cramps are functional, I have shown that prolonged voice misuse and abuse causes vocal cord strain and fatigue triggering vocal cord cramps and spasms. Relieving vocal cord spasms, by themselves, only accounts for a minor part of recoveries from spasmodic dysphonia. Botox is paralyzing the vocal cords and leaving the SD patient without control of the voice and the vocal cords. The SD patients are at the mercy and whim of Botox, which is making patients reliant on medical treatment for life and their recovery remains uncertain one Botox shot to another. Patients have lost control of their voices. Instead of working toward optimal pitch range, changing tone focus, adjusting rate and volume, improving mid-section breath support, and dealing with voice images and identities which all combine to dramatically cure, recover and improve spasmodic dysphonia by DVR, patients remain helpless under the control of Botox.

As long as the focus is on faulty neurology, there's no hope for patients suffering with the strangled voice to attain a cure. Most patients want high-tech solutions where in the best of circumstances, they can be given a Botox shot or put to sleep and wake up with great voices, but that approach isn't realistic with

deep throat, raspy and strangled voice disorders. Other medical conditions like elevated cholesterol or high blood pressure lend themselves well to molecular solutions. Groundbreaking research that began in Framington, Mass. in 1948, set out to uncover risk factors in developing heart disease. While genetics played a part, researchers found that controllable factors, including cigarette smoking, alcohol consumption, diet, exercise and stress all contributed to heart disease. Before the study, the medical paradigm focused almost exclusively on genetics to predict heart disease.

Like the Framingham study, my revealing study of papillomata of the vocal cords yielded some unexpected findings. Before my research in 1964, few imagined that voice misuse and abuse could cause actual physiological changes, leading to a premalignancy of the vocal cords. As Selye pointed out, “stress” or non-specific “wear-and-tear,” is a variable that affects real physiological changes. Peptic ulcers aren’t only caused by bad genetics or bacteria, but a host of situational variables ultimately affecting physical health. Viennese Psychiatrist Franz Alexander’s [1891-1964] helped pioneer the field of psychosomatic medicine, proving that circumstantial factors affect physical illness. My “Voice Suicide” model traces the etiology of spasmodic dysphonia to prolonged and repetitive exposure to deep throat voice projection. I find that with extended voice misuse come organic growths and a host of common voice problems.

There’s no limit to today’s biotech industry busy researching new cures of a wide variety of conditions and diseases. When neurologist Dr. Mitchell F. Brin introduced Botox into the voice field in 1984, there were high hopes about improvements and recoveries from spasmodic dysphonia. Twenty years later, scores of “scientific” studies touting its effectiveness still haven’t yielded a single cure of the strangled voice.

While Botox may have some palliative value for reducing vocal cord spasms, it doesn't seem to give patients with spastic vocal cords back their real normal voices. If voices do return, they may be typically impaired by the combination of Botox and preexisting voice problems. I believe I am correct in saying severe voice disorders are due to voice misuse and abuse causing mechanical breakdowns. Thus, more surgery and drugs won't basically cure disabled voices. Based on my clinical case studies to date, today's search for the next high-tech molecule—like older psychiatric explanations—hasn't yielded a single cure of SD by medicine ever.

### **Common Sense No Longer Common**

Since Austrian monk Johann Gregor Mendel [1822-1884] experimented with pea plants and laid down the modern laws of genetics, heredity has been viewed as a major factor in disease. All medical questionnaires include a section asking about family history, especially as it relates to diseases. Mendel determined, without exception, that anatomical and physiological traits were inherited, whether from human parents or plant parents. Although some characteristics remain recessive [not expressed], they nonetheless would be subject to the same laws of heredity. Real anatomical and physiological conditions, must, according to Mendel's laws of heredity, get passed down to succeeding generations—there are no exceptions to this rule.

State-of-the-art medical theories indicate that the strangled voice stems from renegade nerves creating spasms in the vocal cords. When pressed to explain what causes excessive nerve conduction in the vocal folds, researchers point toward damage to the basal ganglia— another anatomical structure subject to the laws of heredity. Yet, I know of no autopsy exam ever revealing abnormalities in the basal ganglia.

Common sense tells you that genetic laws of probability would produce convincing evidence of inherited spasmodic dysphonia. Though there are some references in the medical literature about a possible defect on Chromosome 9—a gene controlling the larynx—there’s no compelling evidence supporting this speculation. In an article appearing March 11, 1992 in the *New York Times* about spasmodic dysphonia, health writer Jane E. Brody advertises how to get in touch with the NSDA, which gets donations from Allergan, the maker of Botox. She gives a medical carte blanche from the medical industry to medicalize SD stating, “Although the cause or causes of spasmodic dysphonia are not yet understood, experts say the problem is not vocal abuse or strain,” said Brody. The “experts” Brody quotes are medical experts whose expertise in voice use—practical voice use—is not taught in medical schools, leaving ENTs who are in charge of troubled voices unable to sensibly serve voice problem cases simply and directly. ENTs and medical doctors look to drugs, surgery and invasive voice care. That is what they are trained to do, and do do. Brody is not aware of the deficiency of medical experts and the limited voice training given in medical training. Gerald Berke, ENT, Chair of the Head and Neck Division, UCLA Medical Center in a TV interview with me said he may have six hours of training in voice training in his ENT training, if that. He is the norm. Brody has ignored my many years of research and clinical practice reporting verified cures and recoveries from the strangled voice.

Shortly after publishing her March 11, 1992 article in the *New York Times*, Ms. Brody, the health expert, was made cognizant of my best-selling book *Change Your Voice, Change Your Life* and my textbook, *Modern Techniques of Vocal Rehabilitation*, as well as my landmark study in 1980 reporting cures of SD entitled “Recovery from Spastic Dysphonia by Direct Voice Rehabilitation,” which was published in the *International Association of Logopedics and Phoniatrics*. Since 1967, I have published over 50 professional articles, two definitive textbooks, several textbook chapters, three popular books and countless

magazine and newspaper articles, several of which disseminate information about my non-medical cures of spasmodic dysphonia.

Brody's column pointed to the "widely believed" neurological basis of spasmodic dysphonia, touting the promises of Botox to restore disabled voices; astonishingly the Botox treatment has not reported a single cure. Brody dismissed my "Voice Suicide" theory paralleling Hans Selye's "stress" model of dysfunction [AKA "The General Adaptation Syndrome"], which clearly proved that the spasmodic dysphonia is caused by a predictable pattern of voice misuse and abuse, leading to stress, strain, fatigue, exhaustion and eventual symptom formation, including the strangled voice.

I do not see the need to blame severe vocal cord spasms on faulty neurology or biological causes when there's plenty of evidence to indicate it stems from incorrect speaking habits, like muscle leg cramps being caused by punishing muscle stress. I view spasmodic dysphonia and vocal cord cramps and spasms as caused by poor voice habits, especially long-term voice projection from the lower throat, ending in voice cramp, and identified as SD. The medical profession does not Botox a leg cramp or do surgery. You take the pressure off the stressed leg muscles and the leg cramp disappears. You press the heel of the foot forward to break the leg cramp. With SD, I refocus the voice to the face to help break the voice cramp. Were SD a dystonia, I could not change SD, the voice cramp. According to my "Voice Suicide" model, projecting the voice from the lower throat causes prolonged muscle stress, voice strain, fatigue, exhaustion and eventual voice breakdowns which lead to spasmodic dysphonia, or voice cramps. Today's voice industry treats only the symptoms, not the cause, of voice failure, e.g., runaway voice spasms, tremors eye, neck and back spasms for strangled voices, with Botox or surgery.

Before Brin introduced Botox as less draconic than surgery in the 1980's for treating spasmodic dysphonia, patients were often

subjected to risky surgeries. At the time Brody wrote her column on SD cause and treatment, she presented two medical approaches: Botox and surgery. Still viewing the strangled voice as caused by neurological cause with disabling spasms, Dr. Herbert Dedo., a world famous ear, nose and throat surgeon in San Francisco, in the early 1970's, performed a surgical technique cutting the recurrent laryngeal nerve, the primary nerve innervating the vocal cords. Though initially reporting a hundred percent success from surgery, his approach left 2/3 of the patients worse off than before, as reported by, the American Speech-Language-Hearing Association reports (**1994 – 2006 ASHA website**). Dedo's surgery eventually fell out of favor and has been largely replaced by Botox injections. Brody has never written of this finding of Dedo's surgical outcome after writing about this "effective treatment," in the column.

The Dedo surgery left patients with a paralyzed vocal cord in one of three positions: 1) medial (normal), 2) intermediate or para-median (off center), and 3) cadaveric (wide open). If the vocal cord remained in the normal position, the spasms could continue and the strangled strained voice would remain. Dedo could not predict the outcome of his surgery. The state of the art surgery was Russian roulette. Dedo used implants, such as Teflon, to close the gap when the vocal cords were off center or in the cadaveric position. The outcome was unpredictable.

From my experience in following up SD cases I had referred to Dr. Dedo, the patients essentially did not want follow-up voice care (DVR), although they needed post-operation DVR for their paralyzed vocal cord. The surgery basically stopped the vocal cord cramps and spasms, but left patients with a whisper voice or a badly impaired voice which was poorly focused. The patients needed to establish the correct pitch range, balanced tone focus, and proper breath support.

In my opinion Dedo's post-op surgery results would have been far, far better if the patients had chosen DVR following the surgery. Some patients did choose post-op DVR and achieved

excellent voices, proving the surgery and DVR could be successfully integrated.

Unilateral cord paralysis happens in a small percentage of surgical cases involving the head and neck when the recurrent laryngeal nerve is accidentally nicked or cut, impairing the vocal cord. In 1968, in two peer-reviewed medical journals, I published my results with 18 patients with unilateral cord paralysis using DVR, describing 14 cures and 4 patients with 90% recovery out of 18 cases. Since 1968, I have reported a total number of approximately 100 cases of unilateral cord paralysis with 90 cures and 10 patients with a 90% recovery. Some of these patients (who gave permission to have their names mentioned-documentation on my website) are: Jeff, Ted and Rabbi Richard, and others.

Dr. Gerald Berke, chairman of UCLA's Head and Neck Division, sought to refine Dr. Dedo's surgery on SD patients, apparently getting inconsistent results. Both Dr. Dedo's and Dr. Berke's surgeries have in common the belief that surgery which attempts to relieve vocal cord spasms is the way to deal with spasmodic dysphonia. Total loss of voice may also occur from surgery leaving only a whisper voice or limited range of voice or SD as before. While patients may get relief of spasms, no surgeons have reported cures. In my opinion, no amount of Botox or surgery deals with the real cause of spasmodic dysphonia.

Like muscle leg cramps, I find inadvertently practiced incorrect voice habits put too much strain on the vocal cords, creating the spasms and squeezing seen in the strangled voice. Other voice problems also result from voice strain, including benign organic growths, nodules, polyps, contact ulcers, and may result in pre-malignancies like papillomata, leukoplakia and keratosis. Medical studies report a relationship of vocal cord cancer to misuse and abuse of the voice. (See my *Modern Techniques of Vocal Rehabilitation* pp. 12-16, 1973).

### Drug Companies Call the Drug Shots

What has to be described as fast and loose journalism is in the previously mentioned article on SD by Jane E. Brody. Her number one source for her article was Dr. Mitchell F. Brin, the neurologist credited with bringing Botox to the voice field in the 1980's. Pitching Botox and virtually ignoring years of non-medical cures by me of the strangled voice, doesn't pass the test of fair and balanced journalism.

Common sense tells you there's another side to the Botox story. Yet, Ms. Brody and the *New York Times* had no problems reporting on only one side of the issue, sourcing her story with a medical expert vested in using Botox. Botox does not deal with the underlying functional causes of spasmodic dysphonia. If there is no proven neurological basis, what justification would exist for using Botox to paralyze the acetylcholine in the vocal cords to control runaway vocal voice cramps and spasms, four to ten times a year or more each year for life?

Brody's article reads like an infomercial for Allergan, essentially giving the drug maker a pass for using Botox on spastic vocal cords. Brody misses the fact that vocal cord spasms are a symptom not a cause of spasmodic dysphonia. She fails to mention functional, non-medical causes, including incorrect pitch, tone focus, rate, volume, mid-section breath support and the voice image, contribute to the strangled voice and its spasms. Brody's report lists the NSDA as a prime referral source for those with SD. The NSDA's website I understand gets donations of money from a grant made possible by Allergan.

