

Chapter 2

The Botox Story

Until a few years back, cutting into the recurrent laryngeal nerve, which paralyzes a healthy vocal cord, was all the rage. Today's rage is injections of Botox.

Botox is a sugar-coated, glorified Madison Avenue term, but like "a rose by any other name . . .," it is still a deadly poison used in attenuated form. In 1989, the Federal Drug Administration stated that treatment using botulin "was no longer experimental but an established medical practice" -- but "for only two . . . diseases, blepharospasm and adult strabismus." (*Discover*, p. 32) Spasmodic dysphonia was not included. However, the medical profession, I hear and read, basically swears by Botox and injects doses into the vocal cords of patients with SD.

Here are some facts about the Botox poison, which should be of interest to you, as described in *Discover* (August 1992), pp. 29-33 and *Our Voice* (Fall 1992), p. 4:

It is produced by two biochemists, 84-year-old Ed Schantz, who perfected its development, and 36-year-old Eric Johnson.

"When ingested, botulin causes botulism, a form of food poisoning that can result in muscle paralysis and even death." (p. 30) (Johnson has noted that "botulin is six *million* times more toxic than rattlesnake venom," which, for reasons of employee safety, has caused most drug companies to back away.) It is said to be effective in small doses as a treatment for dystonias -- uncontrollable muscle spasms that researchers suspect are caused by involuntary, excessive impulses from the brain.

The toxin works "by attaching itself to nerve endings." (p. 30) People who die of botulism generally suffocate, because their chest muscles have become paralyzed.

In the making of botulin for clinical use, the delicate procedures are as much "touch and lore" as technical knowledge. Admits Schantz: "A lot of these things (steps) are judgment calls." (p. 33)

The toxin is so powerful that Schantz and Johnson are still working from a crop of bacteria produced in 1979. This batch was acquired in 1990 by Allergan Pharmaceuticals. According to Johnson, Allergan "just walked into it . . . without having to invest the years of development and high research costs that accompany most drug research." (p. 33)

POISONED VOCAL CORDS ...

On one hand doctors tell SD patients their condition is hopeless. On the other hand they say that medical procedures will help them get symptom relief if they have SD. The use of surgery or Botox has not reported one single cure that I know of. Surgery indicates success as a breathy voice, often a temporary relief of the spasticity. Botox may be repeated every one to three to six months, and I find the result is often not a clear voice. The voice comes and goes for most patients. They need repeated doses and nobody knows the long-term, downside effects of this substance on the body.

At a leading medical center, one of my SD patients, who had been Botoxed a number of times and still couldn't talk, was told by her ear-nose-throat doctor that Botox was the state of the art treatment and was 99% effective. Another patient of mine, who had been Botoxed forty times, still did not have a voice. A third patient who was Botoxed over a dozen times also did not have a voice.

A SAFE, ALTERNATIVE APPROACH

Patients that I have seen, who have been Botoxed, may look to Direct Voice Rehabilitation as the alternative non-medical approach. People with SD are calling me from all over the United States, Canada, Europe, and South America, as well as coming in for treatment.

Recently, a patient told me that she had received a call from a prestigious clinic (where she had gone for an evaluation), telling her that in thirty minutes they were doing the Botox shots and would fit her in. She was so upset by the directive of "Hurry in to get your Botox shot," that she came to see me the following week.

In my view, medicine in this regard is like the emperor in his new clothing: Naked. As I see it, basically doctors do not understand how to treat the functional voice problem, which includes SD.

Incidentally, Botox is now being used at Columbia Presbyterian Hospital in New York City for the elimination of facial wrinkles, according to *Cosmopolitan* (October 1993, p. 66). However, as with Botox injections in the vocal cords, the effects of the "face lift" may last only four to six months.

Gayle would not commit to any treatment until she did her research.

Gayle didn't like what she discovered about the surgical process for SD. ("Very little can be said about surgery that is good," she comments.) She also refused to have poison shot into her body. Feeling that her situation was indeed hopeless, she became "very different, very withdrawn, very unhappy. And I am usually a very outgoing person." At that point, when Gayle was at her lowest, Dr. Gerald Berke, head of UCLA's Head and Neck Division, referred Gayle to me after she had requested a non-toxic, non-surgical approach.

Says Gayle: "With Dr. Cooper I went from a 'hopeless' spastic dysphonic voice to a clear voice in about ten seconds. He brought my voice back *that* quickly, in one session. That first day it went in and out a little, but by the third session I had my voice back completely."

Initially, Gayle experienced "morning voice" for a time. Morning voice is something most everyone has when they first awaken and the voice is low pitched and guttural.

"I can deal with that," says Gayle, "because I can talk again. My voice is clear throughout the day, and it doesn't hurt. My old scratchy, raspy voice did hurt."

FROM STRANGLED SOUNDS (SD) TO A NORMAL VOICE

Following Gayle's visits to my office, she was referred back to the UCLA Medical Center for a phonatory workup. This was done to compare her new voice to her old spastic dysphonic voice, and she was found to have a normal voice. Her recovery had taken only three sessions. However, Gayle had no voice image to speak of, and she had the ear, the willingness, and the ability to get her voice back quickly. She is unusual. Most SD patients need extensive Direct Voice Rehabilitation.

Gayle's voice remains excellent four years after completing a program of Direct Voice Rehabilitation.

A DIFFERENT VOICE IMAGE

A major factor in changing from a wrong, troubled voice to a right, healthy voice is your voice image. The voice image is the way you hear yourself. It influences you psychologically and emotionally to remain with the old voice as you find and use your new natural voice. Your old voice had become part of you, and you had grown so accustomed to it that any alteration may make you uncomfortable for a time. The new voice may sound too loud, too full, too rich, and too different. If you ask others about your new voice, they will almost always tell you it sounds extremely credible and natural. You must discard your old voice image and establish, as well as accept, a new voice image based on your new, natural voice.

Most people comment about their new voice sounding "different." At first it will sound and feel unnatural. But don't be discouraged. Soon your voice can begin to feel both natural and normal.

PRESSING YOUR MAGIC BUTTON

How did Gayle regain her natural voice so quickly? She began by using my "Instant Voice Press," an exercise that has been so successful that patients often refer to it as "pressing your magic button."

The Instant Voice Press is a holistic technique that basically gives you the correct tone focus, natural pitch level and range, and the sound of your real voice. The Instant Voice Press is a simple 3-for-1 procedure that may give you everything "in a nutshell." (NOTE: If there are any medical problems involving the area of the solar plexus or the abdomen, or if you are pregnant, DO NOT attempt this exercise.)

To use my Instant Voice Press, begin by placing one hand on your solar plexus, the center area at the bottom of your breast bone (or between the solar plexus and the navel). Now relax your stomach so that it moves in and out as you breathe. With your lips closed, hum while repeatedly pressing your solar plexus gently with your fingers in a light, quick rhythm "Hmmmmmm." (Hold that *hmmmmmm*.) "Hmmmmmm." "Hmmmmmm." This gentle jiggling of the solar plexus will cause your "hmmmm" to break up into short bursts of sound like "hmmm-hmmm-hmmm-hmmm-hmmm . . ."

Do this exercise once again. Close your lips and hum while lightly pressing your fingers, gently jiggling, at the bottom of the breast bone where the two sides of the rib cage join. As the sound escapes, you will

feel a buzz around your mouth and nose. You are actually directing your voice into the mask area, precisely where it should be.

Next, do the Instant Voice Press with your mouth open, saying "Ahhhhhhh."

Try the exercise again, this time adding a number as you press. Start with "hmm-hmm-one," "hmm-hmm-two," "hmm-hmm-three." Then use "ahh-ahh-one," "ahh-ahh-two," "ahh-ahh-three."

Finally, carry this sound over to talking, beginning with one word at a time. "Ahh-my-ahh-name-ahh-is-ahh ____." Keep the sentence short and learn to talk on the buzz, which is a resonance around the lips and nose.

Can you achieve that same focus and pitch level without pressing your magic button? Raise both hands high above your head and repeat the following words with energy. "RIGHT." "NO." "REALLY." I call these words "buzz words" because they help bring your real voice forward.

Whenever you seem unable to locate your correct pitch level and focus, revert to the Instant Voice Press and use the "hmmm," "ahhh," and buzz words. I have used these techniques for years to help individuals find their real voices in seconds. It is a good idea to start your day with these exercises. (In the movie, *Sister Act*, I noticed that Sister Mary Clarence, played by Whoopi Goldberg, used the Instant Voice Press on another Sister to bring her efficient singing voice out.)

THE SILENT REVEREND

The Reverend Harold's voice problem was equally severe, but Harold had suffered with a troubled voice for twelve years. For two of those years he could barely speak at all.

When Harold first visited a doctor, he was given a series of tests. He was then treated for an upper respiratory infection. At one point Harold was told by his doctor that he was deaf in one ear. The ear was operated on, but Harold still had a voice problem.

Harold next made an appointment at the University of California at Irvine, where a woman he knew with a similar voice problem was being treated. At UCI, he was tested again. The doctors there were hesitant in their prognosis, not being sure if Harold actually had SD; but they recommended he be injected with Botox poison anyway. He was told that the shot would give him relief even though his voice would get raspy.

Botox poison was injected into both of Harold's vocal cords. He did get some relief, but he lost his voice. Three days later Harold was forcing a whisper as he presided at a funeral.

The injection effect continued over a nine-month period. Says Harold, "I never had a clear voice during that time. To the contrary, it was always raspy, very breathy, and speaking was difficult at times. The doctors never really talked to me, except to tell me there was no cure for my condition. Every so often I was sent reminders to come in for the next shot. By the way, those shots are not cheap."

Looking back, Harold believes that the botulinum toxin contributed to the continuing decline of his voice. "I should never have taken the poison," he says. "It was a very poor first option."

His voice growing worse, Harold changed doctors and new tests were given. At UCLA he was told, as he reported to me, that he had developed spasmodic dysphonia "because of increased pressure on his voice." Injections of Botox poison were recommended. Harold declined.

With Harold's voice continuing its downhill slide, he began to learn more about spasmodic dysphonia, including the fact that he was not alone in his suffering. Spasmodic dysphonia, Harold found, seemed to be common among ministers, teachers, and others who use their voices in a prolonged way. He felt if he could find the right voice coach, someone who could place his voice correctly, he might be all right.

INDIRECT VS. DIRECT APPROACH

Harold spent six months with a speech clinician, Dr. Z., who had him doing neck exercises to stretch the muscles in his throat. "Your throat muscles have tightened up over the years," Dr. Z. told him.

Harold was told to take warm showers, letting the water run down and along his throat to relax the muscles. "Stretch your neck from side to side with your mouth wide open," was more advice. Harold did the exercises unfailingly. They had no effect at all on his voice.

A vocal exercise came next. Harold began climbing the musical scale with his voice, going from a low pitch to a high pitch. Low to high, high to low, over and over again. That didn't help either.

(The neck stretches, warm showers and scale climbing are among the exercises used by speech clinicians. This I term the *indirect approach*. The classic training taught at Stanford University, where I studied voice training, was the *direct approach*, which I refined using natural, simple techniques. This evolved into Direct Voice Rehabilitation or DVR which is basically unknown in this country, I find.)

Surgery became another option for Harold. Again, he declined. He knew that once he had gone under the surgeon's knife his condition could never be reversed.

It was Harold's ENT (ear/nose/throat doctor), Dr. Gerald Berke, who referred Harold to me after Harold requested a non-invasive approach.

THE DANGER ZONE

Like every SD patient who has come to my office, Harold was speaking from his lower throat, which I call the "danger zone." SD patients *always* speak from the lower throat. In over twenty years of successfully treating SD, I have never found an exception. Medicine and I agree that the SD voice is in the lower throat. But here's where we disagree.

Medicine calls it "a focal laryngeal dystonia." That means it is a neurological problem and therefore, treated medically. I find SD not a dystonia, but a *dysphonia*, from mechanical use of the wrong voice unknowingly, or voice misuse and abuse.

