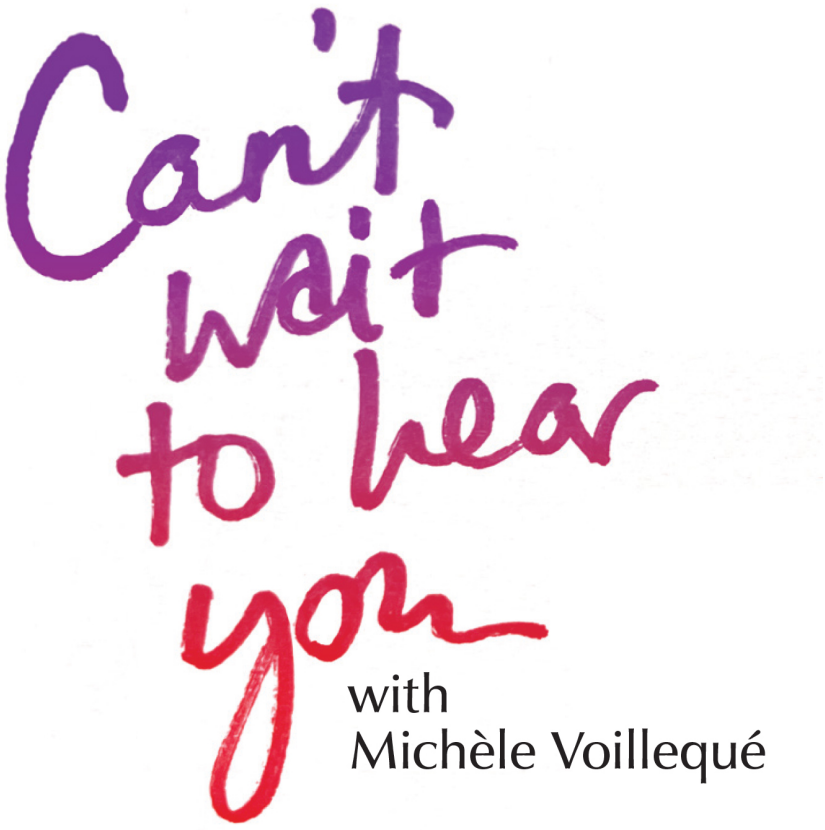
Ep #51: More on the Possibility of Change



Full Episode Transcript

Ep #51: More on the Possibility of Change

Your voice is unique to you. It grows as you grow. It changes as you change. If you're curious about the relationship between your voice and your body, your heart and your mind, welcome. My name is Michèle Voillequé and I can't wait to hear you.

Michèle: Today's episode is a follow up to the last podcast episode called, “Is Change Possible?” I realized after I recorded that episode that I wanted to share the conversation that my friend Matthew and I have been having about my paradoxical vocal fold motion.

He lives in Atlanta, he works for the Shepherd Center, he’s a speech language pathologist, and his expertise has been invaluable to me as I've navigated this interesting vocal problem. And so I wanted to share that with you.

And also I wanna say that if you've got anything really weird going on with your voice, you should not rely on podcasts to diagnose yourself.

You need to call a doctor, a primary care provider and try to get a referral to an ear, nose, and throat doctor, and, really get yourself examined. If you think there's something wrong, keep mentioning it until somebody takes you seriously.

Nothing that we are saying in this episode is intended to be medical advice for you. It's all about me and what I've been going through with my voice. So without further ado, here's our conversation.

So, hi, Matthew!

Matthew: Hi.

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Michèle: I wanna talk with you in public about functional disorders. Because I recorded this podcast about my paradoxical vocal fold motion, and I describe how it's a scary thing and I just, I think you could be helpful as like, a professional speech language pathologist, like, helping us understand what's going on. And just to talk about functional disorders and stuff like that.

Matthew: Sure, I'd be happy to.

Michèle: You and I talked a lot about, when I was trying to figure out this paradoxical vocal fold motion, like, why it was happening. We landed on a theory that I think we like.

And I don't think we're gonna know-know ever why this was happening to me, so correct me if I'm wrong, but I think what we decided was that maybe because I had a lot of asthma as a kid, like I've had a lot of stuff going on in my throat, I've got a neurological pathway that's about things going wrong in my throat.

And then in 2023 when I had an allergic reaction to a salad dressing and that caused my lips and my tongue to swell up, my vocal folds also closed. At the time we thought, I thought, it was anaphylaxis, but it'd since been explained to me that that was probably my first incidence of paradoxical vocal fold motion in response to the stress and the trauma of this allergic reaction that I was having in my mouth.

And then that just got kind of normalized by my brain, like, I feel stressed out, something's wrong, and so we're just gonna close the vocal folds. And that became like, every problem became a nail and that was the hammer of choice by my brain.

