

1 **Clinical Practice Guideline:** **Feldenkrais Method**

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

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5 **Product:** **Specialty**

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8 **GUIDELINES**

9 American Specialty Health – Specialty (ASH) considers Feldenkrais Method (FM) as  
10 medically necessary as a form of movement/exercise within a multi-component  
11 rehabilitative program.

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13 **DESCRIPTION/BACKGROUND**

14 The Feldenkrais Method (FM) is a form of education that uses gentle movements and  
15 directed attention to improve movement and enhance human functioning. It is said to be  
16 based on principles of physics, biomechanics, and an understanding of learning and human  
17 development.

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19 Based on the work of Dr. Moshe Feldenkrais, an Israeli physicist and judo practitioner, the  
20 method is expressed primarily in two formats. Practitioners generally receive more than  
21 800 hours of formal training over a course of four years.

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23 **Functional Integration**<sup>®</sup> (FI) is a hands-on form of tactile, kinesthetic communication  
24 between a practitioner and student. The practitioner communicates to the student how  
25 he/she organizes his/her movements. Through precise touch and movement, the student  
26 learns how to move with less effort and strain. Lessons may be very specific in addressing  
27 particular issues brought by the student or can be more global in scope.

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29 **Awareness Through Movement**<sup>®</sup> (ATM) lessons are verbally directed movement  
30 sequences given primarily in a group setting, though they can also be given to individuals.  
31 There are more than a thousand distinct ATM lessons in existence. Lessons are generally  
32 organized around a particular function, and each practitioner lends their particular style to  
33 each lesson.

34  
35 According to practitioners, use of this method can increase range of motion, flexibility, and  
36 coordination.

37  
38 **EVIDENCE REVIEW**

39 Although an increasing amount of research involving the FM has been performed, only a  
40 small body of empirical research has documented its efficacy. Because FM has such a wide  
41 range of effects, a wide range of outcomes has been evaluated and reported. Many of the  
42 clinical studies have involved small numbers of subjects [six (6) or fewer]. The outcome

1 studies may be categorized into the following four general themes: pain management,  
2 functional performance and motor control, psychological effects, and quality of life.

3  
4 Laumer et al. (1997) studied the therapeutic effects of the FM Awareness Through  
5 Movement with eating disorder patients. Fifteen patients with eating disorders rated  
6 various aspects of their eating disorder before and after participating in a nine-hour course  
7 of FM. The data collected was compared to a control group, also consisting of 15 patients  
8 with eating disorders who did not participate in an FM course. FM course participants  
9 showed increased contentment with problem zones of their body as well as increased  
10 acceptance and familiarity with their own body. Other results were a more spontaneous,  
11 open, and self-confident behavior, decreased feelings of helplessness, and decreased wish  
12 to return to the security of the early childhood, which indicates a general process of  
13 maturation of the whole personality. The outcome points toward the therapeutic  
14 effectiveness of FM with eating-disorder patients within a multimodal treatment program.

15  
16 Another study (James et al., 1998) investigated the effects of FM on hamstring length.  
17 Forty-eight (health undergraduate) participants were randomly allocated into either FM,  
18 relaxation, or control groups. All subjects had their right hamstring measured using a  
19 modified active knee extension test prior to the first session, prior to the fourth (final)  
20 session, and after the final session of intervention. Two-way analysis of variance with time  
21 of measurement repeated revealed no significant differences between the groups. The  
22 findings are discussed in relation to apparent ineffectiveness of the Feldenkrais Awareness  
23 Through Movement lessons used on hamstring length, exposure time to the technique, and  
24 attitudes toward FM.

25  
26 A randomized controlled trial (Lundblad et al., 1999) investigated whether physiotherapy  
27 or Feldenkrais interventions resulted in a reduction of complaints from the neck and  
28 shoulders (prevalence, pain intensity, sick leave, and disability in leisure and work roles)  
29 in 97 female industrial workers (not on long-term sick leave). The workers were  
30 randomized to (1) physiotherapy group, (2) Feldenkrais group, or (3) control group. Pre-  
31 and post-tests were made at one-year intervals. The two interventions lasted 16 weeks  
32 during paid working time. The Feldenkrais group showed significant decreases in  
33 complaints from neck and shoulders and in disability during leisure time. The two other  
34 groups showed no change (physiotherapy group) or worsening of complaints (control  
35 group). This study showed significant positive changes in complaints after the Feldenkrais  
36 intervention but not after the physiotherapy intervention.