Not only was Harold speaking from the lower throat, his pitch was incorrect and he did not use diaphragmatic breathing. We have all been told as children to stand up straight, with "chest out, stomach in!" We never really learned *why*, of course, but the reasoning behind the almost constant reminders was that good posture increased air to the lungs, which, in turn, exercised and expanded our chest muscles, making our blood richer and better.

Unfortunately, that advice was all wrong. Have you ever noticed how a baby's abdomen rises and falls with each breath? Babies breathe as nature intended, from the midsection, without any instruction at all. When you breathe properly, using your midsection (stomach muscles), you relieve tension in the muscles of the lower throat and increase oxygen intake, allowing your voice to project more easily. As your stomach pumps the air up through your mouth and nose, the air reinforces the voice to make it richer, fuller, more resonant, and durable. We cannot talk well without supported, controlled air.

MIDSECTION OR DIAPHRAGMATIC BREATHING

For those who have heard the expression, "Speak from the diaphragm," let me explain the real meaning of the term and its significance. Diaphragmatic breathing is a popular term which means belly breathing, stomach breathing, central breathing, or midsection breathing (or breath support). The diaphragm is a muscle of inhalation which separates the chest cavity from the stomach. Four sets of paired muscles, the rectus abdominus, the transverse abdominus, and the external and internal oblique abdominus, control exhalation; these are a corset of muscles covering the stomach. They are already in place, waiting to be used, if you simply use them properly for breath support. You needn't work out to get them in shape. The expression "Speak from the diaphragm" is a misnomer; we speak from the stomach muscles that control air flowing through the vocal cords for speaking or singing. Few people ever use midsection breath support for speaking; singers use it for singing, but basically not for speaking. People who have SD are notoriously lacking in midsection breath support.

TALKING WITHOUT AIR

People who have voice problems, especially severe voice problems such as "the strangled voice" or SD, often reverse the breathing process. They push the stomach out as they talk, instead of letting the stomach move in. (One approach I do not understand is reverse breathing, or what is referred to as "donkey breathing" *purposely* being taught to SD patients. Perhaps I am missing something.) Other patients let the air out before they talk or as they start to talk. Still others run out of air as they speak. Rather than stopping to take a breath, they keep on talking, waiting until the end of the sentence to breathe. By holding their breath, letting the air out, or reversing the breathing process, they are actually speaking without air -- or with only a minimal amount of reserve air. You cannot drive a car on empty. Nor can you speak on empty, without air. (I am reminded of one particular patient, a young lady with SD, who made the following startling comment when I noted she didn't breathe when she spoke: "I'll talk now," she said, "and breathe later.")

The average person breathes eight to twelve times per minute, more if under stress. The chest cavity is heavy and requires considerable energy to lift up and out. Expanding the chest with every breath is not only pointless, it is exhausting.

The Reverend Harold was not supporting his voice; he was keeping his stomach out without letting it move in as he talked. I explained the proper breathing technique to him, then had him try to talk -- using midsection breath support -- saying "um-hmmm" instead of words, as if he were responding to someone in conversation.

"Say 'um-hmm'," I asked of Harold. "Keep your lips together and try not to force the sound. Be as spontaneous and sincere as possible."

"Um-hmmm," Harold replied.

"Again."

"Um-hmmm. Um-hmmm."

"Now say 'um-hmm' once more, and follow it with the number 'one'. Say 'um-hmm . . . one'."

"Um-hmm . . . one."

As Harold did the exercise I heard a noticeable difference in his voice. The "um-hmm" brought out his natural voice, but he reverted to his damaged voice when saying the word "one." I had him try again, keeping the "um-hmm" and "one" at the same pitch level and tone focus.

"Um-hmm . . . one. Um-hmm . . . one."

Once Harold had his voice focused in the mask, away from the lower throat, I had him lower his pitch level. He practiced using "buzz words," such as "Right," then "Right now," and finally talking on that sound. His voice was full and resonant.

By the end of our session on that first day, Harold's voice was almost back to normal. He had found his natural voice very quickly and easily. Keeping it was another matter. By speaking incorrectly for so many years, Harold had built up bad voice habits. Without concentrating on the proper speaking techniques, it is easy to slide back into the old ways. Add vocational pressures, stress, daily interfacing with people and speaking engagements, and the cycle could start over again. However, today you would never know he once had a very serious voice problem, when he attends to his voice. When he doesn't, his spasticity is still there. It is up to Harold to self-monitor himself and keep aware of what is essential for him to speak easily and correctly until it becomes habitual. I stress that you must attend to your voice. You, like Harold, control your voice destiny.

"POISON IS A POOR CHOICE"

Says Harold: "I feel that a person with SD has only one option -- voice therapy. Poison is a poor choice. It doesn't bring back your old voice, not even close. It does relax the vocal cords some but it also creates

some difficulties. My personal doctor really opposed the procedure. She advised me not to take the injections because botulinum poison is one of the most toxic poisons known to man. Her concern was the poison getting into my system. The doctors who administered Botox didn't say if it was safe or not. They never mentioned the possible long-term downside effects of the poison, never made me aware. I assumed Botox was safe because the doctors were using it."

Harold adds, "I have trouble understanding why the medical field would want to give toxin as a first option when voice therapy is not invasive. If voice therapy didn't work, then try toxin. But *direct* voice therapy does work, and it doesn't do a number on you like toxin does."

SEEK OPTIONS... NOT THE EASY CURE

In defense of the medical establishment, I must say that its use of botulinum toxin is an earnest attempt at helping vocally disabled patients with SD. However, I strongly disagree with the field in general, as well as with many of my colleagues in speech pathology. Patients today seek the easy cure, whether by pills, injections, or the quick cut. For the SD patient -- typically despairing and depressed by their "inexplicable" loss of voice -- medicine advises the magic of a shot or surgery. To me, that is wrong. The patient should first be given the option of direct voice therapy, a procedure that is non-invasive, safe, and with no downside effects.

Recently, *The Crusaders*, a popular investigative television series presented a segment entitled "Endless Silence." This show described my approach to SD and how I treat it by a non-medical natural way, with recoveries covering twenty years, which indicates there is another way to help patients with so-called hopeless voices. It isn't the only way. My way takes time and effort and involves the cooperation of the patient. My way requires you change the way you use your voice, and it requires you to become part of the doctoring that is needed to bring the voice back to efficiency and health. My way is not for everyone when it comes to the strangled voice. My approach to SD is an option and an alternative to surgery, which was once the rage, and Botox, which is now the rage.

The Crusaders' segment brought me calls from people some of whom told me they had been Botoxed, could not talk, and did not want to continue Botox because of concern with the long range effect on the body and the voice. A lady from Florida called me in panic after having received Botox shots for two years. As I was struggling to hear her still broken voice, she said, "But I haven't had a heart attack." A heart attack? Is that the chance a patient must take to be able to speak normally again?

One individual reported curling of her lips and tongue after having taken Botox treatments. Could curling be another possible side effect of the poison? Her doctor believes that curling stems from dyspraxia, a neurological disability, not the Botox. What are the negative effects of Botox? I wonder.

Another person who called told of a severe reaction from a Botox injection. When she called her physician at a leading medical center, at first she was told the reaction was normal and she was imagining the problem. Later the center affirmed that she had received an injection from a "bad batch," and that other patients had been affected.

I also received calls from individuals who told me they had been Botoxed for benign growths on the vocal cords when surgery did not work or when speech therapy was not doing the job. I had not known that Botox was being used for such routine benign growths of the vocal cords, but I did learn that from some callers.

FREEING THE PATIENT FROM MEDICAL DEPENDENCY

I find it interesting that some doctors appear to seek medical intervention by Botox to treat nodules, polyps, and contact ulcers -- problems that the medical field in past years has acknowledged to be in the province and jurisdiction of speech pathology. I differ with the current orientation of what I am hearing about the ever widening medical use of Botox for benign growths, because it seems to me to create a voice that isn't natural in use but dependent upon medical supervision and control, possibly making the patient rely on ongoing medical intervention for voice care and help. My approach seeks to free the patient from dependency upon anyone except the patient.

Botox poison is not a cure-all, not even a cure. The fact is, to my knowledge there are no known cures with Botox, and the improvement factor, I find, is more often than not minimal and temporary with the voice. The injections I am told may be painful, expensive, and repeated at regular intervals. The poison is believed to be safe in the short-term, but the long-term effects are unknown. "Short-term" and "long-term" are relative. The possibility of severe side effects in ten years may mean different things to a twenty-six year old and a seventy year old. In either case, the patient should be advised of potential risks.

Surgery does not seek to produce a normal voice. If it is successful in relieving spasticity (the strangled sound), it essentially leaves the patient with a breathy, whispery voice all too often. And that is too often the norm of success for surgery.

All voice pathologists are not the same; in the hands of a competent direct voice clinician, voice therapy can do no harm. It seeks a normal voice. A normal, healthy voice.

Doctors are trained to do medical procedures. But they have also taken an oath to *do no harm*. It is a wonderful creed, and should be closely adhered to in all aspects of healing.

To condemn the medical field in general would be a gross injustice. All I am saying is, if you have a voice problem and the help you are getting from your doctor works for you and has a lasting effect, fine. If it isn't working, don't give up. Try another approach to heal your voice -- a safer, easier, more positive way to a healthy voice.

Ask questions of your doctor, and don't take everything he or she says as gospel. Remember, you *do* have choices. Know your options by insisting that your doctor tell you about them. As Norman Cousins said, during a lecture at UCLA (September 26, 1985), the job of the physician is to provide to the patient the latest and best available from medical science.

There is hope for "hopeless" voices, just as there is hope for most everything in life if only you find the right person -- and the right approach.

Chapter 4

All the Presidents' Voices

We live in a sound society, but few among us have voices that make positive sound impressions. The speaking voice did not become a major means of influence until the advent of mass media: radio, telephone, and later, movies and television. Answering machines have added to the awareness of sound impressions, and the concerns and interest in the speaking voice. Before that, voice impressions were of little interest and consequence. A voice was a voice was a voice.

Have you heard the General Telephone radio commercial with veteran actor George C. Scott? Scott's closing words are: "Put the most powerful business tool on earth to work for you . . . the power of the human voice." It is good. It is strong. But it doesn't tell the whole story. The human voice is simply the most powerful tool on earth.

The speaking voice inherently carries with it many "abilities" - listen-ability, sound-ability, buy-ability, believe-ability, understand-ability, emotional-ability, respect-ability, intellectual-ability, and, above all, Presidential-ability. Indeed, Presidential voices have become important because of the sound impression made upon the public not only by those in office, but also by those running for office.

THE UP-AND-DOWN VOICES OF THE PRESIDENTS

When it comes to troubled voices, how often do we think of the Presidents? Bill Clinton, whose hoarse, raspy voice is frequently heard, may be an exception. But the others? It may surprise you to know that Clinton is not alone. Other of our Presidents did not use their voices to best advantage, and the majority of them suffered for it in one way or another. Which Presidents had good voices? Which ones did not? On the following few pages is my analysis of Presidential voices since World War II. The good . . . and the bad.

THE VOICE OF FDR

Of all our Presidents within memory, Franklin Delano Roosevelt had one of the best voices. During the Great Depression and World War II, when America needed strength and hope as never before, Roosevelt gave us just that. He was not physically a strong man, but his voice never betrayed him and it lifted the country to great heights. We became indomitable.

President Roosevelt used the power of his voice through radio and theater newsreels. By far the most effective were his weekly "Fireside Chats." In homes throughout the country, families gathered around their radios to listen and be held spellbound. No pictures, just the sound of FDR's voice coming through the speakers. They were galvanizing moments.

