

The Alexander Technique and Parkinson's Disease: A Case Study in Generating Hope for a Degenerative Condition

by Ruth Rootberg

In the summer of 2008 a student of mine who is a physician urged me to see her patient, "Sabrina" (fictitious name), a senior citizen with Parkinson's disease. The physician was concerned because Sabrina's breathing was becoming compromised as her chest increasingly collapsed downward. I agreed to see Sabrina to discuss what the Alexander Technique might offer her and under what circumstances we could arrange lessons. I was both curious and terrified about teaching her to re-coordinate neuromuscular patterning while her nervous system was progressively deteriorating. How could I help her, and for how long? Before meeting Sabrina, I did some research.

Parkinson's Disease

Parkinson's Disease is a progressive, neurodegenerative movement disorder with symptoms that may include trembling in the hands, arms, legs, jaw, and face (tremor), rigidity and stiffness, slowness of movement, difficulty in initiating movement, and postural instability (impaired balance).¹ Parkinson's patients typically develop a stooped, head-down, shoulders-drooped stance with a tendency to lean unnaturally forward or backward, and they tend to walk with a distinctive unsteady shuffling gait.² Parkinson's is generally considered a disease of late middle age with the average age of onset at around 60 years of age.³ Idiopathic Parkinson's disease is the most common form; it is called *idiopathic* because the cause for the condition is unknown.⁴

There is no known cure for Parkinson's disease. Medical treatment involves powerful medications that act to reduce the symptoms and hopefully slow the pace at which the disease progresses. These powerful medications may produce unwanted side-effects, however, so care is taken in regulating and changing dosages as conditions warrant.

Some Parkinson's patients undergo "deep brain stimulation."⁵ In patients with Parkinson's disease, nerve cells in this region degenerate, causing tremors, stiffness, slowed movement, and loss of coordination. During this surgical procedure, electrodes are implanted that deliver electrical impulses to the region in the center of the brain that controls and coordinates movement. Physical therapy treatment stresses increasing patients' comfort level and ability to manage daily life activities independently. This is where the Alexander Technique comes in.

There has been one randomized, controlled study of the Alexander Technique for patients with idiopathic Parkinson's disease (2002).⁶ This study by Chloe Stallibrass, M.STAT, and colleagues included one group that received 24 private lessons and a control group. The results showed that the group receiving the lessons improved at a statistically notable level compared to the control group, as measured after the lessons and six months later. Participants described improvements in walking, speech, improved posture or balance, greater energy, reduced tremor, and reduced rigidity or muscle tension. Some reported reduced stress or greater composure. Fewer changed their medications during the intervention or the six months following.

Sabrina

Armed with the results of my research, I met with Sabrina.

Sabrina's chief complaint was neck pain. That was not surprising: her back was rounded like a crescent roll, and her chest was collapsed, just as her doctor had described, leaving no room for the ribs to move. Her neck jutted forward, and almost every sentence was broken as she struggled for air. She also had a tremor in her jaw and face.

When we began lessons, Sabrina could still drive and walked without a cane or walker. A former Montessori teacher, she responded quickly to my words and touch; I knew she could learn the Alexander Technique and that it could relieve some discomfort, but I had no idea whether her quality of life might change.

After reading Chloe Stallibrass' research, Sabrina's son encouraged her to take regular lessons, but she wasn't sure she could afford them. We made a bargain: she would come to my weekly private lessons with Missy Vineyard and serve as my "practice student." I would pay for the lessons (she would not have to pay), and both of us would receive the benefit of Missy's expertise.

I had been bringing a practice student to lessons with Missy for a couple of years. Usually I simply gave the student a lesson, while Missy put her hands on me, steering me away from my habits of misuse. Now I wanted to draw on Missy's long-term experience and considerable pedagogical, observational, and intuitive skills in dealing with someone whose problems were more severe than those of most students I had encountered.

