

1 **Clinical Practice Guideline: Alexander Technique**

2
3 **Date of Implementation: February 9, 2006**

4
5 **Program: Specialty**

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7
8 **GUIDELINES**

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

13
14 **DESCRIPTION/BACKGROUND**

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

19
20 This technique was developed around 1900 by Frederick M. Alexander, an Australian actor
21 who suffered a recurring loss of his voice. By observing himself in a mirror, he concluded
22 that it was due to the tense position in which he habitually held his head. By correcting the
23 relationship between head, neck, and spine during activity, he solved the problem over a
24 number of years.

25
26 Although the Alexander Technique is considered by those in its field to be primarily
27 educational, it is regarded by the United Kingdom National Health System to offer an
28 alternative and complementary management for many medical complaints. A partial list
29 includes back problems, unlearning and avoiding repetitive strain injury, improving
30 ergonomics, stuttering, speech training and voice loss, mobility for those with Parkinson’s
31 disease, posture problems, and incomplete recovery from injury.

32
33 **EVIDENCE REVIEW**

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

1 and 144 to 24 Alexander technique lessons. Half of each of these groups were also
2 randomized to exercise prescription. With regard to the Alexander Technique, one-to-one
3 lessons from registered teachers have long term benefits for patients with chronic back
4 pain. Six lessons followed by exercise prescription were nearly as effective as 24 lessons.
5 These results persisted for a year. In a systematic review by Woodman (2012), strong
6 evidence was reported in support of the use of Alexander Technique for chronic back pain.
7 Authors suggest it may also benefit Parkinson’s associated disability, balance for the
8 elderly, chronic pain, posture, respiratory function, and stuttering, but state there is
9 insufficient evidence to support recommendations for these areas. Klein et al. (2014)
10 completed a systematic review of controlled trials on the Alexander Technique and
11 musicians. The review aimed to evaluate the evidence for the effectiveness of Alexander
12 Technique sessions on musicians' performance, anxiety, respiratory function, and posture.
13 Twelve studies were included for further analysis, 5 of which were randomized controlled
14 trials (RCTs), 5 controlled but not randomized trials (CTs), and 2 mixed methods studies.
15 Main outcome measures in RCTs and CTs were music performance, respiratory function,
16 performance anxiety, body use and posture. Evidence from RCTs and CTs suggests that
17 Alexander Technique sessions may improve performance anxiety in musicians. Effects on
18 music performance, respiratory function and posture yet remain inconclusive. Future trials
19 with well-established study designs are warranted to further and more reliably explore the
20 potential of Alexander Technique in the interest of musicians.

21
22 MacPherson et al. (2015) compared acupuncture and Alexander Technique lessons versus
23 usual care for persons with chronic neck pain. Subjects received 12 acupuncture sessions
24 or 20 one-to-one Alexander lessons (both 600 minutes total) plus usual care versus usual
25 care alone. Mean attendance was 10 acupuncture sessions and 14 Alexander lessons. No
26 reported serious adverse events were considered probably or definitely related to either
27 intervention. Authors concluded that acupuncture sessions and Alexander Technique
28 lessons both led to significant reductions in neck pain and associated disability compared
29 with usual care at 12 months. Enhanced self-efficacy may partially explain why longer-
30 term benefits were sustained. Hu et al. (2015) completed an exploratory systematic review
31 aimed to identify randomized controlled trials (RCTs) and provide evidence on the
32 effectiveness, cost effectiveness and adverse effects of integrative treatment for low back
33 pain (LBP). Two trials investigated costs, reporting a gain of £5,332 per quality adjusted
34 life years with 6 Alexander Technique lessons plus exercise at 12 months follow-up and
35 an increased total costs of \$244 when giving an additional (up to 15) sessions of CAM care
36 at 12 weeks. The authors concluded that integrative treatment that combines CAM with
37 conventional therapies (i.e., Alexander Technique) appeared to have beneficial effects on
38 pain and function. However, evidence is limited due to heterogeneity, the relatively small
39 numbers available for subgroup analyses and the low methodological quality of the
40 included trials.

1 McClean et al. (2015) explored the perceived impact of Alexander Technique lessons on
2 health status, costs and pain management for those with chronic back pain. Based on
3 limitations with methodology, more research is necessary, but the authors reported that
4 Alexander Technique lessons may be used as another approach to pain management. The
5 findings suggest that Alexander Technique lessons can help improve self-efficacy for those
6 who are sufficiently motivated, which in turn may have an impact on service utilization
7 levels. Lauche et al. (2016) tested the efficacy of the Alexander Technique, local heat and
8 guided imagery on pain and quality of life in patients with chronic neck pain. A total of 72
9 patients (65 females, 40.7 ± 7.9 years of age) with chronic non-specific neck pain received
10 5 sessions of the Alexander Technique aimed at modifying dysfunctional posture,
11 movement and thinking patterns associated with musculoskeletal disorders. Control groups
12 were treated with local heat application or guided imagery. All interventions were
13 conducted once a week for 45 minutes each. Outcomes included pain, neck disability,
14 quality of life and satisfaction. No group difference was found for pain intensity for the
15 Alexander Technique compared to local heat, but exploratory analysis revealed the
16 superiority of the Alexander Technique over guided imagery. Significant group differences
17 in favor of the Alexander Technique were also found for physical quality of life ($P < 0.05$).
18 The authors concluded that further trials are warranted for conclusive judgment.

