

Teaching the Alexander Technique to People with Parkinson's:

Some ideas from my experience

Chloe Stallibrass

INTRODUCTION

This paper outlines some activities in lessons and approaches to teaching that were found to be useful for many or most of the 29 participants in the Alexander Technique group of a recent research trial (Stallibrass, Sissons and Chalmers 2002). My belief is that the principles of the Alexander Technique are so effective in helping people with Parkinson's to manage the main features of their disease that teachers will teach successfully without prior special knowledge of the disease. However, there has been a demand to know how we went about it in the research, and whether there are any generalizations that might be helpful, and this workshop was given in response to that interest.

PARKINSON'S

There is no known cause of idiopathic Parkinson's disease in allopathic medicine. The diagnostic features that are most obvious to the observer are:

Main diagnostic features of Parkinson's

- tremor, which commonly appears to begin as cogwheel tremor in one hand/arm
- rigidity throughout the body, including the neck and the facial expression muscles
- postural instability
- poverty of movement – smaller, slower and less accurate movements.



Illustration 1. Chloe teaching her father in 1994.

Other common features of Parkinson's

The following (except for oily skin) appear to relate to impoverished movement of particular sets of muscles and the effect of being heavily 'pulled down' in front.

- tiredness/weakness
- depression/apathy
- reduced facial expression
- impaired speech
- impaired swallowing
- dribbling
- pain
- bowel/urinary problems
- oily skin.

There is tremendous variation in symptoms among people with Parkinson's. An individual's symptoms and their level of disability can also change from lesson to lesson, apparently unrelated to drug dosage, level of tiredness, etc. Sometimes

people are divided into two groups: those with strong rigidity and little or no tremor, and those with considerable tremor but less extreme rigidity. You may notice this.

After sitting in one position or lying down for an hour or two, people with Parkinson's can be very stiff.

ALEXANDER TECHNIQUE

I have found learning the Alexander Technique useful for all four diagnostic symptoms, including tremor. Our research also found that learning new skills to help manage symptoms in day-to-day situations often alleviated depression and apathy. A recently published paper describes the skill retention of the research sample six months after lessons ended (Stallibrass, Frank and Wentworth 2005).

SOME CHARACTERISTICS OF THE PEOPLE WHO WERE TAUGHT IN THE WAYS DESCRIBED HERE

They could walk up and down 20 steps and get up from the floor with the help of furniture (in some cases with great difficulty); they had reasonable short-term memory and had no history of hospitalization for depression. The average length of time since diagnosis by a consultant neurologist was 4.8 years. Average age was 64 years.

EARLY LESSONS

The first lesson

There were three main reasons, why, in the first lesson, we mainly practised inhibiting and directing during walking and standing, rather than the more traditional approach of using sit-to-stand and stand-to-sit. First, for a high proportion of the sample, arthritis and other painful joint problems made sitting for any length of time impossible without distraction. Second, difficulty with walking was of great concern to all participants, and in most cases of more immediate concern than difficulty getting out of a chair. Third, it was vital to convince them that conscious thought can influence balance and movement.

All but a handful of the group knew absolutely nothing

about the Alexander Technique before starting the course of lessons. Most of them at the start were not particularly hopeful that it could help them. So from the very first lesson we needed to concentrate on an activity during which the participants could easily recognize the immediate, beneficial effects of inhibiting and directing, in order to inspire trust in the method. The practice rooms were 18 feet long, and changes in walking performance could easily be felt over that distance.

During the introduction of the head-neck-back relationship, we used practice in inhibiting starting to walk. While inhibiting and directing, pupils were asked to consciously include awareness of the space around themselves, within the room and even without. We asked them to include in their conscious awareness the space behind them (to the windows, or the houses opposite), the space over their heads (to the ceiling, for instance, perhaps imagining how far away it is in feet or centimetres), the ground beneath the soles of their feet and beneath their heels, and the space to the sides of their upper arms. In most cases there was immediate and marked improvement in balance and reduced poverty of movement when they started to walk.