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And gradually through awareness and massage and like, relaxation exercises specifically for the muscles around my vocal folds, I don't know, and just maybe like tons and tons of noticing it's happening less and less frequently. And so maybe we're done. Maybe it's completely resolved.

One of the things my own, otolaryngologist said was that we could try a nerve block. There are two nerves, one on either side, like we could choose pick one, paralyze it, and that paralysis would wear off after a little bit as kind of like turning it off and on and on again, and seeing if that fixes it.

Matthew: unplugging the machine

Michèle: Yeah, totally unplugging the machine. I have, and I have this quote on my board, Anne Lamont, “Almost everything will work again if you unplug it for a few minutes, including you.”

Matthew: Hmm.

Michèle: So operating on that theory, but, doctor's thought was, this isn't

happening frequently enough for us to be able to tell if the nerve block had done anything. It's not a good science experiment. And I'm happy to not be paralyzed in any way if I don't need to be and so we're not, we're not doing that. So we're just waiting to see if it happens again.

So anyway, that meets the definition of a functional disorder, I think.

Matthew: Yeah, absolutely. Well, I think that's a really good explanation of why you think it happened in your case, and it makes total sense.

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I don't think anybody knows exactly why functional neurological disorders happen. There are lots of theories and science about contributing factors and sustaining factors, but we don't always know why they happen.

We know they're pretty common, and they can take lots of different forms, but what a functional neurological disorder is, is symptoms that are non-volitional, that resemble neurological conditions, but if we were to do an MRI or CT scan, we would not see any structural reason for those symptoms.

Nor is there a structural reason, like, in the voice box, in the case of a functional voice disorder or, or PVFM. So they happen kind of for unexplained reasons. It's a lot of guesswork as to why, but having something like asthma would make a lot of sense as kind of causing this learned misfiring.

Again, not volitional on your part, but it's your brain sort of mis-learning how to protect your airway. It was doing a good job of protecting yourself during asthma, but not such a good job when like, other things were triggering it that shouldn't cause asthma.

Michèle: Or shouldn't even be a problem.

Matthew: Right, right. Like, you know, water's too cold, there's too much ice, and then PVFM, right? Like that's….

Michèle: that's not a thing, I mean.

Matthew: But that's totally a thing with PVFM, is triggers like that can, can happen. So there's lots of metaphors for why functional disorders

happen that I think are useful when you're trying to kind of understand it for yourself.

A really common one is it's more like a software glitch versus a hardware problem. So this idea that if you opened a computer and looked at the hardware, it's all intact, but then there's something still malfunctioning.

So, right, just like if you looked at an MRI, there's no explanation for a structural issue causing the symptoms, but they're still symptoms, right? So that's a common metaphor.

Another one I use sometimes is it's like the chain slipped off of a gear on the bike, right? The bike can still function. It can work. It's not permanently broken. We just have to do treatment to get the chain back on the gear. So, therapeutic activities.

Michèle: So I mean, the elephant in the room is that this is all in my head, right? Separating out the part of me that's responsible for it, from the part of me that isn't responsible for it.

Can you speak to that a little bit? Because I don't think we've talked about functional disorders in quite such a loving, accepting, and supportive way in the history of medicine. Is that fair?

Matthew: That is very fair. Functional disorders have been around as long as, you know, medicine has been around. They've gone under lots of different names and some of those names have been less kind.

Older names include things like “hysteria,” which is not an appropriate way to describe it, but it has been described that way in the past.

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How I like to think of it is there is a temporary loss of control of movement. but control can be regained with techniques, with strategies, with therapy, things like that.

I think if you think of it that way, a temporary loss of control of movement, that's really relatable because everyone has experienced some version of that, right?

Like if I get nervous about speaking on your podcast, which I am, you know, my voice might tremble, my palms might sweat, my stomach might get queasy, right?

It's not that my voice is broken, or my palms are broken, or my stomach is broken. But it's responding to that situation, right? And that's an emotional trigger, but it doesn't always have to be an emotional trigger.

So another example would be if I eat something that makes me sick and I throw up. The next time I see that food or smell that food, or maybe even think about that food I might gag, right? My body's gonna try to protect myself from like, "ooh, that thing made you sick." So I'm just gonna gag preemptively, right?

My body doesn't need to gag, but it's going to gag. It's not me wanting to, it's not in my head. It's not a volition on my part, but it's a protective reflex that my body's created in response to an adverse situation in the past of getting sick on a certain food.

So I think that that's more akin to what you're describing with, adverse situations in the past with asthma and your body learns to respond in this way, but then that way is not actually helpful, right?

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It's just kind of a mis-learning or misapplication, and so therapy is about kind of rewiring that, relearning those movements.