19
20 Preece et al. (2016) investigated the potential clinical effectiveness of the Alexander
21 Technique intervention in the management of knee osteoarthritis and also to identify a
22 possible mechanism of action. A cohort of 21 participants with confirmed knee
23 osteoarthritis were given 20 lessons of instruction in the Alexander Technique. In addition
24 to clinical outcomes electromyography (EMG) data, quantifying knee muscle co-
25 contraction and electroencephalogram (EEG) data, characterizing brain activity during
26 anticipation of pain, were collected. All data were compared between baseline and post-
27 intervention time points with a further 15-month clinical follow up. In addition,
28 biomechanical data were collected from a healthy control group and compared with the
29 data from the osteoarthritis subjects. Following Alexander Technique instruction, the mean
30 WOMAC pain score reduced by 56 % from 9.6 to 4.2 and this reduction was maintained
31 at 15 month follow up. There was a clear decrease in medial co-contraction at the end of
32 the intervention, towards the levels observed in the healthy control group, both during a
33 pre-contact phase of gait and during early stance. However, no changes in pain-anticipatory
34 brain activity were observed. Interestingly, decreases in WOMAC pain were associated
35 with reductions in medial co-contraction during the pre-contact phase of gait. Authors
36 concluded that these data suggest a complex relationship between muscle contraction, joint
37 loading and pain and support the idea that excessive muscle co-contraction may be a
38 maladaptive response in this patient group. Furthermore, these data provide evidence that,
39 if the activation of certain muscles can be reduced during gait, this may lead to positive
40 long-term clinical outcomes.

1 Woodman et al. (2018) evaluated self-efficacy and self-care-related outcomes following
2 Alexander Technique lessons for people with chronic neck pain in the ATLAS randomized,
3 controlled trial. The ATLAS was a pragmatic randomized (1:1:1 ratio), controlled trial
4 recruiting patients with chronic neck pain ($N = 517$) and evaluating one-to-one Alexander
5 Technique lessons, or acupuncture, each plus usual care, compared with usual care alone.
6 The Alexander group ($n = 172$) reported significantly greater improvements, compared
7 with usual care alone ($n = 172$), in most of the self-efficacy/self-care measures, including
8 the ability to reduce pain in daily life. Neck Pain Questionnaire (NPQ) scores at both 6 and
9 12 months were related to improvement in self-efficacy and ability to reduce pain during
10 daily life. Authors concluded that Alexander Technique lessons led to long-term
11 improvements in the way participants lived their daily lives and managed their neck pain.
12 Alexander lessons promote self-efficacy and self-care, with consequent reductions in
13 chronic neck pain. In a systematic review on noninvasive treatments for chronic pain
14 conditions, Skelly et al. (2018) reported that for chronic neck pain at short and intermediate
15 terms, acupuncture and Alexander Technique were associated with slightly improved
16 function compared with usual care (both interventions), sham acupuncture, or sham laser,
17 but no improvement in pain was seen at any time. Strength of evidence was noted as low.

18
19 Hafezi et al. (2022) determined the effect of the Alexander Technique on the intensity of
20 pain in patients with chronic low back pain (LBP) in a clinical trial that was performed on
21 80 patients with chronic LBP in Kashan, Iran. Participants were randomly assigned in
22 control and intervention groups. To assess the participants' LBP, a visual analog scale of
23 pain (VAS-Pain) was completed by both groups. In the intervention group, in addition to
24 routine care for LBP patients, the Alexander Technique was performed in three 60-min
25 sessions per week for 12 weeks. The control group participants received routine care for
26 LBP patients. The two groups completed the VAS-Pain scale immediately after and one
27 month after the intervention. The results showed that there was no statistically significant
28 difference between the two groups in terms of demographic characteristics and mean pain
29 intensity score before the intervention ($p > 0.05$). Immediately after and then one month
30 after the intervention, there was statistically significant differences between the two groups
31 regarding the mean scores of pain ($p < 0.05$). The results of repeated measures ANOVA
32 showed that, in the intervention group, the mean score of pain had decreased over time (p
33 < 0.05). Authors concluded that the Alexander Technique was effective in reducing the
34 intensity of pain among the participants. They recommend the Alexander Technique as a
35 useful and effective intervention for reducing chronic LBP.

36 37 **PRACTITIONER SCOPE AND TRAINING**

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

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

6
 7 Best practice can be defined as a clinical, scientific, or professional technique, method, or
 8 process that is typically evidence-based and consensus driven and is recognized by a
 9 majority of professionals in a particular field as more effective at delivering a particular
 10 outcome than any other practice (Joint Commission International Accreditation Standards
 11 for Hospitals, 2020).

12
 13 Depending on the practitioner’s scope of practice, training, and experience, a member’s
 14 condition and/or symptoms during examination or the course of treatment may indicate the
 15 need for referral to another practitioner or even emergency care. In such cases it is prudent
 16 for the practitioner to refer the member for appropriate co-management (e.g., to their
 17 primary care physician) or if immediate emergency care is warranted, to contact 911 as
 18 appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* clinical practice
 19 guideline for information.

20 21 **References**

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