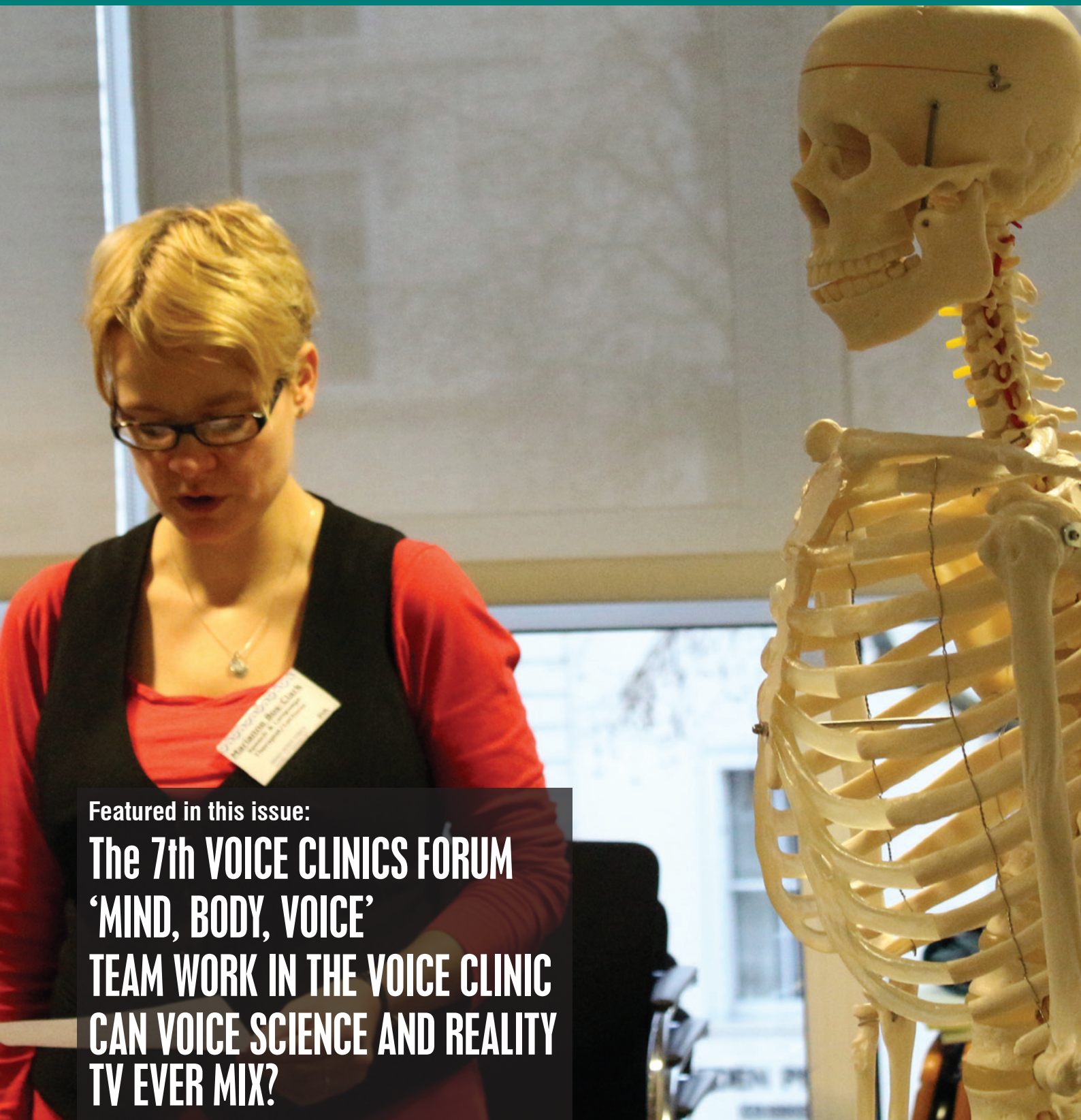


THE BRITISH VOICE ASSOCIATION

# COMMUNICATING VOICE

VOLUME 13: ISSUE 3 - SPRING

 BVA



Featured in this issue:

**The 7th VOICE CLINICS FORUM**

**'MIND, BODY, VOICE'**

**TEAM WORK IN THE VOICE CLINIC**

**CAN VOICE SCIENCE AND REALITY  
TV EVER MIX?**

[www.britishvoiceassociation.org.uk](http://www.britishvoiceassociation.org.uk)

# THE PRESIDENT'S ADDRESS

Welcome to my second address as President...

**I'm pleased to report that the BVA, thanks to the hard work and dedication of the Education Working Party, has a full and exciting calendar of events planned for this year. Our courses, that are the lifeblood of the BVA, are also diversifying and decentralising as a direct result of taking on board membership feedback.**

For the first time, thanks to Jenny Nemko, the BVA is running an event based purely on the speaking voice ("Voice and Podcasting"), and we've got popular courses running again in centres outside of London, for example (in chronological order): the "Accent Method 2013" in Glasgow, "Voice and the Brain" in York, "Weak, Wobbly or Working – caring for the aging voice" in Brighton and the annual Voice Clinics Forum in Birmingham. I'm also pleased to announce two events I'm directly involved with planning: "Lend me your ears – AGM & Study Day" on June 30 and the popular biennial "Rock & Pop Day" at the end of September. Please check in regularly with the "Events" page on the BVA website for the latest information and updates.

It won't be long now until World Voice Day is upon us – the international event for celebrating voices that takes place on April 16 each year. Thanks to the extra help we've had this year from Sara Caldwell, the BVA are making three contributions: a leaflet on acid reflux, a "taste of silence" and making an "audio album".

The acid reflux leaflet is the latest in the range of voice information leaflets that the BVA has produced over the years for World Voice Day. They are available in hardcopy if ordered from the BVA office and in pdf format from the "Downloadable Resources" page on the website. Previous titles include: "The Truth about Vocal Nodules", "Dealing with Dysphonia" and "Paralysed Vocal Folds and Voice". This year's leaflet, available from March, outlines what acid reflux is (more specifically 'LPR' or laryngopharyngeal reflux), its effect on the voice and how it is prevented and treated. These leaflets are designed to be a useful resource for voice clinics and speech therapy clinics in particular.

Our second contribution is a "taste of silence" to encourage people with normal, healthy voices to go for (at least) an hour on World Voice Day without using their voice. The idea is to choose an allotted time in the day when you would normally expect to use your voice and see how well you manage without it. This should provide insight into how much we rely on our voices in every day life. One only has to have a serious bout

**"Our courses, the lifeblood of the BVA, are diversifying and decentralising as a direct result of taking on board membership feedback."**

*Kim Chandler*



*Kim Chandler*

of voice loss from laryngitis to experience how frustrating and debilitating the inability to communicate verbally is. We'd like to hear about your experiences, so please visit the "World Voice Day" page on the website on how to report back to us.

The third contribution I personally feel may be one of the most important and far-reaching suggestions of the year: making an "audio album". This concept was inspired by an article found by our Company Secretary, Kristine Carroll-Porczynski. Called "So Many Snapshots, So Few Voices Saved", it was written by Verlyn Klinkenborg and published in the New York Times on December 29 last year (it can be found online).

We capture special moments in visual formats such as photos and videos. Modern technology, with so many mobile phones having these facilities, makes this process so easy. But what about also capturing audio recordings of the voices of the ones we love? Modern technology, in the form of the mobile phone 'voice memo' facility and dictaphones, makes recording audio clips just as easy. Capturing voices of your children as they are growing up or capturing wonderful stories from aging relatives might be a good place to start. It is a courtesy to let them know they are being recorded however. A leaflet with more details about this project, "Valuing Voices", will soon be available in hardcopy and in pdf format on the website.

Further to my first address in the previous newsletter, I'd like to take this opportunity to reiterate my presidential goals - recruitment of new members and fundraising. To this end, I'd encourage each and every BVA member to approach at least one colleague this year to become a BVA member. For those who work in institutions that would be appropriate candidates for corporate membership, I encourage you to pursue this with vigour. The membership benefits are clearly outlined on the

*Continues at the foot of page 3*



## Supporting Voice Clinic Services

# THE 7th VOICE CLINICS FORUM

8th November 2012  
Wythenshawe Hospital Manchester

Report by Sara Harris

**The day was attended by a relatively small but enthusiastic group of delegates made up largely of ENT surgeons and Speech Therapists. Included was an exhibition of voice clinic equipment with representatives from Pentax, ATMOS, RB Medical, DP Medical and Karl Storz.**

The day began with an excellent talk from Sue Jones, Head of Speech and Language Therapy and Lead Clinician for the Voice Clinic Services at the Wythenshawe Hospital. Her title was 'Multidisciplinary Voice Clinic Services in the Current NHS – the Provider's Perspective'. Sue summarised the aims for Voice Clinic providers as being to provide a high quality service for patients that is efficient and cost effective, and that can demonstrate good treatment outcomes. She added that Voice Clinics are indeed the gold standard for the management of voice disorders in the NHS, but that we need to gather more robust data to demonstrate our arguments and prove our worth.

The next speaker was Dr Peter Christian, a GP Commissioner in London, who has a particular interest in voice clinic services as he is married to an opera singer. He talked us through the changes in store for our services once we move fully to GP Commissioning in April 2013. Dr Christian explained that from April 2013 the Health and Social Care Bill (2012) will be implemented, giving GP Commissioners some £350 million to choose 'Secondary Service Providers'. Hospital Trusts will not only have to compete with one another for 'business' but will also have to contend with the rising number of private companies offering various aspects of health care.