It takes more than words to touch your heart and mind. Franklin D. Roosevelt was a prime example of what a voice can do for a speaker. Although he was an aristocratically reared gentleman, his voice carried a warmth and depth that reached out to the masses, making people at one with him. It is said

that FDR's magnetic baritone tenor voice was the golden voice of radio. Indeed, I believe he had the most trusted voice of his time. It was a voice that could be genial and casual, or blistering and energetic, as he wished it to be, depending upon need and circumstance. His voice was essentially laid back, folksy, avuncular. In campaigns he could make his voice as dynamic and driven as any seeking to create emotion and intensity. FDR used his voice as a major instrument of influence, to attract others, to establish himself and his views. Throughout his career in government, as President, his voice was a major means and asset for him to reach out and touch people, influence Congress, and get his views across. FDR knew the value of an attractive, dynamic voice. He was the first of the Presidents to use the speaking voice as a vital source of influence.

FDR made the sound of the voice a key element in persuasion, in conveying information, in carrying his views and programs to the public. Content was essential, but the voice was the ambiance, the honey that allowed the content of that message to be heard.

FDR's voice remained clear and effective throughout his Presidential stay. His was a well-used voice, placed in the mask (the area about the lips and nose), which kept his voice clear, resonant and healthy.

TRUMAN'S "GIVE 'EM HELL" SOUND

Harry S. Truman had a sharp staccato sound, a voice that carried a tone that was in contrast to FDR's, but nonetheless a sound that called attention to the person and got his message through. Truman's voice carried with it intensity when needed, and clarity of tone. Neither FDR nor Truman had trouble being heard or being listened to. Voice was the key in getting them across to the public.

IKE'S LITTLE KNOWN VOICE PROBLEM

Dwight D. Eisenhower presented the public with an avuncular sound. It carried ease and assurance in its tone and presented the listener with a personae not disturbed by national or global events. Eisenhower had a command of voice, though it was not a commanding voice. His voice carried with it the imprint of knowledge and sophistication. It was an open, friendly voice that continued the importance of the speaking voice in the Presidential era of mass media.

I believe Eisenhower was accustomed to giving orders, and aware of the influence of the speaking voice. His experience as a General during World War II allowed him to realize the value of the speaking voice, and its value in carrying a message. However, after suffering a stroke during his Presidency, he presented difficulty with both his voice and his speech.

JFK: A VOICE UNREALIZED

John F. Kennedy gave us a younger, spirited tone, a voice that reached out to make its points and carried with it the Presidential message. In addressing large crowds, Kennedy attempted to project his voice to the back of the audience by forcing his voice from the lower throat, creating a troubled voice.

Although Kennedy had youth on his side, his public voice was not always used well. He talked better one on one. His conversational voice was more intimate and listenable than was his public speaking voice. FDR, Truman and Eisenhower could talk conversationally if desired in public, particularly at large gatherings, without creating a troubled voice. Kennedy acknowledged his troubled voice by securing a private voice coach to assist him. It is my view that Kennedy did not use his natural effective voice, but relied instead upon the voice he grew up with and became accustomed to, the voice that we knew him to have. He ignored, however, the lower pitches of his voice that had beauty and ease and resonance, elements missing from the voice he presented to the public and to those about him.

In my opinion, Kennedy impressed more with his youth, his energy, his fashion of being, his style, than with his voice. However, his voice was a means of influence, although it was misused in public addresses at times. Both Kennedy and FDR became natural speakers. While Kennedy lacked the experience of Eisenhower, he made up for it with glitz, glamour and his message of hope. If Kennedy had had an FDR voice or a Ronald Reagan voice, how much more effective and influential might he have been?

LBJ'S TROUBLED VOICE

Lyndon Baines Johnson, in contrast to Kennedy, relied upon a deeper, fuller voice as President. In time the focus of his voice, which was in the lower throat, resulted in growths on his vocal cords that were excised by surgery. He was left with a troubled voice which became weaker and less effective after his throat surgery.

Johnson had an accent, as did Kennedy, but Kennedy's accent was considered charming. A Boston accent was Brahmin. Was a Texas accent equal to the Boston accent? That question was not pursued or considered as much as the difference in styles of being and sounding. LBJ didn't use voice as a means and method of influence as did FDR, or later, Ronald Reagan. Voice was not the thing in his time, just as it wasn't the thing with Richard Nixon. Neither Johnson nor Nixon had a trained sound. And neither aspired to make voice talk for them, nor to be an instrument of influence.

NIXON: POTENTIAL GONE AWRY

Nixon's bass-baritone voice was in contrast to the baritone voices of Kennedy, Eisenhower and Truman, and the baritone-tenor of FDR. The fuller voice that is the bass-baritone can carry with it the imprint of authority, experience, awareness and knowledge-ability; the bass-baritone voice is a more somber tone, a sound with the authenticity of being. Many seek the bass-baritone voice, but few learn how to use such a voice.

The desire to seek the bass-baritone voice without knowing how to develop it efficiently, if one has such a range, contributes to a great deal of voice misuse and abuse, resulting in troubled, ineffective voices. Richard Nixon did not have the awareness of making the bass- baritone voice work well for him, especially in contrast to the Kennedy baritone as heard in their Presidential debates. The differences in their personalities and in the way they came across in their styles of delivery have been pointed out time

and again, but little has been noted about the differences in voice that existed between the two as they campaigned against one another or when both eventually became Presidents of the United States.

Sounding Presidential was well within Richard Nixon's capacity. His bass-baritone, however, in contrast to Kennedy's baritone, carried a sound impression that might not have been particularly favorable, since the bass-baritone carries a sound of misgiving and heaviness, if not used well. It was Nixon's poor voice and his facial mannerisms, probably caused by stage fright, that markedly detracted from his delivery, not his five o'clock shadow.

When President, Nixon became a much better speaker than he was in the debates. His voice was well focused in the mask. Although Nixon brought a fuller, deeper sound to the Presidential office, his voice was never a cornerstone of his presence.

FORD'S "NIGHTMARE"

The Gerald Ford Presidency is a case in point of concern with the speaking voice. Nixon's resignation in the light of the Watergate scandal had Ford filling his term, then running for election himself. As the campaign against Jimmy Carter unfolded, Ford began to pitch his voice lower and lower. It was during the beginning of that campaign, over Labor Day weekend, 1976, that I was quoted in a Los Angeles Times interview with Burt Prelutsky as saying, ". . . the politician's nightmare is that he will lose his voice. And it is a legitimate fear because, like actors, they often try for voices far beyond their capabilities. That doesn't seem to be the case with Jimmy Carter. Ford, however, is trying to go lower and adopt an oratorical voice - and, at the very least, he is risking hoarseness and, before the campaign's over, he may blow out all together."

Hearing what Ford was doing with his voice clearly made me aware that Ford wanted a deeper, more manly voice rather than the gentle, friendly baritone he normally used for speaking. He had an even tempered tone, one that did not carry much weight. It was listenable, but not impressive. Increasingly, as his voice began to deepen, I felt he would lose his voice before the end of the campaign.

When I gave my views to Burt Prelutsky, he was concerned and asked if I wanted to allow my prediction to appear in print. I did, and he ran it.

Three days before the end of the campaign, Ford was unable to talk, having gone hoarse. I believe the hoarse voice was caused not by too much talking, but by talking wrong. After this, Burt Prelutsky dropped me a line, saying, "By Jove, you're right!"

Ford didn't have to change his normal speaking voice to a deeper throaty voice in seeking to make his voice manly and fuller. Like so many Americans who want fuller, deeper voices, he dropped the focus of voice, as well as the pitch, and talked from the lower throat - the one spot in the throat nature disallows to be effective and healthy. The lower throat, the deep-throat voice, is the common overall cause of trouble in voices, and the basic overriding cause of hoarseness. Gerald Ford was a leading example.

By giving up the deeper, fuller voice, which he did not use well, and going back to his gentle, lighter voice, Ford regained his normal voice after the election. It wasn't his real voice (the lows of his voice were not used). Was voice a factor in Ford's defeat? If he had a Ronald Reagan voice or an FDR voice, could he have carried the day? Perhaps. Granted the backlash at Ford's pardon of Nixon was a key element in contributing to his defeat, would that backlash have happened had Ford sounded differently?

I believe Ford's lack of voice lessened his ability to carry off the pardon issue and its consequences, therefore costing him the election. Gerald Ford did not have the voice to pull off controversial or questionable issues of his day. Ronald Reagan did, many times.

CARTER: A VOICE WITH FEW LISTENERS

Jimmy Carter was perhaps the poorer for his voice than any of the recent Presidents. It was thin, nasal, accented with a drawl, leaving him with a voice that lacked influence, believability, sophistication or any of the "abilities" that go with a good voice. Though he took lessons for his voice, it remained post-pubertic and juvenile. His was a voice that left few ears willing to listen to the message. As with Truman, Eisenhower, and Johnson, the voice was not of concern. It was merely a means of presenting the **message, the essence of the message being the thing.**

REAGAN: THE MOST TRUSTED VOICE IN AMERICA

In 1980, Ronald Reagan ran for President of the United States. For the first time in several years voice had become a focal point of interest and importance in an election. Hearing Reagan's voice, noting his manner of talking, and then comparing it to Jimmy Carter, I took informal polls of groups I talked with across the United States, as well as on radio and on TV. The overwhelming number of people everywhere told me they were not impressed with Carter's voice and were with Reagan's. Voice had become a key factor in the Presidential race, from what I heard. I predicted early, and stayed with the prediction, that Reagan would win by a voice vote. The economy didn't hurt his candidacy, but I believe his voice was a major influence in the way people perceived him. Reagan's voice was a means of keeping him in the public grace, a key player in his ability to reach out and touch people. He was correctly referred to as "The Great Communicator" for reason; the effective use of his voice was key in his ability to reach out and touch people. The Reagan era was one of voicing it; you can call it the teflon period or anything else. His voice made the negative seem positive. Jimmy Carter's voice did the reverse.

During the 1984 campaign voice again became a meaningful and underlying concern and cause in an election. Aside from the politics involved, people were taken with the voice of Ronald Reagan.

In the first debate with Walter Mondale, Reagan lost on TV. It was said that he appeared distracted while being weighed down with too much factual input. On radio, however, it was a different matter. I noted publicly that radio did not show his fatigue or distraction. Apparently the press agreed with me. An article in the Los Angeles Times cited my views and agreed that the radio debate had indeed been won by Reagan.

In the second debate, Reagan was his old, easy, genial self. With his friendly, warm voice and "by golly" demeanor, he won the debate and the election. That debate alone didn't win it all for him, but I believe the cumulative effect of input and stance did. Reagan knew how to talk in public, to talk conversationally without shouting or trying to reach the back of the audience. Mondale lost the sense of intimacy and oneness with the audience. He forgot or ignored the dictum that one-on-one conversational presence is the key to being heard and listened to, if not liked. It is a method and manner Ronald Reagan, the old pro, mastered.

From the feedback and input given me from different parts of the country - I was doing radio and TV shows at the time - I realized that the poor reaction to Mondale's rather high, whiny voice was not local, but national, and that it was a meaningful undercurrent. Months in advance of the election, I predicted on national radio and in newspapers that Reagan would win the election because his voice was a vital influence.

During the final stages of the 1984 campaign, I was contacted by representatives from Mondale's camp requesting material about my expertise on voice. I provided them with my textbook, articles, and my "self-help" book, *Change Your Voice, Change Your Life*. As I was to learn later, Mondale insisted upon remaining authentic to himself. However, he lost in a landslide against the best communicator of our time, a man who could charm by his manner and through his voice. (Mondale's saying he was going to raise taxes in a very definite voice did not help his chances.)

Reagan was made for modern communication and for the American public, which was taken with his voice, his style of delivery, if not his views. Reagan's voice, regardless of his message, had people listening though they may have differed with him.

I believe Reagan replaced Walter Cronkite as the most trusted voice in America. Were Reagan to have had a Truman voice or a Carter voice, would the message have been the same? Would the listenability and believability and reasonability factors have been as convincing and overwhelming and overriding? If Reagan had had Walter Mondale's voice and style, would the masses have tuned in and accepted the message, and the messenger that Reagan became for his views of government?

