Clinical Practice Guideline: **Alexander Technique**

Date of Implementation: **February 9, 2006**

Program: **Specialty**

GUIDELINES

American Specialty Health – Specialty (ASH) considers the Alexander Technique as medically necessary when used as a form of exercise in combination with other exercise and interventions for patients whose evaluation determines it would be beneficial within the patient's plan of care.

DESCRIPTION/BACKGROUND

The Alexander Technique is a functional approach to movement therapy in which a teacher (practitioner) gently uses hands and verbal directions to subtly guide the student (client) through movements such as sitting, standing up, bending, and walking in an effort to reduce pain, improve function, and/or restore health.

This technique was developed around 1900 by Frederick M. Alexander, an Australian actor who suffered a recurring loss of his voice. By observing himself in a mirror, he concluded that it was due to the tense position in which he habitually held his head. By correcting the relationship between head, neck, and spine during activity, he solved the problem over a number of years.

Although the Alexander Technique is considered by those in its field to be primarily educational, it is regarded by the United Kingdom National Health System to offer an alternative and complementary management for many medical complaints. A partial list includes back problems, unlearning and avoiding repetitive strain injury, improving ergonomics, stuttering, speech training and voice loss, mobility for those with Parkinson's disease, posture problems, and incomplete recovery from injury.

EVIDENCE REVIEW

Ernst (2001) summarized the results of three independent studies. These controlled trials reported enhanced respiratory function in healthy volunteers, greater functional reach in elderly women, and improvements in performance and anxiety in musical students following training in the Alexander Technique. Little et al. (2008) performed a factorial randomized trial to determine the effectiveness of lessons in the Alexander Technique, massage therapy, and advice from a doctor on exercise along with nurse delivered behavioral counseling for patients with chronic or recurrent back pain. A total of 579 patients with chronic or recurrent low back pain were randomized into the following groups: 144 were to normal care, 147 to massage, 144 to six Alexander Technique lessons, and 144 to 24 Alexander technique lessons. Half of each of these groups were also

randomized to exercise prescription. With regard to the Alexander Technique, one-to-one lessons from registered teachers have long term benefits for patients with chronic back pain. Six lessons followed by exercise prescription were nearly as effective as 24 lessons. These results persisted for a year. In a systematic review by Woodman (2012), strong evidence was reported in support of the use of Alexander Technique for chronic back pain. Authors suggest it may also benefit Parkinson's associated disability, balance for the elderly, chronic pain, posture, respiratory function, and stuttering, but state there is insufficient evidence to support recommendations for these areas. Klein et al. (2014) completed a systematic review of controlled trials on the Alexander Technique and musicians. The review aimed to evaluate the evidence for the effectiveness of Alexander Technique sessions on musicians' performance, anxiety, respiratory function, and posture. Twelve studies were included for further analysis, 5 of which were randomized controlled trials (RCTs), 5 controlled but not randomized trials (CTs), and 2 mixed methods studies. Main outcome measures in RCTs and CTs were music performance, respiratory function, performance anxiety, body use and posture. Evidence from RCTs and CTs suggests that Alexander Technique sessions may improve performance anxiety in musicians. Effects on music performance, respiratory function and posture yet remain inconclusive. Future trials with well-established study designs are warranted to further and more reliably explore the potential of Alexander Technique in the interest of musicians.

MacPherson et al. (2015) compared acupuncture and Alexander Technique lessons versus usual care for persons with chronic neck pain. Subjects received 12 acupuncture sessions or 20 one-to-one Alexander lessons (both 600 minutes total) plus usual care versus usual care alone. Mean attendance was 10 acupuncture sessions and 14 Alexander lessons. No reported serious adverse events were considered probably or definitely related to either intervention. Authors concluded that acupuncture sessions and Alexander Technique lessons both led to significant reductions in neck pain and associated disability compared with usual care at 12 months. Enhanced self-efficacy may partially explain why longer-term benefits were sustained. Hu et al. (2015) completed an exploratory systematic review aimed to identify randomized controlled trials (RCTs) and provide evidence on the effectiveness, cost effectiveness and adverse effects of integrative treatment for low back pain (LBP). Two trials investigated costs, reporting a gain of £5,332 per quality adjusted life years with 6 Alexander Technique lessons plus exercise at 12 months follow-up and an increased total cost of $244 when giving an additional (up to 15) sessions of CAM care at 12 weeks. The authors concluded that integrative treatment that combines CAM with conventional therapies (i.e., Alexander Technique) appeared to have beneficial effects on pain and function. However, evidence is limited due to heterogeneity, the relatively small numbers available for subgroup analyses and the low methodological quality of the included trials.

McClean et al. (2015) explored the perceived impact of Alexander Technique lessons on health status, costs, and pain management for those with chronic back pain. Based on limitations with methodology, more research is necessary, but the authors reported that Alexander Technique lessons may be used as another approach to pain management. The findings suggest that Alexander Technique lessons can help improve self-efficacy for those who are sufficiently motivated, which in turn may have an impact on service utilization levels. Lauche et al. (2016) tested the efficacy of the Alexander Technique, local heat and guided imagery on pain and quality of life in patients with chronic neck pain. A total of 72 patients (65 females, 40.7±7.9 years of age) with chronic non-specific neck pain received 5 sessions of the Alexander Technique aimed at modifying dysfunctional posture, movement and thinking patterns associated with musculoskeletal disorders. Control groups were treated with local heat application or guided imagery. All interventions were conducted once a week for 45 minutes each. Outcomes included pain, neck disability, quality of life and satisfaction. No group difference was found for pain intensity for the Alexander Technique compared to local heat, but exploratory analysis revealed the superiority of the Alexander Technique over guided imagery. Significant group differences in favor of the Alexander Technique were also found for physical quality of life ($P<0.05$). The authors concluded that further trials are warranted for conclusive judgment.