Walking, opening doors and turning

We continued with emphasis on walking, opening doors and turning. Most falls in the home are the result of turning too fast, 'leaving the feet behind', or tipping forward due to failure to keep at least one heel on the ground in a confined space.

Working with my father in 1993, I discovered that making dog-legged progress greatly increased his balance and speed. So instead of walking by the shortest route from A to B, he would walk in a series of right angles (Illustration 2).

At every right angle his weight automatically came 100 per cent back onto one heel, which stimulated all the various up-righting mechanisms. Making right-angled turns ensured that his eyes moved around from side to side as he worked out his

route, and this also had a beneficial effect on his balance.

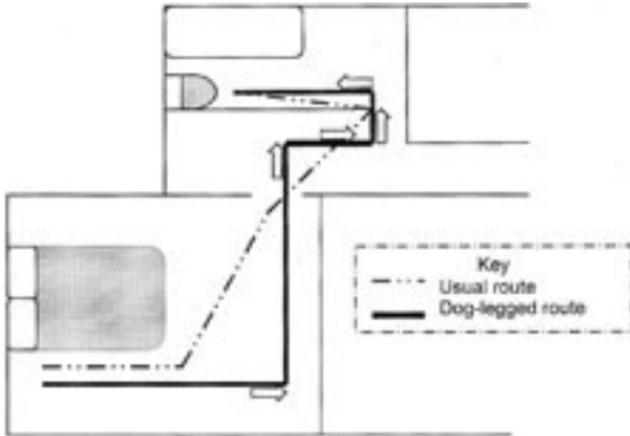


Illustration 2. From bed to bathroom: dog-legged route and usual route compared.

To avoid falling when turning in a tight space, we also occasionally practised becoming familiar with stepping backwards to start a turn. This avoids the likelihood of letting both heels come off the ground at once, as stepping forwards to turn tends to take the weight onto the toes of the leading foot. If the heel of the back foot starts to come *off* the ground before the leading foot is fully *on* the ground, a fall is quite likely.

Walking through doors and down corridors

It is well known that people with Parkinson's tend to freeze in corridors and going through doorways. During the night the effects of the drugs which are administered three or four times during the day, wears off, and this can make it hard to get out of bed and go to the bathroom. Fear of freezing or rooting in the middle of the night when the heating might be turned off

and everyone is asleep can increase anxiety levels, and hence muscular tension and pulling down.

Better not to get stuck in the first place. Again, working with my father in a domestic setting, I noticed how his eyes would fix as soon as he thought of having to get through a doorway. After his eyes fixed, his body fixed. The desire to go forward pulled him further forward and down. Rooting on approaching a doorway could be totally avoided if, the moment he thought of going through it, he looked around the whole doorframe, side to side and the top (Illustration 3).

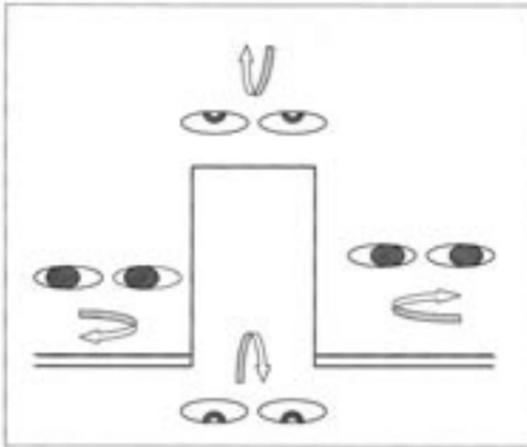


Illustration 3. Eye movements on approaching doorway or corridor and while passing through.

Working in semi-supine

This was much enjoyed by everyone. Some participants spent much of most lessons on the table.

I found similarity among participants in the pattern of holding around the chest and upper arms, which I had not come across in any pupils before. Arm movement, in some cases, was very restricted to start with. But it was a pleasure to be using the Alexander Technique and to know that with time the whole structure would loosen and become more coordinated. I used the ‘bird’s wing’ analogy to help direct awareness of

connections from fingers/wing-tips to the very bottom and top of the back.