Ronald Reagan's voice brought to us the friendly, easy tones that allowed us to remain calm and at ease. He had the voice of having been born to the manor. However, earlier in his career as an actor, I heard him talking with a higher, less effective voice. It was not an impressive voice. It did not have the richness, fullness, and warmth that the later years brought to his voice.

BUSH: NO SOUND IMPRESSION

In contrast to Ronald Reagan, George Bush was not one to make a sound impression. The difference in voices was marked, and the contrast sharp. Their messages might well have been similar, but the means of delivering those messages were vastly different. Was it personality? In part, yes. Was it voice? Definitely yes. The voice can make a real difference in the message, and I believe voice made the

difference between the full, rich sound of Ronald Reagan in his speeches and the thin, nasal sound of George Bush in his.

George Bush inherited his office, so to speak, from Ronald Reagan. George Bush was not unaware of the sound of his voice during his Presidency. It was characterized as wimpy, nasal, lacking drive, unenergetic. Was that true of George Bush, the person? I doubt it. Bush's voice misrepresented him just as many people are misrepresented by their voices, though they needn't be.

Although George Bush already had years of help with his voice, no change was evident until Roger Ailes put his foot down. Roger Ailes insisted (using the four letter word) that he change by lowering his pitch. I had been on Bush's case, too (though with less colorful words), on national radio, TV, and in print, saying that Bush had a fuller, richer voice, but he didn't use it.

Then, in 1988, during Bush's acceptance speech, a manly, full, rich voice emerged. That was the President's natural voice, the voice that George Bush was always capable of using, but never did. Most people, men and women, have that same natural voice - yet never use it.

Thereafter, for some reason, Bush returned to his nasal, thin voice. Only when campaigning against Bill Clinton did the real manly voice of George Bush appear. But it was not consistent. It was now and then, here and there. The nasal, thin tone of the adolescent George Bush returned to prevail, the image of the old voice controlling the impressive tones that might well have gotten him heard, liked and listened to, and even elected, despite the rhetoric and the hoopla.

Nasal resonance is like salt and pepper. Too much and it ruins the meal. George Bush and Jimmy Carter have nasal voices. I believe their messages were diluted in part to the voices.

We basically forgive and ignore a misused voice because our culture accepts the lower reaches of sounds and voices. Gerald Ford was not considered negative when he dropped his pitch and his focus into the lower throat to present a more manly tone. We attributed his loss of voice to voice overuse during his campaign, just as we attributed Bill Clinton's loss of voice to overuse during his campaign. Any misuse is basically overuse. There is really no such thing as overuse if you use your voice correctly and sensibly.

We all experience hoarseness. There were times when even Ronald Reagan became hoarse and talked deep-throat. (I understand he characterized his occasional hoarseness as being due to air-conditioning.) But when he changed his placement of voice to the mask, the hoarseness disappeared. From his years in acting, and his background, Reagan may have discovered that talking in the mask is how he should talk. Or he may have lucked out.

CLINTON'S VOICE: A MEDICAL CONTROVERSY

Bill Clinton's voice is another matter. What he has going for him is likability. He appears to be a genuinely nice and caring man. But his hoarse voice has created more attention, and discussion, than that of any President in modern times.

Cooper on American Journal discussing Clinton's voice difficulties.

Clinton's lack of correct voice use has been treated by allergy shots, and though such injections have been provided for some time, the hoarse voice remains. It has been said that his hoarseness will become worse. That view is from allergy specialists, medical people who believe that the allergy-causing factors in Washington, D.C. are worse for the President than those in Little Rock, Arkansas. The medical view of his hoarse voice is that the President is hoarse, will remain hoarse, and possibly get worse because of allergies. Other medical viewpoints have related the President's hoarse voice to diet. He has been advised to give up everything from fries and burgers to chocolate, tea, and coffee. Milk products supposedly create excessive mucus, and since the President clears his throat a lot, medical people are inclined to believe milk products are adverse to Clinton's voice.

It is my view that many of the factors mentioned by the medical advisers are irrelevant to the President's hoarseness. Clinton talks hoarse because he talks wrong - and he will continue to be hoarse until he changes the way he talks, that is, from the lower throat to the mask.

Have you noticed that President Clinton sips water or herbal tea while talking, as though the liquid will relieve his tense vocal cords. It is a known fact that liquid cannot touch the vocal cords because they are protected by three tiers: the epiglottis, the false cords, as well as the true vocal cords close off as soon as we swallow liquid or food. If a substance or liquid should trickle down to the vocal cords, we would not be able to talk. We would choke, badly.

Water or tea - any liquid, for that matter - may help relieve a sore or scratchy throat, but to suggest that liquids help to overcome recurring hoarseness is quaint and fanciful.

Bill Clinton's problem may be reversed simply by changing the placement of his voice from the lower throat, where he now talks, to the mask, that area around the lips and nose - for starters.

THE PRESENCE OF GREAT SPEAKERS

Great speakers are not born; they are made. Each of the Presidents since World War II has had his moments before a microphone, but only Roosevelt, Kennedy, and Reagan were truly effective speakers. In radio days, Roosevelt influenced by voice alone. In TV days, Kennedy's and Reagan's vocal abilities were embellished by visual properties. Roosevelt, Kennedy, and Reagan knew how to use their voices to scintillate and influence others. They had voices that inspired. Their words and messages were heightened by their sound. Roosevelt was oratorical in public address; Reagan was conversational. Kennedy had a voice presence, and his charisma swayed the populace.

Did you know that most of the very best speakers - learned how to use their voices. They, like you, were born with the God-given ability to have good and great voices. But making your true, natural voice speak for you often requires direction. You have to learn whether you should talk higher or lower in pitch, how to focus your voice, and how to breathe correctly for speech. When you have a voice that talks for you, people pay attention. It takes a voice presence to command attention. Anyone who seeks authority, and is moving upward, needs such a voice. That includes executives, politicians, lawyers, teachers, actors,

men and women in all occupations. The truth is, everyone may have a voice presence at his or her command, but few people know how to use it. Misused, however, that voice can become troubled. If it can happen to our nation's leaders, individuals who have made careers of speaking in public, it can happen to you. Take command of your voice. Be the best you can be.

Chapter 8

Change Your Voice, Change Your Life

We all make excuses in life, even when it comes to our voices. The majority of people honestly believe there is nothing that can be done to make their voices sound better. One of the most common excuses I hear is, "But I've talked like this all my life."

People who misuse their voices are almost always unaware that they have a voice problem. It isn't until something goes wrong, and they start losing their voices, that they seek help. And while it is almost never too late to receive help, the longer you wait . . . well, you know the rest.

Lucille Ball needed help with her voice. (Remember how rough and scratchy she sounded for a time?) So did TV and radio personality Shadée Stevens, talk show host Joan Rivers, and author Harold Robbins.

My program of Direct Voice Rehabilitation is essentially similar, but with appropriate modifications, for all types of organic, neurological, and functional disorders. Organic voice disorders include nodules, polyps, and contact ulcers, which are benign lesions. Neurological voice disorders include Parkinson's Disease and cerebral palsy. Functional voice disorders, which I find are related to voice misuse and abuse, include tired voice, spasmodic and spastic dysphonia, and bowed vocal cords; these conditions, if untreated, could well be a prelude to organic voice disorders. In functional voice disorders, the voice shows wear and tear, and is inefficient without organic or neurological factors being present, indicating that voice misuse or abuse basically is occurring within the normal laryngeal structure. The greatest number of cases in this category normally result from the simple fact that the patient is talking incorrectly. In other words, the patient is doing it to himself or herself.

MIND-BODY TECHNIQUES

In Direct Voice Rehabilitation, the first step is locating and identifying the optimal or natural pitch level and range as well as the correct, balanced tone focus. A simple method, which I use, is my "um-hum" technique. With this exercise, the patient is told to simply say "um-hum" spontaneously and sincerely as if agreeing with someone in conversation. If the "um-hum" is produced with the proper pitch and tone focus, the patient should feel a slight buzz or tingle in the mask area around the lips and nose, as in humming "Happy Birthday."

Another simple, total mind-body technique that may allow for immediate correct and natural pitch and tone focus is this: The patient bends over from the waist, keeping the legs straight, letting the arms fall forward toward the floor with the head hanging downward in a relaxed position with the chin on the chest. As the patient is in this position, a hum ("um-hum") or "oh" is sustained. This position often breaks the body tension and the body armor--which is the habitual, but not natural, use of the voice--allowing the real voice to come forth.

Still another approach is to have the patient hum (staying in the bent chin-on-chest position) while the patient or clinician gently jiggles with the fingers in a staccato fashion on the patient's midsection or

higher (at about the level of the solar plexus). Or in another exercise, the clinician may also gently jiggle with the hands on both sides of the patient's midsection (at about the bottom of the rib cage) in the staccato fashion while the patient is humming and is in either an upright or bent-over position. "Jiggling" with the fingers or hands may be likened to jogging in place in aerobics. (These are variations of the Cooper Instant Voice Press, which was described earlier. As mentioned earlier, do not try these exercises if you are pregnant or have medical problems involving the stomach or area of the solar plexus.)

ON HEARING YOUR NATURAL VOICE

All of these approaches may allow the real or natural voice to be heard. It must be emphasized that almost all patients initially react negatively to the new voice by saying that it is too loud or that they are shouting. Reassurance that the new voice - or the natural voice - is normal in volume must be made by the clinician, by other patients, and by others outside of therapy.

To review, if the patient does not have midsection or central breath support, the correct breath control should be developed. The patient is instructed to lie on his or her back, with one hand on the chest and the other hand on the midsection (waist). He or she is told to breathe easily through the nostrils as though resting or going to sleep. The patient must experience the midsection moving gently out as the chest remains stationary. The exercise is then repeated while breathing through the mouth while in the same supine position.

The next step is to practice this exercise while standing, breathing first through the nostrils and then through the mouth. The last step is to practice in a sitting position, again breathing first through the nose and then the mouth. Keep in mind, we basically breathe through our mouth when talking.

Following the identification and establishment of the new pitch, tone focus and breath support, the patient must become accustomed to the sound and feel of the new voice. He or she also must then learn to use the new breathing technique together with the new voice in a controlled therapy environment, which will be carried over to outside situations.

As I mentioned earlier, the length of time required for voice rehabilitation depends on such variables as the ear of the clinician, the "feel" of the voice in the mask and the ear of the patient, and the cooperation of the patient. A survey of patients seen over a thirty-year period indicates good to excellent results with those who completed the voice rehabilitation process.

VOICES THAT SING

Over the years, I have worked with some internationally famous singers from the various stages of musical entertainment, including Stevie Nicks (lead singer for the rock group Fleetwood Mac), Diahann Carroll (multi-faceted singing star of Broadway, motion pictures, nightclubs and television), and Jerome Hines (famed star of the Metropolitan Opera). Mr. Hines, in fact, insisted on mentioning his one-time voice problem in his book *Great Singers on Great Singing* (Doubleday, 1982) and inviting me to contribute a chapter in this book.

He wrote, in part:

"In the mid-1960s, when I was suffering from a severe vocal problem, I consulted Dr. Morton Cooper, a most successful speech therapist in Westwood (Los Angeles), California. The short time I spent with him provided insights that were very important to my vocal recovery. . . . (It was) Dr. Cooper who pointed out that much of my trouble had its roots in incorrect speaking habits. Giving heed to this has also been most valuable."

The singing and speaking voices should have basically the same pitch level, range and tone focus. A marked difference between the singing and speaking voices should tell you that one of the two voices is not being used properly.

Amateur singers frequently do not sing in the proper range, either because they are unaware of their optimal pitch range or because they are assigned incorrect pitch ranges to use in group singing. The untrained singer also uses too much forced volume and usually lacks good midsection breathing for tone support. This weakening of the singing voice often results in hoarseness, laryngitis, poor range control, voice breaks, and volume problems.