Michèle: Yeah, it's not exactly the same, but certainly like the fear of public speaking, right? You have to give a speech in seventh grade and it doesn't go very well, and so then every other time you have to get up in front of other people, it doesn't go very well. Sort of like compounding?

Matthew: Mm-hmm.

Michèle: I guess you would say that's more emotional learning than motor learning. But are they really very different?

Matthew: No, I don't think they're all that different. I guess I'm just trying to illustrate that that's not always an emotional situation that can cause functional disorders.

Michèle: Yeah. She's not always hysterical.

Matthew: Correct. And I think that's really important because the primary treatment for functional disorders is not psychological, right?

For some people there are psychological risk factors that can predispose them to have more functional disorders than other folks. And psychotherapy can be an adjunct to the treatment of functional disorders, but it is not usually the main treatment.

Typically the main treatments are, if it's a physical issue, it's PT. If it's like a speech or voice issue, it's speech language pathology. It's treating the movement and the actual functioning rather than the psychology of it.

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And that matches my own clinical experience where I've had many clients who have functional disorders that don't need psychotherapy to treat them. They need speech therapy, right?

Michèle: Can you give an example?

Matthew: Yeah. So an example might be a functional stutter after a concussion, right? So functional stutters can appear different than other types of stutters, and they're uncommon after concussion, but they can happen.

And the treatment for that is not psychotherapy. The treatment for that is speech therapy, learning how to regain control over the speech movements, and speech therapy is very effective for functional stutter.

Another example would be a functional voice disorder. So, someone like, losing their voice after some inciting incident. So I work in a concussion clinic, so I keep going back to concussion.

Michèle: Yeah.

Matthew: But again, that's not you know, a typical thing that happens after concussion, but it can happen.

I'm thinking of a client who went to see an ENT after her injury 'cause she lost her voice. And they scoped her and the vocal folds were looking good. There was no kind of structural abnormality that would explain the voice loss.

And they told her, “Well, you just need to relax.” “You should go get a massage.” I can tell you that didn't work for her. The massage didn't

really work. And also like, telling people to just “relax” usually doesn't work in my experience.

Michèle: I think that's the worst of all possible instructions to give a human.

Matthew: “Just relax.”

Michèle: “If I could…”

Matthew: I'll tell you, what did work was voice therapy. Targeting, reducing tension in her voice box.

Michèle: Yeah, so putting that in even more lay people terms. So, did that look like massage? Did that look like breathy onset or like…

Matthew: Yeah, so there was, um, some circumlaryngeal massage, so kind of massage around the voice box, but also actual voice production exercises that worked on having a gentler voicing, kinda reducing tension.

Michèle: Rather than trying to grab with the voice right away…

Matthew: Right.

Michèle: Softer, more fluid. Sing-y. Was it more sing-y?

Matthew: Yeah. So oftentimes the cues are actually kind of redirecting, people to think about like, having more tone in their voice, like more

intonation, right? In order to kind of get more air flow, a little bit more free flowing.

Michèle: Yeah.

Matthew: Also doing exercises like I know you do with your students, like semi occluded vocal tract, making voice into a straw or like doing a lip drill as a way to create some back pressure as you make voice to help relax the muscles of the throat. So using that as a warmup before speaking tasks.

Michèle: Yeah, and those are both things that, they can take a lot of mental energy to learn how to do, but they only work in a condition of release. Like, I can't lip trill if my lips are tense, right? I can't lip trill if I don't have sufficient airflow.

Matthew: Mm-hmm.

Michèle: So it's, it's sort of tricks you into, well, I don't know what tricks you – performing the exercise generates the conditions of health of, of easier voicing.

Matthew: Yeah. Another one is like, if jaw tension is contributing to the voice being tense, then maybe doing – I know you do these with your students, too – but like doing yawn-sighs to help get a more spacious jaw maybe after some jaw massage. And just kind of feeling how spacious the vocal tract can be with a yawn-sigh.

Michèle: Yeah.

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Matthew: So there's a lot of overlap between the speech therapy for voice therapy anyway, and some of the things I know you do with your students.

Michèle: Yeah, well, it, I mean, it's all the same equipment. It's not always one-to-one the same human, but we're still all humans trying to use it. So it, when it fails, it kind of fails in really typical ways.

Matthew: Mm-hmm.

Michèle: My PVFM I think is a little off the charts – not trying to make me into more of a snowflake than I am – but like, really? Other things like not being able to project your voice in the way that you might, and that being because you have too much tension going on.

Matthew: Mm-hmm.

Michèle: …in your throat and in your neck, that's actually dampening the sound that you are making, right? So yeah, you don't need a concussion to benefit from a semi-occluded vocal tract exercise.