Without a credible neurology hypothesis, there would be no justification for using a powerful nerve-agent like Botox. Drugs that paralyze neuromuscular transmitters such as acetylcholine are designed to interrupt nerve conduction, considered by the medical community the primary cause of spasmodic dysphonia. Botox

treatments don't automatically return disabled voices to normal without retraining of faulty voice habits, forcing the voice into the lower throat where it eventually fails. Brody's easy dismissal of vocal abuse or strain causing spasmodic dysphonia mirrors the prevailing medical paradigm but doesn't tell the whole story behind spasmodic dysphonia.

Common sense tells you that if neurology were really at the root of spasmodic dysphonia, then it could be genetically inherited. Mitchell Brin believes defective genes are associated with spasmodic dysphonia. I find clinically that by changing the voice from the lower throat to the face, a clear voice can quickly emerge.

### **Doomed to Repeat**

Believing in the correctness of the SD medical paradigm, true believers have difficulty processing new information with which to revise theories. Without gaining access to new information, science can't expand its boundaries offering new hope—and treatments—to patients afflicted with dreaded diseases. SD is considered to be a focal laryngeal dystonia, a disease.

Thomas Kuhn, Ph.D. of Massachusetts Institute of Technology lamented the glacier-like movement of paradigms in his seminal book *The Structure of Scientific Revolutions*, commenting how paradigms determine admissible facts and set the rules and agenda for normal science.

Kuhn found that paradigms prevent new information and change. When I found that prolonged misuse and abuse of the speaking voice caused spasmodic dysphonia and a wide variety of other common voice problems, the medical paradigm couldn't open the door. As predicted by Kuhn, the paradigm slammed the door shut. Perceiving my new findings as a threat, or as Kuhn calls it an "anomaly," the field closed ranks, essentially blackballing me from disseminating my findings.

What the medical paradigm didn't realize was that my "Voice Stress Model" (or Voice Suicide Model), fits neatly inside Selye's "Stress Theory," identifying repetitive "wear-and-tear," through bad voice habits, as causing voice breakdowns. But until the medical paradigm can accept my "Voice Stress Model," the same blinding indifference will perpetuate the ignorance (with respect to the cause of spasmodic dysphonia and appropriate treatment), leading to today's repetitive failures in the medical drug voice industry. Only by expanding paradigms and accepting new ideas can new discoveries help patients overcome stubborn conditions and obstacles.

Adding a new twist to Kuhn's description about paradigms cannibalizing new knowledge are publicly traded corporations, whose financial support of products extends into academia, the research community, professional journals, and, yes, even daily newspapers whose advertising revenue have grown increasingly dependent on drug companies. Revelations about Wall Street, especially about stock analysts working for investment banking firms, demonstrated egregious conflicts of interest, forcing Congress to enact new legislation. Many similar conflicts of interest exist in the drug trade where the pharmaceutical companies, endow universities, fund research, subsidize researchers, influence journals and threaten to withdraw advertising dollars in major newspapers, magazines and broadcast cable and networks for reporting unfavorable stories about their products.

When minds remain shut, history repeats itself. When I discovered a cure for spasmodic dysphonia in the early '70s, the speech field should have been all ears. I found that the strangled voice was indeed not based on faulty psychiatric problems or faulty neurology but on mechanical breakdowns caused by bad voice habits. My discovery disturbed the medical community. I had no intention of embarrassing the medical community, hopelessly fixated on faulty neurology. I found all patients with

spasmodic dysphonia speaking with a resonance focused in the lower throat, a bad voice habit leading to voice stress, strain, fatigue, exhaustion and eventual voice breakdown.

When, after many years of clinical practice, I incorporated optimal pitch range, tone focus, rate, volume, diaphragmatic breathing, and the voice image into my specialized form of behavior modification called Direct Voice Rehabilitation, my theory was not accepted. All too many physicians and researchers ignore new discoveries, and are doomed to repeat past mistakes.

### **Wrap Up**

For more than 90 years, psychiatric approaches proved fruitless in restoring voices back to pre-strangled conditions. Generations of speech pathologists were warned about treating the ominous condition of spasmodic dysphonia. While better than attributing the condition to devil possession or tainted heredity, psychiatric approaches never addressed the real causes of the strangled voice.

By 1964, I completed my doctoral dissertation, a definitive study about wrong pitch and focus, namely, deep voice speaking, was associated with papillomata of the vocal cords, rocking the medical voice paradigm. My biopsied study showed that actual pre-malignant growths were reduced or eliminated when patients changed their pitch, tone focus, and voice identity.

Ullman in 1923 reported on ten cases of vocal cord papillomatosis stating that the growths were due to a virus. Scott and Ferguson and Paul Hollinger, ENTs were critical of the Ullman findings, indicating it was flawed. My study tested the outcome of Direct Voice Rehabilitation (DVR) for the papillomatosis growths to see if they responded to a change of voice, tone focus, pitch, breath support, and voice image. The fact that five of eight were either reduced or eliminated answers the

question is papillomatosis of the vocal cord/s is responsive to non-medical DVR. This approach has never been used before or after in the treatment of papillomatosis in medicine or in academia.

What Ullman did not realize was that fifteen to twenty percent of all voice problems start with a cold, virus, or upper respiratory problem or bronchitis, and these conditions were contributing to voice problems. Why? Because patients with a virus or cold or bronchitis were dropping the voice from the face into the lower throat, pressuring the vocal cords and creating vocal cord strain and edema, inflammation, or redness, nodules polyps and contact ulcers, all benign, and premalignancies as well as papillomatosis, leukoplakia and keratosis. Smoking has a similar effect of dropping the voice into the lower throat.

In Ullman's time ENTs thought and still do that papillomatosis of the vocal cord or cords is a virus causing the growth. And they believe it is hopeless despite all medical intervention, and the medical interventions are numerous, without a cure that I know of.

With the advent of publicly traded drug companies, paradigm shifts are now affected by corporate politics now infiltrating universities, research institutions, government watchdog agencies, professional journals, non-profit organizations and now broadcast and print journalism. Calling the shots, drug companies now sponsor 96% of all drug studies, touting the benefits of products. With reflux drugs and Botox now dominating today's voice treatment, most patients—and clinicians—assume that common voice problems are due to acid reflux or neurological impairments.

Over the last forty-five years, I have shown that most common voice problems—and for the last thirty-five years including spasmodic dysphonia—are caused by prolonged “wear-and-tear” or vocal misuse and abuse. I've also found that so-called

neurological problems like the strangled voice from deep throat talking, bowed vocal cords, unilateral cord paralysis and papillomata and other premalignancies of the vocal cords respond well to Direct Voice Rehabilitation, a specialized type of all-natural behavior modification used to reverse common voice problems.

### **Talking Points**

- Spasmodic dysphonia is not a psychiatric problem save for a case here and there.
- Spasmodic dysphonia is not caused by faulty neurology, or biological cause save for a case here and there.
- Neurological problems follow Mendel's laws of genetics.
- Biological explanations don't explain spasmodic dysphonia.
- The medical paradigm has difficulty processing new information.
- Powerful corporate interests affects how paradigms operate.
- My "Voice Stress Model" or "Voice Suicide Model" is related to Selye's "Stress Theory."
- Without changing the SD medical paradigm, medical history is doomed to repeat itself, and ongoing failure to cure

## Chapter 4

# Bad Habits or Bad Neurology?

### **What's Inside**

In this chapter you'll hear the truth about whether spasmodic dysphonia is caused by bad voice habits or bad neurology; you decide

- Voice breakdowns
- Kicking bad voice habits
- Fixing broken voices
- Stuck in the wrong paradigm
- Wrap up

### **Voice Breakdowns**

Can you imagine patients with knee injuries being told they have “organic inferiority,” namely, constitutional weakness causing their injuries? A few, yes. Most, not so. Most orthopedic surgeons try to fix broken bones and joints, not find esoteric genetic or inherent structural causes. They accept the idea that

prolonged stress and undue strain causes a wide variety of injuries. Yet, somehow, in the voice field, broken voices are viewed as having genetic predispositions, constitutional inferiority, and, yes, mysterious neurological damage that has neither been shown nor proven on examination. When voices break down, I have shown the predictable cycle of decline, beginning with wrong pitch, misplaced tone focus, forced volume and reversed breathing, all of which leads to voice stress, strain, fatigue, exhaustion and negative symptom formation. The results are possible deep throat, raspy voices, laryngitis, hoarseness, and then to organic growths on the vocal cords and at times crossing the line to eventual spasmodic dysphonia.

### **Kicking Bad Voice Habits**

Similar to the behavior modification treatment called Reciprocal Inhibition Therapy of Dr. Joseph Wolpe, I counter-condition wrong voice habits by systematically changing wrong pitch, wrong tone focus, wrong volume, and wrong breathing to the right optimal pitch, tone focus from the lower throat to the face, and establishing correct midsection breathing which allows the normal voice to emerge.

Spasmodic dysphonia is considered a hopeless “dystonia,” an incurable neuromuscular condition refractory to both indirect voice therapy and medical intervention. Prevailing wisdom holds that only Botox or surgery controls runaway nerves leading to vocal cord cramps and spasms. Minutes into my initial voice consultation with new patients, I demonstrate immediate improvements in countless strangled voices and provide an alternative treatment and theory about SD. I show patients firsthand it’s easy to get clear voices temporarily back. Using my “um-hmm” technique or my C-spot (the instant voice press) and having patients hum “Happy Birthday,” automatically realigns the proper pitch and tone focus, popping strangled sounds into normal

voices about 90% of the time. No gimmick or magical technique can reverse neurological or biological damage.

When clear unstrangled voices pop out by my DVR program, patients are astonished. It's no magic that strangled voices return to normal so easily. Such demonstrations are usually met with mixed feelings. Patients seem overjoyed but skeptical, after being told by medical doctors that only Botox or surgery can relieve voice symptoms. **Disbelief turns to euphoria, as patients realize there may be a cure for the strangled voice.**

Confronting voice images—those internal representations of the dysfunctional voice—patients usually show resistance, despite seeming eager for treatment. In other words, they want to end their suffering, and, at the same time, prolong their misery. What was old and familiar developed over years and finds ways of lingering. So, an otherwise simple process of diagnosis and Direct Voice Rehabilitation is made more complicated by the voice image, documented by my 1971 article “Unspoken Behavior The Vocal Image” in the *Art and Science of Psychotherapy* and in my 1973 textbook *Modern Techniques of Vocal Rehabilitation*. The voice image is not even considered by conventional voice or speech therapy or medical intervention. *It is the voice image and voice identity that is basic to the undoing of deep throat, raspy voices, especially strangled voices.* Almost all troubled and failing voices involve the wrong voice image and voice identity, contributing to or causing voice disorders.

Rooted in genetics and biology, today's voice field can't move out of the prevailing medical paradigm. Former Mayo Clinic speech pathologist and researcher Dr. Arnold E. Aronson separates spasmodic dysphonia into two categories: neurological and psychiatric. To Dr. Aronson, the real strangled voice is neurological. He concedes that my Direct Voice Rehabilitation works on “psychogenic” varieties with cures of SD. Aronson doesn't believe my DVR can cure neurological SD. It does.

Meanwhile, Neurologist and Botox pioneer Dr. Mitchell F. Brin I hear says he's never seen a case of psychogenic spasmodic dysphonia. What Dr. Aronson fails to address is that my "Voice Suicide" model explains how "wear-and-tear" eventually creates strangled voices. Continued use of the SD voice I find then creates emotional problems. I find emotional and psychological problems essentially stem from *having* SD, not causing SD, but are created by suffering SD as hopeless and the SD patients made helpless. With my success with the strangled voice, I am a psychiatric wizard to Dr. Aronson and I would be a neurological genius to Dr. Brin. **Recently, Dr. Aronson agreed his SD patient, The Reverend James Johnson, diagnosed by him at the Mayo Clinic, with a hospital record of neurological SD has been cured from his neurological SD for 20 years. Dr. Aronson called The Reverend Johnson at my request and characterized The Reverend Johnson's voice as perfect.**

### **Fixing Broken Voices**

Watching voices fail is no easy matter. Usually patients suffer through a slow progressive deterioration, typically beginning with deep throat, raspy voices, coughing, laryngitis and other forms of vocal strain. To offset the decline, they compensate in many ways, frequently speaking more in the lower throat—the exact spot where voices wear out. There's nothing "psychogenic" about voices literally wearing out and breaking down from misuse and abuse. It is a mechanical problem.