The next presenter was Mr Steven Wyeth, who provided us with the patient's perspective on voice clinics services in an interview with Speech and Language Therapist, Sara Harris. Mr



*Broadcaster and patient – Steve Wyeth*

Wyeth told the audience that he had first come into contact with ENT services when his voice became hoarse approximately 4 years ago. At the time he was working as a sports reporter for

**“A key aspect of the day was the opportunity to discuss the material presented and it was clear that the delegates had found the presentations stimulating and thought provoking.”**

*Sara Harris*

*The President's address continued from page 2*

BVA website along with the online procedure for signing up on the “Membership and how to join” page.

Lastly, I'd like to remind the membership to sign up to **www.giveasyoulive.com** for those who regularly do online shopping. To recap, once one signs up to this website and assign a particular charity (i.e. 'The British Voice Association') to be the recipient, the vast majority of online shopping can be conducted via their service where a small percentage of each sale is donated to the designated charity by the online vendor (raising over £3,000,000 for charities to date). The important issues to take on board are that: a) the price remains exactly the same for the buyer and b) it has a very convenient, user-friendly interface.

An organisation the size of the BVA incurs a lot of running costs and, despite the modest rate increase this year (the first rise in seven years), unfortunately the membership fees don't cover these. This results in the BVA running at a significant financial loss each year. I sincerely believe that an altruistic service such **www.giveasyoulive.com** provides somewhat of a solution, but at this stage, only 1.5% of the BVA membership has signed up to this very easy, no-risk revenue stream. With the many members (and friends & family) who I hope will sign up, the resulting extra funds have the potential to make a significant difference to offsetting this financial deficit. On behalf of the BVA, I thank you for your help.

**SEE BACK PAGE FOR MORE DETAILS OF 'GIVE AS YOU LIVE'.**



*Administrator – Stuart Bethell*

the BBC, commentating mainly on cricket and football, often in less than ideal surroundings. Initially, his GP referred him to an ENT surgeon and he was assumed to have an infection and prescribed a course of antibiotics. When they did not resolve the problem he was referred to the Manchester Voice Clinic Services where he was seen jointly by ENT Surgeon, Phil Jones, and Speech and Language Therapist, Sue Jones. He was diagnosed as having muscle tension dysphonia and provided with a programme of voice therapy. His voice problem improved rapidly and he was discharged five months later. When his voice deteriorated again in 2010, he had no hesitation in asking to be referred back to the Voice Clinic. Although his larynx again appeared to be within normal limits, the left vocal fold was described as 'slightly sluggish'. Mr Wyeth had further voice therapy and was also seen by Voice Coach, Dane Chalfin, to help him with projection for his performance voice. Once again, his voice improved but this time he requested to stay under regular review. When his voice deteriorated suddenly in April 2011, he was able to request a review appointment directly and at this examination he was found to have developed a large intracordal cyst, which was successfully removed in September 2011. Mr Wyeth said that since the surgery his voice feels better than it has been done in years. So much so that he felt confident enough to leave the BBC and begin the freelance career he had always wanted.

The administrator's perspective was represented by Mr Stuart Bethell, Directorate Manager for Head and Neck Services, Central Manchester University Hospitals, who gave us a practical and helpful break down of how to build a business case.

This was followed by a brief report by Sara Harris on the World Voice Day Questionnaire (covered in detail later in the Newsletter).

The afternoon session was dedicated to the role of the voice clinic in training. The three speakers took quite different approaches and although it could be argued that it might have been helpful if they had been given greater guidance and addressed the same points, the different approaches provided a broader view of the area in general.

Mr Jon Bernstein, an ENT Registrar in Manchester, presented the current voice training available for ENT surgeons and highlighted how much more detailed the voice training has become over a relatively short period of time. Training remains very variable however, with wide differences between what is available in different regions across the country.

Amanda Carr, Speech and Language Therapist from Bristol, spoke about the training required to become a voice specialised Speech and Language Therapist, with particular reference to the role of the voice clinic in their training. She outlined the knowledge and skill base that therapists needed in terms of anatomy and physiology, instrumental and perceptual voice assessment measures as well as the need to understand vocal pathologies and the range of appropriate treatments. While some of this can be learned through reading, the benefits of observation in a voice clinic cannot be overestimated.

Kim Chandler, a singer and singing teacher specialising in contemporary music, then talked about how exposure to voice clinic observation and the British Voice Association had furthered her understanding and benefited her teaching. In particular, she talked about the demands placed on singers in general, and pop and rock singers in particular. She stressed how important it is for the voice clinic personnel to be aware of these demands when dealing with singers in distress. She strongly supported the presence of a voice coach as part of the voice clinic



*SLT – Amanda Carr*





Surgeon – Yakubu Karagama

team to act as interpreter between the singer and the clinical staff as well as being able to provide a bridge between voice therapy and extending techniques into singing exercises and performance.

Mr Yakubu Karagama updated us on the progress of the new British Laryngological Association, which has its inaugural meeting on 5th December 2012. Mr Karagama took us through the history of laryngology and I was surprised at how big a role it had during the early development of ENT in comparison to the present day. Mr Karagama talked about the aims of the BLA, which are ultimately to advance the field of laryngology through research, education and training for the benefit of the public. The aims will be achieved through regular meetings on current clinical practice, dissemination of new relevant research, and the promotion of specific training in laryngology for junior ENT trainees. A further BLA role will be to advise other relevant medical associations, such as ENT-UK, and Government committees on matters pertaining to laryngology. He also reported on a brief survey of the training available in laryngology in Europe and the UK, which showed that there are still serious shortcomings. Hopefully the BLA will help rectify this situation over the coming years.

A key aspect of the day was the opportunity to discuss the material presented and it was clear that the delegates had found the presentations stimulating and thought provoking. The information they received was both relevant and practical. It is hoped that the clinicians present will feel more confident about presenting the case for Voice Clinic Services effectively as a result of Voice Clinics Forum.

# VOICE AND PODCASTING

**Whether to promote research, highlight expertise in your field or advertise to attract new funding, podcasting is a great way to reach your audience.** This workshop focuses on the effective vocal delivery of a podcast. The opening presentation gives a step-by-step demonstration on how to record, edit, host and up-load a podcast using the free software Audacity. Having explored the technical side, we move on to the practical application for the speaking voice. The session will focus on how to deliver the spoken message in a natural, conversational manner. In the afternoon, speaking exercises in pairs culminate with the recording of several podcasts followed by playback and critique. The day ends with a round table discussion.

**Voice and Podcasting is suitable for Speech Therapists, Voice/Singing Teachers, Academics and Medics who deliver pod-cast and for those who help pod-casters to deliver their material.** It is also suitable for those who wish to use podcasting as a way for clients to hear their own voices. This event provides a unique opportunity for Voice Teachers to explore podcasting as a new area to work with the voice.

**NO TECHNICAL KNOWLEDGE IS REQUIRED.**

## PROGRAMME TO COVER

- **What is pod-casting and how it can help you in your work**
- **Examples of effective/ineffective podcasts**
- **How to use the software Audacity to produce a podcast**
- **Microphone best practice**
- **Pitching content appropriately to your intended audience**
- **Finding the story to tell in your research/work of your department**
- **Writing the spoken word**
- **Managing tension, posture and breathing**
- **Vocal delivery – clarity, tone, pace, pause and intonation**
- **Recording your podcast**

*You will need to down-load/install AUDACITY recording software on to your lap-top and make sure it is fully charged and has a microphone. Please also prepare a 500-600 word synopsis of your research/ work/interest/area of expertise.*

**Sunday 12 May 2013**

Phoenix Artist Club, Phoenix Street,  
London WC2H 8BU

More details available on our website



# MIND, BODY, VOICE

**A workshop-based event exploring alternative approaches that can contribute to work with the voice**

Sunday 13th January 2013  
Baden Powell House, London

Report by Lucy Legg

Photos by John Baines

**The Mind, Body, Voice day provided participants with an opportunity to find out about three different approaches to working with the mind and the body that have the potential to be useful to voice users. The Alexander Technique presented by Glynn MacDonald; The Feldenkrais Method presented by Rosemarie Morgan-Watson and Mindfulness presented by Chris Cullen.**

Many of the ways that scientists, doctors, psychologists and other practitioners in the western world have looked at human beings in the recent past have involved separating the mind from the body and treating each component in isolation.

There is now a growing multi-disciplinary interest in the way that these two parts of ourselves actually influence each other and work together. The collection of empirical data in this field of research has always been a problem. However, there is new hope with the development of techniques, such as Functional Magnetic Resonance Imaging, that allows us to see which areas of the brain are active. Unfortunately for our research these techniques are still not always affordable, but the body of evidence is growing.

Every second, the human brain receives an enormous amount of information from the sensory nerves of the body, along with information from every other nerve. If we were to be consciously aware of this quantity of information it would almost certainly drive us mad. Therefore, there are filters in place that decide when information is important enough for us to become consciously aware. Pain is a good example; as soon as the signals from a particular part of the body are strong enough, we know about it immediately; there might be danger, we must pay attention. We can learn to pay attention to low level signals too by consciously resetting the thresholds of the information sent along these same nerves.

As well as gathering sensory information, our brains are designed to monitor the positions of our bodies in space. This is called proprioception. It is what helps us to move around the world without bumping into things: to accurately throw and catch etc. We know from the experiences of people with dyspraxia, and other related conditions, that this is an ability that is on a continuum in human beings. Some people have a highly developed proprioceptive sense and others find this much more elusive. However, with attention and practise we can gradually alter our thresholds of awareness in this area too. The above mechanisms therefore provide the basic tools used by the practitioners of these three approaches as they aim to encourage us to 'be' rather than 'do'.

I have been lucky enough to spend many hours observing both Feldenkrais and Alexander Technique practitioners as they work



*Chris Cullen*

with singing students and have also studied both approaches myself, but this was my first experience of Mindfulness.