37  
38 The effects of a Feldenkrais Awareness Through Movement program and relaxation  
39 procedures were assessed on a volunteer sample of 54 undergraduate physiotherapy  
40 students over a two-week period (Kolt et al., 2000). Participants were randomly allocated  
41 into an FM group, a relaxation group, or a no- treatment (control) group, and state of  
42 anxiety was measured using the Composed-Anxious scale of the Profile of Mood States-

1 Bipolar Form (Lorr and McNair, 1982) on four occasions. Analysis of variance showed  
2 that anxiety scores for all groups varied significantly over time and that participants  
3 reported lower scores at the completion of the fourth intervention. Compared to the control  
4 group, females in the FM and relaxation groups reported significantly lower anxiety scores  
5 on completion of the fourth session (compared to immediately prior to the fourth session),  
6 and this reduction was maintained one day later. These findings can be interpreted as  
7 preliminary evidence of the efficacy of FM and relaxation procedures in reducing anxiety.  
8

9 Hopper et al. (1999) investigated the effects of FM on flexibility, perceived exertion, and  
10 hamstring length. In Study 1, 79 healthy participants undertook measurement of flexibility,  
11 perceived exertion, and hamstring length prior to being randomly allocated into a  
12 Feldenkrais or control group with the same measurements taken after the group  
13 intervention (Feldenkrais Awareness Through Movement lesson or control procedure).  
14 Although the Feldenkrais participants improved significantly more in sit and reach  
15 measurements than their control counterparts, no differences between the groups were  
16 found for measures of perceived exertion or hamstring length. In Study 2, a subsample of  
17 39 participants took part in further three-intervention sessions with the three measures  
18 being taken again prior to and after the fourth (final) intervention. No group differences  
19 were found for any of the outcome indicators across time. Ullmann et al. (2010) examined  
20 the effects of Feldenkrais exercises on balance, mobility, balance confidence, and gait  
21 performance in community-dwelling adults age 65 and older. After completion of the  
22 program, balance and mobility increased while fear of falling ( $p = 0.042$ ) decreased  
23 significantly for the FG group and not the control group. No other significant changes were  
24 observed. However, participants of the FG group showed improvements in balance  
25 confidence and mobility while performing concurrently a cognitive task. Authors  
26 concluded that Feldenkrais exercises are an effective way to improve balance and mobility,  
27 and thus offer an alternative method to help offset age-related declines in mobility and  
28 reduce the risk of falling among community-dwelling older adults. Connors et al. (2011)  
29 investigated the effects of Feldenkrais Method balance classes on balance and mobility in  
30 older adults. Compared to the Control group, the Intervention group made a significant  
31 improvement in their ABC score, gait speed ( $P = .017$ ) and FSST time ( $P = .022$ ). These  
32 findings suggest that Feldenkrais Method balance classes may improve mobility and  
33 balance in older adults. Teixeira-Machado et al. (2015) assessed changes in QoL and  
34 depression in older adults with PD through use of Feldenkrais method-based exercise. The  
35 treatment group underwent 50 sessions of an exercise program based on the Feldenkrais  
36 method. The control group received educational lectures during this period. After the  
37 exercises based on the Feldenkrais method, the treatment group showed improvement in  
38 QoL scores as well as a reduction in the level of depression compared with the control  
39 group. Authors suggested that it is likely that the practice of a program based on the  
40 Feldenkrais method can contribute greatly to the QoL of patients with PD.

1 Hillier and Worley (2015) completed a systematic review on the effectiveness of the  
2 Feldenkrais method and for which populations. Twenty RCTs were included (an additional  
3 14 to an earlier systematic review). The population, outcome, and findings were highly  
4 heterogeneous. However, meta-analyses were able to be performed with 7 studies, finding  
5 in favor of the FM for improving balance in aging populations via the timed up and go and  
6 functional reach tests. Single studies reported significant positive effects for reduced  
7 perceived effort and increased comfort, body image perception, and dexterity. Risk of bias  
8 was high; thus, caution should be taken with in interpretation. Authors suggest that the  
9 effects are generic and not disease-based, according to the literature. According to the body  
10 of evidence, clinicians and professionals may promote the use of FM in populations  
11 interested in efficient physical performance and self-efficacy. Palmer (2017) assessed  
12 Feldenkrais Moving Forward movement lessons for older adults. Participants (N = 87  
13 returning from original sample of 124; median age = 76 years) were assigned to movement  
14 (n = 51) or waitlist control (n = 36) groups. Pretests and posttests included Base of Support,  
15 Timed Up and Go, Tandem Stance, Functional Reach, modified OPTIMAL, and questions  
16 about individual priorities and outcomes. Results included significant correlations between  
17 lessons attended and both improved Functional Reach and improved OPTIMAL score. A  
18 significantly higher proportion of the movement (vs. control) group reported positive  
19 changes at the posttest in both prioritized and newly identified activities. Palmer concluded  
20 that results show that Feldenkrais lessons are helpful to older adults for promoting balance,  
21 mobility, and confidence.