A LECTURER'S TROUBLED VOICE

Let me tell you about some patients who are not singers. Dr. F. began to lose his voice in early 1973 while he was lecturing at a university in Iran. At first he felt a strange sensation in his vocal cords, but they gradually weakened until he was barely able to speak. An ENT doctor in Tehran prescribed antibiotics, which failed to help. That summer he traveled to England to see a voice specialist. "That trip was of no use," says Dr. F., "and my problem became worse."

He struggled with his voice until the following summer when he flew to the United States to consult with his cousin, a medical pathologist who was then doing research at a prominent medical school. His cousin recommended Dr. W., then added, "If that doesn't work out, see Dr. Hans von Leden in Los Angeles." Dr. W. did not work out. According to Dr. F., "His prescription for me was odd. He had me chew a golf ball and, for that, one of my teeth broke apart."

In September 1974, Dr. F. flew to Los Angeles. It was in Dr. von Leden's office that "my problem was first diagnosed as spastic dysphonia. After extensive examination he referred me to Dr. Morton Cooper."

On September 12, 1974, Dr. F. came to my office. Although he had been told about his condition and its severity, I emphasized to him that it was not that unique, nor hopeless, as many people are led to believe. By using my Direct Voice Rehabilitation exercises, he could indeed regain his speaking voice in time. How long that would take was impossible for me to project. I knew nothing about his dedication and willingness to practice.

Dr. F. remained in Los Angeles from September 1974 to July 1975. During this period I saw him twice a week. Dr. F. admits: "In the beginning I was pessimistic toward the outlook of the treatment, but after a few months I found that my voice was going to its natural level without slipping back too low. Dr.

Cooper's treatment was so effective that after eleven months I was back to my real voice. And it has remained strong, not losing ends of words or sentences.

"Dr. Cooper's treatment was a new experience in my life as I regained my natural voice and also my career. Personally, I owe my voice to Dr. Cooper. Of course, I worked very hard during the period of rehabilitation, exercising his methods of first humming words and, later, sentences, and breathing correctly.

"Finally, I have been able to teach regularly every semester since September 1975, carrying a full load of 15 hours per week on the average. I am forever grateful to Dr. Cooper and his rehabilitation program for making it all possible."

Dr. F.'s voice remains excellent twenty years after DVR.

THE ADVERTISING EXECUTIVE

Rachel is an advertising executive. She had been having problems with her voice and throat for approximately eight years when she came to see me. She had been to four different doctors - ENT specialists - who told her she had a variety of problems ranging from a vivid imagination to allergies, sinusitis, and postnasal drip. One doctor recommended that she read psychology books on self-esteem. She was also told that she had "globus hystericus," a term defined by the medical dictionary as "a lump in the throat in hysteria and other neuroses." This essentially means the problem is said to be in the mind, not in the throat. I have seen this term numerous times in medical reports ascribing the lump in the throat or feeling of a foreign substance in the throat to hysteria, when in actuality the patient may feel the lump and may experience the foreign substance feeling because they are squeezing the voice from the lower throat. A throat examination does not reveal a lump or a foreign substance, but tension produced by wrong placement of voice creates the sensation of a lump. After completing voice rehabilitation patients have reported to me time and time again that the "lump" is gone. (See symptom chart.)

Another physician informed Rachel that she had swollen nasal membranes. It was the mucus draining from these membranes, he said, that gave her the sensation of having a lump in her throat. She received a shot of cortisone in her nose to "combat the inflammation." For the next two years she returned regularly to the doctor for cortisone injections in her nose. Says Rachel, "It got to the point where I'd wake up every morning believing I had a lump in my throat."

Why the doctor continued to give Rachel shots over an extended period when they weren't helping her, I don't know. Then, again, why would he have told her she had swollen nasal membranes? The only answer is that the doctor wasn't listening to Rachel. He was only looking for something to treat. If he had known about symptoms of voice problems he would have known that many people who are misusing their voices have the feeling of a foreign substance, such as a lump, in their throats.

The treatment for Rachel's non-existent lump continued for nearly three years. At one point a scope was inserted down into her throat. On the doctor's recommendation a piece of tissue at the back of her

tongue was removed because it appeared to be enlarged. Rachel says she had some relief for about a month before the pain returned.

Because Rachel's voice condition seemed to come and go with the seasons, then worsen for long periods, it was believed she had an allergy. She was given a variety of medications, plus an inhaler spray. She was on drugs for about a year. Says Rachel, "The pain didn't worsen. In fact, I started feeling better so I stopped taking the medication. Then, gradually, everything came back. This time I thought, 'Oh, well, I really do have allergies' and started in again with the drugs. But they didn't work like they did before."

RACHEL'S "TIRED VOICE"

Rachel was back where she started. Her throat ached as if a foreign body were lodged in it, and her voice was rough and breaking. Rachel's case is typical and symptomatic of a condition called myasthenia laryngis, a big term for "tired voice." If not corrected, tired voice can lead to voice suicide. Rachel was on her way.

You've heard people after a long, hard day or an extended period of talking. Their voices sound like sandpaper. They not only look tired, they sound tired. Tired voice comes from talking down in the lower throat. Instead of talking into the mask - around the lips and nose - they let their voices drop into the danger zone. They do it because they want authority, status, position. Or they don't know any better and just let their voices sink. As their bodies tire, so do their voices.

"I let my voice drop because I wanted a strong voice," admits Rachel. "I thought it made me sound older, more powerful. I didn't realize I was doing it, or how I got my voice down there, but I liked what I heard."

By the time Rachel came to my office she had been from doctor to doctor, enduring throat pain, along with difficulty in speaking, for eight years. "After one day with Dr. Cooper," she says, "I could feel the pain lessening. He started me with humming exercises, then 'um-hmm' and counting with 'um-hmm.' He worked on my breathing, on raising my voice and on getting it focused correctly. I could actually feel what was happening in the mask, where it belonged. And I didn't feel any pressure in my throat as the air passed through. I was forming words, making sounds, without putting a lot of effort into it."

Rachel didn't particularly like her new voice when she heard it played back to her. She thought it sounded strange, more like a little girl than the image she had created for herself. She also had a confession of sorts. She liked to sing. When she started singing lessons her teacher told her to sing in the mask. Singing gave her relief, she said. Every time she ended a lesson her voice was higher than when she began. That higher, natural, feel-better voice stayed with her about an hour on lesson days. Then she'd revert back to her troubled voice without realizing why or how. "Singing and talking were two entirely different things to me," she said. "I never connected the two. Now it makes sense . . . focusing in the mask and breathing properly. When I sang, my stomach went in. When I spoke, it went out. I was

doing all the wrong things before, speaking in the lower throat and reversing my breathing, things I didn't do when I sang."

While Rachel is thrilled to have a strong, healthy voice again, and to be living without pain, she cannot help but remember the wasted years she spent trying to find help, and the thought makes her angry. "The doctors are all too ready with their needles and knives and drugs. I saw four of them and not one knew what was wrong with me."

MISDIAGNOSIS: IS IT A VOICE PROBLEM?

Rachel is not an isolated case. The condition that sent her to a series of doctors is all too common today; millions of patients across America may be misdiagnosed or undiagnosed. These patients may be given checkups to see if anything is medically wrong, but they usually receive a clean bill of health. That doesn't mean there isn't anything wrong. All too often there is a voice problem. The patient is talking in the wrong direction, from the wrong area - the danger zone - so the cause goes untreated and the patient continues to suffer, physically and mentally.

I have said it before, but it bears repeating: many doctors do not hear the problem because they are not trained to listen. I am not knocking the doctors. It isn't their fault. The medical profession is to blame for ignoring voice by not making it part of required training.

JOE'S "SEXY VOICE"

Joe had a serious voice problem, which he lived with for forty years. During most of that time he thought he was "talking sexy." It wasn't until he realized his voice was killing him that he sought help. As Joe explains, "I used to have a very deep, raspy voice. People used to say, 'That's a sexy, deep voice, Joe.' I thought that was great, so I went along with it, never knowing it was doing me harm, causing problems."

For Joe, speaking deep-throat seemed natural. He had been talking that way for so long he didn't know there was any other way. He even admits that if anyone had criticized his low, authoritative voice when he was younger, he probably would have ignored the criticism. But warning signals were ahead. "I'd get tired talking," he says. "If I had a conversation that lasted for ten or fifteen minutes, I felt like I'd run around the track. Now I wish I'd had voice training with a good speech therapist when I was a kid."

When his doctor advised surgery for polyps on Joe's vocal cords, he took his doctor's advice and went ahead with the surgery. His voice not only didn't improve, it became worse, very hoarse. This time Joe's doctor told him to seek out a voice clinician. "I went every week," says Joe, "but I was never taught the proper mechanics of speaking. Instead, he concentrated on my breathing, and that was about it."

Two months before Joe came to my office he had a second surgery for polyps on his vocal cords. Following that operation his doctor said to him, "You don't want to keep having surgery because that could result in more problems, very serious problems, such as premalignancies and cancer."

At sixty-five years of age, Joe began Direct Voice Rehabilitation. He was talking from his lower throat when I first saw him. His voice was down. It grated when he spoke, much like a highly advanced geriatric voice - only worse. I told Joe he was wearing his voice in the wrong place. "If you don't wear your glasses in the right place, you can't see," I said. "It's the same way with your voice."

It took one session for Joe to find his right voice. He then followed with exercises every day, concentrating on the correct placement of his voice so that it would become natural for him to speak correctly without thinking about it. Now Joe says, "I've had people call me on the phone and hang up when I answer. They can't believe it's me. Even my doctor can't get over it. He says I'm like another person!" Joe simply needed to get his voice focused and to learn diaphragmatic breathing.

SUCCESSFUL RECOVERIES FROM ALL WALKS OF LIFE

There are so many success stories like Joe, Betty, and Rachel, all documented. Zelda, a teacher, was diagnosed by Robert Feder, M.D., a well-known laryngologist in Beverly Hills, as having spastic dysphonia. After undergoing an intensive six-month program of Direct Voice Rehabilitation, she recovered her speaking voice. Zelda had had polyps on her vocal cords fifteen years prior to the onset of spastic dysphonia; the polyps were eliminated in three months by Direct Voice Rehabilitation. She attributes the onset of the spastic dysphonia to stress and a desire for a lower pitched voice. Although she still has stress she now knows how to handle her voice.

Rabbi Alan was diagnosed at the UCLA Medical Center with spasmodic dysphonia in early 1989. Following a program of Direct Voice Rehabilitation, he was referred back to UCLA for a phonatory analysis and was found to be speaking normally. At that time, he says he was told he could not have had spasmodic dysphonia because there is no recovery from it. He was told that the original diagnosis must have been wrong.

In 1996, three years after completing DVR, Rabbi Alan speaks with a normal voice 99% of the time. In a recent letter I received from him he says that the final 1% of SD continues to diminish. In his description of his voice problem, he writes that "self-expression manifests through the vocal mechanism. If the vocal mechanism is blocked, the self is stifled. And if the self is stifled, the vocal mechanism is blocked! And so one spirals down into SD."

He continues to explain, "You have discovered how to reverse the spiral, from a descending to an ascending one. First you unblock the vocal mechanism, and the self begins to become more free. The increasing freedom of the self further unblocks the vocal mechanism! And so on. Reflecting back on the process of my own healing, that's how it seemed to progress for me."

Marjorie was diagnosed at the UCLA Medical Center as having severe spastic dysphonia eight years ago. She was unable to produce a single word. She declined surgery. Through a program of Direct Voice Rehabilitation over a period of years, she recovered her normal voice. She is now able to talk under the conditions and in situations she once avoided.

Lisa was diagnosed as having spasmodic dysphonia by a well-known laryngologist in Los Angeles. She was treated by antibiotics but did not improve. A six-month program of Direct Voice Rehabilitation helped her to recover a normal voice. Five years later she appeared on a TV program with me, reaffirming that her voice remains excellent.

I could go on and on introducing you to patients who have recovered from the most severe voice problems with Direct Voice Rehabilitation. These are people from all walks of life and spanning a wide range of ages, whose voices simply gave out on them. They were losing their voices, but they went on for years without knowing it.