Alexander developed his technique because he was experiencing vocal problems and realised that it was what he was doing with his body that was causing them. He carried out a lot of careful observation and then developed a whole-system approach where instructions from the brain to the body, such as: "head – forward and up, back – lengthen and widen" would free the body to operate in its natural way. The aim was to stop habitual behaviours that interfered with the body's natural instinctive mechanisms. Those who train in the Alexander technique then strive to maintain this freedom across all settings and activities.

Feldenkrais developed his method based on the idea of neuroplasticity in the brain (ie. that the brain has the capacity to carry out tasks in more than one way and that the ongoing potential for learning can change the neural structures in the brain itself) although the word 'neuroplasticity' itself wasn't used until 1985, a year after his death. Feldenkrais used a series of small, repeated movements made with increasing constraints to teach the brain to listen to the signals from, and learn to use alternative combinations of, muscles for carrying out particular movements. Thus the habits that restrict us and

**"An excellent conference – really so good to participate in every topic rather than having to make a choice."**

*Delegate feedback*





*Rosemarie Morgan-Watson*

cause us pain can be unlearned and new choices can be made.

As you can see, both the Alexander Technique and the Feldenkrais Method are increasing the person's conscious awareness of the sensory and proprioceptive information flowing between mind and body. So some might say, well who has got it right? Which is better? In my opinion these are the wrong questions. We all learn in different ways. In the same way that some of us find it easier to see something if we want to remember it and others might prefer to hear it, I think that it is up to us to judge the way that our own systems learn physical information. If you like your head to take the lead then Alexander technique may suit you better. Start with a mental thought and then carry out the action. If, on the other hand, you only find out that a sensory pathway exists because you have felt it operating, then you might prefer the Feldenkrais method. Try them both and see.

Well, what about Mindfulness? I have saved this until now because to me, as a beginner, it seems less related to posture and how we move, although it does seem to be an extremely good way of deepening awareness and increasing our levels of sensory perception so that we can focus our thoughts, controlling what we think about, and when, and also reducing the judgements we place on these thoughts. Our attention can be given to particular tasks or opened up to take in the world around us.

The power of thought, used as the main tool in Mindfulness, is also used in the other two approaches. Many Feldenkrais exercises ask the individual to carry out a series of movements on one side of the body and then imagine carrying out the same movements on the opposite side of the body, leading to effective results on both sides; whilst the Alexander Technique is taught via thought instructions and imaginings.

So why is any of this relevant to voice users in general and singers in particular?

Well, as singers we are trying to play an instrument that is more than 90% hidden from view. The exact size and shape of this "vocal instrument" is also dependant on what we do with our bodies. For this reason, any techniques that help us to develop our conscious, sensory and proprioceptive awareness so that we know what is going on, both inside and outside our bodies, will aid our ability to build the most free, resonant instrument that we can. This in turn will allow us access to the emotive qualities in our speaking or singing voices.

The next problem is how to ensure that we play these 'vocal instruments' to the best of our abilities. Even the most experienced professionals experience the rush of adrenaline that in many people can lead to problems with performance anxiety. Again, all three approaches have something to offer, but this may be where Mindfulness really comes into its own. Learning how to control negative self talk, how to draw attention away from a racing heart or shaking hands and how to enhance stage presence are just some of the extremely useful skills that Mindfulness can teach.

## So how did the actual day operate?

We began the day with an opportunity for each speaker to outline the basic principles of their approach. These contrasted significantly in style but many areas of potential overlap became apparent even at this stage.

Participants were divided into three equally sized groups for the next 3 contact hours as we moved from one practitioner to another.



*Glynn MacDonald*



The Feldenkrais and Mindfulness workshops both used practical activities and exercises to give us individual experiences of the approaches. Only a few people got a chance to have a physical experience of the Alexander Technique, but luckily a show of hands at the end of the day indicated that the majority of participants had had at least one previous experience of it, which was not the case with the other two.

We finished the day with a review session moderated by Professor Graham Welch where he provided details of other research related to Mindfulness and singing and also how the mind operates when we are singing or just imagining that we are singing.

In true BVA style it left me certain of the value of collaborating with colleagues from other fields, not just for my own development as a person, singer and teacher, but also so that my students can benefit from the specialist knowledge and training of these professionals.

### Feedback from 'Mind, Body, Voice'...

#### Feldenkrais

Experienced many good ideas to add to my teaching especially using the skeleton to support singing technique and also to help students to become much more aware of the space occupied by the rib cage - how it moves under normal circumstances and how that movement can be a real asset to breath control.

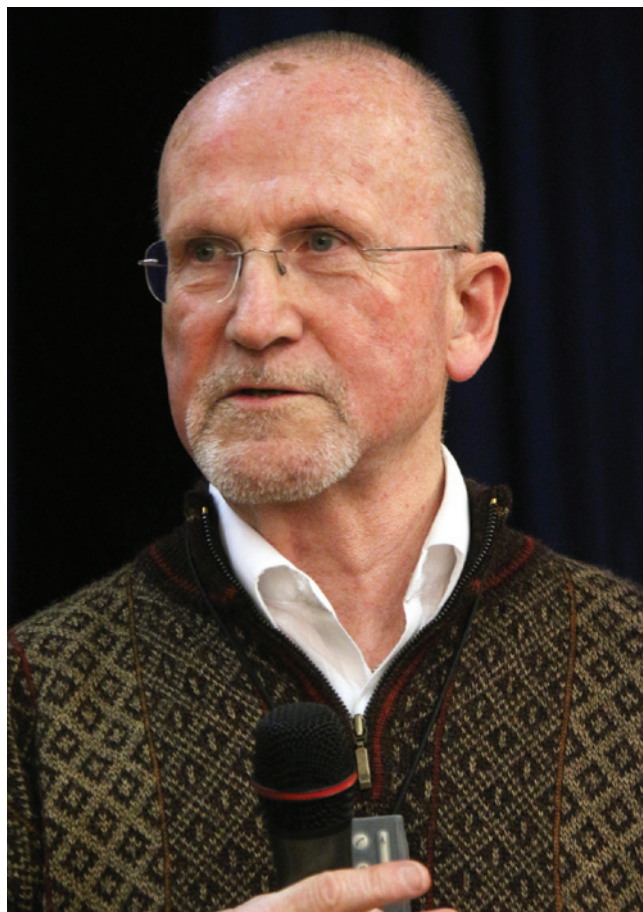
#### Alexander Technique

Very practical ideas for working with groups of performers. Inspirational.

#### Mindfulness

Incredibly useful and essential to life. More, more, more please!

It is evident that we all derived so much benefit from this conference – being able to learn and share from each other and from the specialists in each field. An excellent conference – really so good to participate in every topic rather than having to make a choice.



*Professor Graham Welch*



*(right) Meditation, (below) Chris Cullen addresses the audience*





# TEAM WORK IN THE VOICE CLINIC: TWO CASE STUDIES

Alison Mary Sutton

**I have been the singing rehabilitation coach at Cheltenham General Hospital's Voice Clinic for fifteen years and in that time I have worked with many singers who have been referred to me by the ENT Consultant Surgeons: Michael Hardingham, Charlie Hall and Mike Thomas.**

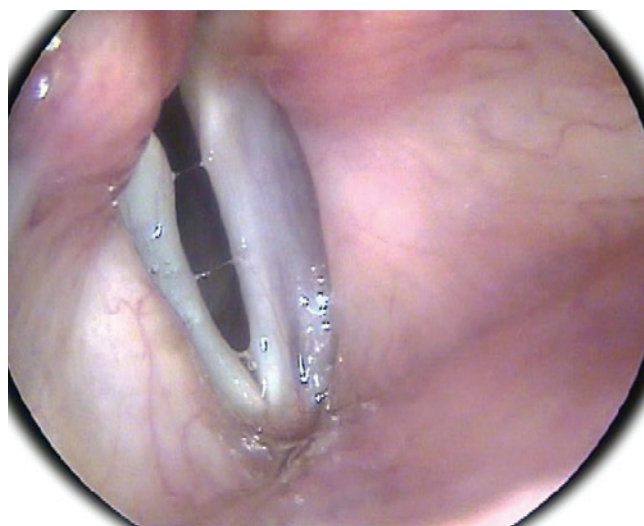
Over the last three years, I have worked with two voice clinic patients (Clients 1 and 2) who both presented with a vocal fold paralysis. This condition occurs as a result of abnormal nerve input to the laryngeal muscles and can be caused by damage to the recurrent laryngeal nerve (RLN). As a result one, or rarely both, vocal fold can no longer move. The RLN carries impulses to different laryngeal muscles responsible for opening the vocal folds for inhalation and closing them for phonation. Because this nerve is relatively long and takes a 'detour' to the larynx, it is at greater risk of injury from different causes: viral infections and potential damage caused by complications during surgery in the head, neck or chest. These can directly injure, stretch or compress the nerve.

Paralysis of the vocal folds can present in two ways. The more common type, as in the case of Client 1, is an adductor muscle paralysis (see Fig.1), where the folds are easily abducted or moved away from the midline. This produces an open airway, but a weak and breathy voice due to insufficient closure of the folds (adduction). It most often occurs with just one vocal fold being paralysed or having limited movement, resulting in the breath escaping too quickly. The fold is unable to vibrate in synchrony with the healthy fold or, if there is vibration, it is



**Fig. 1: Left vocal fold adductor paralysis in voicing with poor closure. Note the recruitment of surrounding muscles.**

*Reprinted from the British Voice Association leaflet 'Paralysed Vocal Folds and Voice' © 2012*



**Fig. 2: Bilateral abductor vocal fold paralysis in breathing, with poor airway**

abnormal. In some cases, there is no vibration at all. The other type, as in the case of Client 2, is an abductor muscle paralysis (see Fig.2), where voicing will usually be good, with efficient vocal fold adduction, but serious airway obstruction occurs because the paralysis restricts the opening movement of the folds necessary for inhalation (abduction).

