

# **Taking Charge; Choosing a New Direction**

**A Service Evaluation of Alexander Technique  
Lessons for Pain Clinic Patients (SEAT): an  
Approach to Pain Management**



**Stuart McClean and Lesley Wye**

**June 2012**

## ACKNOWLEDGEMENTS

We would like to acknowledge the Avon Primary Care Research Collaborative (APCRC) NHS Bristol for funding both this evaluation and the Alexander Technique teaching service at St. Michael's hospital. The views expressed in it are those of the authors and not necessarily those of APCRC or St. Michael's, University Hospitals Bristol. We would like to thank all those who have participated in this evaluation for their contributions and engagement with the evaluation team.

The evaluation research was overseen by a steering group, membership of which comprised:

Dr Stuart McClean, Evaluation Lead (University of the West of England, Bristol)

Dr Lesley Wye, Evaluation (University of Bristol)

Dr Peter Brook, Consultant (University Hospitals Bristol, NHS Trust)

Rachel Molyneux, Specialist Nurse (University Hospitals Bristol, NHS Trust)

Anita Bennett, Alexander Teacher (Society of Teachers of the Alexander Technique)

The evaluation could not have been possible without the efforts of a number of other individuals who gave their time, effort and expertise towards both the service and the evaluation. We would like to thank the contribution particularly of Peter Brook, Rachel Molyneux, Charlotte Steeds, Nilesh Chauhan, and Jayne Connell, and all the staff at St. Michael's Pain Clinic, as well as the guidance and expertise of Dr Kathleen Ballard from the Society of Teachers of the Alexander Technique (STAT), and Sally Cottrell from APCRC. We are grateful to the patients who gave their time and energy to complete questionnaires and take part in telephone interviews. We would also like to extend our gratitude to the Alexander teachers who helped set up and run an energetic and efficient service: Anita Bennett, Rachel Stevens, Gudi Schepokat, Anne Lammar, and Bethan Evans. We appreciate their knowledge, skill and dedication in ensuring that the service was launched successfully and in supporting the evaluation team in terms of the logistics. Finally, thanks are due also to Sam Brilleman, Tom Griffin, Helen Lewis, Jane Powell, Pete Shiarly, and Leigh Taylor at both UWE and the University of Bristol who supported the evaluation and helped to produce this report.

## CONTENTS

1. Executive Summary	4
2. Background to the Study	5
3. Evaluation Approach and Design	9
4. Results of Analyses of Health Outcome, Quality of Life and Resource Use Tools	11
5. Results of Analyses of Qualitative Data: Interviews with Service Users	34
6. Results of Analyses of Qualitative Data: Alexander Teachers and Pain Clinic Staff	63
7. Conclusions and Recommendations	76
8. References	79
9. Appendices	81

## **1. EXECUTIVE SUMMARY**

### **1.1. Introduction**

A high quality clinical trial carried out in an experimental setting has demonstrated the therapeutic value and effectiveness of Alexander Technique (AT) lessons for chronic back pain, but little is known about the use of AT in NHS outpatient pain clinics.

### **1.2 Aims and study design**

The aim of this exploratory mixed methods service evaluation was to explore the role, acceptability and impact of an Alexander Technique teaching service at a hospital outpatient NHS Pain Clinic, including service users' (n=43) experiences of the service and the perceived benefits to the NHS. To capture changes in health, wellbeing, quality of life status and resource use amongst service users, we administered four validated, widely used questionnaires at three time points: baseline, 6 weeks and three months after baseline. We also carried out 27 semi-structured qualitative telephone interviews with service users, three months from baseline. The views and experiences of Pain Clinic staff and Alexander Teachers were explored in a series of face-to-face interviews.

### **1.3 Findings**

The findings suggest that the AT teaching service is feasible, acceptable, and beneficial (in terms of improving service users' quality of life and improving patients' management of pain). Greatest changes were found in how service users managed their pain, for example more than half stopped or reduced their medication, and the impact that the pain had on their daily life. This also led to some behaviour change and changes in awareness and self-knowledge from the service users. These attitudinal and behavioural changes may explain the finding that users of the AT teaching service appeared to reduce their pain related NHS costs by half.

### **1.4 Conclusions**

Over time participants' relationship to their pain may change as a result of Alexander Technique lessons, which may lead to reductions in medication use and other NHS pain related costs.

### **1.5 Recommendations**

Alexander Technique lessons can be seen as a useful adjunct to other pain management services provided in secondary Pain Clinics.

## 2. BACKGROUND TO THE STUDY

Chronic back pain (upper and lower) is a very common disorder that affects around 1 in 3 adults in the UK each year (see NICE 2009). It is estimated that backache costs the NHS £480 million per annum with non NHS costs (such as private consultations and prescriptions) being an additional £197 million (HMSO 1994). Research estimates annual UK production losses due to back pain are in excess of £3,000 million (Maniadakis and Gray 2000). For some people the pain will go away in days or weeks, but for many the pain is more long-term and distressing. However, it is difficult to cure chronic back pain and hence treatments tend to focus on reducing its effect on people's lives (NICE 2009).