During the lessons, I remained in the teacher role most of the time. Missy had a dual role, sometimes putting hands on me, sometimes on Sabrina. In our first meeting as a three-some, Sabrina shared her worries that she couldn't stop her tremors. Missy said: "Your tremor simply *is*. It happens. It's not your job to control it." That simple statement inspired me. It reinforced the role I wanted to play as teacher: It was not my responsibility to cure Sabrina's tremor; my business was to teach her to inhibit and direct. I would use my hands and also teach her these cognitive skills, so she could apply them by herself.

During the first several lessons, I worked with Sabrina while she lay on the table. She told us about the neck pillow that sent her head back and down all night long as she slept. No wonder she was aching! Missy and I convinced her to discard the neck pillow and put a regular pillow under her head instead. We also showed her how a few well-placed pillows under her shoulders and knees could support her more comfortably. She returned the next week, amazed at how well she had adapted to the new pillow arrangement in such a short time. Then she showed us how she tugged her head back first thing after she woke up in the morning, believing this was a good stretch. We taught her to just lie still for a bit, quieting her thoughts, before she got out of bed.

After a half dozen sessions, she started reading Missy's book, *How You Stand, How You Move, How You Live*.⁷ Her attention during the lessons deepened. Sabrina attends Quaker meetings, and she related "quieting her mental chatter"⁸ to sitting

"Your tremor simply *is*. It happens. It's not your job to control it."

at meetings. As I witnessed Sabrina's increasing ability to quiet her mind, I shifted focus to chair turns and taught her to think "up," while Missy helped me encourage direction with my hands. During the first chair lesson, something amazing happened: Sabrina's torso lengthened and her tremor stopped. We saw it, and Sabrina felt it. The tremor ceased only for moments at a time, but she realized her new thinking had influenced her ability to lengthen, and when she lost it, she could reclaim it if we gave her a reminder.

Missy and I offered her a more complex thought: "Your neck needs to come back—it is collapsed, and the weight of your head pulls your neck farther forward, but then you also pull your head back on your neck as you try to see ahead—this is why your neck hurts. The weight of the head is also dragging your torso down, which makes it harder for you to breathe. Can you think of your neck coming back as you also think up?" We waited as Sabrina tried this thought. Then her neck went back, her head shifted forward and up, and her torso opened up. She blossomed like a rose and floated up out of the chair.

During the following weeks, Sabrina walked in with a smile on her face, but on several occasions she complained that she had felt "just horrible" during the previous week, and her neck hurt. Even though we told her from the beginning that she needed to lie down several times a day, she admitted she was too interested in her activities to stop for semi-supine. But during successive lessons, it was increasingly clear that she remembered what she had learned the previous week and was able to re-create her new thinking skills.

After several more lessons, Sabrina arrived one day, again complaining, and reported that she would see her neurologist soon. As we worked, I observed more pronounced characteristic Parkinsonian movement: exaggerated sway, stiffness of the arms and hands, and a more extensive range of movement in the tremor through the head and neck. But Sabrina was not responsible for her tremor, I reminded her. I hoped I wasn't either, and we continued the lesson.

At the following lesson, Sabrina happily reported that she was feeling much better and that her neurologist had reduced her medication. The neurologist explained that sometimes overmedication can cause the movement symptoms to worsen. It seemed that Sabrina needed LESS medication than previously. Missy and I wondered—is the Alexander Technique having an effect? In the Stallibrass research, no participants reduced their medication; the research only reported that patients progressed more slowly towards stronger medications. We were cautiously hopeful.

At the next lesson, Sabrina and I were alone. Once again she entered the teaching studio with a smile. Her movements were more controlled again, but she quickly complained about her neck, saying she was in terrible shape.