Since each type of paralysis significantly affects breathing, my initial aim with both clients was to refine their breath management in order to maximise efficiency of subglottic pressure beneath the vocal folds and establish the best possible phonation. With Client 1, I hoped that this approach would strengthen both her speaking and singing voice by stimulating the paralysed fold to move towards the midline to create a better adduction. With Client 2, I hoped that by establishing balanced voicing, it might encourage increased abduction/opening of the vocal folds and an easing of her breathing problems.

I believe that if sensation and feeling can be established to create the optimal conditions for efficient phonation, for both speaking and singing, the voice has more of a chance of finding its own way to wellbeing. This depends upon frequent and regular repetition of suitable exercises, which are carefully monitored. It is best managed by recording all sessions to CD for the client to use in their own time at their own pace at home.

## Client 1: Frances 62 years old A singer and music teacher

### Diagnosis

Frances was diagnosed with a paralysed left vocal fold at the clinic in March 2010. There was a gap between her vocal folds along their full length, but most significantly at the posterior end. There was considerable leakage of air through the glottis in phonation, and her voice was hoarse and breathy. Speaking was an effort and she was not able to access her singing voice at all. The consultant recommended a referral for rehabilitation before considering surgery, which would involve a substance being injected adjacent to the paralysed fold to move it into a medial position to allow for better adduction. It would also provide a buttress for the normal vibrating fold.

## Rehabilitation

### BREATHING

Over a six month period, Frances and I worked to achieve precise levels of engagement of the abdomen (Transversus Abdominis/TA), employing a yoga-based relaxation exercise that I use in my singing teaching. As breathing for singing is based on a 'pressure system', we first had to establish the correct use of the vocal folds as a controlling valve, which would encourage full adduction by creating the appropriate level of subglottic pressure i.e. resistance to the upcoming air flow from the lungs. Although it is principally the diaphragm that regulates subglottic pressure, it relies on the action of the TA, to which it is attached, for the appropriate stimulus when voicing. Because the necessary movement of the TA can be quite challenging, Frances initially performed the exercise lying down on her back, when the rise and fall of the abdomen can be felt more readily.

### EXERCISE

By maintaining a gentle pursing of the lips on exhalation, a valve is created and consequently the breath pressure rises, causing the abdomen to engage and flatten of its own accord. By letting go of the strong instinct to pull the air in, and instead allowing the body to deal with the inhale as a natural response to the exhale, the abdomen will rise and air will automatically be taken back into the mouth. The breathing can then gradually fall into a natural pattern as the focus is fixed on the rise and fall of the abdomen (rather like the movement of a foot pump). Once this is established, I begin voiced counting to gradually move the client towards doubling the length of exhale to inhale. At all times, the body is allowed to find its own pace so that there is no forcing or tightening of the breath. Finally, short pauses are introduced after both the exhale and inhale. This helps to strengthen the muscles and pattern the movements into the muscle memory. When practised standing up, the abdomen is more prepared to fall into a gentle swinging movement, as it is gently 'zipped and unzipped', with the initial engagement on exhale being no more than 50% muscular effort. As with muscle training for athletic activity, the exercise is practised little and often to produce the best results.

Once established, this exercise is then applied to voicing, initially by continuing to use the lips as a valve as mentioned above, but with the addition of sounds that create a gentle resistance to the air flow e.g. ZZ, VV, TH.

Despite the fact that this is the breathing pattern we use at birth, it is overridden as we start to experience the world. Learning to return to this system and to release the abdomen on inhale is very challenging, as we become deeply conditioned to tighten these muscles and gasp at the air, particularly when anxious – fight or flight breathing. This causes the shoulders to rise and the subglottic pressure generated is achieved through the use of compensatory muscle patterns. When vocal problems occur, it is important to work on creating a precise balance between abdominal exhale and inhale if one is to achieve a safe, efficient and consistent level of subglottic pressure under the vibrating vocal folds. The success depends on learning to feel exactly how much to engage/disengage the TA muscles and to monitor potential substitute patterns. Overdoing as well as underdoing the movements can be equally unhelpful!

### SIRENS

I also introduced Frances to sirening (pitch gliding), to help the vocal folds to gently stretch and release. I hoped that this

would encourage the paralysed side to start moving towards the midline, especially if the siren was accompanied by a gentle 'zipping' of the abdomen to be sure that subglottic pressure was activated to encourage precise fold adduction.

### EXERCISE

After first experimenting with an OO vowel, Frances moved on to making an NG sound, being sure to keep the jaw relaxed and to feel the vibrations high up at the back of the mouth on every repetition. This gave the folds the best chance of efficient movement, but initially there was a considerable 'cracking' in her middle/speech range, which dismayed her. However, by conscientiously maintaining the same movements and sensations, this was ironed out quite quickly and the pitch range extended both higher and lower as the voice gradually found its way. At this point she tried pitch gliding on a rolled RR which, with its reliance on a higher level of subglottic pressure, gave the sound more stability.

### ONSETS – VOWELS AND CONSONANTS

Maintaining an awareness of the relevant sensations and feelings as the way forward, Frances also did some work on onsets i.e. making a clean start to each sound. This helped to stabilise it, both by preventing leakage of air prior to voicing and by creating as clean an adduction of the vocal folds as possible – rather like vocal aerobics!

### EXERCISE - VOWELS

Starting with spoken vowel onsets, we used the Estill-based UH-OH glottal onset with prior deconstriction of the larynx. As many readers will be aware, this entails making sure that the false vocal folds that lie slightly above and to either side of the true ones are kept apart, in order not to impinge on the free vibratory movement of the true vocal folds (note the constriction in Fig.1). There are various ways of achieving this – creating a gentle silent giggle builds up subglottic pressure, the feeling of which is then maintained on abdominal inhale, prior to voicing the UH-OH with an open mouth. To consolidate an awareness of deconstriction, I like to add a visual image of widening the throat on the inhale e.g. the drawing apart of curtains/sliding doors or the widening of an angry cobra's neck! Using the same approach, Frances also practised onsets on the words "Ah hello!"

This was followed up with better management of consonant onsets. By going back to the idea of the lips acting as a valve, I encouraged Frances to place her consonants as far forward as possible, including sounds like K and G, and to feel the build-up of some resistance to the air behind them, which creates an appropriate level of subglottic pressure. The consonants can then act like a spring as enunciation takes place, with the result that both clarity of sound and safe vocal projection are achieved.

### EXERCISE - CONSONANTS

Having a goal for them to be aimed at, such as the wall on the opposite side of the room, consonants are gently 'fired' forward with small repetitions e.g. BBBB, TTTT, GGGG etc, with the focus being on the control of the air flow. With fricative consonants like VV, ZZ and TH, the escape of air through the sound needs to be carefully balanced with maintaining some breath pressure behind them. I then introduce double and triple consonants e.g. PL, CH, STR to be tried in the same way.

## Outcome

Although slow and painstaking work, Frances learnt how to take control of her voice, including the importance of vocal



hygiene and also how to deal with it on her vocal 'down days'. By the fourth session, she was beginning to sing and over the next six months her tone became less airy and the weakened middle register began to grow stronger. Although still a little breathy, she started to own her voice again and once we had consolidated other aspects of technique, she was singing repertoire and feeling more comfortable in her natural soprano register. After nine months, she achieved her goal of singing at her son's wedding in Australia!

A review in the Voice Clinic in October 2010 revealed that although there was still some vocal fold irregularity, the posterior gap was significantly smaller and the vocal folds were more flexible. The previously paralysed vocal fold was looking stronger and moving more readily to the midline with better adduction and her breath analysis was normal. Frances was discharged on that day, and she and I were both delighted!

"The three things that helped me most were re-establishing my breathing and at the same time learning about the mechanics. This, and all the exercises for bringing the folds together, made me so much more aware. The siren really was the yardstick to feel how the paralysis was diminishing. Lots of frustrating days, but a fantastic exercise! Everything you gave me to do increased the strength and gradually the range of my voice. But the most important thing was the encouragement! It is a long journey with lots of bad days, but now it is fabulous to know that when I open my mouth a singing voice will come out!" (Frances)

## Client 2 – Carol 64 years old A retired teacher

### Diagnosis

Carol had a persistent bilateral abductor vocal fold palsy following a total thyroidectomy in October 2010. She had had a significantly enlarged goitre for eight years before her operation, by which time there were difficulties with its size and, as a result, the recurrent laryngeal nerve had been severely stretched. When this happens, there is no knowing whether a vocal fold paralysis will occur post surgery or not. If it does, as in Carol's case, the RLN is only thought to be able to make any significant recovery within twelve months.

Immediately after the operation, Carol had great difficulty with breathing and speech. She spent five days in a high dependency ward, having her breathing, speech and calcium levels monitored. Surgical treatment was considered to help with her breathing, but a conservative approach to management was adopted. In the following weeks, Carol had speech therapy to restore basic enunciation and pronunciation. Over the next eighteen months she began to resume her normal activities, including swimming, yoga and pilates, but she could not breathe comfortably and displayed a considerable stridor (noisy inhale). She had shortness of breath with exertion and her quality of life was greatly impaired. Towards the end of 2011, she was told that there might still be some scope for recovery, as there was some flickering of the right vocal fold, but by New Year 2012 she was warned that it was unlikely that she would recover any further mobility of her vocal folds. In February 2012, she was offered an operation to 'tie back' her vocal folds which would widen her airway, but there was a definite risk that this could impair her vocal quality.