Recent research from a well-conducted clinical trial (ATEAM) suggests that Alexander Technique (AT) lessons are clinically and cost effective for patients with chronic or recurrent back pain and can lead to a significant reduction in pain (Little et al. 2008). This HTA and MRC funded randomised controlled trial (RCT) found that six one-to-one AT lessons followed by prescription to take exercise had long term benefits for patients, with a significant reduction in days in pain and disability. Although 24 one-to-one AT lessons led to significantly better results, the economic analysis found that the best-value dual intervention was 6 lessons in Alexander Technique followed by exercise prescription (Hollighurst et al. 2008). More recently a systematic review has been published into the evidence of effectiveness and safety of Alexander Technique in health related conditions more generally (Woodman and Moore 2012). However, studies have not yet been reported that explore the role and impact of a specific AT teaching service within an NHS pain clinic, providing six one-to-one lessons, followed or not by exercise.

The Society of Teachers of Alexander Technique (STAT) recommends individualised one-to-one lessons that allow a teacher to find out if an individual has some postural or movement or other habit or misunderstanding that is causing or aggravating their problem. A teacher's role is to lead people to a better understanding and empower them by teaching the AT and showing them how to apply it in their daily activities. An individual is shown what not to do and how to avoid doing it by using the Technique;

opportunities are provided for self-observation and practice during closely monitored activities with constructive feedback being provided by the teacher.

Empowerment comes through becoming more aware and learning gentler, more skilful ways of eliciting postural support and of moving. Once the Technique is learned, people need to practise it regularly on their own during their daily activities, so the benefits can last after the formal teaching period ends. In private practice, people normally have considerably more than six lessons, depending on the severity of their problems. The AT teacher's aim is to teach the technique and show the individual how to reduce the intensity and frequency of poor habits and how to facilitate improvements in muscle tone, co-ordination and musculoskeletal use. This approach to learning and putting into practice the skills necessary to make and maintain beneficial changes to health and wellbeing is frequently termed 'self-management.' Self management has been the mainstay of professional Pain Management Programmes for at least 20 years, predating the Expert Patient Programmes (EPP) (DOH 2001), which are patient led groups rather than Pain Management Programmes which teach evidence based self management approaches to managing chronic pain. A recent review of more than 550 research studies indicates that facilitating self-management has benefits for patients' quality of life, clinical symptoms and use of healthcare resources (de Silva 2011).

Alexander Technique lessons are primarily educational and do not provide treatment in the normal sense, even though teachers use frequent hand contact. This is used to observe and interpret subtle changes in muscle tone and co-ordination and also to convey non-verbal information. This teaching method is particularly appropriate for people whose first language is not English. Hand contact teaching is normally integrated with oral and written advice and information, including diagrams. The content of each lessons varies according to the observed and reported needs and limitations of each individual, with lessons usually lasting from 30 to 40 minutes. All students are encouraged to spend some time each day (15-20 minutes) lying semi-supine while practising the AT mental 'directions', and encouraged to incorporate the AT in their everyday activities (Gelb 2004).

A note on terminology: as Alexander Technique is an educational and taught approach, practitioners in private practice are referred to as teachers and the clients are called students; individual sessions are called lessons. However, given that this is an evaluation of AT lesson delivery within the NHS we have used the term *service user* to denote the student; we have retained the terms teacher and lessons.

Given that a high quality clinical trial carried out in an experimental setting has already demonstrated the therapeutic value and effectiveness of AT lessons for chronic back pain, the little that is known about the use of AT in NHS pain clinics, together with the fact that we were interested in evaluating the wider context of an NHS service, we designed a mixed methods service evaluation in a real world setting, taking account of all key stakeholder agendas. The outcomes will contribute further to the debate on the role of AT lessons in the self-management and reduction of chronic back pain.

This service evaluation of Alexander Technique (SEAT) lessons within a hospital pain management clinic is a clinically-led collaboration across the NHS (Pain Management Clinic) and private sectors (AT teachers and STAT), supported by researchers at UWE and the University of Bristol. The service evaluation was generously funded by APCRC, including service delivery costs such as AT teacher fees for the provision of lessons. The evaluation explored the role and acceptability of an Alexander Technique service at the Pain Clinic at St. Michael's Hospital in Bristol, including service users' experiences of the service and the perceived benefits to the NHS.

Mixed methods were used in the study. Four questionnaires were completed by service users at three time points (baseline, 6 weeks and 3 months or more after baseline) to see if there was any change to the service users' experience of pain, quality of life, and/or personal and NHS costs and whether those changes were maintained. In addition, telephone interviews were conducted with service users to explore their experiences of the AT service. We also asked the AT teachers to participate in interviews to gather their views on how the service progressed and the benefits and drawbacks of an AT service in an NHS pain clinic. In addition we also collected additional data from the pain clinic staff (two consultants and a specialist nurse), about

their views on the service, re-referrals to the pain management clinic, as well as potential improvements and recommendations.