Matthew: It's a little long for a bumper sticker, but…

Michèle: Oh yeah! Maybe we'll come up with a shorter bumper sticker.

Matthew: We'll make it pithier.

Michèle: Okay, so what do you think as a professional, do you think my PVFM is resolving?

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Matthew: Well, I'll just say right now that I'm not treating you. So this is based on just some conversations, but

Michèle: Asking for friend…

Matthew: Correct. What you're describing sounds like it's happening a lot less. You've regained a lot more control through building awareness through exercises you've done. You have some kind of rescue techniques to get you out of a PVFM episode if you're having one.

Michèle: Thanks to you actually. You taught me rescue breathing before the grownups in Northern California did, and that, for that, I'm very grateful.

Matthew: All functional disorders are prone to recurring. That is kind of part of their nature, is that they can get better very quickly, so that's the good news is that with the right treatment, with the right approach, they can resolve very fast. But they can come back very fast, too, and given the right conditions.

So when I have clients who have functional symptoms, I always try to prepare them that their symptoms may come back one day and that the same tools they used the last time to get back on track they can use again. Because they're all very prone to recurring.

Michèle: Well, I feel like about rescue breathing, that I have that for life now. I am never gonna forget how to do that. It's nice to know that I have that tool in my pocket.

And yeah, I guess the rest maybe boils down to maintaining awareness. I mean, I'm noticing my voice all the time 'cause I'm using it all the time.

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It feels like it could very easily be on the verge of neurosis how much I think about it.

But I am, I do feel like I have a different understanding of how the balance of tensions work in my throat with my tongue. And, it doesn't feel very specific, but I do feel like I have things that I can watch for, things that I can look for.

Matthew: Have you felt for yourself any like, early warning sign that something will come off, or does it always come out of, the blue?

Michèle: I have felt an early warning. My last major episode was in February, late February. Before that, the major episode was just before Christmas. So sometime between Christmas and February, I was at a choir rehearsal and somebody was wearing really strongly perfumed hair product or perfume or something.

I was fine when I first arrived at the rehearsal, but then I guess I moved toward this person or I don't know, or the air circulation in the room changed and I felt like I got hit with this wave of perfume that like, immediately closed my throat…

Matthew: Mm-hmm.

Michèle: …in a very familiar asthma kind of way. And I felt like, oh, this could be a PVFM moment, you know? But I moved very quickly out of the room, coughed a little, took a drink of water, did a little rescue breathing, even though I didn't need it yet. You know, like, "Okay, no, honey, we're fine. That's just perfume." I guess that's a little preemptive.

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But before the other times there's a little twinge that maybe something is off. I don't know what I could compare it to. Sometimes, like, I walk a lot and I, you know, carrying my groceries and going, you know, up and down hills.

I live in a hilly neighborhood and there's a kind of, there's a particular kind of knee pain, you know, that's like, “You need to stop and stretch your hamstring, darling, before you go further.” Like, “just do that now.”

I'm 54, so I'm kind of creaky. Like I, there's a certain creakiness that I expect in my life, but then there's like a, there's a particular kind of thing, like, it's like, “No, okay, that we need to take seriously.” “Just stop, stretch your hamstring.” Sure enough, that does the trick and I'm good to go.

So it's not quite that obvious, I don't think. But there are glimmers.

It certainly doesn't feel emotional. There wasn't anything reactive, you know, like I wasn't having when this happened, aside from when I was, having the allergic reaction, all of the other moments of PVFM have been in an atmosphere of emotional calm.

Matthew: Yeah, and the triggers you've described like a drink that's too hot or too cold, right? A perfume, right? These aren't emotional triggers and the treatment for it hasn’t been emotional regulation.

Michèle: Yeah.

Matthew: The treatment for it has been entirely physical, right?

Michèle: Yeah. Well, thank you for talking on the podcast about this.

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Matthew: Oh, it's been a pleasure.

Michèle: We haven't said anything now that we hadn't said in private, but I'm glad that we're recording it, so to kind of help other people understand, if it happens to them or to understand more about what happened to me.

But I think also just like the fact that things go sideways with the voice all the time, and that there's generally a physical cause for that, that we can do something about.

And sometimes we need an SLP and sometimes we need a voice teacher, but it's solvable, would you say?

Matthew: Mm-hmm. Yeah. I mean, barring like, you know, certain illnesses, right? That might really change how your voice box moves or it's even structural form, but

Michèle: Yeah. Setting biology to the side…

Matthew: Right, right. But most voice complaints people can have are, are fixable.

Michèle: Yeah, I am so much happier to be in this business than oncology.

Matthew: Same. Totally.

Michèle: Well, thank you.

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Matthew: Oh yeah. It's been my pleasure.

Michèle: We'll do it again.

Matthew: Absolutely.

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