She was advised of two other possible surgical options for opening up her airway, but Carol chose to try to address her breath management before going ahead with further surgery. Following discussion with her surgeon, Mr Thomas, we started rehabilitation treatment in April 2012.

### Rehabilitation

#### BREATHING

This was the main focus for Carol. We followed the same exercises as with Frances, my idea being that if she could regulate her subglottic pressure on exhalation, it might enable her vocal folds to 'swing open' a little more on inhalation. It was by no means assured that any progress would be made, but Carol was both determined and prepared to work hard. At this point, her speaking voice was quite strong, as the vocal folds were adducting well, but her inhalation was very effortful and noisy. She still tired quickly when trying to walk uphill.

Having been previously physically active, including doing yoga, Carol's response to the recommended exercises was excellent. The concept of abdominal breathing was straightforward for her and she quickly mastered a well-controlled abdominal exhale, but initially she found herself unable to stop gasping on inhale. However, by practising the exercise on an hourly and daily basis, using the CD recordings of our sessions, the abdominal muscular patterning became easier and her inhale less effortful. Even much later into our work together, Carol still had a tendency to gasp at the breath between sentences, especially when in animated conversation. Relinquishing control of the inhalation and allowing the body to deal with it instead was a key factor in the eradication of her stridor. In Carol's own words – "in February 2012, when offered another operation to improve my breathing, I wanted to be able to breathe more easily, but did not want further surgery, especially when it might impair what hesitant speech I had. When I met Alison two months later, I was quite desperate for help. Because of the specificity and clear delivery of the breathing exercises, I could see after only one session that this was exactly what I needed. The exercises were extremely helpful since they involved both what to do and what not to do." (Carol)

#### SIRENS

By encouraging Carol to try sirening, I wanted to give her easily adducted folds a chance to have a good stretch! She was willing to try this, and it reinforced her breathing as it had to lengthen as she explored higher and lower pitches. All the time I had in mind that the other side of the coin to a well produced sound was, hopefully, a more active movement of the folds on inhale that may enable them to open a little wider. "After so short a time, it is excellent that I can even do a siren. Each one I do brings a huge smile and warmth to me – it just seems so extraordinary that I, who could not even sing before the operation and could not talk after it, can now almost sing!" (Carol)

#### ONSETS

Again, both the deconstriction of the larynx prior to speaking and the gentle building up of air pressure behind consonants helped to reinforce Carol's breathing. They also encouraged appropriate energy levels when projecting her voice and had a strengthening effect on her vocal tone. "Reciting melodious and metric poetry was excellent practice for my breath control and also gave me good consonant practice. It was also good fun and gave me lots of laughs which were a great confidence boost. All those things one does such as laughing, coughing,

sneezing etc have become so much easier because I can 'relax' and let my body take over." (Carol)

In parallel with the vocal rehabilitation, Carol underwent some fascial release technique with physiotherapist Nicola Ellis. This helped release the chronic muscular tension which had built up with her prior inability to breathe properly. "Nicola said that my upper body looked as if it was vacuum-packed, but now I have greater freedom in my diaphragm, chest and shoulders. I had become very round-shouldered through trying desperately to breathe. Tips from both ladies on deportment also gave significant and immediate relief." (Carol)

Towards the end of rehabilitation, Carol paid a visit to laryngeal physiotherapist Ed Blake. "My one visit to Ed Blake was terrifying in anticipation of what could go wrong, but very satisfying in that the discomfort I expected with the treatment was in fact pleasurable. Joyful when leaving his room, I took a breath which was something beautiful that I had not felt for a long time. He seemed to give me a clear airway which felt wonderful – a motorway as opposed to a narrow country lane – that feeling has not gone!" (Carol)

## Outcome

Carol now swims for an hour several times a week, including underwater, which had been one particularly long-term goal. Some atrophy of her right vocal fold had been observed at her voice clinic review in April 2012, but by July, following the prescribed exercises, it was much plumper and more flexible. This was also due in part to steam inhalations on a daily basis,

which Carol had found to be both soothing and effective. At the same time, her stridor was significantly diminished and she could walk uphill without getting breathless. Better abduction was evident and there was a reduction in laryngeal tension. By January 2013, she presented with a normal voice quality and no stridor. Again, better abduction of the vocal folds was seen during inspiration as was a good mucosal wave within the adducting folds during phonation. The best news was that, after eleven years almost to the day since she had been diagnosed with an enlarged thyroid, she was discharged from the voice clinic!

In conclusion, although in these two complementary cases of vocal fold paralysis there was significant benefit gained from having rehabilitation alongside and following the ongoing medical process, the outcome was unknown at the beginning. Perhaps this article may give hope to others with the same diagnosis, but each case is unique, and it is by no means assured that the same course of action would result in the same outcome. However, it has to be true that if appropriate breathing and vocalising exercises are not pursued with persistence and regularity over several months, there will not be any significant recovery.

I would like to express my sincere thanks to Frances and Carol for their co-operation in the writing of this article. Equally to ENT Consultant Mike Thomas, who has given me every support and kindly verified the accuracy of all the medical terminology.

## Healthy Vocal Folds

Back of the neck

Right

Left



ABducted or Vocal Folds Apart

ADducted or Vocal Folds Together

Front of throat



# CAN VOICE SCIENCE AND REALITY TV EVER MIX?

Past BVA President, Singing Coach & Conductor, Stuart Barr writes...

**One of my biggest frustrations with TV programming is that it shies away from intelligent discussion of music (furthermore, if sports commentators are always ex-sportsmen/women, why are Proms TV commentators gardeners or chat show hosts?). TV is going through a phase where jeopardy is everything and people's narrative "journeys" are often more important than the content. Hardly the place for voice science?**

So, when I was approached by a new reality Channel 4 TV show Hidden Talent protesting it was going to change all that, I was intrigued but suspicious. This article is my 18 month journey (sorry, "narrative"... ) as the programme's off-screen consultant and on-screen singing coach.

The concept was clever and unique. Take nearly 1,000 people and objectively test to find latent aptitude in skills from rock climbing, language learning, freediving to opera singing (but from the process remove anyone with formal training or experience), and then give them 6 months full-time training. It would be almost a scientific experiment in itself with an emphasis not on creating a particular end result (as most reality TV seeks to do), but seeing what could be achieved when latent aptitude is realised through good tuition.

My first task was to devise objective testing processes to find the person with the most latent singing aptitude. Aural tests were my first round of course, starting with "Happy Birthday" - picked because it's a song everybody knows but which c.  $\frac{2}{3}$  would not be able to sing its 4th, 5th and octave leaps accurately. Then came progressively harder pitch and rhythm replication tests, culling the pool down to 150. Performance testing came next: a line each of the Neapolitan Aria "O Sole



*Stuart conducting*

Mio" (thank you Walls Ice Cream adverts for a song that allows the uninitiated to sing quasi-operatically!). After weeding out those with any experience or training, we took the top 12 for voice profiling (with former BVA President Prof David Howard) and a performance workshop to examine communication, teachability, vocal quality, musicality and ability to connect with internal emotions. This climaxed with sung musical improvisation at the height of emotion (which to me gets to the heart of where the opera voice comes from).

Our top three candidates then performed another Neapolitan aria "Return to Sorrento" in front of myself and the teacher I'd appointed to teach them technique for the next six months: former international opera singer, RAM/GSMD teacher and no stranger to the BVA, Joy Mammen. There was one clear winner, Jayson Khundkar (a charity project manager in his mid 30's), but before we could be certain all three were taken for a voice MOT (inc. videonasendoscopy) from Otolaryngologist John Rubin. Fortunately none were found to have any medical reason why training shouldn't take place.

Jayson was fascinating: when he auditioned for the choir at university he was told that despite having a beautiful voice he couldn't join because he couldn't read music! I designed for him a six-month course of full-time training with Joy Mammen (technique) and myself (repertoire, performance skills), Italian and musicianship classes, fitness sessions, trips to the opera, people-watching & acting session, the AIMS residential summer school etc. There were also several performance opportunities, from busking in Covent Garden piazza, playing a minor role in Peter Grimes at AIMS, to the two climaxes: playing Benoit in La Bohème at Opera Up Close's fringe production, and singing Belcore's aria from Donizetti's L'Elisir D'Amore (with me conducting the Kensington Symphony Orchestra in Cadogan Hall).

He worked hard and his voice transformed during this time into a rich lyric baritone. I brought back Prof Howard for more voice profiling at the end, which compared Jayson with a professional operatic baritone. His Closed Quotient, Max. SPL and Singer's Formant had all improved massively in six months and were now approaching that of the professional. Those objective measures were very crude of course. What was more exciting was seeing him become a wonderful musician and acting his roles with great competence. Most important was that he had discovered something new about himself (back to his "journey" I'm afraid): he now had music in his life, where before he had none. The conclusion of the programme made



*Stuart and Jayson Khundkar*

very good TV, and yet I felt tinged with sadness. Lots of people have latent aptitudes, but many/most? people never get the opportunity to develop, or even discover, them.

Reality TV programmes are rarely made by experts in the field in which they're working. However, I was fortunate to have producers who trusted me to create something that worked well both televisually and in serving my artistic purpose. Unusually, most of the budget was spent on off-screen training (and most of which was filmed didn't make the final edit). This is in stark contrast to primetime TV shows I've worked on where contact time with the singer is purely for the benefit of the cameras/viewers to show that the person is being coached rather than allowing any meaningful learning to take place. I was delighted that we were able to show some things that are rarely shown on primetime TV: the artistry behind singing, the immense training required for it, and more than a little voice science. It was definitely a positive experience for all concerned, the only gloom was caused because as soon as the Dancing Dog phenomenon on ITV's Britain's Got Talent overwhelmed the public, the viewing figures for our series on Channel 4 declined. Such is the way of telly scheduling. A Dancing Dog, I ask you...