There's something comforting to patients being told they have acid reflux or neurological or biological conditions. Responsibility for the condition is placed into the context of biochemical imbalances or genetic predispositions. Here's where automatic obedience kicks in. When told they have biological disorders, patients experience a strange sense of relief combined with dread that conditions are incurable. Despite the severity of symptoms with spasmodic dysphonia, it's a relief to find a definite

diagnostic cause. Most patients may not flinch when told they suffer from incurable neurological/biological conditions. It's a classic good news-bad news scenario. On the one hand, it's good to know the diagnosis. On the other hand, it's bad to learn the condition is incurable. Once diagnosed with SD, the SD patients become a disease and are dismissed as human beings; they are told not to question the SD condition. The SD diagnosis essentially makes the SD patient a non-person. Botox or surgery is the medical treatment of choice. The SD patient has been medicalized and made helpless and hopeless. Just make an appointment for your lifetime Botox voice shot with the secretary.

Yet, medical options represent good news for patients seeking a quick fix. You can't blame patients for wanting fast-and-easy treatments. Though Botox or surgery seem scary to some, it's also reassuring to think that submitting to Botox or an operation will "correct" a miserable condition. Even the prospect of getting Botox injections assuages patients' worried minds looking for instant recoveries. Statements about efficacy by touting the benefits of Botox or surgery also reassure patients not yet cognizant that medical treatments may not restore normal voices—at least for extended periods of time. Telling patients Botox is 99% successful gives the impression that voice recoveries are close at hand. It's only after the failure of Botox or surgery to affect a cure that patients realize that voices don't readily snap back to normal. The "success" outcome is not what they have come to expect.

High-tech gadgetry at medical centers and medical offices also raises high hopes that state-of-the-art treatments, like Botox and surgery, offer the best chances of recovery. MRI's and Cat Scans help rule out cancer or other structural anomalies. There may be relief, but there is no cure. The SD patients are assured they have a disease but informed that it can't be located. The vocal cord cramps and spasms of the vocal cords are only symptoms. When patients see medical doctors and undergo procedures using

videostroboscopy and/or oscilloscopes, the process creates the image of expected help. With spasmodic dysphonia, everything hinges on the medical paradigm that voice problems stem from faulty neurology or imbalanced biochemistry. Physicians that prescribe reflux drugs for deep throat, raspy, and strangled voices, for example, must assume the reflux causes the patient's symptoms. Prescribing acid-blockers seems like sound medicine but, once again, is based on the premise that biochemistry causes common voice problems, and SD is not evidence based.

Patients want their broken voices to be like broken watches that can be fixed. Taking Botox injections, swallowing pills or getting anesthesia and submitting to surgery conjure up images of quick fixes and rapid recoveries. No one can blame patients for seeking to take the easy way out. The voice patients have little awareness they can change the SD voice for the better by meaningful Direct Voice Direction. Voices are far less complex than genetic predispositions and presumptions about faulty neurology. When patients discover they're speaking incorrectly, causing undue stress-and-strain on their vocal cords, they can't believe it. The irony is, I tell patients that I can help fix their SD voice problem mechanically, but they are medically told this is impossible, that only symptom relief is available and there is no cure possible. This places them in a situation called Cognitive Dissonance (psychological conflict resulting from incongruous beliefs and attitudes held simultaneously, *Merriam-Webster Online Dictionary*) — which makes it difficult to decide whether to leave modern medicine with its promises and technology — behind.

Instead of feeling relieved when I tell SD patients that SD is caused by wrong counter productive voice use not neuromuscular problems, patients feel blamed. How is it possible they're speaking incorrectly? The answer is simple. Parents and teachers don't give direction and classes on proper voice speaking. Few people ever take a single lesson on the speaking voice. Yet during and after puberty, our voices change extensively. Many

post puberty voices are either too low or too high-pitched and a number are focused in the lower throat. It's inconceivable to medical specialists that laryngospasms, eye, neck and back spasms could be caused by a maladaptive voice process creating vocal stress, strain, fatigue, exhaustion, disintegration and symptom formations.

Today's medical voice approaches only treat symptoms, not primary causes. Treatments remain palliative because they only operate on surface and superficial aspects of the problem. Treating conspicuous symptoms for any syndrome won't automatically arrest effects without dealing with underlying causes, such as misuse and abuse of the voice.

Physicians aren't entirely to blame for prescribing palliative treatments. Patients are demanding customers, expecting powerful drugs and sophisticated surgeries. They can't comprehend that spasmodic dysphonia—and many other common voice disorders—stem from bad voice habits leading to dysfunction. Doctors aren't trained to listen to voices, diagnose optimal pitch and tone focus, correct diaphragmatic breath support, or understand the voice image, and develop a systematic plan to counter-condition bad habits. Bad habits may not go easily when patients acknowledge their existence and do not make a commitment to change them. They remain stubbornly in place until they're identified, targeted, modified, and eliminated. "Habit is habit and not to be flung out of the window by any man, but coaxed downstairs a step at a time."— Mark Twain

This is similar to fad diets that after which people gain more weight. That is why so many opt for gastric bi-pass surgery; they want a quick makeover and fix.

Ideal patients are obedient and cooperative, taking medical treatments as articles of faith. Good patients follow instructions, don't ask questions and do what they're told. Yet, patients with deep throat, raspy voices and spasmodic dysphonia show almost

excessive compliance, continuing reflux drugs and Botox injections sometimes for years even when there are no improvements or voices get worse. I report case histories of SD patients who have undergone Botox shots and reported no success but were told to continue by their respective doctors. Despite watching voices that may stay the same—or in cases deteriorate—patients follow treatments with the mistaken expectations that more ongoing reflux drugs and Botox will eventually work, though there's no tangible proof. Believing in the infallibility of the medical model leaves patients more passive and lost about appropriate treatments.

Cognitive Dissonance and the infallibility of the medical model may also leave many otherwise rational patients suspending disbelief and accepting the status quo. If the status quo involves lowering expectations and accepting poor results, patients adjust perceptions to maintain infallibility of treatments—regardless of whether treatments are actually working. Following reflux drugs, Botox treatments or surgery, patients typically ask doctors how long their voices will stay improved. They're told to show patience. When patients do not accept the infallibility of medical treatments for deep throat, raspy and strangled voices, with doubt creeping in and trust out the window, disillusioned patients finally seek alternative treatments or simply give up.

### **Stuck in the Wrong Paradigm**

In Kuhn's paradigm world, there are paradigms inside paradigms and recognized pecking orders. In the medical paradigm, for instance, Selye's "Stress Model" took 50 years to gain partial acceptance, but, even today, lacks the prestige of genetics, neuroscience and conventional biology. My "Voice Suicide" model gets little attention because the treatment involves voice behavior modification, not drugs or surgery, so medical treatments and medical support. Even Selye's approach to heart disease, diabetes or cancer involved real lifestyle changes,

consistent with the groundbreaking 1948 Framingham study, urging prevention by recommending exercise and avoiding high fat diets and smoking.

Drug makers aren't prone toward giving up market share once securing direct or indirect FDA approval. Research and funding goes toward expanding applications for their products. Reflux drugs that originally were used appropriately for heartburn and indigestion are now used ineffectively and inappropriately for deep throat, raspy and strangled voices for which treatment FDA approval is not secured. Take Botox, for instance. Allergan is currently developing numerous applications beyond its limited use with blepharospasms [eye spasms], tortocholis [neck spasms], and most recently, frown lines. Research and clinical trials are now underway for treating migraines, carpal tunnel syndrome, underarm odor, perspiring hands and bodies, enlarged prostrates, and, yes, even female sexual dysfunction. Get ready, there are many new applications already in the works for Botox. Allergan's CEO is looking to 93 different uses for Botox (in a *Los Angeles Times* interview).

The problem with using Botox for SD is that the substance is only looking to temporarily relieve symptoms, not cure the problem and cause, voice misuse and abuse.

Looking into the vocal cords with fiber optic tubes doesn't tell you why the cords appear irritated or in spasms. Jumping to a neurological or biological explanation ignores the process by which the vocal apparatus goes out of alignment. Those who suffer leg cramps don't believe the excruciating pain is caused by bad genetics or biochemistry. The American Red Cross simply instructs patients to extend the heel forward with the toes pulled back toward the body. So the debilitating cramps go away. In the case of the strangled voice, vocal misuse induces the voice cramp we call the strangled voice. No one denies vocal cord spasms. But what causes them becomes a pivotal issue in treatment and cure.

Keeping cures by DVR out of the picture satisfies the special interests of the few, but doesn't help suffering patients seeking recoveries and cures from serious voice problems. It's no accident that my cures are discredited by Christy Ludlow, Ph.D., of the National Institutes of Health, for lacking Phase 1, Phase 2 and Phase 3 clinical trials. I find that SD is not a disease, not a medical problem, not a dystonia or neurological condition and therefore doesn't require Federal Drug Administration approval. Phase 1,2 and 3 are reserved for medical problems and diseases. My cures of SD leave no doubt of the ongoing cures of SD being real, not experimental. On the other hand, Botox for SD is experimental and is not directly approved by the FDA. Because Botox for SD is not yet FDA approved and is considered an off label drug, serious side effects need not be reported and usually aren't. I have reported ongoing cures of SD for over thirty-five years. There are no health risks by my DVR program. Sadly, Botox cannot make this statement.

In my book *Stop Committing Voice Suicide*, the ASHA reviewer, Donna Lundy does not tell you of my cures of SD by Direct Voice Rehabilitation; she says I present "successful" treatment for SD, not cures. A leading laryngologist defines "successful" on SD by surgery when the vocal cords come together on the vowel "e", even though the SD patient has no voice to speak with except a whisper. **I define "success" differently.** I pointedly separate myself from "successful" and "effective" which can mean failure is success and effective is a roller coaster ride for life from Botox's Russian Roulette use for SD. **I report cures.** A cure means the normal voice is back and is natural, automatic and lasting. A vast difference. Lundy adds I "admit to holding a contrary view of the commonly held beliefs about the etiology and standard of care." Take medical care for SD. It has yet to report a single cure. The medical community (which Lundy is associated with) "admits" it has no cures of SD, ever. Lundy is also involved with the NSDA as a SD support group leader. A *USA Today* story in April 2004 characterized Botox as the cat's meow and a

godsend, running a story, “Botox Eases Voice Disorder.” ASHA claims it maintains neutrality concerning treatments for SD. Yet, ASHA exclusively links to the NSDA and the Dystonia Medical Research Foundation’s information about SD being incurable, a neurological condition and Botox the treatment of choice.

In 1993, ASHA’s official position was that there are “no cures of SD.” Since this official ASHA position was reported in the ASHA Magazine, I asked Russ Malone, Ph.D., the editor of ASHA Magazine, who was responsible for the official ASHA position on SD. Malone did not respond. I then e-mailed Diane Paul-Brown, Director for Clinical Affairs for ASHA, asking her who was responsible for that official ASHA position that there are no cures for SD in 1993. She e-mailed me back, saying Dr. Malone did not recall who was on the committee. I found the official ASHA position to be undocumented. Was there a committee?

In 1994, the official ASHA position was revised to read that SD is incurable again, but this time, ASHA stated that Botox was the treatment of choice and that SD was a dystonia. I again inquired who was on the committee that reported this official ASHA position. Dr. Jeri Logemann, President of ASHA in 1994, wrote to me, “ASHA has developed a fact sheet on spasmodic dysphonia for consumers. The fact sheet was reviewed by a group of professionals including Dr. Arnold Aronson and Dr. Christy Ludlow. The National Spasmodic Dysphonia Association also reviewed the fact sheet.”

I contacted Dr. Ludlow, who e-mailed me stating “I was not involved in establishing an ASHA 1994 position..., I was not aware that ASHA had a position statement in SD.”

Dr. Aronson emailed saying “I was NOT involved and have never been in any ASHA SD review.”

In 2004, ten years after Dr. Logemann wrote to me in 1994, both Drs. Ludlow and Aronson were positive they were not involved in the 1994 revision of what became the ASHA official

position on SD. Dr. Logemann wrote that she did not remember writing to me; I sent her a copy of her letter sent to me for her files. Apparently the only source for the ASHA official position on SD turned out to be the NSDA, which gets funding from Allergan, the maker of Botox.

On August 20, 2004 I asked Dr. Logemann by email, “Could you please tell me who was involved in the NSDA other than Ludlow or Aronson? I’d be most appreciative if you could jog your memory as you were directly involved with that SD position outcome.” She answers, “Hello Morton, Good to hear from you. I’m sorry to say my memory on that issue is unjoggable. Ten years is a long time. I’m afraid I can’t help you there. You might try someone at ASHA.” (Interestingly enough, both Dr. Ludlow and Dr. Aronson remembered ten years later that they were not involved.)