Have you listened to your voice lately? Do you like what you hear? If your tape recorder isn't broken, your voice is. Actually, when you come right down to it, your recorder - or your answering machine - may be your best friend. Where else can you find out that your voice isn't working right for you? Your friends won't tell you.

Listen to the warning signals. Do you clear your throat a lot when you talk? Does your throat ache? Does talking tire you? Is it difficult or effortful for you to speak? Does your voice get weak or fade in and out? Does your voice get all used up during the day? Is it clear, or gravelly? Do you become hoarse after talking for a while or by the end of the day? Do you have an irritation around your throat, as if you have a foreign substance or a lump in there? Do you have a feeling of tightness or tension in your throat? The well-used voice should not have these negative voice symptoms.

There is a widespread mistreatment of our voices. The cover of this book lists some of the common symptoms of voice misuse and/or voice abuse, including sore throats, throat clearing, weak voice, poor projection, pain when talking, strangled voice, voice strain, hoarse voice, lump in throat, tired voice, deep-throat voice, hurts to talk, throat tension, and nasality. (Voice Evaluation Charts are in Chapter 7.) You may have additional problems or define your symptoms in different terms. If you will, add to these lists by writing down your symptoms and sending the list to me. Your voice can be symptom free.

Talking should be as easy as 1, 2, 3. It should come naturally. It should give you confidence and make you feel secure. Your voice should never hold you back. It should - and can - help make you a better person, in every way. Your voice can be your fortune. We live in a sound society.

If you want a healthy, more effective speaking voice, isn't it time you did something about it?

Chapter 9

The Madness of Medicine

Remember Network, the 1976 movie that satirized the world of television? One of the great moments from the film had Peter Finch, playing anchor-man Howard Beale, the "mad prophet of the airways," shouting the now-famous line: "I'm mad as hell, and I'm not going to take this anymore!"

Sometimes I feel like Howard Beale. Sometimes I feel like going to the window, opening it wide, sticking out my head, and yelling, "I'm hungry as hell, and I'm not going to listen anymore to the doctors. I want a Big Mac, and fries, and chocolate. I want tea and coffee, and all the good things in life. I am tired of being fed myths!"

Food is not really the enemy. Some foods consumed at some time or another may affect the voice, such as an allergic reaction to shrimp, spicy foods, etc. Food does not cause most people to become hoarse on a continuing basis, but the wrong way of talking does. You, the person, are doing your voice in. In my many years of practice, I have been told by patients that they are allergic to coffee, milk, caffeine, chocolate, and dairy products, yet when I show patients how to use their voices properly, food may no longer be a basic issue. Just be a friend to, and with, your voice. The point is, when you talk right, in most cases you may talk as much as you want - without any advice from well-meaning but misguided doctors.

CONFLICTING BELIEFS

My being at odds with the doctors is not a sudden happening. Over the years, by accident not intent, I have managed to offend very powerful people in the fields of speech pathology and medicine. Early in my career when I was on the staff at UCLA Medical Center, I was privileged to work with Dr. Joel Pressman, Chairman of the Head and Neck Division, and with other knowledgeable faculty members including Dr. Hans von Leden, Dr. Alan Nahum, and Dr. Sam Pearlman. While I did therapy with patients, my ear told me the overwhelming majority of voice problems were caused by too low a pitch and forced lower throat resonance, not by too high a pitch, which was believed at that time. After producing excellent results for three years with my approach to voice, Dr. Pressman called me into his office to tell me I was doing everything ass-backward, but nonetheless, my results were excellent. Three years after this incident, Dr. Pressman again spoke to me, assuring me at this time that since my results continued to be excellent, that the field I was in was ass-backward, and that I should tell the field what was going on. Dr. Pressman wrote of my services that I was the best speech pathologist he knew.

When I received my Ph.D. from UCLA, I was invited to join the faculty as an assistant clinical professor in the Head and Neck Division. My dissertation had involved a clinical program of voice rehabilitation, over a period of three months, for eight patients with biopsied papillomata (pre-malignant lesions) of the vocal cords. Although a review of the literature indicated that vocal abuse and irritation were possible etiological factors, as were virus infection and hormonal imbalance, the main methods of treatment were medical, immunological, and surgical. The lesions were reduced or eliminated by Direct Voice Rehabilitation in four of the eight patients, thus indicating a link between voice misuse and abuse and

papillomatosis. The study was supervised by the medical faculty and the results were affirmed by the faculty, who did before-and-after laryngeal examinations. Dr. Pressman was astounded at the results. This study was published in the *Journal of Speech and Hearing Disorders* in 1971.

EARLY SUCCESSES

My dissertation was originally prompted by a case I had seen at the Marion Davies Children's Center at the UCLA Medical Center. It was there I worked with a twelve-year-old boy whose medical chart stated he had papillomatosis of the vocal cords. His voice was produced from the lower throat; the quality of voice being severely hoarse. He was also a yeller. His growths disappeared after about one year of Direct Voice Rehabilitation.

Two biopsied cases of papillomatosis were also seen by me. The first involved a general manager of a large pharmaceutical company who came to me after surgery because of his hoarse voice. He realized he had been talking in an intimate, confidential voice for years as part of his job. After a period of many months, his voice was produced in the mask and not in the lower throat. Approximately five years after the completion of therapy, he appeared on public television, describing and demonstrating his excellent voice. The other case involved a physician who had had three surgical procedures to remove the growths. He reported that he used his voice as a weapon, forcing his voice from the lower throat. He was seen twenty years following the completion of therapy, reporting that he had never had a recurrence of the problem. Margaret C. L. Greene, one of the foremost speech pathologists, has written in her textbook, *The Voice and Its Disorders*, 5th edition, that: "A case confirming Cooper's view that speech therapy can reduce or even eliminate papillomata in children was encountered by Greene in Auckland." (p. 246) She describes the case of a nine-year-old boy whose papillomata were reduced in number and in size following voice therapy.

My findings regarding papillomatosis conflicted with the beliefs of a local surgeon who had insisted that surgery was the only answer and who had performed almost 200 (two hundred) surgeries on one patient for this problem. With a program of Direct Voice Rehabilitation, the patient improved. Physicians apparently still do not see the relationship between voice misuse and abuse and papillomatosis from my experience.

After Dr. Pressman's untimely death, the new chairman of the Head and Neck Division at UCLA had an orientation to voice problems that was not the same as mine. It was time for me to leave.

MEDICAL PROOF

Sometime later I testified in a court case involving a patient who had gone from a benign lesion to a malignancy, requiring a laryngectomy. The patient was seeking Workers' Compensation since he had lost his voice as a result of having to yell on his job. The expert ENT physician testifying for Workers' Compensation said there was no proof that a relationship between voice misuse/abuse and malignancy of the vocal cords exists. I presented medical studies indicating that voice misuse and abuse can lead not only to benign lesions but also to malignancies. After I presented the evidence, the physician recanted

his testimony. At a subsequent meeting of the Otolaryngological Society, I ran into this well-known doctor who was highly critical of my testimony against his orientation.

In 1977 at the Houston Medical Center, I was part of a national program that included two colleagues. In introducing me to the group, one of the individuals called me "the fastest gun in the West." I took that as a compliment at first. Then he went on to describe his colleague's patient who suffered from a hoarse voice and had not improved during nine months of therapy. In a challenge, of sorts, he appeared to me to doubt my ability to help the patient locate his natural voice in seconds, which I find is often possible.

The patient, a minister, was brought to the podium where he offered a few words in his hoarse, troubled voice. Contrary to what was expected of me, I found the minister's natural pitch and correct tone focus in only seconds. It was then that a person in the audience spoke up. What I did, he said, was a fluke. My answer to that individual, and to the audience, was: "On a slow day it takes but ten seconds." My remark apparently didn't set well with this member of the audience, who turned out to be Wilbur Gould, M.D., the founder of The Voice Foundation, which publishes The Journal of Voice, directed to otolaryngologists, speech-language pathologists, singing coaches and voice scientists.

CLOSED EARS - AND MINDS

At the same meeting, one of the ENT doctors heatedly questioned the validity of the papillomatosis study. These experiences, I believe, have demonstrated a difference in orientation toward the treatment of voice disorders. "The powers that be" do not care to consider my approach to voice, and have closed their ears to what I have had to say for the benefit of their patients and themselves.

Over the years, trying to lead the fields of medicine and speech pathology out of the Dark Ages in regard to voice rehabilitation or voice improvement has been an on-going battle. It is inconceivable to believe that in these times a medical doctor will advise a patient to use his tongue, instead of a brush, to clean his teeth as a possible cure for a troubled or abused voice, or write a prescription directing a patient to chew on a golf ball to improve his strangled voice. Another patient was advised to change his liquor from scotch to bourbon, and when that didn't help, to have surgery. Still another was instructed to stop eating peaches. All too often, the simple, corrective techniques are overlooked in favor of more complicated, outdated and bizarre methods that are irrelevant to the problem itself.

It is almost as if these professions do not want to advance or help the patient. When years of successful rehabilitations have proven that it basically takes only seconds to determine someone's real voice, why are others in my field so taken aback by the simplicity of my approach?

Criticism from some colleagues is not new and comes as no surprise to me. In 1980 the prestigious Wall Street Journal ran a lengthy, front-page article chronicling the success of my voice techniques, under the headline, "How Norton Simon, With Help, Finally Found Voice He Had Lost." While the article was ninety-five percent positive, including Mr. Simon's comment, "it's really miraculous," it did note, by an unnamed source:

Mr. Cooper's methods are somewhat suspect among his fellow speech pathologists. Most of them maintain it takes months to analyze the causes of the speech difficulty before treatment can begin. Mr. Cooper says that by first finding the natural voice, he can often solve the whole problem.

To repeat again, finding the natural voice is not difficult nor time consuming. Learning to use and maintain the natural voice requires time and cooperation.

THE POLITICS OF VOICE

The field of voice rehabilitation, I find, is rife with politics. In 1984, I was interviewed by Los Angeles Times reporter Beverly Beyette for a story about the successful recovery of my patients through the use of Direct Voice Rehabilitation.

One afternoon, shortly after the interview, Ms. Beyette called to tell me that the story had been pulled. It seems that during the course of Beverly Beyette's research, she was told by four different sources in the field that I had never been published in medical or scientific journals, nor had I ever had peer review of my findings.

My list of published credits, books and other writings, fills two-plus printed pages and I immediately forwarded this information to Ms. Beyette. Shortly thereafter a comprehensive and complimentary article appeared in the Los Angeles Times, discussing my philosophy, my techniques, and my positive results with patients with several types of voice disorders as well as with spasmodic dysphonia. Beverly Beyette had done her homework. Unknown to me, she had interviewed former patients who were willing to go on record telling their stories of voice recovery. Although the article included several negative comments by one source, who remained anonymous, Ms. Beyette did acknowledge my credits and peer review at such highly acclaimed hospitals as Walter Reed and Cedars-Sinai, and before audiences of peers at the American Speech-Language-Hearing Association (ASHA) and the California Speech-Language-Hearing Association meetings. "At Odds with Establishment" was the headline above the story. A more appropriate title might have been "Establishment at Odds with Reality."

It appears to me that ASHA was also downplaying the success of Direct Voice Rehabilitation for severe spasmodic dysphonia even as early as 1980, as indicated in the Wall Street Journal article:

He (Dr. Cooper) even claims to cure Spastic Dysphonia, a serious organic vocal condition in which the patient can barely gasp a few words at a time. Most therapists say the condition requires medical treatment rather than speech instruction alone. An official of the American Speech-Language-Hearing Association says, "Many pathologists who listen to Cooper's 'before' tapes think his patients have a less severe malady."