Postscript: I received a call the following week from an ITV researcher that reminded me of just how bad TV could be (and how fortunate I'd been with Hidden Talent). I was asked to find a singer to appear on their Sat Night's "Hit" Show Lemonaid as an excuse for Russell Watson to plug his new album. What singer was I asked to find? "An 8-12 year old opera singer"... I didn't return the call. I mean, where would I have begun the conversation?!

You can still watch the show here: <http://www.channel4.com/programmes/hidden-talent/4od#3363598>



*Stuart and orchestra with Jayson Khundkar*



*Joy, Jayson, Stuart and Richard Bacon*

## CAPTION COMPETITION

You may have noticed a change in Newsletter format over the past few editions especially the front page, thanks to BVA designer, David Siddall. The image chosen this time was taken at the Mind, Body, Voice workshops. However, there seems to be something missing .....a caption perhaps? Medics are known for their "gallows humour," teachers need to keep a sense of fun and performers are known to have funny bones!

So, if you can think of an amusing caption to be used in this shot please e mail it to me with your details.

The winner and runners up will be published in the Summer edition of Communicating Voice.

Editor

[lynne@lynnewaymanvoicecentre.com](mailto:lynne@lynnewaymanvoicecentre.com)





# **WORLD VOICE DAY QUESTIONNAIRE 2012**

**Voice Clinics Forum 2011 highlighted a need to provide Service Commissioners with objective evidence to support our assumption that Voice Clinic Services are the 'gold standard' model of care for voice disordered patients. It was therefore decided to design a questionnaire as part of our World Voice Day contribution for 2012 that would gather data to help determine whether Voice Clinic Services are demonstrably more efficient in providing quality management for voice disordered patients when compared with the management provided through the general ENT Clinic.**

## Background

Judgements about efficiency and cost effectiveness rely on many different aspects of a patient's journey from initially seeking help for their voice disorder to finally resolving the problem through successful treatment. Some of the cost implications include aspects such as unnecessary prescription of antibiotics or other medications, days lost from work and repeat reviews with either the GP or the general ENT surgeon, and these need to be captured through careful questioning.

The different routes through the system and the time-frames involved also need to be captured and these are often complex and different for each individual. For example, a patient might see the GP two or three times, be referred to ENT, have to go back to the GP, be referred on to Speech Therapy, then back to either the GP or ENT before finally finding their way to a Voice Clinic. Others are referred directly from GP to Voice Clinic. This meant that our questionnaire needed to be in the form of a flow chart, so that patients could complete only the sections that applied to their particular experience.

Finally, efficiency of treatment depends on an accurate diagnosis which results in appropriate management. A secondary data collection sheet was included for the Voice Clinics to document the initial diagnosis given to the patient in the general ENT clinic and whether this was altered or extended as a result of their Voice Clinic assessment.

## The Questionnaire

The questionnaire was divided into a number of sections: The first was entitled "You and Your Voice" and included questions about the duration of the voice disorder, its progression (better, worse or intermittent) and how long patients waited before seeking help from their GP.

The second section was entitled "Your Voice and Your Work" and covered the patient's occupation, the voice use required in their work and whether they had lost significant time from work as a result of the voice disorder.

Section 3, "Getting Help for your Voice Problem" reported on how many times patients had seen their GP before being referred on and whether the GP had prescribed medication for the voice disorder before referring them on for further investigation. It also recorded which services GPs chose to refer their patient on to for further investigation or treatment (e.g. the general ENT clinic, a Voice Clinic or Speech Therapy).

Patients then went on to complete only the relevant sections about the services they were referred to, in most cases, the general ENT surgeon. They were asked about how long they

had to wait before being given an appointment, whether they were prescribed any medication, whether they were given specific advice on how to manage the voice problem, and whether they were given any further referral for treatment from other specialists, such as the Speech Therapist or Physiotherapist.

The final section concerned the outcome for those who had completed treatment. Patients were asked about which service they felt had helped them most and which service they would prefer to be referred to should the problem recur.

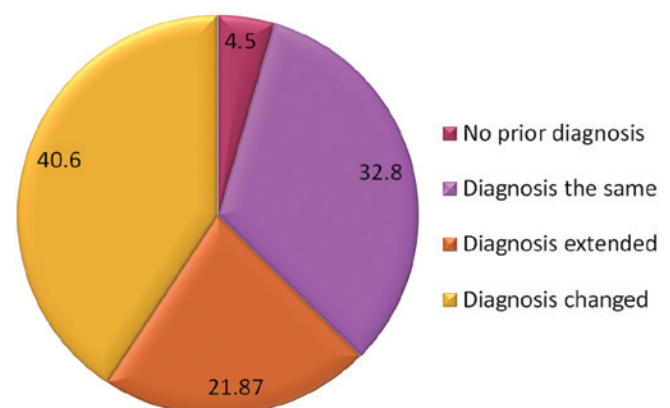
## Results

There were 116 questionnaires sent out, which required clinicians to ask 10 patients to complete. The voice clinics were also provided with a record sheet to document any changes or extensions in diagnosis. The pilot trial period was between 16th April 2012 and 15th October 2012. Unfortunately, only 26 completed questionnaires were received and two Voice Clinics provided data about changes in diagnosis. This was disappointing but probably reflected the pressure NHS clinicians are experiencing and the lack of any help they are able to receive from volunteers or students in the current climate. It is also likely that the complexity of the questionnaire may have deterred some clinicians and patients from responding.

## Changes in Diagnosis

The 2 Centres who returned their data on diagnoses provided information on a total of 65 patients. The results showed that 40.6% of the sample demonstrated a clear change in diagnosis as a result of the Voice Clinic assessment and the diagnosis was extended in a further 21.87%, giving a total of some change in 66.94%. Also, 4.5% of cases had not been given any prior diagnosis; some because they were direct referrals to the voice clinic but in several cases, because the referring general ENT surgeon had not provided a diagnosis. In 32.8% the diagnosis remained unchanged.

Change in diagnosis



## You and Your Voice/Your Voice and Your Work

The mean duration of the voice problem for the 26 patients who completed the questionnaire was high at 2.74 years with a range between 3 months and 12 years and 44% of our sample left it more than 3 months before seeking help from the GP.

These results may reflect the relatively high number of retired people in our sample (6).

Professional voice users made up 42.3% of our sample and included teachers (5), singers (4) and administrators/managers (3). As a result, 53.8% of our sample reported having to use their voices 'constantly' in their work and that their voice problem made it difficult for them to do their jobs. Fifty percent reported having to take time off work and while 61% of these reported only a few days absence, 38% reported that their absence had run into months.

### Getting Help from the GP and ENT surgeon

On average, our sample of patients saw the GP 2.5 times before being referred on to the ENT department. Antibiotics were prescribed in only 27% of cases but when these data are combined with those for other medications (such as antacids, antihistamines, medications for asthma and cough medicines) the number of patients prescribed medications for problems relating to their voice disorder rises to 61.6%. Seventy eight percent of GPs referred on to general ENT clinics, 17% to a Voice Clinic and 4.4% to other specialties. Most commonly people waited between 1-2 months to see the general ENT surgeon and had an average of 2.6 visits with them. General ENT surgeons appeared to rely less on treating voice patients with medication than the GPs in this sample. They prescribed for only 23.8% of patients, usually for the treatment of acid reflux.

When patients were asked whether they were given a clear diagnosis by their general ENT surgeon only 47% felt that they had, and again, only 47% felt they were given useful advice on how to manage or treat the problem. Fifty four percent of patients were referred on by the general ENT surgeon for Speech Therapy.

### Getting Help from the Voice Clinic

Generally, the waiting list to be seen in the voice clinic was longer than for the general ENT service, with the majority of patients waiting an average of 7.2 weeks. All the voice clinics had a voice specialist ENT surgeon and a speech therapist as their core staff and one clinic reported having a voice coach available. However, all the patients attending the voice clinic reported that they received a clear diagnosis and all felt they had received valuable advice about how to manage their voice problem. Of the 16 people who were seen in a voice clinic, only 3 were treated with medication (2 received anti-reflux medication and 1 a cough medicine) while 12 were referred on to the Speech Therapy department. Two patients were referred on to an osteopath, 1 to a singing coach and 5 received medical treatment from the ENT surgeon, either through surgery or for further investigation of other health problems.

### Help from the Speech therapy Department

Thirteen patients were referred from the general ENT surgeon or the GP to the Speech and Language Therapy Department. On average they waited approximately 5 weeks to be seen and the speech therapist referred 7 of the patients (53.8%) on to another service for further investigation or treatment.

Four patients (30.7%) were referred to an ENT/Voice Clinic service, 2 (15.3%) to an osteopath and 1 (7.7%) to a singing teacher.

### Outcomes

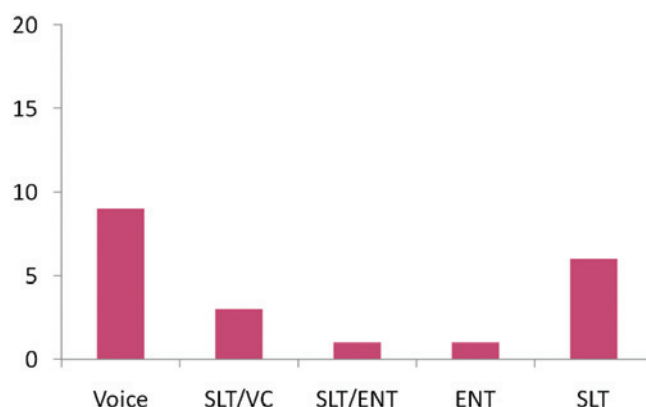
Twenty five people completed this section of the questionnaire. Of these, 19 were either starting or already in active treatment.