As Dr. Logemann suggested, I tried someone else; I contacted the Executive Director of ASHA, Arlene Pietranton, Ph.D. in November 2005, in an email, as follows:

“Could you please be kind enough to tell me who invited the National Spasmodic Dysphonia Association (NSDA) to review ASHA’s official position on SD in 1994?”

Dr. Pietranton answered in the following email:

“In response to your question – ASHA published a fact sheet for consumers on spasmodic dysphonia in the early 1990’s. The fact sheet is out of date and has not been distributed for at least five years. The fact sheet was not an official ASHA policy document. We do not have any record of the ASHA members who were asked to review the fact sheet; however, we have no recollection of inviting the National Spasmodic Dysphonia Association (NSDA) to review it.”

The official ASHA SD fact sheet in 1994 was only reviewed by the NSDA. Diane Paul-Brown, the Director or

Clinical Affairs, states, that after the official SD fact sheet was written, the records pertaining to who was involved were destroyed.

Dr. Pietranton said that ASHA in 1994 published the fact sheet for consumers; this means that those with SD were told in writing that there are no cures of SD, that SD is a neurological problem, and that Botox is the treatment of choice. Dr. Pietranton adds that the fact sheet is out of date and has not been distributed for five years. This is inaccurate. The official SD fact sheet remains in place since 1994 until the present time. This fact sheet was slightly revised in 2001.

As of February 22, 2006, ASHA links its website on Spasmodic Dysphonia to the NSDA [www.dysphonia.org](http://www.dysphonia.org) as well as the Dystonia Medical Research Foundation [www.dystonia-foundation.org/defined/spasm.asp](http://www.dystonia-foundation.org/defined/spasm.asp). On the Dystonia Medical Research Foundation's website, the following information is provided to those looking at this website: "The design and implementation of the Dystonia Foundation's website was made possible by a generous educational grant from the Allergan Foundation." If you look on the NSDA's website as of February 22, 2006 you will find the following statement: "The design and implementation of the National Spasmodic Dysphonia Association website was made possible by a generous educational grant from the Allergan Foundation." If you look at the Dystonia Medical Research Foundation's website as of February 22, 2006, you will find this statement: "In addition, the National Spasmodic Dysphonia Association, managed by the Dystonia Medical Research Foundation, offers further support to those persons affected by SD. The NSDA also works, under the umbrella of the Dystonia Foundation, to advance medical research into the causes of and treatments for spasmodic dysphonia, promote physician and public awareness of the disorder, and sponsor support groups for patients and their families." Both the Dystonia Medical Research Foundation and the NSDA receive grants from Allergan.

Dr. Pietranton said that the fact sheet was not an official ASHA policy document. As far as I can tell, ASHA has an official policy that SD is incurable, that SD is a neurological problem, and that Botox is the treatment of choice. As mentioned above, Dr. Pietranton wrote: “We do not have any record of the ASHA members who were asked to review the fact sheet...” Dr. Jeri Logemann, President of ASHA in 1994, officially reports three sources were involved in the ASHA SD fact sheet, Dr. Christy Ludlow of the NIH, Dr. Arnold Aronson of the Mayo Clinic and the NSDA. Both Dr. Ludlow and Dr. Aronson, in writing, say they were not involved. Dr. Logemann and Dr. Pietranton have informed me that they have no recollection who invited the NSDA to review the fact sheet. How then did the NSDA become the only source for ASHA’s official SD position since 1994 and remains in place at the present time?

Those with SD, looking at the premier organizations dealing with SD, the National Spasmodic Dysphonia Association and the Dystonia Medical Research Foundation, both non-profit organizations are leading us to believe that there are no cures of SD. This is in the face of my reporting on-going cures at ASHA National Conventions in 1974, 1979, 1980 and 2000. I have peer review of cures in the *International Association of Logopedics and Phoniatrics*, a prestigious international organization.

Both of these organizations do not appear to be neutral on treating SD. The NSDA declines to report cures of SD by me in its newsletter and website. The NSDA receives grants from Allergan, the maker of Botox, for the NSDA website, SD support groups, national and local meetings and for its NSDA newsletter, as NSDA’s website reports. One of the high representatives of the NSDA visited me on October 14, 2000 and insisted I not report cures of SD in exchange for a featured report in the NSDA newsletter if I called my cures “effective care.” I declined to do so. I presented SD patients cured of SD to the NSDA official. She “lost” the SD patients cures of SD and their telephone numbers by

my DVR program. She also “lost” the cures of SD video and audio of cures of SD by my DVR program. Again, I sent her the list and the audio and video of cures of SD. I did not hear from her regarding my cures of SD.

### **Wrap Up**

No one, including the drug Botox maker Allergan, knows the long-term health risks from prolonged Botox use. The *New York Times* on March 2, 2003, on the Sunday Edition front page, proclaimed, “Botox is giving those with spastic vocal cords back their voices.” What kind of voice? Has anyone at the *New York Times* heard the Botox voice? Have you heard the Botox voice?

### **Talking Points**

- Optimal pitch, tone focus, rate, volume and mid-section breath support are key variables in treating voice disorders, in a step by step order.
- Psychiatric problems don’t basically cause spasmodic dysphonia.
- Faulty neurology has little to do with dysfunctional voices.
- Molecular biology, including acid reflux, has little effect on disabled voices including deep throat, raspy and spasmodic dysphonia voices.
- Bad voice habits cause the lion’s share of common problem voices.
- Direct Voice Rehabilitation reverses counterproductive voice habits.

- Most patients want instant cures and quick fixes.
- Failed paradigms interfere with adopting new discoveries and information.
- Surgery and Botox treat hypothetical neurological and biological voice problems.
- The strangled voice (SD) and deep throat raspy voices stems from bad voice habits causing disabling “wear-and-tear.”
- Does Botox give patients back lasting, normal voices, or does it create the “Botox voice”?

## Chapter 5

### Botox in Wonderland

#### **What's Inside**

In this chapter you'll learn many surprising things about Botox and treatment for spasmodic dysphonia. □ World's next penicillin or dangerous poison? □ The Johns Hopkins paradigm of SD □ Promises about scientific precision - repeated □ When science becomes art □ Physician's intuition □ Wrap up

#### **World's Next Penicillin or Dangerous Poison?**

Featured March 2, 2003, the *New York Times* showcased a story touting exciting new applications for Botox, recently FDA approved to treat frown-lines. Creating the buzz, the manufacturer Allergan has ambitious plans for its "wonder drug," hoping to find endless new applications. Though FDA approved (1989) for eye

spasms [blepharospasms] and neck spasms [torticollis], its approval for treating facial wrinkles is by far its most popular use. By paralyzing acetylcholine, a neuromuscular transmitter, facial muscles no longer contract, relieving wrinkles and giving overlying skin a more relaxed look. It takes powerful drugs to block synapses responsible for muscle contractions, much the same way lethal injections work. It's beyond ironic that patients getting Botox may drink bottled water, fearing trace contaminants in tap water, yet readily take one of the world's most deadly toxins.

Discoveries about various Botox applications sometimes occur inadvertently, like Dr. Jean Carruthers, a Clinical Professor in the Department of Ophthalmology at the University of British Columbia, who along with her dermatologist husband Dr. Alastair Carruthers, noticed in 1987 that Botox when used for eye spasms relaxed wrinkles in the adjacent area to the eyes.

Ironically, it was University of San Francisco dermatologist Dr. Richard G. Glogau who found that patients treated with Botox for frown-lines incidentally obtained relief from migraine headaches. Since publishing his findings in 2000, some headache specialists—even dermatologists and cosmetic surgeons—are already using Botox for migraines, despite its lack of FDA approval for this purpose.

The widespread usage of Botox doesn't ease concerns that Botox may still be a deadly toxin even in therapeutically diluted doses. Designated by the Pentagon as bioterror weapon of mass destruction [WMD], it's not unreasonable to question its cumulative, long-term negative effects. Actually, Allergan purchased the Army's stockpile of concentrated botulinum toxin in 1991 for its therapeutic raw material. "Botox has a 25 year safety record," said Allergan spokesperson Christine Cassano, offering no assurances about the long-term use of Botox. Those same guarantees were made by Allergan in full-page ads in major newspapers around the country, attesting to Botox's safety record, which drew a warning from the FDA. Nor are there any

independent longitudinal studies confirming safety. Of course Botox has a “25 year safety record,” but that doesn’t tell you about serious unreported long-term side effects—or more worrisome, camouflaged side effects influencing other organ systems or masquerading as other problems.

As most people know, cigarette smoking or asbestos do not produce immediate dramatic injuries, reactions or deaths, although exposure over time has been shown to have lethal effects. Toxic drugs like Botox need to be used with the utmost caution, not marketed as “the next penicillin,” seeking the widest possible applications. New applications previously mentioned, include treating migraines, hyperhidrosis [excessive sweating], urinary incontinence, underarm odor, clubbed foot, carpal tunnel syndrome, and, more recently, vaginismus, a female sexual dysfunction. Whatever its therapeutic benefits, the potential long-term risks of Botox should be carefully vetted and proven before its applied to a wide swath of non-life-threatening problems and elective treatments.

When neurologist Dr. Mitchell F. Brin introduced Botox for treating spasmodic dysphonia in 1980’s, few imagined that its twice-yearly applications might expand to some with possible monthly treatments for patients. Brin operated under the assumption that arresting vocal cord spasms would dramatically improve spastic voices. A generation of clinical evidence amassed by me now shows that Botox produces dicey results for patients with the strangled voice. I question both its therapeutic value and wonder of its possible long-term risks. Under the NSDA, an entertaining video touts the benefits of Botox, without exploring either its disappointing results or its short and long-term negative side effects. The NSDA video exaggerates therapeutic efficacy for treating spastic vocal cords and minimizes possible adverse reactions. The NSDA also demonizes a change of pitch and tone focus as dangerous to one’s health. Yet I continue to find a pitch change is key to a better voice and a focused voice in the face, the face being the saving grace for all good and great voices. The way

out of SD, the way to a cure of almost all kinds of voice disorders, is by DVR.

Many patients report there are not only exaggerated claims about therapeutic benefits but Botox may also create immediate adverse reactions to Botox injections. Otherwise healthy patients may develop acute upper respiratory symptoms, fatigue, weakness and lethargy. Allergan may regard these adverse reactions as “idiopathic”. When you hear about a 250-pound weightlifter, used to bench-pressing 350 pounds, weak as a kitten after getting a Botox voice injection, you might suspect there were some unreported side effects.

Claiming that the Botox voice can't have long-term side effects because its immediate effect is short-lived, denies the cumulative effect of various toxins on the human body. With expanding applications and current treatments for spasmodic dysphonia increasing in frequency, can one expect greater cumulative toxicity? Increasing the number of injections to treat spastic vocal cords automatically exposes patients to greater long-term risks, regardless of whether the manufacturer or FDA claim the drug is “safe and effective” or “has a 25-year safety record.”

### **The Johns Hopkins Paradigm of SD**

“The precise cause of SD is unknown and may involve multiple factors. It does appear to be a neurological (not psychiatric) disorder, similar to other focal dystonias,” says the official word at Johns Hopkins Center for Laryngeal and Voice Disorders.

That same report advocates botulinum toxin injections, without exploring the so-called “multiple factors.” Researchers allude to possible involvement of the basal ganglia, a neural structure in the midbrain, but there's never been medical confirmation.

Although Johns Hopkins refers to “multiple factors,” they fail to specify the variables instead, focusing on presumed neurological causes as the primary culprits. “Currently, the most effective treatment for SD is the use of botulinum toxin [Botox] . . .” says the Johns Hopkins’ literature, yet they make no mention is made of my breakthrough cure of spasmodic dysphonia called Direct Voice Rehabilitation.

According to the Johns Hopkins’s Website:

#### SPASMODIC DYSPHONIA

“Spasmodic Dysphonia (SD) is one of a group of neurologic disorders called dystonias. A dystonia is a movement disorder characterized by inappropriate contraction of muscle groups. With SD, the intrinsic laryngeal muscles are involved. There are two primary types of SD. The most common type is adductor SD. This occurs when the muscles which close the vocal folds (thyroarytenoids and lateral cricoarytenoids) contract with excess force. Abductor SD involves the muscles, which open the vocal folds (posterior cricoarytenoids). A "mixed" form involving both the abductor and adductor muscles also exists.