The Alexander Technique service under evaluation was provided as part of the Pain Management Service at St. Michael's Hospital, University Hospitals Bristol NHS Trust from June 2010 to May 2011. At the time of the study, patients were referred to the Pain Clinic by their GP, where they saw one of four consultants who assessed the patient to see what treatment was suitable, such as medication, injections, psychological therapy (one-to-one), TENS, physiotherapy or acupuncture (as well as possible referral for a surgical opinion). The options also include the pain management programme that is for patients who have come to the end of the line in terms of treatment options. Using clear criteria for referral to the AT service the consultant referred AT to patients with chronic or recurrent back pain who were not getting better, were not responding to conventional treatment and expressed an interest in AT lessons as a pain management approach.

Once referred, the service user received six one-to-one Alexander Technique lessons with a qualified and experienced STAT registered AT teacher, over a period of six consecutive weeks. The lessons took place in one of the treatment rooms at the Pain Clinic. Each AT session lasted on average 40-45 minutes in duration, although the first lesson lasted longer as a first consultation. Unfortunately an exercise prescription, as described in the ATEAM trial, could not be provided.

This report highlights the key findings of the evaluation.



### **3. EVALUATION APPROACH AND DESIGN**

#### **3.1 Aim(s) of the study**

The aim of this exploratory mixed methods service evaluation was to explore the role, acceptability and impact of an Alexander Technique teaching service at a hospital out-patient Pain Management Clinic, including service users' (n=43) experiences of the service and the perceived benefits to the NHS. In particular:

- To identify any differences in health status, quality of life, or NHS costs found amongst service users before and after their use of an Alexander Technique (AT) teaching service in the Pain Clinic.
- To examine the service users' views and experiences of the service, as well as their perceptions of the impact of Alexander Technique lessons on changes to their condition.
- To explore the experiences of both Alexander Teachers and Pain Management Clinic staff of the benefits and drawbacks of an AT teaching service for Pain Clinic service users.

#### **3.2 Methodology and research design: summary**

This service evaluation used mixed methods drawing upon quantitative and qualitative data collection tools. Quantitative outcome tools were used to measure improvement and the level of progress that a service user underwent since visiting the AT teaching service, as well as collecting data on personal and NHS costs. Qualitative research offered a useful means of exploring service users' perceptions of the AT teaching service and strengthened the evaluation of complex interventions by providing data to help understand the quantitative findings.

We used four tools to collect data on health status, quality of life and resource usage. These are detailed in the following section. In addition, for the qualitative component we carried out 27 semi-structured telephone interviews with service users, three months from baseline. The views and experiences of Pain Clinic staff and Alexander Teachers were explored in a series of face-to-face semi-structured interviews.

This study is a real world evaluation, not a randomised controlled trial, as a good quality trial already had been conducted. Instead, this is an exploratory study, or 'implementation' study. As there is no control group we were not required to do a power calculation to determine the numbers of service users needed to show statistically significant effects. However, based on a review of over twenty five NHS complementary therapy service evaluations (Wye, Sharp, and Shaw, 2009) we believe that the 43 service users recruited for the study provided sufficient data to explore differences amongst service users before and after visiting the AT service, and to help generate hypotheses that would be of benefit to a future definitive study.

## 4. RESULTS OF ANALYSES OF HEALTH OUTCOME, QUALITY OF LIFE AND RESOURCE USE TOOLS

### 4.1 Questionnaire selection and content

To capture changes in health, wellbeing, quality of life status and resource use amongst service users, we administered four validated, widely used questionnaires.<sup>1</sup>

With regards to health status, we administered two outcome tools. For capturing pain, we considered several tools including the McGill Pain Questionnaire. However, the Brief Pain Inventory (BPI), was selected as it is the standard tool used in the BRI hospital pain clinic and we wanted to collect data that could be comparable to other pain clinic patients. The Brief Pain Inventory is a one page questionnaire consisting of two parts:

1. pain severity (questions 1-4), which tries to capture the intensity and severity of pain experienced across four dimensions (e.g. pain at its worst, pain at its least etc.) and rates each dimension from 0-10, with ten as most severe and 0 as least severe.
2. pain interference (question 5, a-g), which aims to measure the extent to which pain interferes with emotional states, relationships and usual activities such as sleeping and walking. Again, each dimension is rated 0-10, with ten as most severe and 0 as least severe.

To capture patient identified health outcomes, the second health status outcome tool used for this evaluation was MYMOP, which stands for Measure Your Medical Outcome Profile. This one page questionnaire was selected to capture how well the service met service users' objectives and often is used to capture patient reported outcomes (PROMs). MYMOP consists of four domains: symptom 1, symptom 2, activity and wellbeing. For the first two domains, respondents are asked to name a symptom that

---

<sup>1</sup> We thank Sam Brilleman for the statistical analysis of the health outcome and quality of life data and Tom Griffin for statistical analysis of the resource data.

currently 'bothers' them and then rate the level of interference from the symptom on a scale of 0-6, with six most severe. Respondents then are asked to identify an activity that is affected by the first symptom and rate from 0-6 the extent to which the activity is affected. Lastly, respondents rate their current wellbeing from 0-6, estimate how long they have suffered from the symptom (less than a year, 1-5 years, more than 5 years), list any medication they are currently taking and assess the importance of cutting down or stopping medication (very important/ not that important/ not important). For symptom 1, symptom 2, wellbeing and activity, a 'profile score' combining all four separate scores can be calculated.