22  
23 Paolucci et al. (2017) sought to determine the efficacy of the Feldenkrais method for  
24 relieving pain in patients with chronic low back pain (CLBP) and the improvement of  
25 interoceptive awareness. Fifty-three patients with a diagnosis of CLBP for at least 3 months  
26 were randomly allocated to the Feldenkrais (mean age  $61.21 \pm 11.53$  years) or Back School  
27 group (mean age  $60.70 \pm 11.72$  years). Pain was assessed using the visual analog scale  
28 (VAS) and McGill Pain Questionnaire (MPQ), disability was evaluated with the Waddell  
29 Disability Index, quality of life was measured with the Short Form-36 Health Survey (SF-  
30 36), and mind-body interactions were studied using the Multidimensional Assessment of  
31 Interoceptive Awareness Questionnaire (MAIA). Authors concluded that the Feldenkrais  
32 method has comparable efficacy as Back School in CLBP. The two rehabilitation  
33 approaches are equally as effective in improving interoceptive awareness, which helps with  
34 pain management. Paolucci et al. (2018) highlights the evidence supporting the different  
35 rehabilitative techniques described for low back pain management. In total, 26 studies were  
36 found suitable to be included in the review (14 articles about Pilates, six about McKenzie  
37 (MK), one article about Feldenkrais, three about Global Postural Rehabilitation (GPR) and  
38 two about Proprioceptive Neuromuscular Facilitation). Authors concluded that all the  
39 techniques are effective for the study groups with respect to the control groups in reducing  
40 pain and disability and improving the QoL and maintaining benefits at follow-up; Pilates,  
41 Back School, MK and Feldenkrais methods reduce pain and are more efficient than a  
42 pharmacological or instrumental approach in reducing disability and improving all

1 psychological aspects also. GPR shows long lasting results for the last outcome. To date,  
2 it is difficult to affirm the superiority of one approach over another. Authors suggest that  
3 further high-quality research is needed to confirm the effect of these techniques, together  
4 with the use of more appropriate evaluation measures.

5  
6 Phuphanich et al. (2020) suggest that The Feldenkrais Method has broad applications for  
7 changing bodily perceptions; easing function; and promoting awareness, self-efficacy, and  
8 health. Yet, there is a paucity of scientific evidence validating the benefits of Feldenkrais.  
9 Authors conclude that at this time, clinicians may only offer Feldenkrais as a  
10 supplementary therapy to patients interested in efficient physical performance and self-  
11 efficacy. Ahmadi et al. (2020) investigated the effect of the Feldenkrais method versus core  
12 stability exercises on pain, disability, quality of life and interoceptive awareness in patients  
13 with chronic non-specific low back pain. Sixty patients with chronic non-specific low back  
14 pain randomized equally into the Feldenkrais method versus core stability exercises  
15 groups. The intervention group received Feldenkrais method consisting of training  
16 theoretical content and supervised exercise therapy two sessions per week for five weeks.  
17 The control group received educational program and home-based core stability exercises  
18 for five weeks. Regarding outcomes, all patients were examined by World Health  
19 Organization's Quality of life Questionnaire, McGill Pain Questionnaire, Oswestry  
20 Disability Questionnaire and Multidimensional Assessment of Interoceptive Awareness  
21 Questionnaire. All outcomes were measured at baseline and the end of the intervention.  
22 Results demonstrated statistically significant differences between groups for quality of life,  
23 interoceptive awareness and disability in favor of the Feldenkrais method. McGill pain  
24 score significantly decreased in both the Feldenkrais (from 15.33 to 3.63) and control  
25 groups (from 13.17 to 4.17), but there were no between-groups differences ( $P = 0.16$ ).  
26 Authors concluded that the Feldenkrais method intervention gave increased benefits in  
27 improving quality of life, improving interoceptive awareness and reducing disability index.

28  
29 Berland et al. (2022) identify the populations and conditions for which the FM can be used  
30 in physiotherapy and to determine the intervention modalities in a systematic review. Meta-  
31 analyses (MA) were performed whenever populations and outcome measures were  
32 comparable in at least two studies. Sixteen studies were included. In elderly people, in three  
33 of the four selected trials, the FM group significantly improved gait, balance, mobility and  
34 quality of life. The MA showed significant differences between interventions in the Timed-  
35 Up-and-Go test. FM significantly improved pain, functional balance, and perceived  
36 exertion in three trials performed on subjects with cervical, dorsal, or shoulder pain. FM  
37 demonstrated improvements in pain, disability, quality of life and interoceptive awareness  
38 in the three trials performed in subjects with chronic low back pain. In multiple sclerosis,  
39 an improvement in functional capacity was observed in the two selected studies. The MA  
40 showed no significant differences between groups in the Function and Control dimensions  
41 of the Multiple Sclerosis Self-Efficacy Scale. In Parkinson's disease, two studies showed  
42 significant effects on quality of life and functional tests. In conclusion, evidence shows that

1 FM has therapeutic effects comparable to other physiotherapy techniques in patients with  
 2 spine pain. In addition, improvements in mobility and balance were seen in the elderly and  
 3 people with neurodegenerative diseases.

#### 4 **PRACTITIONER SCOPE AND TRAINING**

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

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

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

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

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