LATER IN THE COURSE

Turning over in bed to get up

After several lessons we had usually practised turning over on the floor to get up. This may seem somewhat early in a course of lessons for such an apparently complicated movement. However, turning over in bed to get up (especially in the night) is particularly difficult for people with Parkinson's, and of vital importance to quality of life. It also helps a great deal in locating the head on the spine and experiencing the power of allowing the head to lead. We used the model of vertebrates – cats, horses, tortoises – getting up from their backs.



Illustrations 4 and 5: Cat turning during a fall.

Breathing

Of course, severe holding in the neck and thorax adversely affects breathing, swallowing and speaking. We devoted a considerable proportion of time to breathing, often in semi-supine. Perhaps the most important aspect of working with breathing was inhibition. We used 'games' to explore inhibition.

Bent arms

We also worked directly on the hands and on turning the forearms, with directions and inhibition, in such a way that the whole nervous system was stimulated up the arms.

People with Parkinson's commonly hold their arms bent, particularly on the side affected by tremor. A particularly effective movement for releasing this contraction was devised by Kathleen Ballard in 1994:

1. While inhibiting and directing, the seated pupil is asked to let their hand rest on their thigh, with its outer (little finger) edge on the cloth, and then to move the hand slowly over the thigh, and from the top of the thigh and down the outer side to the seat of the chair, constantly stimulating the outer edge of the hand.
2. Then move the hand on, down the edge of the chair seat, until the arm is hanging, and leave it there for a while, (directing, of course). This is very effective in encouraging the arm to lengthen and straighten.
3. The hand is then rotated, so that the thumb edge is stimulated as the hand is brought back up to the start position.

Writing

With some people we worked on writing. The writing of people with Parkinson's is distinctive: small, illegible, sloping upwards on the page towards the right. It can, of course, be improved by lengthening to the elbow, and all the normal ways of influencing handwriting. However, if I pulled in my inner upper arm in the pattern I had noticed in some pupils on the

table (as mentioned above), my own handwriting instantly took on the Parkinson's characteristics. It was impossible to stop it sloping up to the right, or to prevent the letters from getting smaller.

If practising writing, it was particularly effective to include (along with inhibiting and overall directing) attention to lengthening up the upper inner arm; to lengthening up the sides of the back from the iliac crests through the armpits, being sure to include widening across the bottom of the back (i.e. below the pelvic symphysis), and being aware of the whole upper limb, like a wing, from the lower back to the hand, and aware of the connections from the shoulders up over the head.

Although we rarely applied the Alexander Technique to other specific fine movements apart from writing, the results of the trial show that improvement in the performance of fine hand-eye coordinated movement of the AT group, when compared to the 'no extra treatment' group, was as statistically significant as the comparative improvement of gross movements like walking. (Paper in preparation).

FACIAL EXPRESSION MUSCLES

Reduced mobility of the facial expression muscles in people with Parkinson's impairs communication and makes socializing more difficult. The following procedure was very effective in restoring flexibility of the facial expression muscles, and hence of expressiveness. One woman's dimple reappeared as her face recovered its liveliness.

1. The student begins by imagining that the skin of their face, neck and throat, right into the hairline, is one or more centimetres deep.
2. Then, beginning under the chin, the student directs for expansion, slowly working up the face in bands and taking the attention right across into the hairline at each stage.

It is important to include bony bits, such as the nose and brows, and parts that have no name in our language, such as

the lower part of the cheeks or under the lower lip. When at the lips it is helpful to think of the lips from inside the mouth, and in the shape of an athletics track (mapping the *orbicularis oris*), when directing for expansion. The lower lids can be 'mapped' as extending a centimetre down the face. With the eyes, encourage attention to both the nasal and the temporal sides. The idea of panda-eyes can be helpful.

I use this 'game' from time to time with most of my students. Stress and tension stiffen the facial expression muscles, and anyone can take ten years off their age by applying directions in this way. In the research it was mainly practised while lying on the table, but participants enjoyed the fact that they could practise anywhere, even while in company. It gave them a secret agenda.

Eyes

Applying inhibition and direction to the following simple eye movement changed impassive lids to twitching liveliness, adding greatly to expressiveness in the face.