The third outcome tool, EQ-5D, was selected to assess quality of life as the Alexander Technique teachers believed that improving quality of life was an important dimension to their work. We considered using SF36 or SF12 but in consultation with the Alexander Technique teachers, EQ-5D was chosen as the teachers believed the EQ-5D covered all of the key domains that their intervention might affect, and it was shorter. EQ-5D is a one page questionnaire that covers five domains: pain, self-care, mobility, usual activities anxiety/depression. Within each of the five domains, in assessing their current state respondents can select from three levels e.g. no pain or discomfort/ moderate pain or discomfort/ extreme pain or discomfort. Respondents also rate their health on a visual analogue scale from 0-100 for worst to best imaginable state.

To capture resource use, we administered the Client Service Resource Inventory. This questionnaire is widely used in economic evaluations and can be adapted according to the client population under study. The Client Service Resource Inventory is a four page questionnaire that covers:

- hospital use (emergency, in-patient, out-patient)
- primary and community resource use (e.g. GP and practice nurse visits, community physiotherapy)
- tests and investigations
- medication (prescribed and over the counter)
- personal costs (e.g. private healthcare, travel costs, lost earnings due to illness)

Respondents were asked to record their costs for each of these domains for the previous two months.

## **4.2 Questionnaire administration and data input**

All four questionnaires (BPI, MYMOP, EQ-5D and Client Service Resource Inventory) were administered at three time points: baseline, six weeks and three months. The baseline questionnaire was administered by the Alexander Technique teacher during the first consultation to capture initial assessments of health and quality of life status and resource use. The six week questionnaire was administered by the Alexander Technique teacher at the last consultation to capture any changes occurring while the participant was actively using the service. A final set of questionnaires was administered at three months after baseline to assess whether changes were maintained once the participant was discharged from the service. After three months post-baseline, the BPI, EQ5-D and Client Service Resource Inventory were sent by post by the evaluation lead. The evaluation lead then followed up with a telephone call to complete the MYMOP questionnaire and to obtain any incomplete questionnaire data. The data for all four health outcome questionnaires were entered into an Excel spreadsheet by a university administrator.

## **4.3 Data analysis**

Two independent statisticians analysed the data. One analysed resource data from the Client Service Resource Inventory and the other from the health outcome and quality of life tools. Analysis was performed using STATA Version 11.2<sup>2</sup>

### *The Client Service Resource Inventory*

---

<sup>2</sup> StataCorp. 2009. *Stata Statistical Software: Release 11*. College Station, TX: StataCorp LP.

In consultation with an economist, we decided to compare across the time points using standard weekly societal costs (NHS plus personal costs). The costs incurred directly by the NHS were calculated, as were the constituents of this cost. These included costs associated with the intervention, those reported to be due to the reason for referral and those not associated with the referral condition.

The Client Service Resource Inventory data with NHS and personal cost data required cleaning and pricing before analysis. The statistician cleaned the dataset by taking out all duplicate information recorded in more than one place in the questionnaire. With only two follow-up time-points and a limited number of study participants, it was felt there would be insufficient information to impute missing costs. Mean weekly costs were calculated using all study participants and compared to costs of participants without missing data.

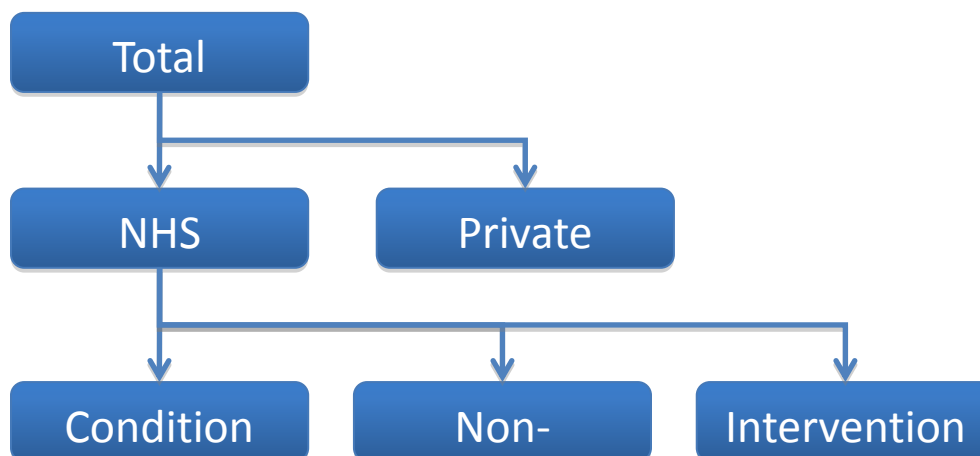
Personal cost data included over the counter medications, childcare, lost earnings, travel and private healthcare. To price these data, we trusted the information provided by service users in their questionnaires. Lost earnings were calculated using reported values.