Of those in treatment, 5 reported that they were improving. Only 1 person had actually completed treatment and the outcome was regarded as successful by the patient concerned.

When asked which service had been most helpful in their treatment only 7 people responded. Of these, 4 said the joint voice clinic, 2 the Speech Therapy and 1 the ENT surgeon.

Patients were asked which service they would want to be referred back to should they have a voice problem in the future. Twenty patients responded and of these, 9 preferred the voice clinic, 3 preferred the voice clinic and the speech therapist jointly, 6 preferred the speech therapist alone, 1 preferred the general ENT surgeon and the speech therapist jointly and only 1 preferred the general ENT surgeon alone.

### Service preference



### Conclusion

Since only 26 completed questionnaires were received for analysis, no real conclusions can be drawn from the data. The low return rate is likely to be a reflection on a combination of factors, such as the pressure speech therapists and Voice Clinics are operating under at present, a lack of suitable help to administer the questionnaire and the complexity of the questionnaire itself. Although the 'n' is too small to offer any useful evidence to support the efficacy of voice clinics some possible trends emerge. The first concerns how long patients with minor vocal changes tend to wait before asking for help. This warrants further investigation in case it highlights a need for better education of both the general public and GPs about the risks and costs of voice disorders. The number of patients who did not feel they had a clear diagnosis or helpful advice from the general ENT surgeon is also of concern and should be investigated further. If found to be a real issue, after further data is gathered, it will have implications for the training of ENT surgeons in the future. However, one thing that is encouraging that emerges from these meagre results is the trend towards both a satisfaction with and a preference for the multidisciplinary model of management of voice problems.

*For the full analysis of the data please visit our website at [www.britishvoiceassociation.org.uk](http://www.britishvoiceassociation.org.uk) (Events diary - World Voice Day)*

**“The low return rate is likely to be a reflection on a combination of factors, such as the pressure speech therapists and Voice Clinics are operating under...”**



# SPEAKING WITH SKILL

## An Introduction to Knight-Thompson Speechwork

Dudley Knight

Methuen, ISBN 978-1-4081-5689-6

Review: Melanie Mehta

This book is written by an American Voice Practitioner and regularly reminds the reader of the American focus of the book. British English referred to often with a nod to sounds found in other languages. The skills he is describing transcend the divide of the Atlantic as he encourages the reader to be specific with sounds both in listening and production in order to attain clear speech.

The instruction at the beginning is "Do everything. Don't just read it – do it!" This was good advice and I would recommend this course of action throughout the book. It is divided into 4 parts: Making Sounds, Finding Language, Phonetics and The Skills of Intelligibility and has an accompanying audio CD. The first section was fascinating and following a basic introduction to how sound is made, the components of the vocal tract and oral cavity and the muscles involved in articulation with clear diagrams, the speaker/reader then goes on a journey from silence to sound (not words yet) and is encouraged to playfully explore what happens to the airflow and sound as the shape of the vocal tract and oral cavity are altered.

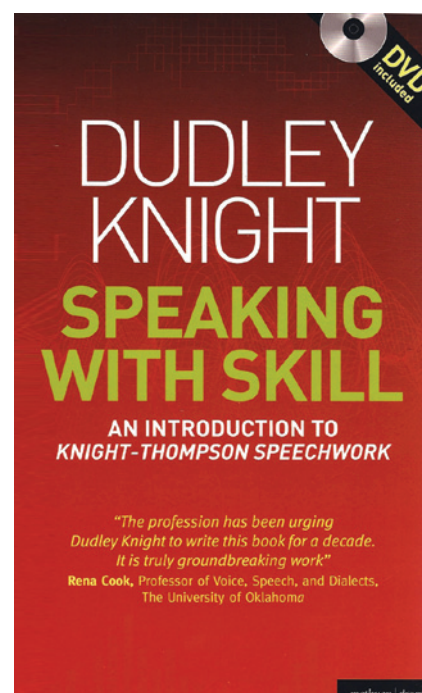
The second section continues this playful approach and starts to introduce familiar

phonetic terms e.g. trills, fricatives, etc. This section follows a standard route explaining how these sounds are made i.e. voiced or unvoiced, place and manner of articulation and the outline structure of the International Phonetic Alphabet chart itself is introduced and then we are encouraged to play again with more sounds with meaning, but no formal or known words or language structure with the encouragement to feel the shape of the sounds.

Onto the pure phonetics section, the claim is that this is not a phonetics book, correct but this section is definitely a phonetics section and goes into great detail about the different sounds and variants including the use of diacritics. It is suggested that this is useful for analysing accents which of course it is. I found this section hard going (albeit a very useful revision for my rusty phonetics) and I would suggest that only the actors who get a buzz from phonetics would persevere through this section. I suspect this shows up the slightly different way in which phonetics and accents are taught in England and America. The American students I have taught have had a strong grasp of the phonetics symbols. I'm not saying the British/English students do not, but it is a question of degrees in my experience. Obviously, pronunciation of the symbols is a different matter and this is where the audio samples are of most benefit.

The final section brings it all together discussing formal and informal speech, coarticulation and similar strategies which are used in conversational speech and recapping both consonant and vowel production. There are some good reading passages for the speaker to try out for specificity and clarity, and again are backed up by clear audio examples.

I was left wondering if someone without previous knowledge of the subject may get put off particularly as the phonetics started to come in. With previous



knowledge, this makes great revision material. Not all actors work on accents via the phonetics route – as we know, one size does not fit all and so this will not be an appropriate way for all actors to be reminded about speech sounds. If you want to recap the work you have done with a good accent/phonetics teacher and do some more practice, then this book provides an enjoyable way to do it.

The voice of the author, his sense of humour, passion and knowledge comes through and it is mostly a very easy and enjoyable read. This is in no small part due to the excellent layout, clear typeface and appropriate practical examples and exercises for the reader to try out. I would suggest it would be a good reference book for students in the library of an acting academy or school as long as it is backed up by class based teaching.

*Melanie Mehta is a Specialist Speech & Language Therapist and Voice Coach (Spoken Voice)*

## WORLD VOICE DAY 2013

This year the BVA has a number of contributions that we hope will help our membership and highlight the importance of voice.

**Voice information leaflet:** We are planning another of our popular voice information leaflets, this time on Acid Reflux – more specifically laryngopharyngeal reflux (LPR), its effect on the voice and how it is prevented/treated.

**Valuing voices:** We all value our memories. Many of us capture special memories in photos and video, sharing these

with our friends and family. But, how many of us record the voices of those who are special to us?

**World Voice Day Posters (A4 size):** These will be sent out with the other World Voice Day material.

As always, we are hoping many of you will want to become involved in celebrating World Voice Day. If you would like ideas please see the guidelines on our website and have look at the report of activities that took place in 2012.

**See the 'World Voice Day page on the BVA website for guidelines and more details: [britishvoiceassociation.org.uk](http://britishvoiceassociation.org.uk)**



# SPEECH AND VOICE SCIENCE

Second Edition by Alison Behrman

Plural Publishing,  
ISBN 978-1-59756-481-6

Review: Nimesh N Patel

This is a book written largely for speech and language therapy students, both undergraduates and postgraduates. It may also be of interest to ENT surgeons with an interest in voice/communication disorders. It comprehensively covers voice and speech science and there are clinically orientated chapters on sound waves as well as breathing. The bulk of the book refers to phonation and speech, but also includes anatomy, physiology and measurement. There is a good emphasis on clinical relevance throughout and as a non speech therapist, I found the chapters on the production and perception of vowels and consonants well explained and thoroughly enlightening! The layout is good but there are often quite large chunks of text to wade through.

The book has some very useful features for the undergraduate student especially - summary boxes, study questions and

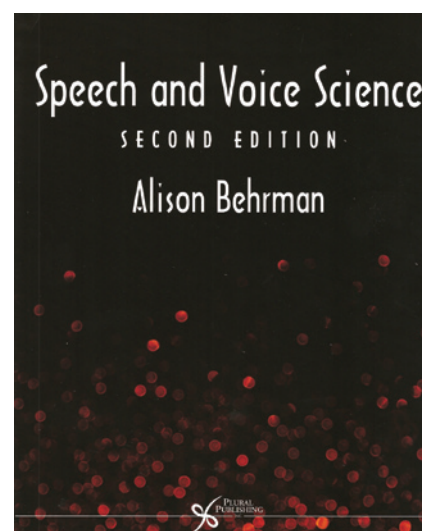
review questions. Answers are given for the review questions in the appendix. For the teacher, there are some useful classroom activities that go with the chapter, designed to emphasise key concepts. In many ways this is a course manual rather than just a textbook.

The book is well referenced with traditional literature, but also Internet resources, many of which are both entertaining and instructive. The illustrations are in black and white, which is a shame as colour would most definitely have improved the "readability" of the text. Generally, however, the illustrations and graphs were lucid, accurate and often amusing.

The appendix contains a game called Speech Science Taboo adapted from a Hasbro game from the late 1980's. This is designed to solidify the many definitions of terms covered in the various chapters. The game encourages participation and tests the understanding of concepts as terms have to be explained to others within defined gaming rules. This is certainly a novel way of engaging students learning some very "dry" subjects.

The indexing seems accurate and there is little repetition - an advantage on a single author text, in this era of multi-author tomes.

I would recommend this book to students of speech therapy. It would also be a very



good resource for teachers and lecturers in speech therapy. For medics, there are chapters on speech production that are not covered very well in many standard ENT books. These chapters would be well worth reading by the ENT surgeon. For singing teachers and vocal coaches the chapter on phonation (measurement) might be particularly useful as it summarises very well key aspects of this topic which would certainly be of interest.