And she had questions from her continued reading. She understood how to quiet her mind. She understood inhibition, e.g., having the thought NOT to tense her neck. But she didn't understand Missy's concept of the "attic."⁹ Missy uses the word *attic* as a metaphor: if you imagine your brain as a house with many rooms, then the part of the brain that gives us the capacity

for conscious inhibition is located in the most forward and up area of the house. Neurologists call this area of the brain the *pre-frontal cortex*. Using the metaphor of the brain as a house, Missy refers to this area of the brain as the *attic*. She theorizes that the thought of "forward and up," or of "rising up to the attic," can improve the functioning of this area of the brain, and so improve our ability to inhibit. She teaches students the skill of shifting their attention upward, or rising up to the attic, as a necessary first step for learning conscious inhibition.

Sabrina asked if the concept of the attic was going to help her. Instead of offering a verbal answer, I suggested we just work for a while. I put hands on Sabrina for a few minutes. Then I played a version of a game Missy uses to help students learn to differentiate between focusing the mind on "feeling a part of the body" (focusing on internal sensation tends to pull one down) versus "thinking up in the attic" (from the attic we can send inhibitory messages, while also receiving sensory information from the body). As Sabrina sat on the chair, I put my hand on her knee and asked her to feel her knee. Then I asked her to rise up to her attic. We journeyed back and forth between feeling the knee and rising up to the attic. Each time Sabrina went to her attic, I could feel her body lighten under my hand. Then I asked her to describe the difference. "Well, there isn't much," she replied. I explained that recognizing even a slight change is actually important. Then she said it was more comforting to feel the heat of my hands when she was in the "feeling" zone. Of course, I had hoped she would prefer the attic, but I was not daunted. I agreed that warmth can be quite comforting, and pursued another tack.

I put my hands on her neck and asked her to feel the discomfort in her neck that she had mentioned at the beginning of the lesson. Then I asked her to shift her awareness upward, toward her attic. She switched back and forth several times

between mentally "going down" to feel her neck and "rising up" to the attic. This time when I asked her what she noticed, she said there was less pain in her neck when she was up in her attic.

Sabrina had answered her own question; one significant benefit of thinking from the attic is that it often reduces pain quite suddenly. Perhaps the broader, more global view of the whole self that is generated from thinking up to the attic gives one a different

perspective on pain, rendering it less overwhelming. Sabrina's experience was teaching her that inhibiting and directing while thinking up to the attic could help her to manage pain as well as her posture and coordination.

At the end of the lesson, Sabrina rose gracefully from the chair and walked forward toward something across the room, allowing her brain to organize her movements to get there more easily. Her hands were still stiff, but she was much more upright than when she had entered the teaching room. She said she was feeling calmer, too.

That watershed day inspired me to write this article. Sabrina, after about 20 lessons, had transformed how she felt and moved, simply through her own thinking.

Sadly, in the weeks following, Sabrina's condition worsened. She sustained a head injury after falling at home.

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However, during her recovery, she used her time well. When she returned to lessons, she reported she had been practicing her thinking. After a few minutes in the chair, she went “up.” But weeks later, during a period when she was not receiving lessons, her pain increased so much that she was hospitalized. Currently she no longer drives, has been in and out of a nursing home, uses a cane or walker to get around, and has the beginnings of dementia. I made some home visits, after which she said she felt “wonderful and hopeful.”

My lessons with Sabrina taught me that there are tangible benefits for Parkinson’s patients in learning the Alexander Technique, and that these benefits are tempered by the fact that the disease inevitably continues to progress. It is a delicate balance, offering a student “conscious control” to improve circumstances that neurologically change unconsciously, but I as teacher would encourage people with Parkinson’s to have lessons because the potential for temporary relief and some improvement in coping with daily activities are desirable prospects, even under deteriorating circumstances. The hope for a better quality of life is something we can always offer our students, whether they have the possibility of progressing towards health or suffer from a progressively degenerative disease.