“Symptoms: The symptoms of SD depend on which form is present. The adductor type produces a strained or strangled voice quality. Abductor SD usually produces a breathy and effortful voice. Both types cause abrupt breaks in phonation and decreased intelligibility. Voice is often worse on the telephone or when the speaker is under stress. Some voice production can be normal, such as laughing, coughing, and singing.

“Causes: The precise cause of SD is unknown and may involve multiple factors. It does appear to be a neurological (not psychiatric) disorder, similar to other focal dystonias.

“Treatment: Currently, the most effective treatment for SD is injection of botulinum toxin - type A (Botox). Botox is injected into the laryngeal muscles via the neck (just under the Adam’s apple) using EMG guidance or transorally using a special needle that curves over the tongue. Botox interferes with the transmission of the electrical impulses which result in the inappropriate contraction of the laryngeal muscles and prevents the spasms associated with SD. Botox treats the symptoms of SD, but it does not cure the disorder.

“The effects of Botox injections are usually apparent within 24 hours and last four to six months. Risks and discomfort during the procedure are minimal. After an injection for adductor SD, patients may experience a weak, breathy voice and mild difficulty swallowing for one to two weeks. Voice therapy is used in conjunction with Botox injections to maximize voice capabilities during the breathy period, minimize the dysfunction as the spasms return, and lengthen the time between injections.”

Now, my findings differ markedly.

A young man with severe SD tried Botox at Johns Hopkins Medical Center only to find it didn’t work for him. Instead, DVR helped him to find his normal and efficient voice in my office, despite the fact that had had been told he had a disease, a neurological problem and that Botox was the answer for his SD. Another SD patient was given a Botox shot. Seeking a second opinion, he visited a well-known medical center where he was told by the ENT that he had glottal insufficiency and surgery was considered. He later found a normal voice in my office by DVR.

Unfortunately, patients get Botox as the treatment for spasmodic dysphonia because it’s an approved *medical* treatment. Medical specialists recommending treatments basically don’t even consider non-medical approaches for possible consideration, though I occasionally receive referrals from MDs familiar with my work.

What's most ironic is that psychiatrist Dr. Joseph Wolpe, a medical doctor trained in classical psychoanalysis, developed his phobia treatment based on the breakthrough research of behaviorists Ivan V. Pavlov and John B. Watson. Like so many other discoveries, Dr. Wolpe created "Reciprocal Inhibition Therapy" after accidentally curing phobic patients with relaxation techniques. During his day, he found that psychoanalysis, group therapy, electro-convulsive shock therapy [ECT], psychosurgery, bibliotherapy [reading and relaxation], hydrotherapy and isolation, had little effect on phobias. In a nutshell, Dr. Wolpe found that deep relaxation reciprocally inhibited anxiety or fear connected with phobias, phobias went away in a technique called Systematic Desensitization—the form of behavior modification he used to treat phobias. Drug companies, fellow psychoanalysts and general practitioners weren't thrilled that his therapy deviated from conventional treatments.

In treating spasmodic dysphonia, which may become a phobia, I discovered certain techniques that reciprocally inhibited the strangled voice. I developed the "Um-hmm" technique and my Cooper C-spot to change patients' pitch and tone focus out of the lower throat into the mask, the area between the lips and nose. Once the voice is in the mask and diaphragmatic breath support is in place, this process takes stress and strain off the voice box. Like Dr. Wolpe's approach, I reciprocally inhibit strangled voices by elevating voice projection out of the lower throat. Medical SD or systematic desensitization as with psychiatry is not trained in voice use nor is ENTs or neurologists, or MDs in general to cure SD, as does DVR.

### **Promises About Scientific Precision - Repeated**

In a well-polished video touting state-of-the-art treatments for spasmodic dysphonia, speech pathologist Dr. Michael Rolnick, also listed on the masthead of the NSDA, describes in great detail

the scientific procedure by which physicians administer Botox injections for the strangled voice. He reassures viewers about how carefully measured doses of Botox are injected into precise locations in the patient's larynx with the aid of videostroboscopy, by placing fiberoptic tubes into the vocal cords. While it's true that he uses fiberoptics, it may not be true specialists scientifically determine precise locations of injections or the amounts of Botox delivered to the vocal cords.

Highlighting successes, the video fails to discuss the failures where patients get worse or remain the same with Botox treatments. No mention is made of my non-invasive treatment DVR treatment for spasmodic dysphonia. Rolnick emphasizes that Botox offers a predictable cycle of initial vocal cord paralysis and eventual return to "normal" speaking when adductor [squeezing] symptoms get converted into abductor [breathy] symptoms. When Botox degrades and loses its potency, there's a brief window during which speech returns. But, far from normal, what may be a "Botox voice," combining both sounds of spasms and vocal cord paralysis. At best, Botox is a palliative treatment that hopefully provides some temporary relief but is not curable.

Botox does not give the SD patient knowledgeable control of the pitch, tone focus, rate, volume, mid-section breath support, and yes, voice image or voice identity causing the strangled voice.

Science is as good as the researchers that publish the findings. When research is supported and funded by drug companies, there's unwritten pressure on researchers to produce positive results. Admittedly, it's difficult to remain neutral or disinterested when getting paid large sums of cash to conduct and disseminate important information. It's also difficult for scientific journals to carefully scrutinize studies when they're simultaneously earning advertising dollars from the very companies sponsoring the research. When non-profit organizations become financially dependent on publicly traded

drug companies, it's also difficult to separate public responsibility from advocacy and marketing. Because Allergan financially supports the NSDA and the Dystonia Medical Research Foundation, and because its key board members are heavily involved in research and advocacy, it's difficult to give equal time to alternative treatments that don't promote Botox. It's a situation that may lead to bias and unproven treatment and one that fails to protect the patient and consumer from harm.

### **When Science Becomes Art**

Scientific discovery is supposed to be the orderly process by which disinterested researchers test theories and hypotheses, craft experiments and clinical studies, methodically collect data and subject findings to rigorous statistical analysis designed to either accept or reject preliminary predictions. Ancient Greek lore tells about the myth of Theseus in which a robber named Procrustes would abduct victims and fit them to his magical bed. In order make his victims fit, Procrustes would either stretch his prisoners or cut off their legs, leading to the modern definition of Procrustes: That which stretches. Responsible scientists are admonished to avoid the "Procrustean Fallacy," fitting data to hypotheses and theories.

Since 1871, the voice field has had a difficult time reconciling theories with clinical findings. For 90 years, the medical voice field diagnosed spasmodic dysphonia as a psychiatric problem, attributing "the strangled voice" to mental problems. Today, no matter how much information presented the contrary, physicians held the view that spasmodic dysphonia stemmed from psychiatric problems. Like Procrustes, they made certain their data was stretched to fit the idea that the strangled voice was due to psychiatric causes. Regardless of clinical contradictions, spasmodic dysphonia was and is still made to fit the psychiatric theory.

Ms. J. completed her treatment during which I helped cure her of vocal spasms, and she regained her normal voice. Unfortunately, she stopped practicing her voice exercises, regressed back to spasmodic dysphonia and ultimately opted for surgery. Following surgery, Ms. J no longer had a strangled voice—she had no voice at all. She was able to communicate only in whispers, something she could have done with her spasmodic dysphonia. You don't need surgery to get a whisper voice. SD is known as the whisper voice. Two-years out of surgery and still no voice, Ms. J has been informed by her doctor she has "reflux." Using computer-based videostroboscopy and using high-tech surgical procedures hadn't restored Ms. J's voice. Hiding behind medical technology and undergoing "state-of-the-art" voice surgery or reflux drugs did not improve her voice.

Ms. J's. surgery left her with severe cord impairment. (She was told to wait for her vocal cords to recover; the recovery didn't occur.) Some months after he surgery Ms. J returned to my office. Her surgery had left her with limited ability to respond to DVR. I have found that surgical procedures for SD may be a form of Russian roulette.

A number of my spasmodic dysphonia referrals come from failures with Botox injections. These patients were originally diagnosed as having SD at prestigious medical institutions around the nation and world.

After years and years of my reporting a number of on-going cures with SD by DVR, the medical profession refuses to acknowledge such cures are possible. In answer to those physicians who question that my SD cases are correctly diagnosed, the patients' hospital and medical records document the cases I am working with. The SD patients had SD. The medical paradigm does not allow doctors to judge cures of SD with their own ears and eyes—that the strangled voice and the spastic vocal cords are gone, cured by DVR. A Chairman of an ENT Division diagnosed

a patient with Adductor/Abductor SD and gave the patient two Botox shots. The patient reports she was left with bowed vocal cords and no voice. A one-month program of DVR gave the patient the fundamentals to find a cure of her SD problem. She returned to tell her doctor of her normal voice. He agreed she had a normal voice and advised her to have a third Botox shot. He said he was treating the neurological cause and told her I was treating the functional cause. She had been of the view that her doctor would want to know that she had been cured of SD. She remains cured of SD for years now.

### **Physician's Intuition**

Creating the illusion of science, the medical profession hides behind uncertain neurological and biochemical theories of the strangled voice. Attributing the strangled voice to faulty neurology, has given the medical voice field a distinct marketing advantage. In the early '60s, R.W. Sperry's was establishing an exciting split-brain research in the forefront. It only made sense to emphasize neuroscience, Sperry's neuro-deterministic view of human behavior—something Sigmund Freud abandoned in 1893 when he ended his futile "Project for Scientific Psychology," an attempt to explain all psychological events with human biology. It only made sense to attribute the human voice, and its major dysfunction, spasmodic dysphonia, to the same circuitry.

Looking to neuroscience gave a generation of physicians reason to believe that the practice of medicine was less art and more science. Reliance on high technology became the cornerstone of more sophisticated diagnostics and treatments. Putting spasmodic dysphonia in the context of new, exciting technological developments gave physicians more prestige and patients higher expectations. With all the modern technology and sophisticated drug and surgical treatments, today's neurological approach has no cures.

Patients consulting physicians for disabling voice problems including spasmodic dysphonia are often surprised to learn they have gastroesophageal reflux disease [GERD]. In the old days, voice problems were caused by nonspecific allergies, infections, postnasal drip, or sinusitis, requiring urgent antibiotic treatment. While somewhat different, GERD is equally implausible as an explanation for deteriorated voices. It is difficult for gastric contents to wind up in the larynx. Be this as it may, the likelihood of GERD affecting the voice would be a rare exception, not the current widespread application of acid reflux drugs to treat deep throat, raspy voices. There's certainly no real clinical basis to assume that acid reflux affects anything but a marginal share of deep throat, raspy voices, other common voice problems, and especially spasmodic dysphonia.

Today's voice industry has a clear bias toward medical approaches requiring long-term chronic treatments. Non-medical approaches, like my DVR, are virtually nonexistent, relative to the profusion of medical treatments practiced by medical institutions and promoted by specially created non-profit organizations designed to support medical approaches to voice care. As mentioned previously, sponsoring the original research into GERD and pathological voices, Merck, one of the nation's biggest drug companies, conducted the original research suggesting the connection between reflux and bad voices. Reflux drugs are now widely prescribed to treat disabled voices; one of the leading theories report acid reflux is linked to and causes SD. In reviewing Sheldon Krimsky's book, *Science in the Private Interest: Has the Lure of Profits Corrupted Biomedical Research?* Richard Horton in his review titled *The Dawn of McScience* in *The New York Review*, March 11, 2004, Volume L1, Number 4, pages 7-9, states, "Even scientific journals, supposedly the neutral arbiters of quality by virtue of their much-vaunted process of critical peer review, are owned by publishers and scientific societies that derive and demand huge earnings from advertising by drug companies and from the sale of commercially valuable content. The pressure on

editors to adopt positions that favor these industries is yet another example of the bias that has infiltrated academic exchange. As editor of *The Lancet* I have attended medical conferences at which I have been urged to publish more favorable views of the pharmaceutical industry.”

### **Wrap Up**

Marketing Botox as the next “penicillin,” as did the *New York Times* front Sunday page, March 2, 2003, Allergan continues to find new applications for its “wonder” drug, insisting the drug has minimal short-term side effects. Whipping up great expectations about the strangled voice, Botox has a mixed twenty-year track record, getting some temporary improvements at the expense of creating chronic treatment. When neurologist Dr. Mitchell F. Brin introduced Botox to treat spasmodic dysphonia in the 1980’s, the therapeutic regime called a Botox shot every nine months. After clinical experience demonstrated its brief effects, laryngologists began increasing its frequency, now averaging about 4-10 shots a year or more. Neither Allergan nor any other independent research lab has studied Botox’s long-term effects, as far as I know, leaving the jury still out on potentially adverse side effects.