To price the data, for NHS costs, we consulted Unit Costs of Health and Social Care ([www.pssru.ac.uk](http://www.pssru.ac.uk)) for 2010. We priced hospital use (emergency, in-patient, out-patient), investigations (e.g. MRI, x-ray) and primary and community care resource use (e.g. GP and Practice nurse consultations, attendance at community clinics, counselling). For hospital staff, we priced consultations with doctors at qualified consultant level with overhead per patient related hour and nurse consultations at nurse team manager level with overhead per hour of patient contact. For investigations, we used the hospital procedure rate of £152 per test and £5 per blood test which corresponds to the cost of a full blood count and is a reasonable approximation of the cost of most blood tests. We priced all GP consultations per surgery consultation of 11.7 minutes and practice nurse per hour of patient contact. We priced Alexander Technique lessons at £40, which is the price per hour of contact time with overheads with a qualified hospital physiotherapist.

To price prescription medications, we used the British National Formulary ([www.bnf.org](http://www.bnf.org)). Service users had only provided data on the name of the preparation, the reason for use and how often it is taken. This was insufficient to accurately identify exactly which medication was prescribed, and so we priced medications based on recommended or lowest dose. In addition, we assumed that the prescription had been re-issued at every time point when service users reported taking the medication. We also included medications when a service user named a prescription drug but commented 'no longer in use', because we assumed that the prescription had been issued during the time period. To price the medications, we calculated the cost per day per participant for taking that medication, multiplied by seven to obtain a weekly cost.

Because the Alexander Technique teaching service was assessed specifically for pain reduction, we identified pain (condition related) and non-pain (non-condition related) costs. We classified an item as condition related if the 'reason for use' specifically mentioned pain. If these data were missing or unclear, we consulted the relevant MYMOP return for further clarification. The statistician and LW carried out this classification exercise together and any divergence of opinion was discussed and resolved.

Figure 1. Breakdown of Reported Costs



Weekly mean costs were calculated by summing costs incurred over the prior eight week period and divided by eight. Means, standard deviations and 95% confidence intervals were calculated and values compared across the three time points.

#### *The health outcome and quality of life outcome tools*

For the health and quality of life outcome tools, after checking for normality, the data for the BPI, MYMOP and EQ-5D were analysed separately. For each dataset, we were interested in changes:

- between baseline and 6 weeks
- between baseline and three months
- between 6 weeks and three months (to see if any changes are maintained)

For each outcome measure, the statistician calculated mean values at each time point and also the mean change between each pair of time points (baseline and 6 weeks, baseline and 3 months, 6 weeks and 3 months). For all mean values the statistician calculated the associated 95% confidence interval (CI).

Additional analyses were conducted with MYMOP. The symptoms and activities identified by patients were classified, grouped and totalled. Data on length of time with condition was grouped into short term (less than one year), medium term (1-5 years) and long term (more than five years).

## **4.4 Results**

This study is exploratory and the quantitative findings must be taken with caution as the numbers were small and there was no control group to investigate whether changes would have occurred over time anyway. We did not carry out any sub-analyses on any groups within the study population, as the numbers of participants would be too small to construct reliable estimates and/or draw any meaningful conclusions. However, we have carried out exploratory descriptive analyses on the entire dataset to identify trends that could be tested in larger studies.



#### **4.4.1 Characteristics of the study population**

43 service users returned questionnaires at baseline, 41 at 6 weeks and 39 at 3 months. In total 41 completed the service but only 39 completed the questionnaires at 3 months. Of those 43, 23 were women and 13 were men with the sex of the remaining 9 not known. The age of respondents ranged from 23 to 80 with an average age of 52, although this information is not known for 12 respondents.

#### ***Brief Pain Inventory***

To recap, the Brief Pain Inventory tries to capture severity and interference of pain. The interference scales intend to measure the extent to which the pain interferes with emotions, relationships and usual activities and changes in severity of pain (e.g. pain at its worst/ least etc.). Higher values indicate greater levels of interference.