Not so. The spasmodic dysphonic cases I have worked with were extremely severe. Lately patients have come with medical diagnoses from the leading medical centers throughout the United States, including UCLA Medical Center, the Mayo Clinic, and Stanford University. For example, in the previously mentioned Beyette article, she reported:

Dr. D. started having voice problems 10 years ago and was diagnosed at Stanford University as having Spastic Dysphonia, probably incurable. "I was finally discharged after being told they'd done everything they could," he said. Dr. D., who is assistant vice president, academic affairs, University of _____, remembered reading a Morton Cooper book and sought him out. "It took me a year of working with him to really catch on to the techniques," Dr. D. said, "and another two years to work them into everyday speech." Today, he said, it is an automatic response - "If I find myself starting to slip into the lower throat, I'll try to hop back up."

And the spasticity has not returned.

So much of what I read in print is appalling to me. Information that is grossly false and misleading. These are not Johnny-come-lately publications or tabloids, but honorable newspapers, magazines and journals that are known for their accuracy and high standards. For example, in 1989, the prestigious New York Times health guru Jane Brody, known in some circles as "the most trusted voice in health," wrote in her column that "one voice disorder, Spastic Dysphonia, has no known cure."

Because that statement is so blatantly incorrect, I wrote to Ms. Brody. In my letter to her, I told of patients who have recovered from SD by Direct Voice Rehabilitation. The patients were purposely listed by name (with their permission) as their "before" and "after" diagnosis had been verified by ENT doctors.

I did not hear from Jane Brody or the New York Times. Because of their silence and unwillingness to print a more objective (and correct) view in her column, and because I believed so wholeheartedly that the truth should be told, I took space in the American Speech-Language-Hearing Association's monthly journal, *Asha*. It was my intent to run my letter to Jane Brody as an Open Letter in a full-page ad under the heading.

"A Response by a Voice and Speech Pathologist to the New York Times 'Personal Health' Column Written by Jane Brody"

ASHA would not accept the ad as submitted. Would I be willing to forward a revised version or substitute another ad? My answer was "no" since the Brody statement needed addressing. Janet Ciuccio, Director of the Professional Ethics Division of ASHA, remained firm. The ad could not run "as is," because portions of its wording were found to be objectionable.

Two months later, in its November 1989 issue, my Open Letter ad to Jane Brody made its way into the pages of *Asha*. Despite my protests, and offer to submit documented evidence, three paragraphs had been deleted. The censored paragraphs presented positive proof of my successes with patients using Direct Voice Rehabilitation. To make matters worse, ASHA refused to openly acknowledge that the ad had been censored and why until months later. Only after an angry exchange did ASHA finally admit the elimination of paragraphs containing valuable and relevant documentation.

It is unfortunate that the prevailing views of some practitioners in medicine can so influence, even dictate, how speech pathologists learn and respond to spastic or spasmodic dysphonia and other voice

disorders. Speech pathologists should be the primary service providers for spasmodic dysphonia and other voice disorders. Reliance on the medical model has not worked. However, speech pathologists depend on M.D.'s for referrals, and therefore may take a deferential position. The medical model in the treatment of voice disorders, especially spasmodic dysphonia, is wide of the mark with a number of patients. As a matter of record, when I was on staff, and later a clinical assistant professor on the medical faculty, at UCLA Medical Center from 1962 to 1969, we never had one success with spasmodic dysphonia using the medical model. But as a single practitioner and in private practice, I have been successful for the past 20 years.

AN ON-GOING CONTROVERSY

The prevailing views were on display at a Symposium ("Understanding and Treatment for Spasmodic Dysphonia. . ."), sponsored by the Department of Neurology at the University of California, Irvine, in March of 1991. During the meeting, the audience and the panel, which included Dr. Herb Dedo, "suggested . . . that at present there is no cure for SD," according to a newsletter dedicated to those with spasmodic dysphonia, entitled *Our Voice* (Nov. 1991), p. 2. As a member of this audience, I took exception, during this meeting, specifically recalling one patient, the Reverend James Johnson, who recovered within one month of intensive therapy using my Direct Voice Rehabilitation. Following that, I said, the Reverend Johnson continued therapy on his own and has maintained the right voice, an excellent voice, ever since. I also discussed recoveries and cures of other patients. No mention of my comments appeared in this newsletter.

In the same issue of this newsletter (p. 2), it was reported that "Dr. Dedo suggested that voice therapy may well be effective, but that it is difficult for patients to continue with the rigorous demands of speech pattern modification exercises."

I wish I had heard Dr. Dedo make these comments at the meeting.

The editor of *Our Voice*, apparently thinks I am controversial. I am not sure if her opinion is of me or my methods used to reverse wrong voices. Either way she might be right. The same may be said of any number of advances and breakthroughs, as well as those who pioneered them. Through the years, progress and controversy have gone hand in hand.

Still, I find it difficult to understand why a newsletter devoted to providing information about a debilitating voice condition, including the latest happenings in the field relating to it, almost always ignores my name and my work. Meanwhile, the newsletter hammers home the myths that there are no successes with voice therapy in articles by-lined by different sources, mainly medical people and speech pathologists. As far as *Our Voice* is concerned, my successes with spastic or spasmodic dysphonia by Direct Voice Rehabilitation seem not to exist.

WHAT'S GOING ON?

Another meeting took place at the Pacific Voice Conference, held in San Francisco during October, 1991. This Conference did not recognize the contribution of Direct Voice Therapy for SD. Instead, the stress was on Botox poison; not once did I hear anyone remind us of a leading doctor's statement at Irvine - withdraw Botox at the earliest possible time - or was I hearing things at the Irvine meeting and did he not recommend Botox be replaced?

A top authority suggested the Isshiki surgical procedure (mentioned previously) that can help a person move from a normal to a professional voice. From my experience, a professional, artistic voice cannot be created by a surgery.

One of the most interesting comments came from Dr. Arnold Aronson of the Mayo Clinic. He said he supported the position that I had produced recoveries with psychological cases of SD. (He separates SD into psychogenic and neurological cases, among other categories.) I do not find SD to be neurological; I find it to be a mechanical problem (voice misuse), with psychological overtones.

Recently, I received a copy of a letter written by Dr. Aronson that indicates he supports my techniques in psychogenic SD cases. The original was addressed to Lawrence Kolasa, President of the National Spasmodic Dysphonia Association (NSDA).

With all due respect to the various treatments for SD, I feel SD patients should also be informed about Direct Voice Rehabilitation. Incidentally, although NSDA states that they do not endorse any specific drug or treatment for SD, in NSDA's Spring 1994 Quarterly Report, they thanked Allergan Laboratories for a \$15,000.00 grant. As previously mentioned, Allergan Pharmaceuticals in 1990 acquired the substance that produces botulinum toxin.

A VOICE IN THE WILDERNESS?

Since I have had success in helping patients with spasmodic dysphonia, I want to persuade physicians and voice pathologists to try my techniques. But I feel as though mine is a voice crying in the wilderness. The only way I know to announce that spasmodic dysphonia may be helped by Direct Voice Rehabilitation is to let patients who have recovered from spasmodic dysphonia tell their stories, and I can only hope that other voice pathologists will help other patients.

I have devoted my long career to bring the field of voice rehabilitation out of obscurity and to the attention of the public - to tell everyone that there is help for misused and abused voices, for voice disorders, and for people who want to improve their speaking voices.

I have used every means possible to publicize voice rehabilitation. I have written articles, chapters, and books. I have given many radio and television interviews. I have made speeches and conducted seminars. I have been fortunate that some celebrity patients I have helped have allowed me to use their names in an attempt to make voice rehabilitation vocally visible to the general public. Quietly doing

voice rehabilitation and being successful will help a few, but in order to get many patients with voice problems to seek help from professionals in this field, voice and speech pathology must be publicized.

After many years of attempting to educate, I felt that the Open Letter approach for relaying information was in order. The Brody letter brought added attention to spasmodic dysphonia, but it seems obvious the field of voice and speech pathology does not want attention. Nor does it care to listen to the recoveries or discuss them.

The spasmodic dysphonic patients, whose case histories report recoveries and cures, were diagnosed by notable and knowledgeable laryngologists and by leading medical centers, including Stanford University, Mayo Clinic, and UCLA, among others. There are those in academia and medicine who are of the view that recoveries and cures from SD involving DVR are anecdotal and without independent confirmation or independent verification. These are proven, documented cases of patients who had SD with follow-up reports to show the successful treatment producing a normal voice by DVR, a special therapy that was developed and perfected over many years of practice.

Speech and voice pathologists throughout the country and around the world can do what I am doing. I simplify. They can, too. The public benefits. Direct Voice Rehabilitation has benefited many people and continues to do so.

And so I write these words not only to speak directly to readers experiencing problems with their voices which they wish to remedy, but also to speak to physicians, voice clinicians, and allied professionals in the hope they will expand their openness to Direct Voice Rehabilitation. If I am able to reach some colleagues and professionals, I will be gratified. Having success with afflicted patients has been and will continue to be my greatest satisfaction.

It is my fondest hope and dream that voice pathologists or clinicians will work with strangled voice patients using Direct Voice Rehabilitation. Patients who come to see me from different areas of the United States, as well as from other countries, often need on-going follow-up assistance, when they return home, to maintain the gains, progress, and/or recoveries they have made in my office. These patients need a support system of voice clinicians, physicians, other patients, and support groups, such as the NSDA, in order to continue the recovery progress. By working together we can all look forward to an orientation that is geared to recoveries and cures for strangled voices.

Chapter 11

How to Get a Voice That Really Talks for You

God bless Bill Clinton. His hoarse voice has been a blessing in disguise for opening a real discussion about voices. That is something many in the medical field have been able to avoid until now.

To read all the conflicting advice offered by doctors, one would think these doctors may not know what they are doing. One says “do this”; the other says “do that.” They all have their own definite opinions as to what are workable procedures, some as ridiculous as chewing on a golf ball, avoiding dry rooms, and taking warm showers to relax the throat muscles.

I have long been at odds with the medical profession on these procedures and others, specifically those relating to spasmodic dysphonia, a condition considered hopeless by the doctors, as well as most speech pathologists. Their treatment of spasmodic dysphonia is to contain the symptoms, not to cure the problem.

According to current reports in medical and speech pathology literature, the suggested area of the disorder is the basal ganglia of the brain. In other words, the condition is thought to be neurological. Others believe the condition to be genetically related. I disagree markedly with the theory of genetic and neurological causations, finding the cause to be mechanical — voice misuse and abuse — with psychological overtones. I also disagree that spastic or spasmodic dysphonia is “hopeless.” Over the past 20 years, I have documented success — cures and recoveries — with Direct Voice Rehabilitation that totally destroy that theory.

A patient may have a neurological problem, such as cerebral palsy, and SD as well, but the SD is not necessarily caused by the cerebral palsy. One patient with cerebral palsy had no voice problem until he had a severe cold. Following the cold, the voice problem that had begun during the cold continued, eventuating into SD. His physician said his voice problem was due to his neurological problem, namely, cerebral palsy. The patient said his physician did not understand that the voice problem began during the cold, and that he had not had a voice problem before the cold.

Another patient was diagnosed by her physician as having SD due to a neurological problem, namely “a mini-stroke.” She did recover her normal voice through direct voice rehabilitation.

A CONCLUSIVE STUDY

As early as 1973, I conducted a study and analysis at the UCLA Medical Center involving 155 patients. These patients underwent voice rehabilitation for 14 types of medically diagnosed functional and organic dysphonias, including nodules, contact ulcers, polyps, bowed vocal cords, paralytic dysphonia, spastic (or spasmodic) dysphonia, falsetto voice, weak or tired voice (wrong voice), and incipient spastic dysphonia (a less severe form of spastic or spasmodic dysphonia, and frequently a forerunner of either spastic or spasmodic dysphonia). The ages of the adult patients, men and women, ranged from 15 to 73 years. Three boys were of ages 13, 12, and 11, with the conditions of contact ulcer, nodules, and wrong voice, respectively.