Today’s Botox industry promises treatments for “club foot,” carpal tunnel syndrome, migraine headaches, urinary incontinence, underarm odor, excessive sweating, and, yes, most recently human sexual dysfunction. With a drug derived from one of the deadliest toxins on the planet, it’s difficult to understand the casual manner in which the drug is currently getting prescribed. With respect to treating spastic vocal cords, it requires ongoing chronic Botox to get its main effect to stopping adductor [squeezed] spasmodic dysphonia, the only treatable variety, according to Dr. Christy Ludlow with the National Institutes of Health. Yet, Botox is prescribed for abductor [breathy] spasmodic

dysphonia, where it's basically known to have limited clinical value.

Patients currently wait in line for Botox injections, believing that it's the best, high-tech treatment available for the strangled voice. Most laryngologists give patients two medical options for spasmodic dysphonia: risky vocal cord surgery or Botox. They don't discuss with patients my DVR that has reported ongoing documented cures of spasmodic dysphonia for over thirty-five years. I have supplied compelling before and after clinical case studies, with numerous verified testimonials of patients successfully recovered or cured of spasmodic dysphonia with DVR. Dr. Arnold Aronson insists that I succeed because I treat "psychogenic" types of the strangled voice, a variety disputed by New York neurologist Mitchell F. Brin, who doesn't believe spasmodic dysphonia is psychogenic, or curable.

Many of my patients have been rigorously diagnosed with spasmodic dysphonia and treated for SD at some of the most prestigious medical institutions around the country, including the Mayo Clinic, Scripps, UCLA, Cedars-Sinai, Vanderbilt, USC, to name a few. After I help cure patients diagnosed with spasmodic dysphonia, the medical model still denies cures for the strangled voice.

Muscle Tension Disorder at times may be diagnosed when the condition is SD. SD is not diagnosed correctly in many patients.

### **Talking Points**

- Is Botox the world's next penicillin?
- Botox is a therapeutically diluted form of botulinum toxin.

- SD Patients wait in long lines for Botox because they're desperate for treatment.
- High-tech gadgetry and diagnostic equipment don't improve outcomes.
- Botox injections rely on doctors' clinical judgments.
- Science becomes art when needle placement and dosage are subjective.
- Science becomes politics when non-profits market for public corporations.
- Botox is a voice roller coaster ride
- No one knows the possible long-term risks of using the Botox voice.
- The Botox voice effectiveness in the short-term is questioned by the e-mails, letters and calls I receive as well as my clinical SD cases.

## Chapter 6

### Perils of the Voice Image

#### **What's Inside**

In this chapter you'll learn how "voice image" and "voice identity" either make or break successful voice treatment □ Following new directions □ Programmed to fail: the voice image □ Deep-throat mystique □ Laryngitis □ False promises from white jackets □ Fighting demons within □ Voice suicide symptoms □ Wrap Up

#### **Following New Directions**

Watching voices deteriorate can be a frightening experience, especially for patients relying heavily on voices to earn a living—among other things. When voices unravel, it's like a steamroller that eventually flattens the human personality. Ordinarily strong and forceful people can be reduced to a shell of their former selves. Healthy voices breed energy, enthusiasm and

self-confidence. Pathological voices create discouragement, pessimism, lethargy and, yes, panic, leaving individuals battling anxiety, depression, hopelessness, despair and even self-destructive behavior.

Voice image and voice identity are internal mirrors of the personality and also an essential part of self-esteem and self-confidence. Without realizing it, so much of everyday identity and purpose depend on a healthy, robust and energetic voice. Human communication begins and ends with voice, though non-verbal communication, like body language and physical appearance, play a part in face-to-face interaction. Strained, fatigued or disabled voices pull the rug out from underneath otherwise secure and confident people. Thin, nasal, strained or raspy voices may hurt self-confidence, giving a sense of inferiority to otherwise strong individuals.

Patients have little trouble following medical advice and treatments for spasmodic dysphonia. Taking prescriptions or injections or receiving surgery seems straightforward, registering few objections until treatments don't produce the desired results. When medical treatments fail, especially with respect to returning normal voices, patients may seek different options including Direct Voice Rehabilitation (DVR). Unlike medical approaches, in DVR, patients learn from the beginning that voice problems are not caused by faulty neurology, tainted genes or molecular imbalances, but rather by counterproductive voice habits. It's not easy for patients to change maladaptive speaking habits. Direct Voice Rehabilitation gives patients the training and tools for reversing the strangled voice and other disabling voice disorders, such as deep throat, raspy voice problems.

Unlike taking shots or getting surgery, DVR patients learn that unlearning bad habits takes more than passive participation. Patients become the architects of their own recoveries by recognizing counterproductive speech patterns and practicing

special techniques designed to elevate voice production out of the lower throat into the face, the area around the lips and nose called the mask.

I find the patient's correct voice—the pitch, tone focus (resonance), quality, and breath support—by listening to the patient's voice. The clinical ear of the therapist is the key to determining the new right voice. If the clinical ear is deficient, a cure of SD or deep throat, raspy voices is not possible. Ear, Nose, and Throat doctors and speech therapists are basically not trained to hear a patient's new and correct voice or taught how to direct the patient to this voice. Their eyes are trained, but not their ears.

After finding the right voice and implementing the specific technology of change, patients' new voice identities become activated, creating resistance and opposition to retraining. Patients almost always comment or complain that the right voice does not feel right, sound right, or work right. They compare the new voice to the old voice and are almost always negative with respect to the new voice. While medical approaches breed passivity and compliance, Direct Voice Rehabilitation creates defiance as patients perceive new changes as threatening existing self-structures attached to voices called voice images or identities. Voice images are powerful protective shells to the personality, deeply enmeshed in maintaining the status quo. Regardless of how much patients despise spasmodic dysphonia, they resist change. It's easier to trust what's old and familiar, than the unknown promised by Direct Voice Rehabilitation. Medical treatment requires automatic obedience and passivity, e.g., Botox or surgery, no matter how painful or counterproductive; Direct Voice Rehabilitation requires active participation and full cooperation by the patients.

While the medical paradigm views voice as an anatomical and physiologic event, I see “voice image” and “voice identity” as an integral part of Direct Voice Rehabilitation and recovery from

spasmodic dysphonia. Without dealing with the voice image and identity, I find, no high-tech medical treatment producing lasting cures.

Medical treatment and speech therapy for voice do not recognize the indispensable role of the “voice image” and “voice identity” in the treatment of spasmodic dysphonia as well as deep throat, raspy voices. With the medical community’s fixation of neurology, it’s no wonder they’ve missed voice image and voice identity as key factors either supporting or sabotaging lasting recoveries from common voice disorders, including the strangled voice. For over forty-five years, I found both factors crucial to short and long-term success and cures.

Voice health is a good barometer of a person’s overall life-adjustment. Voice image and voice identity mirror the patient’s overall level of adjustment. Failure to heed this essential factor affects the outcome.

### **Programmed to Fail: The Voice Image**

I discovered the “voice image” and “voice identity” in 1964. I wrote about the affect of the voice image in 1967 and 1970. In 1971, I wrote a peer reviewed article entitled, “The Vocal Image and Voice Suicide,” which was published in *Voices: The Art and Science of Psychotherapy, Special Issue: Unspoken Behavior*. Then in 1973, in my textbook, *Modern Techniques of Vocal Rehabilitation*, I extensively detailed 1400 patients with various voice problems and the influence of the voice image and voice identity on the outcome of DVR.

By exploring the voice mage and voice identity, I reported outstanding results with Direct Voice Rehabilitation with evidence based statistical research involving before and after reviews of these cases. I recognized early that faulty genetics could not possibly account for the disproportionately high numbers of voice failures. My clinical research indicated that minimally 25% of the

general population develops voice problems, stemming from poor speaking habits influenced by cultural and familial pressure, which induced deep throat speaking. Take spasmodic dysphonia, for instance. Some estimates suggests between 50,000-500,000 cases. But that estimate doesn't take into consideration the hoards of people in various stages of voice breakdowns, moving toward the strangled voice. I estimate that one to three percent of our voice use is SD voice talk. My estimate of SD voices is one to two million cases in the United States alone. Worldwide, the number is frightening. SD cases basically remain undiagnosed; on this issue, the medical community and I agree.

When conventional medical treatments produce unsatisfactory results, patients may stumble into my alternative care with great reservations and apprehension. Non-medical practitioners are viewed with great skepticism, since the medical community insists that (a) spasmodic dysphonia is an incurable dystonia and (b) Botox is the treatment of choice. Patients seeking alternatives know conventional treatments, such as speech therapy or medical treatment doesn't cure SD. Few patients start Direct Voice Rehabilitation without undue suspicions and false beliefs about irreversible neurological damage; these beliefs create unnecessary obstacles to recoveries and lasting cures. Society and individual circumstances create enough counterproductive "voice images" to oppose progress, above and beyond unhelpful programming from the medical community or trade associations who support medical drug treatment (Botox, reflux acid drugs, etc.)

Before the medical community insists on telling patients with strangled voices they suffer from incurable neurological problems, they should be absolutely certain that alternative treatments, such as DVR don't exist. Some SD patients have characterized medical doctors in ENT and neurology as Drs. Doom and Gloom. They offer no hope for a cure of SD. They guarantee no hope for a cure. And they do not report a single cure of SD, ever.

The entire medical profession worldwide in ENT and neurology assure all SD patients that cures are not possible despite my ongoing reports of cures covering thirty-five years.

My Direct Voice Rehabilitation gives patients hope and assistance and demonstrates that strangled voices aren't based on medical causation or on faulty neurology. When patients discover that strangled voices are within their control by my DVR program, that they can unlearn bad voice habits and develop healthy speaking skills, they are filled with hope towards recoveries and cures.

### **Deep Throat Mystique**

Popular culture—that phenomenon expressed through mass marketing, advertising arts and entertainment, including TV and film—telegraphs counterproductive messages about the voice and influences the types of voices viewed as desirable, even mandatory. Most people find pre-pubescent, high-pitched male voices objectionable, much like scraping fingernails across a blackboard. High-pitched voices are considered immature, childlike and frivolous. For men, pop culture insists upon “Darth Vader-type” voices, reflecting a type of Marlboro-man machismo, leading otherwise adjusted individuals to lower voices into the deep throat. Deep throat voices mirror cultural expectations about masculinity, not realizing that forced laryngeal resonance, namely, lower throat tones, leads to stress, strain, fatigue, exhaustion to voice breakdowns. Pop culture expectations for women is high-pitched “girly” voices lack credibility and sex appeal. For women, it tells them sexiness is best expressed through laryngeal resonance, projecting voices from the lower throat. With women competing in a male-dominated workplace, credible lower throat raspy voices may become prerequisites for success. As I wrote in *Change Your Voice, Change Your Life*: “Many professional people seem to feel that this lower throat ‘just-between-you-and-me’ sound is a must.” Pop culture falsely conveys that all too many deep-throat voices can be taken seriously leading countless

individuals to develop “voice images.” Eventually these negative images blow out their voices. Today’s emphasis on deep throat voices may leave patients with deep throat, raspy voice problems, including spasmodic dysphonia.

I hear these misguided voices everywhere. It is de rigueur for all too many men. And women are right in fashion, too.

A prevalent voice type that is frowned upon by society is the nasal voice. Nasal voices are not considered fashionable or nice. I do not regard nasality as a pathological condition. Nasality is a sound pollution. It does not create pathology of vocal cords. I have yet to hear an SD case with nasal resonance. Yet, SD patients are quite negative to nasal resonance. Nasal resonance is not nasality. All good and great voices have a marked degree of nasal resonance. SD has none. SD is a cultural problem stemming from the emphasis on deep throat resonance and the avoidance of nasal resonance.

With my “Voice Suicide” model, getting positive results happened methodically. Despite awareness of cultural influences, regressions took place because “the voice image” wasn’t getting enough attention. Patients learned new skills, but they didn’t deal with the “voice image,” undermining lasting progress. Voice images and voice identity directly mirrored indoctrination from pop culture, pushing rehabilitated patients to return to old, dysfunctional voices. Despite improvements with Direct Voice Rehabilitation, patients may hang on to dysfunctional voices, believing that new, functional voices are unappealing and objectionable. Some patients with grossly disfigured voices—even patients nearly mute from spasmodic dysphonia—preferred deteriorated voices over new healthy ones.