Figure 2

Brief Pain Inventory Interference scores

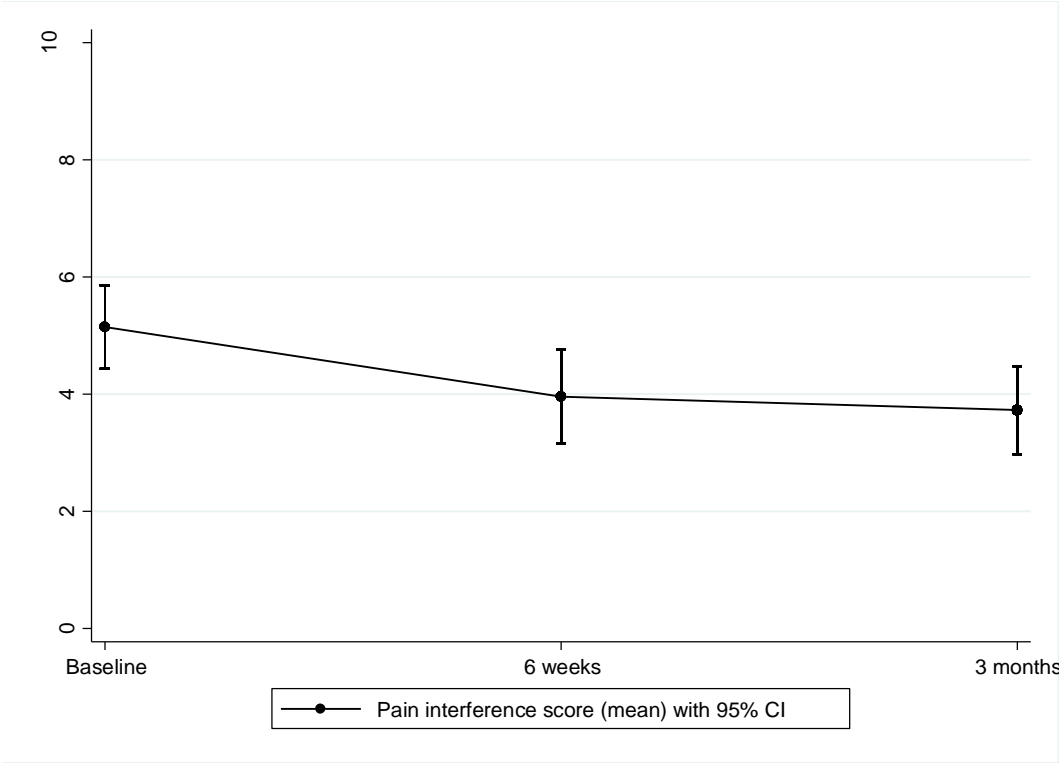


Table 1 Brief Pain Inventory Interference scores for entire dataset<sup>3</sup>

	Baseline	6 weeks	3 months	Difference baseline to 6 weeks	Difference baseline to 3 months	Difference 6 weeks to 3 months
Number	43	41	39	41	39	38
Mean interference score (95% CI)	5.1 (4.4 to 5.9)	4.0 (3.2 to 4.8)	3.7 (3.0 to 4.5)	-1.10 (-1.62 to -0.59)	-1.17 (-1.69 to -0.65)	0.02 (-0.34 to 0.39)

Table 2 Brief Pain Inventory Interference mean scores (with 95% confidence interval) for each domain over time

	General activity	Mood	Walking ability	Normal work	Relationships	Sleep	Enjoyment of life
Baseline (95% CI)	5.3 (4.9 to 5.8)	5.4 (4.9 to 5.9)	4.6 (4.0 to 5.1)	5.9 (5.5 to 6.4)	4.1 (3.6 to 4.6)	5.1 (4.5 to 5.6)	5.5 (5.1 to 6.0)
6 weeks (95% CI)	4.2 (3.7 to 4.7)	4.5 (4.0 to 5.0)	3.4 (2.9 to 3.9)	4.1 (3.6 to 4.6)	3.5 (3.0 to 4.0)	3.8 (3.3 to 4.4)	4.2 (3.7 to 4.6)
3 months (95% CI)	4.3 (3.8 to 4.8)	3.7 (3.2 to 4.2)	3.1 (2.6 to 3.6)	4.2 (3.8 to 4.7)	3.3 (2.8 to 3.7)	3.6 (3.1 to 4.1)	3.8 (3.4 to 4.3)

<sup>3</sup> Mean (paired) difference is not calculated on the same set of patients as the raw mean because not all participants have measurements at both time points (and therefore we don't observe a value for the change for these participants). Note that there are 39 participants with data at both baseline and 3 months, which is fewer than the number of participants at either one of the individual time points, hence difference between two figures e.g. 5.1-3.7=1.4 but in table reported as 1.17.

The mean scores for pain interference, as captured by the Brief Pain Inventory, show a pattern of a small decrease in score of about one point on a ten point scale at 6 weeks, which was then maintained at three months. In breaking this down into the separate domains comparing baseline to three months, mood, walking ability, normal work, sleep and enjoyment of life showed the greatest shift with a decrease in mean score of 1.5 or more. Interestingly, between six weeks and three months, mood continued to improve substantially with a decrease in average score of 0.9 points. These findings suggest that service users found that pain interfered less with emotional states and usual activities such as sleeping and walking.