The purpose of the study was to evaluate the relationship between pitch and hoarseness in dysphonia. Although some writers, prior to the study, had discussed hoarseness as a major deviant quality found in patients with voice disorders, and a correlation between hoarseness and lower pitch level had been noted, few clinicians had attempted an objective evaluation before and after therapy.

The results of this study were conclusive. Of the 155 dysphonic patients, 150 had been using too low a pitch before therapy. The pitch was raised to the optimal or natural pitch level with balanced oral and nasal resonance (mask focus). Diaphragmatic or midsection breath support was developed. The patients were also afforded voice psychotherapy to help them adjust to a new sound and voice image, since nearly all had a wrong voice image. After therapy, the patients were basically free of hoarseness. A follow-up of 128 of these 155 patients indicated that three months to seven years after the completion of voice therapy, 98 percent of the 128 patients had remained good or excellent, which is a remarkable success ratio. The study also confirmed that the use of a pitch which is below the optimal or natural level is a major factor in contributing to or in continuing most types of dysphonias.

Of late, the treatment of severely troubled voices is being pursued by aggressive medicine, and aggressive intervention, with injections of botulinum toxin or surgery. These practices carry risk factors and, in general, simply abate some of the symptoms while ignoring the cause. Medicine acknowledges its symptomatic treatment of spasmodic or spastic dysphonia, and voices in general.

One of my ear-nose-throat colleagues referred a patient, saying that seventy to eighty percent of all benign growths do not need surgery; they can be eliminated through direct voice rehabilitation. Interestingly enough, when the patient is a famous singer, or a well-known star, surgery may be contraindicated since the quality of voice may be adversely affected.

GETTING BACK TO BASICS

Physicians need to go back to basics. They need to listen to voices and make their diagnoses by ear as well as by visual symptoms. They need to relate hoarse voices to possible misuse of voice, not just to a medical cause and medical treatment. The cure to a hoarse voice may lie in changing the wrong voice to the right voice.

I try to help people to learn how to use the voice easily and well so that they can talk without the use of hormones, steroids, drugs, surgery, and Botox to help the voice. (Hormones, steroids, medication, and surgery, when relevant, are appropriate care for medical conditions.) I try to help the patient with a troubled voice find that the voice is not a complicated instrument, but rather a simple mechanism that takes some learning and practice to use well and efficiently. This way the patient can take control of the voice without me or others and have a voice that is well used.

KEEPING IT SIMPLE

What I do is no mystery. It is simple, maybe too simple for some to accept. In a nutshell, I help you find your right, natural voice, and then help you to keep it.

My credo has always been to “keep it simple.” Life is already too complicated, and time is much too precious. Medicine needs to simplify, to make what is generally perceived as difficult easy to understand.

One of the easiest, least complicated procedures is to make a wrong voice right, a sick voice healthy again. The field may not agree, but to me, it is as simple as 1, 2, 3. The magic is within you — given a simple right direction and competent hands-on by Direct Voice Rehabilitation, as I see it. My goal is to help you develop your voice into a user-friendly, listener-friendly voice.

A NON-RISK APPROACH TO VOICES

My approach to all types of voice disorders, as well as to improving the speaking voice from a normal to a professional sound, is the same. It is a non-risk, non-invasive, non-medical approach, one that is in keeping with the tradition of the medical creed, Do No Harm, while helping people talk again with a normal, healthy voice.

Direct Voice Rehabilitation is not speech therapy or the usual voice therapy. It is a new approach I originated and developed and hope many others will adopt and practice for treating voice disorders and all types of voices; this approach emphasizes the variables of pitch, tone focus, and breath support which are the variables that affect and control quality of voice and volume.

Each voice has a natural or optimal pitch level at which an individual gets the most amount of sound for the least amount of effort. In addition to the optimal pitch level, there is the habitual pitch level. This is the pitch level the person uses from day to day. These two pitch levels, optimal and habitual, should be the same. But too often the habitual pitch is not at the optimal or natural pitch level. If your habitual pitch level is too far above or below the optimal pitch level, you are misusing your voice.

Closely related to the pitch level is the tone focus, or resonance, in the voice. The resonance of the voice comes from three areas: the upper throat or nose, the middle throat or mouth, and the lower throat (the area around the larynx or voice box). There should be a balance of resonance in these three areas. When the voice is correctly placed, the voice has a buzz or ring that centers around the mouth and nose, the mask area.

A very simple way to check your pitch level and tone focus is to say “um-hmm” naturally and spontaneously as though agreeing with someone. Then say “um-hmm . . . one,” “um-hmm . . . two.” Is the pitch of the “um-hmm” at the same pitch level as the numbers? If they are approximately the same level, chances are you are using the correct pitch.

A back-up method to check your habitual pitch and tone focus is to place one hand on the chest and the other hand on the stomach and breathe in with your stomach moving out. Then, keeping your lips closed, make a humming sound and press in on the stomach in a quick staccato fashion. (This is my Instant Voice Press, as noted earlier in Chapter 2.) The sound escapes through the nose, and you will feel a buzz around the mouth and nose, or the mask area. Talking with resonance in the mask gives the voice

a clear and efficient sound. You may talk easily and comfortably throughout the day without tiring your voice.

LISTENING IS ESSENTIAL

Despite the extreme severity in some problem voices, such as spastic and spasmodic dysphonia, it is still possible in most cases to hear and locate the correct optimal pitch level and range quickly. Listening to the speaking voice is essential to realizing that the tone focus in spastic or spasmodic dysphonia is always coming from the lower throat.

Spasmodic dysphonia and spastic dysphonia are not the beginning or early symptom of a wrong voice. More often than not, it is the end or the completion of a cycle of misuse that usually begins with a hoarse voice, a tired voice, fatigue of voice or effortful voice that may move through nodes, polyps or contact ulcers of the larynx. In fact, I have noticed that some of my patients with SD have had such growths before getting SD or at the same time they experienced SD.

Bowed vocal cords are also basically produced from the wrong pitch, incorrect focus of the voice, poor breath support, and/or an inept voice image, but can occur at times from intubation. Although this condition, in general, is considered to be neurological in cause, I find it to be essentially functional and mechanical in nature. That is, the individual is misusing the speaking voice, talking from the lower throat with an inappropriate pitch level and poor breath support.

I am reminded of a patient from San Francisco who had been diagnosed by a Bay Area research facility as having bowed vocal cords. He was to be scheduled for a surgical procedure on the superior laryngeal nerve, enervating the vocal cord and larynx to correct the problem, when he came to me. I listened to the young man, and it was obvious to me that he had functionally created bowed vocal cords from voice misuse. Within a couple of sessions he had his voice back. When he returned to San Francisco his ENT confirmed that his “bowed vocal cords were going away” by his change of voice from a deep-throat low pitch to optimal pitch and mask focus.

In seeking voice rehabilitation, the ear of the clinician is the key to directing the procedure. The clinician must know what to listen for to locate and secure the optimal pitch level and range as well as a balanced tone focus. A person who is trained in voice must know how to listen.

Direct Voice Rehabilitation is similar for all types of voice disorders and voice improvement. I find that almost all types of voice patients have in common the misuse or poor use of pitch, tone focus and/or breath support. They also have the wrong voice image of what is right in voice. The voice image must be addressed directly and openly, or else the patient will pursue the correct mechanical variables but will not pursue the correct voice.

PROGNOSIS: GOOD TO EXCELLENT

I believe and find that the prognosis for almost all problem voices, including spastic and spasmodic dysphonia, is good to excellent. But the patients must be cooperative. As I noted earlier, some patients are simply more gifted than others, some are more willing to change than others, and some are so resistant to change they will never recover.

But don't let me mislead you. Not everyone has a severe voice problem. Many people simply want to improve their voices by making them more pleasing and listenable. And that too is part of voice fitness.

For anyone with a voice problem, it is important to know this: YOU ARE NOT ALONE. Medical intervention may have failed you, but hopeless may not be hopeless at all. DO NOT GIVE UP.

If you do want to improve your voice, start by finding your natural voice. You may do this in only seconds, but it takes practice to keep it. Practice is not something you have to do. It is something you want to do because you want to better your voice and your life. By practicing you have the chance to learn how to identify, locate and establish your right voice, the one you want to represent you at your very best.

WHAT YOUR VOICE SAYS ABOUT YOU

It is no secret that when you speak with a tired voice you generally come across as a weak or vulnerable person. Conversely, a strong, healthy voice gives you a more confident, forceful and dynamic persona.

The majority of adults have poor or tired voices, but we weren't born that way. Nearly all of us were born with the ability to have "star quality" voices. As we grew older, however, we began to misuse and abuse this God-given gift. We began to lose our voices — and we didn't know it. As long as our voices worked, and we could communicate, we believed everything was fine. It wasn't until you heard yourself on a recorder that you knew something was wrong. Or perhaps your voice began to falter or fail, sounding hoarse and scratchy. Then you really knew something was wrong.

Part of the problem is that we rarely hear ourselves as we are. We think we sound better than we do, until we actually hear ourselves. We also have different voices for different occasions and different people. All too often we let our emotions and feelings speak for us. Haven't you found that it is easy to "read" a person just by the sound of his or her voice? You can almost always tell whether that person is happy, sad, apprehensive, angry, tired, not feeling well, or whatever. Then, again, you may think a person's voice — even your own — is implying one thing and the reverse is true. How many times has a friend asked, "Do you feel all right? You sound tired." Your reply may very well have been: "I'm fine. I feel great."

Isn't it time you let your voice really speak for you? Get your voice back on track by talking in the mask, around your lips and nose. That's the area that makes your voice so likable and listenable, and allows you to talk without fatigue. All good and great voices talk on the buzz.

Voice fitness care is simple to do, if you have the right direction. Learning a new voice requires that you hear, feel and sense it in the mask. If you now talk too low in pitch or let your voice stay in the lower one-third of your throat (the lower throat around your voice box), try my basic exercises for starters.

A CLOSING REVIEW

Let's review them one more time.

Say "um-hmm" naturally and spontaneously and feel the buzz, the tingle of your voice around your mouth and nose. Then try adding "um-hmm . . . one," the "one" being at the same pitch and focus as the "hmm" sound. Then, throughout the day, when you're alone, instead of thinking thoughts, "hmm" them to yourself. That is called private practice. Next, match the words to the "hmm."

In order to practice while communicating with others, simply affirm hearing them by saying "um-hmm" gently and easily in agreement, which we all like to hear. The "humming" allows you to focus on your voice throughout the day. This is public practice.

Again, let me remind you: Another way to find your right voice is to use my Instant Voice Press. (Remember — do not attempt this exercise if you are pregnant or have stomach problems.) Take a finger and gently jiggle it at the solar plexus — the bottom of the breast bone — keeping your mouth closed and letting the voice come forth on a "hmm" as you gently but persistently press on the area. You should find a resonance around your lips and nose, and that is where you should focus your voice to talk.

Don't forget correct breathing. Are you now breathing from the stomach or from the chest? Put one hand on your chest and the other hand on your stomach. Breathe in through your mouth and see what happens. Does your chest move? Rise? If so, you are breathing incorrectly for speech. You are lifting a weight. Your chest is composed of cartilage, bone, and muscles, and if you lift the rib cage (which you are doing when you feel it rise), you are basically lifting a weight eight to 12 times per minute. It is a weight you don't need or want, a weight that fatigues your body from the continued effort to lift the weight throughout the day. When you breathe from the midsection or stomach, you have flexibility and real control of your voice and volume.

These exercises are quite simple, yet they may help you find your natural voice, and relocate it whenever you are in doubt. Practice for seconds at a time throughout the day until your new, healthier voice becomes second nature to you. If you have problems understanding or using these exercises, or if you have a serious problem with your voice, such as vocal fold growths, a paralyzed vocal fold, bowed vocal folds, or spasmodic dysphonia, seek professional help from a competent voice clinician. Additionally, if you have a voice that continues to be fatigued or lacks strength or if you have continued raspiness or hoarseness, go for a medical check-up. Discuss your voice problem with your physician and request information so that you have options and alternatives for appropriate care.