It takes formidable teaching to remind patients with dysfunctional voices that old voices were counterproductive, even destructive. Teachers, salespeople, corporate executives and politicians require vigilant reeducation to not return to their bad

voice habits. To stop the slide, I place recovering patients in groups, where they receive direct feedback regarding new voices. Patients with formerly deep voices hear themselves internally as nasal and high-pitched, despite the group hearing them as having normal clear voices. Patients with formerly high-pitched voices perceive themselves as too mature, even stuck up. With group feedback, patients with recently rehabilitated voices get the best reality check, realizing new voices sound OK.

Few people learn how to use voices correctly. They may instead take their cues from the voice culture at large. No one warns anyone about the risks associated with protracted deep throat speaking. Only when individuals develop disabling or problem negative voice symptoms, do they possibly realize voices must change or face unending problems. Doctors give the mistaken impression that disabled voices will simply disappear with the right combination of medication or surgery. Patients have great difficulty accepting non-medical evaluations that voices must change to avoid relapse and voice suicide. Only after patients learn new ways of speaking do they avoid senseless voice suicide, easily prevented by changing incorrect voice habits to positive voice use.

It takes much reeducation for patients to realize that “voice images” and “voice identities” can be preserved, or slightly modified, to maintain a lifetime of healthy voice habits. Voice professionals need to pay attention to optimal pitch range and tone focus, rate, volume and mid-section breath support, as they help patients unlearn bad voice habits. While it’s easier to swallow medication or take a shot, voices don’t automatically improve because of reductions in vocal spasms or reduced acid reflux. Cultural influences create obstacles to recoveries in Direct Voice Rehabilitation, creating false beliefs about voices. Once patients get the facts and focus on the right factors, Direct Voice Rehabilitation goes surprisingly well.

Speaking voice styles may evolve through emulation. Soft, withdrawn or contained voices often don’t pay off in families in

which rivalry for attention and approval is fierce. As a result, individuals evolve speaking voice styles based on role, models that don't work leading to counterproductive habits that may eventuate into voice problems. Despite these powerful cultural influences, today's medical field views voice as a static, physiological mechanism, governed by genetics and underlying neurobiology. Treatments for common voice disorders tend to address biological determinants through medications and surgery. Most common voice problems, including strained, fatigued and hoarse raspy voices are dealt with like bacterial or viral infections.

### **Laryngitis**

There are approximately 200 causes of laryngitis. The Johns Hopkins website describes laryngitis as shown below.

“Laryngitis, or inflammation of the larynx, is probably the most common disorder affecting the larynx and voice. This inflammation may be of primary origin or secondary to other disorders. Laryngitis can be acute (short-term) or chronic (long-term).

“Symptoms: The classic symptoms of laryngitis are hoarseness and loss of voice. Occasionally, laryngitis may cause pain in the laryngeal area during swallowing or speaking.

“Causes: Laryngitis can have many causes. Acute laryngitis frequently accompanies viral or bacterial upper respiratory tract infections. Chronic laryngitis can have a number of causes. Among the most common are misuse or overuse of the voice and chronic irritation by smoke, dust, or other airborne irritants. Reflux of acid from the stomach is another frequent cause of laryngeal inflammation. Laryngitis can be secondary to a more serious condition such as benign or malignant growths. Therefore, if hoarseness lasts longer than two weeks, or is accompanied by a lump in the neck or blood-tinged sputum, medical attention should be sought.

“Treatment: Acute laryngitis is treated with resting the voice as much as possible, increasing intake of decaffeinated fluids

(particularly water), and using a humidifier. If a bacterial infection is the suspected cause, antibiotics may be prescribed. Chronic laryngitis is treated differently, depending on the cause. As mentioned above, if symptoms persist for longer than two weeks or if common treatments are ineffective, seek medical advice.”

The Johns Hopkins ENT department is considered to be the best in the nation. They represent the medical view of the cause for laryngitis. A medical ENT checkup is basic to dealing with laryngitis. I refer all of my voice cases for a laryngeal examination.

I find that medical cause for laryngitis is minimal. Laryngitis is not caused by overuse of the voice. Laryngitis is basically caused by wrong use of the voice or misuse of the voice, which I call voice suicide. Nearly all voices affected by laryngitis are deep throat voices with tone focus placed in the laryngeal area and use of an inappropriate pitch level.

A cold, or upper respiratory problem may cause laryngitis. Dropping the voice into the lower throat can set off SD, or other serious problems if continued.

I do not find the need for decaffeinated fluids or water or the use of a humidifier to help cure chronic laryngitis. Acute laryngitis I find is amenable to a clear voice without resting the voice as much as possible or increasing the intake of decaffeinated fluids, particularly water, and using a humidifier. Acute laryngitis can be overcome quite quickly in most cases by a change of pitch range and tone focus without medical treatment.

Rarely do primary care doctors consider anything other than medical and biological causes for laryngitis. When patients seek help for voice problems, they're typically given reflux drugs, regardless of whether patients ever report reflux symptoms. Before acid reflux came into fashion, patients received antibiotics or allergy drugs, again, assuming infections or allergies cause voice problems. Like night and day, my “Voice Suicide” model

demonstrates that the vast majority of voice disorders stem from mechanical “wear-and-tear”. Unlike common medical explanations, I have found that bad voice habits, causing patients to speak for prolonged periods in the lower throat, create common voice problems, including hoarseness, laryngitis and the strangled voice. In my view, medications may provide palliative relief while failing to deal with the real causes of voice failure.

### **False Promises from White Jackets**

Patients are acutely aware of their voice breakdowns. They may recall their former voices but aren’t sure how to get them back. Unfortunately these voices may have been misused. Physicians seem more focused on underlying neuropathy than listening to deteriorated voices.

Another problem with the medical grounds for treating spasmodic dysphonia concerns the lack of standardized outcome measures. When I measure outcome from Direct Voice Rehabilitation, there’s clear before-and-after tape recordings of patients’ voices. Before-and-after outcome measures are essential because there’s no other way to test improvements without comparing test-and-retest outcomes. When patients receive Botox treatments, physicians may not compare voices before-and-after injections. Too often, patients are told to give Botox time to work, yet Botox may not provide improvements in voices. Here’s where outcome becomes murky and even esoteric. Physicians may evaluate Botox treatments not by asking for patients’ self-reports but by measuring ongoing vocal cord spasms. If spasms diminish, outcome may be considered successful, regardless of before-and-after voices.

Promising to reduce vocal cord spasms often misleads patients into believing voices will dramatically improve following Botox treatments. SD patients may not routinely be informed about the transient nature of Botox injections. While some patients get temporary improvements, voices may sound unnatural,

artificial and marked by a peculiar sound reflecting both vocal spasms and paralysis induced by Botox. Prior to Botox treatments, patients assumed that Botox would give patients with spastic vocal cords back their voices, as reported in the story on the front page of the *New York Times* on March 2, 2003. What the *New York Times* and physicians don't report is that patients may get a "Botox voice," a disfigured voice combining strangled sounds with vocal cord paralysis, not the voice promised at the outset of treatment.

When consulting medical specialists for dysfunctional voices, patients need to ask specific questions, including, "Will my voice really improve?" "If so, for how long?" "And will my voice last?" It's surprising to find that medical outcome doesn't involve listening to voices, per se, before-and-after voice treatments. Patients find themselves dismayed when their voices don't improve or improve minimally and return to strangled strain all too quickly; yet the physicians inform them they have a successful medical outcome, because the vocal cord spasms are reduced or temporarily eliminated. No outcome should be considered successful unless patients experience firsthand meaningful improvements in voices.

Even with temporary change, I find lasting improvement can't be achieved without modifying the voice image and voice identity to fit the new functional voice. Changes in voice image and voice identity must accompany corresponding improved voice habits to assure lasting results. Since medical approaches don't consider voice image or voice identity, and other essential voice parameters, only define temporary voice change remains.

### **Fighting Demons Within**

Voice image and voice identity are both valuable assets and stubborn liabilities. Voice image and voice identity give a good estimate of ego-strength during voice treatment, especially when patients insist they seek to improve voices. Some patients with spasmodic dysphonia, whose careers and social lives have been

handicapped by the condition, have ambivalent feelings about changing voices.

When submitting to medical treatments, patients don't have time to figure out how voice images or voice identities impact the outcome of treatment. The medical profession does not address the essential parameters of voice change, reflecting voice image and voice identity. Unlike standard medical treatments, Direct Voice Rehabilitation requires determined patient participation in treatment programs. The treatment involves an active process by which patients orchestrate their own recoveries by following instructions and specific exercises.

Patients sometimes prefer old strangled voices over healthy voices because of false and misleading perceptions. Hearing voices differently, patients incorrectly assume that changes adversely affect personalities. Even patients with the most extreme strangled voices, for whom communication is markedly disabled, attempt to hold onto voice images' supporting ego structures. Ego defenses get in the way when Direct Voice Rehabilitation is viewed as a threat to patients' self-esteem. When egos get engaged, DVR becomes a counterproductive battle where patients unleash frustrations on the therapist and indeed on themselves. Countering these trends, it's necessary to remind patients that change doesn't come easily, often at the expense of maladaptive bad voice habits.

Direct Voice Rehabilitation deals patiently with the voice images and identity, recognizing it's the key to lasting change. My emphasis on creating optimal pitch range and tone focus, rate, volume, diaphragmatic breathing and the "voice image," revolutionized treatments for a large swath of common voice problems.

With deep throat, raspy voices, with strangled voices, the mantra, as in real estate, is location, location, location. Nearly all deep throat, raspy voices are placed or focused in the lower throat, involving excessive laryngeal resonance or deep throat voice use. All spasmodic dysphonic voices are focused in the lower throat.

Deep throat, raspy voices stress lower throat resonance, called laryngeal resonance; however deep throat, raspy voices do not cross the line to create spastic vocal cords. Deep throat, raspy voices may have sufficient facial resonance to take the pressure off the vocal cords. Spasmodic dysphonia voices singularly use forced laryngeal resonance, causing spastic vocal cords to go into spasms. The distinguishing difference between deep throat, raspy voices versus spasmodic dysphonia voices is one of pathological degree. It is a matter of time that ongoing misuse in deep throat, raspy voices can determine when these voices can turn into spasmodic dysphonia.

Spasmodic Dysphonia can be created by too high or too low a pitch, as can deep throat, raspy voices. In SD, abductor SD patients usually have too high a pitch level; adductor SD patients usually have too low a pitch level. It is essential to determine the appropriate pitch range level for each voice or else the inappropriate pitch can put too much pressure on the lower throat. Some voices may be pitched appropriately whether they are deep throat, raspy, or strangled voices; the pitch may be right and the focus wrong.

Deep throat, raspy voices can create bowed vocal cords, unilateral cord paralysis, premalignancies of the vocal cords (keratosis, papillomatosis, leukoplakia), red and inflamed vocal cords, as well as vocal fold growths (nodules, polyps, contact ulcer fossa and granuloma).

### **Voice Suicide Symptoms**

The common symptoms of voice misuse and abuse, which I call voice suicide include: sore throat, throat clearing, tired, weak voice, pain when talking, poor projection, hoarse voice, lump in throat, throat tension, voice strain. I have included a symptom sheet of negative sensory and auditory symptoms which I find are associated with misuse and abuse of the voice.

SENSORY SYMPTOMS

1. Non-productive (without relief) repetitive throat clearing
2. Coughing
3. Progressive voice fatigue following brief or extended voice usage
4. Acute or chronic irritation or pain in or about larynx or pharynx
5. Sternum pressure and/or pain
6. Neck muscle cording
7. Swelling of veins and/or arteries in the neck
8. Throat stiffness
9. Rapid voice fatigue
10. A feeling of a foreign substance or a "lump" in throat
11. Ear irritation or tickling or earache
12. Repeated sore throats
13. A tickling, tearing, soreness or burning sensation in the throat
14. Scratchy or dry throat
15. Tenderness of anterior and/or posterior strap muscles

16. Rumble in chest
17. Stinging sensation in soft palate
18. A feeling that talking is an effort
19. A choking feeling
20. Tension and/or tightness in the throat
21. Chronic toothache without apparent cause
22. Back neck tension
23. Headache
24. Mucus formation
25. Arytenoid tenderness
26. Trachael pressure
27. Anterior or posterior cervical pain
28. Pain at base of tongue

#### AUDITORY SYMPTOMS

1. Acute or chronic hoarseness
2. Reduced voice range
3. Inability to talk at will and at length in variable situations
4. Tone change from a clear voice to a breathy, raspy, squeaky, foggy, or rough voice

5. Repeated loss of voice
6. Laryngitis
7. Pitch too high; pitch too low
8. Voice too nasal; voice too throaty
9. Voice comes and goes during the day or over a period of months
10. Clear voice in morning, tired/foggy voice later in day
11. Missed speech sounds

When Botox was introduced for treating spasmodic dysphonia, powerful corporate influences infiltrated the voice business, making it increasingly difficult for anyone to disseminate an alternate or groundbreaking SD treatment. Just as I wrestled with the voice image and voice identity, I faced a new dilemma: How to introduce a non-medical cure of spasmodic dysphonia in a field controlled by the drug industry. Years later, my Direct Voice Rehabilitation is not considered a legitimate option to conventional medical treatment, despite thirty-five plus years of cures and improvements of SD. I knew how to deal with the voice image and voice identity, but found myself at a loss to confront an industry committed to popular expensive drug treatments.