Figure 3 Brief Pain Inventory Severity Scores

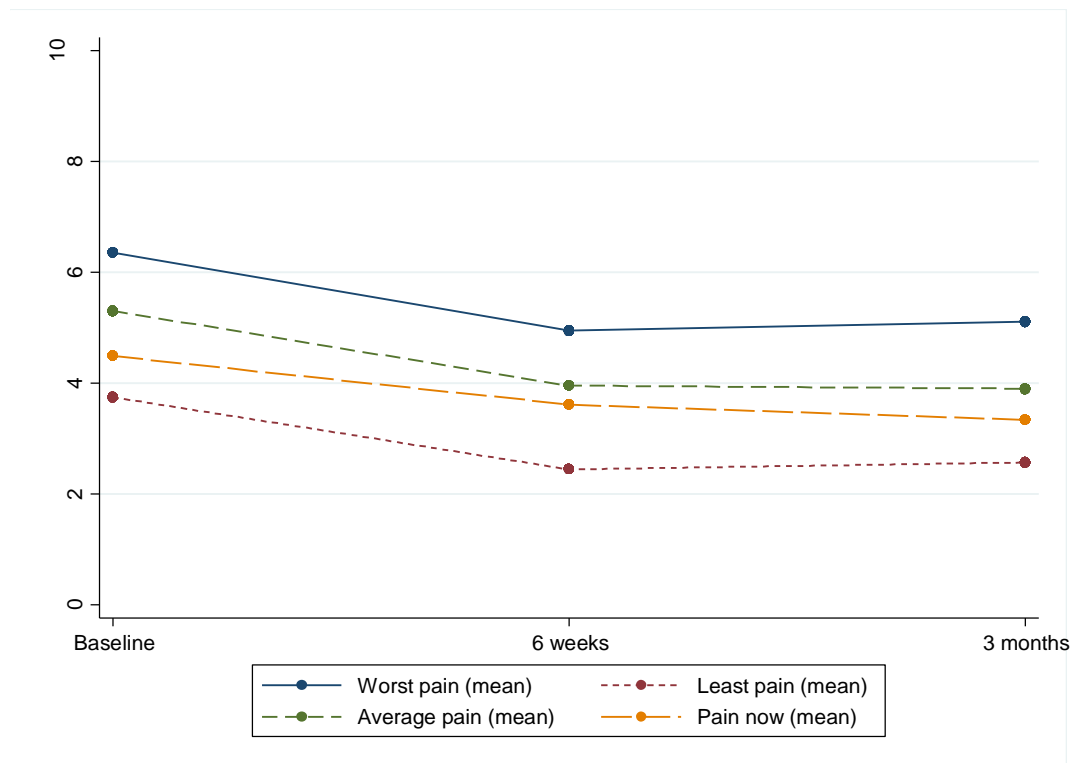


Table 3 Brief Pain Inventory Severity Scores 3

	Baseline	6 weeks	3 months	Difference baseline to 6 weeks	Difference baseline to 3 months	Difference 6 weeks to 3 months
Number	43	41	39	41	39	38
Worst (95% CI)	6.3 (5.7 to 7.0)	5.0 (4.1 to 5.8)	5.1 (4.3 to 5.9)	-1.34 (-1.91 to -0.77)	-1.13 (-1.81 to -0.45)	0.16 (-0.42 to 0.73)
Least (95% CI)	3.7 (3.0 to 4.5)	2.4 (1.8 to 3.1)	2.6 (1.8 to 3.3)	-1.27 (-1.93 to -0.60)	-1.10 (-1.83 to -0.37)	0.24 (-0.31 to 0.78)
Avg (95% CI)	5.3 (4.7 to 5.9)	4.0 (3.2 to 4.7)	3.9 (3.2 to 4.6)	-1.32 (-1.89 to -0.74)	-1.26 (-1.87 to -0.64)	-0.03 (-0.49 to 0.44)
Now (95% CI)	4.5 (3.7 to 5.2)	3.6 (2.8 to 4.4)	3.3 (2.5 to 4.1)	-0.88 (-1.5 to -0.26)	-0.97 (-1.63 to -0.32)	-0.11 (-0.75 to 0.54)
Mean (95% CI)	5.0 (4.4 to 5.6)	3.7 (3.1 to 4.4)	3.7 (3.0 to 4.4)	-1.2 (-1.66 to -0.75)	-1.12 (-1.65 to - 0.58)	0.07 (-0.37 to 0.5)

The mean scores for pain severity, as captured by the Brief Pain Inventory, show the same pattern of a small decrease in score of about one point on a ten point scale at 6 weeks, which was then maintained at three months. This suggests that the experience of pain of service users was slightly less severe following service usage.

## **MYMOP**

To recap, the symptom and activity domains of MYMOP are named and rated by the participant on a 7 point scale. A MYMOP profile score includes the mean scores of symptoms, activity and wellbeing.

All but one of the 43 respondents identified an area of pain as the first symptom that 'bothered' them. The majority had back pain (22) followed by shoulder/ neck pain (8) or pain in hips, legs, knees or sciatica (7). Two service users had pain in more than one area e.g. knee and shoulder, one person had pain in her feet, another had pain in her thumb and one did not specify the area of pain. The individual who did not identify pain as their primary symptom had depression.