Overall, this is an excellent book. I only wish medical undergraduate books were as well written and presented as this, and they had similarly innovative ways of engaging the learner as this manages to do.

# WHERE DO I START?

A Vocal/Instrumental Warm-up & Ear Training Workout

A CD with brief instructions for each track, 30 tracks in all, some with demonstrating vocals and some without, for practice. The exercises are accompanied by a jazz instrumental ensemble.

Clare Foster and Shanti Paul Jayasinha with:

Pete Billington, piano & bass  
Shanti Paul Jayasinha, keyboards & percussion (also SnowBoy on 3 tracks)  
Javier Fioramonti, guitar  
Andres Lafone, bass guitar

Duration: 1 hour 5 mins.

Issued by 33 Records  
Jazzwise On-line Store

Review: William Leigh Knight

Clare Foster presents a series of exercises accompanied in a variety of styles, such as Swing, Salsa, Samba, and Rock. The CD starts with long held notes, four bar then eight bar, followed by scales, major and minor, arpeggios, progressing through various chord types, such as Major, Dorian minor, Dominant 7th and Diminished, together with chromatic scales and exercises for 'rhythmic positions'. The disc concludes with a whole song 'Clear Blue' written by Clare and Shanti, with just the backing in the final track

Like any set of exercises, these do need to be worked with the guidance of a teacher if you are beginner or of modest experience, but the concise notes are very much to the point and clear, describing what to do and what you should get out of each exercise. Clare herself suggests working with a good teacher to avoid developing bad habits



and says working with the disc must not substitute for one-to-one lessons. I would add that it is important to try some of the exercises unaccompanied, making sure to listen really carefully to oneself un-masked by the instruments.

Apart from the notes, the accompaniments help an intuitive working of the exercises; they make for a fun warm-up with lots of variety and also serve to develop the ear: an understanding and feel for harmonic and



rhythmic patterns will come naturally from working carefully through this regularly.

A possible small criticism is that the volume level of Clare's voice in some of the demonstration tracks is a little low, but listening carefully in conjunction with the written notes it is quite clear what is needed; I appreciate the subtlety of the balance which allows one to join in without being dominated by Claire's voice. One is rapidly drawn into the patterns expected, led by the piano. The overall quality of singing, playing and

recording is excellent.

I was intrigued by the subtitle, wondering how a warm-up disc would be equally suitable for singers and instrumentalists, but I can now find no issue with this. The patterns of notes and the harmonic treatment are the basis of the warm-ups and for a singer there is technical guidance in the handbook.

I have enjoyed and benefited from working through the exercises. The effect for me was similar to the idea of doing dance workouts to music compared to

exercising the body without. For more classically trained musicians the strong element of beat is valuable, to develop ones inner sense of pulse and because the physical-vocal system responds well to regular, rhythmic exercise just as the body in general does. I would heartily recommend this disc to singers and teachers, of any persuasion, although obviously aimed at the non-classical, especially jazz and theatre vocalists.

*William Leigh Knight – baritone, teacher and lecturer in the Music Department of Morley College.*

## TEACHING SINGING TO CHILDREN AND YOUNG ADULTS

Jenevora Williams

Compton Publishing  
ISBN 978-1-909082-00-7

Review: Frith Trezevant

Whilst recognising the importance of intuitive and imaginative elements in the context of teaching and learning, Jenevora Williams' book is primarily about information, setting out the building blocks of good technique, founded in the nature of the instrument, bringing current voice science to bear on the accumulations of received wisdom and tradition, illuminating the rationale behind some beliefs about singing, and enlightening the reader as to the limitations of others.

It's hard to miss the good sense that underlies this book. Thoroughly researched and thoughtfully written, it wears its scholarship lightly, but a quick glance at the references on the way through gives the reader plenty of fascinating pathways down which to ramble for further insights – what will it be? Singing enhancing the immune system? Visuo-auditory mapping in humans and chimpanzees? The journey starts here.

And returns here too if you want to find practical applications from the accumulated knowledge and expertise of a creative and inspirational teacher.

Case histories draw the author's ideas

together neatly into vignettes all teachers will recognise from their own work. The colourful illustrations are delightful and the technical information displayed in graphs and diagrams is clearly explained. The first four chapters concern the growth of the voice from babyhood, outlining the limitations of the instrument and strategies to enhance the child and young person's experience of singing.

The heart of the book is in the fifth chapter, where the workings of the voice are explained and exercises given for body balance, breath, tone, deconstriction and articulation, and resonance alongside an explanation of vocal tract structure, form and function.

The DVDs that accompany the book are notable for clarity and while not essential to understanding the content, give a snapshot of Ms Williams' teaching. Vocal technique is presented as an illustrated lecture, which presumes no prior knowledge of the material. In the context of the exercises, there are examples of the use of imagery and gestures that may ignite kinaesthetic awareness to accompany technical explanations. Student subjects are at all levels of training and the problems encountered in these examples will be familiar to all teachers. The examples are of work in progress and not meant to be templates for complete technique.

Ms Williams is an acknowledged authority on boys' adolescent voice and the DVD on boys' voice change is particularly interesting and engaging. There are 11 pages in the book dealing specifically with this subject and the DVD expands on the text, giving illuminating examples of the stages of change.

Anyone working with young singers – conductors, classroom teachers, peripatetic teachers - will find plenty to stimulate and inform their practice in this book.



*Jenevora Williams*

### Additional comments from Sarah Dunstan

'Teaching Singing to Children and Young Adults' is a very thorough and practical guide. I particularly liked the 'down to earth' approach, combined with a sense of humour and wonderful illustrations. It is good that the book covers topics such as teaching children with special needs and children who are trained to sing professionally. The sections on the physical development of the voice of a newborn baby until early adulthood will be particularly helpful to those who work with young people and who have not yet had the opportunity to study the vocal instrument in depth.

The book is based on thorough research and a personal understanding of what is involved in teaching children and young adults. Jenevora's guidance and tips are clear and concise, and will definitely inspire singing teachers and choral directors to be imaginative in their work whilst understanding the importance of developing a sound knowledge of vocal health. The extract 'Children will listen' encapsulates the spirit of this book and it is definitely one to keep at hand.

## The ABC of the BVA



'The ABC of the BVA' is a new social media feature that will give our friends and followers on Facebook and Twitter a new voice-related term for each letter of the alphabet every few weeks. In addition to a simple definition there will be links to other relevant sources of information and interest.

Like us on Facebook and follow @BVAVoice on Twitter to get involved

### AGM and Study Day

## LEND ME YOUR EARS

**The role of hearing in voice from medical, acoustic science and pedagogical viewpoints**

**SUNDAY JUNE 30TH 2013**

The Assembly Hall, Baden Powell House, 65-67 Queens Gate, London SW7 5JS

Experts presenting include: **Mr Philip Jones**, ENT Surgeon, giving a medical overview of hearing and voicing, **Prof. Graham Welch** and **Dr Karen Wise** on pitch perception problems.

BVA President **Kim Chandler** will interview **Dr Paul Whittaker OBE** from *Music and the Deaf* about his experience as a deaf musician, sign singing and his ability to identify pitch by touch.

**David Howard** will present the **2013 Gunnar Rugheimer Lecture** "The singing voice in performance - the shape of the vocal tract; its acoustics and intonation".

## diary dates

### ACCENT METHOD 2013: A THREE DAY COURSE

Wed 1st & Thurs 2nd May 2013 plus  
Wed 4th Sept 2013  
Glasgow Caledonian University,  
Cowcaddens Road, Glasgow

### VOICE AND PODCASTING

Sunday 12th May 2013  
The Phoenix Artists Club, London  
*Maximum 40 attendees*

### LEND ME YOUR EARS – The role of the ear in voicing from a medical, acoustic science and pedagogical viewpoint

Sunday 30th June 2013  
Baden Powell House, London  
*Includes BVA AGM*

### VOICE AND THE BRAIN

14th September 2013  
St William's College, York  
A second chance for those who missed this popular study day

### THE AGEING VOICE

Saturday 26th October, 2013  
The Brighthelm Centre, North Street, Brighton

### VOICE CLINICS FORUM

Friday 8th November 2013  
The Post Graduate Centre,  
Wolfson Lecture Theatre,  
Birmingham City Hospital.

*See our website 'Events' page for more information and a application forms (when available)*

## Have you thought of becoming a director of the BVA?

The BVA's Annual General Meeting will take place on Sunday 30th June 2013 at Baden Powell House Conference Centre, London. At that meeting, some new directors will be elected to serve on the Council and to act as Trustees. A Call for Nominations will be mailed to all BVA members after the middle of April.

Do you know someone who might make a good director/trustee of the BVA? Are you such a person?

A director and trustee must be a member of the BVA, must have enthusiasm for the multidisciplinary work of the BVA and be able to devote time and effort to the BVA. There are six Council meetings each year and directors/trustees are expected to attend all of them unless there is a sudden and urgent reason they cannot attend. Reasonable expenses for attending Council and Working Party meetings are reimbursed for directors who live outside London.

Email [administrator@britishvoiceassociation.org.uk](mailto:administrator@britishvoiceassociation.org.uk) for more information.



**Give as you Live™**

The BVA has signed up to the fundraising website [www.giveasyoulive.com](http://www.giveasyoulive.com) that raises money for charities. If you, friends or family shop online, you can help raise money for the BVA with online purchases AT NO EXTRA COST TO YOU. A percentage of each online purchase made goes to your designated charity, provided solely by the online store. Over £2,500,000 has been raised for charities so far through this system.

### WORLD VOICE DAY

16th April every year

World Voice Day is celebrated annually on 16th April. The idea began in Brazil and then spread to the USA. The idea is to celebrate healthy voices and highlight the importance of voice at work and in society. See page 17.



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