I base my treatment of spasmodic dysphonia on thirty-five years of clinical experience showing that the human voice is subject to the laws of learning. I chose direct voice behavior modification because it offered hope to otherwise hopeless patients, doomed by medical diagnosis of incurable neurological conditions. Developing a specialized form of voice behavior modification, I was able to get successful results with confirmed cases of spasmodic dysphonia.

Just as patients with the strangled voice must deal with the “voice image,” the medical voice business should accept alternative approaches that assure patients the best chances of cures and recoveries. Locking out treatments only because they don’t fit the bottom line of publicly traded drug companies or the methods used by the medical community, turns back the clock on treatments of the strangled voice and other common voice problems.

### **Wrap Up**

When I developed Direct Voice Rehabilitation in the early ‘60s, I found that in a nutshell DVR alone wasn’t enough to produce lasting results with spasmodic dysphonia. DVR had to include direct voice behavior modification to deal with the voice image and voice identity. I also found that conventional medical approaches yielded uncertain results because they didn’t address essential parameters of voice change. Instead of treating the strangled voice as a neurological condition, I treated it as a mechanical breakdown, much the same way Dr. Hans Selye viewed stress-related illness. Developing a series of techniques, I learned how to change incorrect voice habits, and then I discovered how to make them last. I found unattended voice images sabotaging treatments, because patients found it difficult to match their identities with changed voices. Once successfully managed, the voice image and voice identity enables patients to reinforce healthy voice habits, not sabotage them.

Patients pursue medical treatments for the strangled voice with the best of intentions, following doctors’ orders with obedience and precision. Today’s Botox injections or surgeries fail to take into consideration my essential factors of voice treatment, including optimal pitch range and tone focus, rate, volume, mid-section breath support and the voice image. As a result, medical treatments and many speech pathologists deal with superficial symptoms, rather than addressing key variables at the root of common voice problems as well as the strangled voice.

Whether the voice changes with Botox or Direct Voice Rehabilitation, voice images and voice identities must be addressed to assure lasting results. Harboring unlabeled voice images and voice identities can undermine progress by creating unwanted resistance to change. Closely tied to the ego, voice images and voice identities arise from culturally programmed and medically misconceptions about voice.

Unmanaged voice images and voice identities predispose individuals to fail in voice treatment by dictating counterproductive voices. As long as patients hang on to old voices, they continue to develop severe voice symptoms. But the medical voice field also contributes to unhelpful misconceptions by insisting that the strangled voice is an incurable neurological condition. When patients begin Direct Voice Rehabilitation they're already programmed to believe that no treatments other than Botox or surgery can produce results. Patients considering DVR must be deprogrammed before non-medical treatments have an optimal effect. Pop culture also doesn't help matters by conditioning false beliefs, favoring deep-throat, husky voices, when such voices contribute to eventual voice breakdowns.

### **Talking Points**

- Voice image and voice identities are essential parameters in Direct Voice Rehabilitation.
- Voice image and voice identity can interfere with following directions in treatment.
- Unresolved voice image and voice identity undermines successful treatment.
- Pop culture and family background contribute to faulty voice images and voice identity.

- Medical approaches breed deep suspicion about alternative treatments.
- Society values deep-throat voices in both men and women.
- Deep throat voices in men and women can lead to voice breakdowns.
- Physicians need to spend more time listening to disabled voices.

# Chapter 7

## Voice Charisma

### **What's Inside**

In this chapter you'll learn about how Direct Voice Rehabilitation helps create voice charisma. □ Fighting the quick fix □ Getting back in control □ Deprogramming misconceptions □ Change through Direct Voice Rehabilitation □ Medical myths about unchangeable voices □ Developing voice power

### **Fighting the Quick Fix**

Fighting the quick fix requires recognition that the vast majority of disabled voices are caused by voice misuse and abuse, not unidentified ganglia neuropathology, gene problem, or biochemistry. Focusing on faulty neurology and biochemistry addresses surface symptoms, justifying the use of Botox and reflux

drugs or possible surgery, but doesn't deal with the cause of most voice problems. My "Voice Suicide" model deals directly with the causes of disabled voices by systematically identifying and correcting incorrect voice habits leading to voice breakdowns. Once wrong voice habits are addressed, it's then possible to develop voice charisma, a methodical transformation from a symptom-free "normal" voice to one with full resonance, endurance and power. No drug or surgery can take mediocre voices and transform them into superlative communication tools.

### **Getting Back in Control**

Voice charisma begins with the recognition that the human voice is subject to voluntary control, learning and modification. Recognizing that the human voice is subject to the laws of learning and principles of behavior modification goes a long way in opening the doors toward improvements, recoveries, cures and ultimate expansion. Direct Voice Rehabilitation provides the tools needed for improvements, recoveries and cures for the most disabling voice disorders. It also gives individuals the tools necessary for developing charisma and superb voice skills. Patients looking to recover from common voice problems—and take voices to the next level—should be wary of quick fixes and encouraged by the payoff of Direct Voice Rehabilitation.

### **Deprogramming Misconceptions**

Patients seeking Direct Voice Rehabilitation must be deprogrammed from popular medical misconceptions that voice problems stem from faulty neurology and biochemistry. I have found that serious voice problems like spasmodic dysphonia originate not from aberrant neurology but poor voice habits, causing forced laryngeal resonance, eventually leading to voice breakdowns. Medical and non-medical experts agree that the strangled voice often involves vocal spasms in the larynx. Where we disagree is on causes and treatments. There's plenty of evidence that prolonged deep throat speaking eventually blows out

voices. There's scant evidence to indicate neuropathy or brain damage causes the strangled voice or other common voice disorders.

My "Voice Suicide" model identifies misalignment and progressive "wear-and-tear" as the culprit in most voice disorders, including spasmodic dysphonia. Direct Voice Rehabilitation diagnoses counterproductive voice patterns and retrains the voice with a specialized form of behavior modification. Rather than conceptualize voice as faulty biology, my "Voice Suicide" model views voice problems as learned behaviors. Through behavior modification, patients find healthy ways of using voices.

### **Change Through Direct Voice Rehabilitation**

Direct Voice Rehabilitation for spasmodic dysphonia may involve an intensive process, requiring five hours a day, five days a week of behavior modification, designed to reverse years of voice misuse and/or abuse and grappling with the aspects of voice image and voice identity. Like refining a golf swing, progress takes time and doing. Changing incorrect voice habits requires a carefully tuned ear, capable of hearing and correcting faulty pitch range, incorrect tone focus and inadequate breath support. Working with a voice mirror and practicing Direct Voice Rehabilitation begins the slow, but methodical, process of reversing incorrect voice habits and working toward cultivating an optimal voice. Here's where overcoming misinformation either makes or breaks patients' prognoses. Most patients with normal intelligence, healthy motivation and adequate persistence can succeed at Direct Voice Rehabilitation.

Contrary to conventional wisdom, voice problems aren't inherited, but modeled, based on certain cultural and familial stereotypes. Many different sets of voice images or voice identities contribute to protracted deep throat speaking causing

excessive “wear-and-tear” and leading to eventual voice breakdowns.

With Direct Voice Rehabilitation, patients learn to undo bad voice habits and develop superlative voice skills, keeping voice projection directed through the mask, the area between the lips and nose. Once patients learn optimal pitch range, balanced tone focus and diaphragmatic breath support, they can better control rate and volume, enabling them to control voice production. Voice control improves clarity and power, leaving patients speaking out of the mask.

Direct Voice Rehabilitation not only gives patients the best chance to overcome common voice problems, but the best opportunity to develop voice charisma. Voice charisma comes from cultivating meaningful voice control.

Charismatic voices don’t stem from toxic Botox injections or risky surgery but by learning how to control the place of projection, pitch range, tone focus, rate, volume and mid-section breath control. Shallow upper-chest breathing may take the wind out of charismatic voices, leaving voices thin, nasal or strained. Diaphragmatic breathing can give added power to otherwise listless voices.

### **Medical Myths about Unchangeable Voices**

Prolonged deep throat speaking robs the natural voice of projective power, leading to a host of common voice problems and SD. Direct Voice Rehabilitation enables patients to retrain voices for optimal control. Voices become finely tuned instruments capable of selective modulation and pitch range, allowing greater persuasive power. Persuasive power stems not only from presentation, articulation and appearance but also from voice clarity and force. Direct Voice Rehabilitation demonstrates the inherent trainability of the human voice, challenging theories that voice is a biologically determined phenomenon, controlled genes

and biochemistry. Botox can reduce vocal cord spasms but can't teach the skills needed to develop voice charisma. Voice charisma develops from the confidence that emerges from overcoming voice deficiencies and training the voice as an instrument of influence and persuasion.

Medical voice treatments take control away from patients and place it into drugs and surgery. Researchers at the National Institutes of Health are personally invested in perpetuating the prevailing medical view that spasmodic dysphonia is caused by neuropathy, whose future treatment lies in molecular biology. That's one of the views of Allergan and the cadre of otolaryngologists earning their living from Botox injections.

Without accepting responsibility for poor voice habits, the medical paradigm attributes all voice failures to medical causes i.e., disease, neurology, etc, medicalizing SD and other voice problems. While it's reassuring to patients, it's also discouraging to believe voice problems are due to irreversible and incurable neurological and biochemical problems when cures and alternative treatment leading to lasting improvement is available.

Acid reflux drugs, it appears, have largely replaced antibiotics as the medical treatment of choice for chronic laryngitis or deep throat, raspy voices. Before 1960, patients with the strangled voice were treated with standard psychiatric treatments, psychotropic medications and psychotherapy. Originally sponsored by Merck in 1992, the maker of reflux drugs and leading advocate for the relationship between reflux and deep throat, raspy voices, drug studies indicated that disabled voices, including spasmodic dysphonia, were brought about by gastroesophageal reflux disease [GERD], the main cause of heartburn and gastritis. While reflux drugs are prescribed widely all across the country for treating disabled voices, I have not found any clinical proof that acid reflux causes SD, let alone deep throat, raspy voices save in a

few cases here and there. Patients deserve more options than Botox, surgery, or any reflux drug.

Direct Voice Rehabilitation gives power back to patients, reminding them voice disorders are not irreversible and incurable. Telling patients they have only two options, namely, drugs or surgery, fails to inform them of my proven treatment of Direct Voice Rehabilitation.

### **Developing Voice Power**

Voice charisma involves refining the voice like a finely tuned instrument. Direct Voice Rehabilitation provides the tools to undo bad voice habits and develop superlative voice skills necessary toward developing voice charisma. Voice charisma emerges from mastery over voice images and voice identity. The right voice image and voice identity allows patients to overcome resistance to DVR and to expand existing personalities to accommodate new and improved voices. Voice power basically stems from recognizing that voice use is under voluntary control, not controlled by underlying neurology. While it's tempting to take the quick fix, there's no easy way out when it comes to fixing broken voices. Undoing bad voice habits and learning new effective ways of speaking enables patients to take back control of their own voices.

### **Talking Points**

- The Medical Paradigm basically attributes voice problems to medical causation.
- Direct Voice Rehabilitation is based on proven learning principles.
- Prolonged deep throat speaking leads to voice problems and voice breakdowns.

- It's necessary to deprogram misconceptions about voice problems.
- Most voice problems are not caused by faulty neurology or biochemistry.
- Quick fixes, like drugs and surgery, are no substitute for voice behavior modification.
- Direct Voice Rehabilitation corrects counterproductive voice habits.
- Voice Charisma stems from learning improved voice control.