The student, in semi-supine, is asked to think of letting their eyes move from left to right – but, when on the brink of doing so, to stop, inhibit and direct several times before allowing the eyes to move.

Part of the directions is to think of the eyes as releasing from the *left* corner of each eye, so as to allow movement to the right as if by unmooring a boat – in contrast to our habit, which is to think of the eyes being pulled to the right by the right-hand corners. It is a kind of lengthening into movement for the eyes. Continue to direct with the focus of attention on the left side of both eyes.

One participant used to practise on the tube-train, letting his gaze shift from one of his knees to the other.

Tremor

One in 10–15 participants was not distressed by their obvious tremor, but most of them were bothered by it, some quite severely. Commonly used conscious ways to 'control' or hide tremor in the upper limb included putting hands in pockets

or behind their backs, and putting the moving hand under the weight of the other hand – even sitting on it. The unconscious response to tremor was to tighten through the arm (or leg), beginning in the neck, and this may help account for the stereotypical posture of people with Parkinson's, including the thickened neck and pulling down on the main tremor side.

Our argument was that the Alexander Technique would not cure tremor, but that it could help manage it.

On the assumption that the unconscious habit of tightening starts at the top of the neck (close to the basal ganglia), and applying the principles of the Alexander Technique, I asked participants to direct imaginary tremor out through the top of the head in one direction, and out through the fingertips of the hand with the tremor, in the opposite direction. The common effect was for the tremor to get momentarily stronger and then to peter out for an interval from several seconds to a minute or two, or even considerably longer. Such temporary relief, we argued, was probably beneficial in reducing the RSI pain that some experienced in the tightened limb.

Some participants, when directing tremor out through the top of their heads, showed a slight tremor in the jaw, which had not been there before. I deduced from these observations and others, that the unfamiliar feeling of the tremor had been interpreted as 'wrong' and had consequently been blocked unconsciously by muscular contraction.

The bent-forward posture that is characteristic of Parkinson's could also be partly due to tightening unconsciously around the hip joints to control the tremor through the legs. Participants could experiment with asking the imaginary tremor to go out through their head and also through a leg. Some participants could switch the tremor from an arm to a leg in this way. In general it helped release the hip joints.

Pain from Parkinson's is a common but not universal feature. It sometimes related to the area the participant unconsciously favoured in tightening against the tremor. Most men tightened the forearm, and if they had pain, tended to have it

there or around the elbow; one tightened in the armpit, and his pain was between the shoulder blades.

CONCLUDING REMARKS

People with Parkinson's may have slow and indistinct speech, but that is no reflection of their quickness and clarity in other spheres. Our research shows that they can learn and apply the Alexander Technique to good effect.

One of the distressing aspects of receiving a diagnosis of Parkinson's is the common accompanying stricture that they can do nothing about it except to keep up exercise. The Alexander Technique gives them a tool for managing disability, and enables them to reclaim some of their autonomy by giving them a means to influence the progress of the disease in terms of its impact on their daily and social lives. As one person put it, 'it's a godsend'.

References

- Stallibrass C., Sissons P. and Chalmers C. (2002) 'Randomised controlled trial of the Alexander Technique for idiopathic Parkinson's Disease.' *Clinical Rehabilitation* **16**: 705-718.
- Stallibrass C., Frank C. and Wentworth K. (2005) 'Retention of skills learnt in Alexander Technique lessons: 28 people with idiopathic Parkinson's disease.' *Journal of Bodywork and Movement Therapies* **9** No. 2 150-157.

Chloe Stallibrass MA (Oxon); PhD (LSE); PG Dip Man (UEL); Member: Society of Teachers of the Alexander Technique; Associate Research Fellow, School of Integrated Health, University of Westminster. Chloe qualified from the Constructive Teaching Centre in 1992. She had previously worked as an economist and policy adviser. Alongside her teaching activities she has continued her interest in research. She is interested in new ideas and new research methods and welcomes collaboration.

Tel. +44 (0)207 483 4830
stallc@wmin.ac.uk
www.Londonalexander.co.uk