Preece et al. (2016) investigated the potential clinical effectiveness of the Alexander Technique intervention in the management of knee osteoarthritis and also to identify a possible mechanism of action. A cohort of 21 participants with confirmed knee osteoarthritis were given 20 lessons of instruction in the Alexander Technique. In addition to clinical outcomes electromyography (EMG) data, quantifying knee muscle co-contraction and electroencephalogram (EEG) data, characterizing brain activity during anticipation of pain, were collected. All data were compared between baseline and post-intervention time points with a further 15-month clinical follow up. In addition, biomechanical data were collected from a healthy control group and compared with the data from the osteoarthritis subjects. Following Alexander Technique instruction, the mean WOMAC pain score reduced by 56 % from 9.6 to 4.2 and this reduction was maintained at 15 month follow up. There was a clear decrease in medial co-contraction at the end of the intervention, towards the levels observed in the healthy control group, both during a pre-contact phase of gait and during early stance. However, no changes in pain-anticipatory brain activity were observed. Interestingly, decreases in WOMAC pain were associated with reductions in medial co-contraction during the pre-contact phase of gait. Authors concluded that these data suggest a complex relationship between muscle contraction, joint loading and pain and support the idea that excessive muscle co-contraction may be a maladaptive response in this patient group. Furthermore, these data provide evidence that, if the activation of certain muscles can be reduced during gait, this may lead to positive long-term clinical outcomes.

Woodman et al. (2018) evaluated self-efficacy and self-care-related outcomes following Alexander Technique lessons for people with chronic neck pain in the ATLAS randomized, controlled trial. The ATLAS was a pragmatic randomized (1:1:1 ratio), controlled trial recruiting patients with chronic neck pain ($N = 517$) and evaluating one-to-one Alexander Technique lessons, or acupuncture, each plus usual care, compared with usual care alone. The Alexander group ($n = 172$) reported significantly greater improvements, compared with usual care alone ($n = 172$), in most of the self-efficacy/self-care measures, including the ability to reduce pain in daily life. Neck Pain Questionnaire (NPQ) scores at both 6 and 12 months were related to improvement in self-efficacy and ability to reduce pain during daily life. Authors concluded that Alexander Technique lessons led to long-term improvements in the way participants lived their daily lives and managed their neck pain. Alexander lessons promote self-efficacy and self-care, with consequent reductions in chronic neck pain. In a systematic review on noninvasive treatments for chronic pain conditions, Skelly et al. (2018) reported that for chronic neck pain at short and intermediate terms, acupuncture and Alexander Technique were associated with slightly improved function compared with usual care (both interventions), sham acupuncture, or sham laser, but no improvement in pain was seen at any time. Strength of evidence was noted as low.

Hafezi et al. (2022) determined the effect of the Alexander Technique on the intensity of pain in patients with chronic low back pain (LBP) in a clinical trial that was performed on 80 patients with chronic LBP in Kashan, Iran. Participants were randomly assigned in control and intervention groups. To assess the participants' LBP, a visual analog scale of pain (VAS-Pain) was completed by both groups. In the intervention group, in addition to routine care for LBP patients, the Alexander Technique was performed in three 60-min sessions per week for 12 weeks. The control group participants received routine care for LBP patients. The two groups completed the VAS-Pain scale immediately after and one month after the intervention. The results showed that there was no statistically significant difference between the two groups in terms of demographic characteristics and mean pain intensity score before the intervention ($p > 0.05$). Immediately after and then one month after the intervention, there was statistically significant differences between the two groups regarding the mean scores of pain ($p < 0.05$). The results of repeated measures ANOVA showed that, in the intervention group, the mean score of pain had decreased over time ($p < 0.05$). Authors concluded that the Alexander Technique was effective in reducing the intensity of pain among the participants. They recommend the Alexander Technique as a useful and effective intervention for reducing chronic LBP.

PRACTITIONER SCOPE AND TRAINING

Practitioners should practice only in the areas in which they are competent based on their education training and experience. Levels of education, experience, and proficiency may vary among individual practitioners. It is ethically and legally incumbent on a practitioner to determine where they have the knowledge and skills necessary to perform such services.

It is best practice for the practitioner to appropriately render services to a patient only if they are trained, equally skilled, and adequately competent to deliver a service compared to others trained to perform the same procedure. If the service would be most competently delivered by another health care practitioner who has more skill and expert training, it would be best practice to refer the patient to the more expert practitioner.

Best practice can be defined as a clinical, scientific, or professional technique, method, or process that is typically evidence-based and consensus driven and is recognized by a majority of professionals in a particular field as more effective at delivering a particular outcome than any other practice (Joint Commission International Accreditation Standards for Hospitals, 2020).

Depending on the practitioner's scope of practice, training, and experience, a member's condition and/or symptoms during examination or the course of treatment may indicate the need for referral to another practitioner or even emergency care. In such cases it is prudent for the practitioner to refer the member for appropriate co-management (e.g., to their primary care physician) or if immediate emergency care is warranted, to contact 911 as appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* clinical practice guideline for information.

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