Endnotes:

1. “Parkinson’s Disease—a Unique Survey Launched,” World Health Organization Press Release/71, October 14, 1998, www.who.int/inf-pr-1998/en/pr98-71.html. Accessed May 1, 2010.
2. “Overview: Parkinson’s disease,” Health communities.com, www.neurologychannel.com/parkinsonsdisease/index.shtml. Accessed May 3, 2010.
3. “At what age can signs of Parkinson’s Disease be noticed?” www.seniorhealth.about.com/od/parkinsonsdisease/f/age_park_sympt.html. Accessed May 1, 2010.
4. “Overview: Parkinson’s disease.”
5. Anne Harding, “Brain implant better than meds for Parkinson’s disease,” www.cnn.com/2009/HEALTH/01/06/parkinsons.deep.brain.stimulation/index.html. Accessed April 16, 2010.
6. C. Stallibrass et al, “Randomized controlled trial of the Alexander Technique for idiopathic Parkinson’s disease,” *Clinical Rehabilitation*, 16 (2002): 707–718.
7. Missy Vineyard, *How You Stand, How You Move, How You Live* (New York: Avalon, 2007).
8. *Ibid.*, 152–154. Missy recommends quieting mental chatter before sending inhibitory thoughts.
9. *Ibid.*, 115–121.

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Two Parkinson’s Patients Who Are Students of the Alexander Technique Comment on Their Experiences

Semi-Supine as Recuperation

Physics professor and author Shimon Malin was diagnosed with Parkinson’s disease almost 19 years ago. At first, the symptoms were fairly minor. With the help of medication, he continued teaching and writing for several years with little modification. This included periods when he took weekly Alexander Technique lessons, which he considered “a feel-good thing.” He didn’t recognize that his own thinking could play a part in bringing about the good feeling.

After 13 years of living with Parkinson’s, the disease had progressed until the symptoms were severe. Shimon needed a lot of help with daily life activities and could not continue his accustomed professional life without great difficulty. He became a candidate for and successfully underwent a surgical procedure called deep brain stimulation. “It was a night and day thing,” says Shimon. “The boost that I got out of the implant was totally remarkable. I mean, right after they put in the implant, I could start moving normally. I was completely amazed. In fact, I call June 20 my second birthday.”

A few years ago Shimon began attending Missy Vineyard Ehrgood’s training course, and the intensity and depth of his Alexander Technique exposure led him to a new understanding of the Technique: “I accept the Alexander Technique now as a whole big body of knowledge that one can get into and emerge like Dewey and those people did—in a much better place within themselves.”

The disease continues to progress. Just as Shimon is realizing the value of the Technique and learning to put hands on, he is less able to sustain the benefits on his own. He gets tremendous relief when an Alexander teacher has hands on him, but the uplift lasts only an hour or two. He tires easily and finds that semi-supine plays an important role in recuperation. His wife, Alexander teacher Tova Malin, explains:

“It’s hard for Shimon to think about good use when he walks, unloads the dishwasher, etc. Often any exertion brings about discomfort. And he knows very well now that the best thing he can do for it is semi-supine.”

—Ruth Rootberg

A Different Body Every Day

Laurel Miller, former opera singer and retired voice faculty at the University of North Texas, has been studying the Alexander Technique and applying it in her own life for over 25 years. She was diagnosed with Parkinson’s disease five years ago. “Having Parkinson’s is like being handed a different body every day. I never know what I will have to deal with on a daily basis. Some days are more difficult than others,” she says. “Singing and talking cost a lot. It is hard to work on how I know to use my voice because it takes so much energy. The rigidity in my neck, shoulders, and diaphragm tends to pull me forward and down; makes it hard to breathe; and increases the tremor in my left arm. I can’t stop the tremor without stiffening more, so it takes constant awareness not to stiffen. It is hard for me to inhibit the stiffening on my own, the way I used to be able to do. Alexander Technique lessons help me release the rigidity, and then the tremor lessens, and I can breathe better.” With regular lessons, her muscles do not become as rigid. She can maintain the improvement on her own to a certain extent, she says, but she tires very easily. “I have increasing trouble with pulling down and forward. I’d have to be doing nothing else but Alexander Technique to keep that from building up. It’s a constant battle.”

—Phyllis G. Richmond