There was more variety of symptoms identified for the second symptom. Of the 36 service users who named a second symptom, ten identified a mood related condition such as anxiety, depression or "low spirits"; eight identified back pain; seven named neck or shoulder pain; seven named pain in hips, legs, knees or sciatica, one mentioned migraine, another pain in her bottom, another pain in feet and a fourth had problems of balance.

Most commonly, 30 of the 43 participants in this study experienced back pain. Nearly a quarter of the service users also experienced emotional distress, possibly related to their pain.

Table 4 MYMOP Symptoms

	Symptom 1 (n=43)	Symptom 2 (n=36)	Total
Back pain	22	8	30
Shoulder or neck pain	8	7	15
Hip, leg, knee pain or sciatica	7	7	14
Anxiety, depression, "low spirits"	1	10	11
Pain in more than one place	2	0	2
Feet	1	1	2
Thumb	1	0	1
"pain" unspecified	1	0	1
Migraine	0	1	1
Bottom	0	1	1
Balance	0	1	1

Over half of the service users (22) had experienced their pain for longer than five years, a third had been in pain for 1-5 years (16) and only five participants had short term pain.

Twenty five service users stated that their pain most commonly affected movement (e.g. sitting, bending, carrying), six found that physical activities like sports, hiking and dance were impeded, four had trouble sleeping, four had difficulty gardening, two had problems reading, one found her musical performance affected and another had poor concentration.

Figure 4

MYMOP profile score

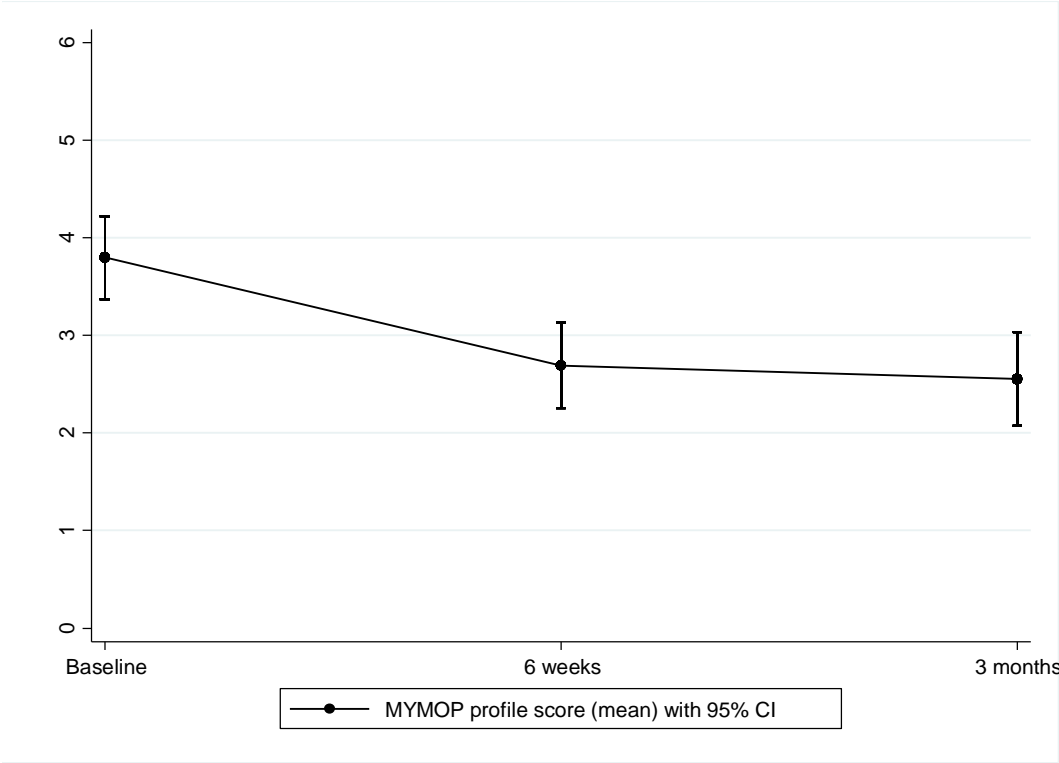




Table 5 MYMOP scores 3

	Baseline	6 weeks	3 months	Difference baseline to 6 weeks	Difference baseline to 3 months	Difference 6 weeks to 3 months
Number	43	41	39	41	39	38
Symptom 1 (95% CI)	3.9 (3.4 to 4.3)	2.9 (2.4 to 3.4)	2.9 (2.3 to 3.6)	-0.85 (-1.27 to -0.44)	-0.87 (-1.49 to -0.26)	0.03 (-0.31 to 0.36)
Symptom 2 (95% CI)	3.9 (3.5 to 4.4)	2.8 (2.3 to 3.4)	2.7 (2.1 to 3.3)	-1.06 (-1.47 to -0.65)	-1.06 (-1.55 to -0.58)	-0.03 (-0.42 to 0.35)
Activity (95% CI)	4.2 (3.7 to 4.7)	2.7 (2.2 to 3.2)	2.6 (2.0 to 3.1)	-1.32 (-1.74 to -0.89)	-1.41 (-2.03 to -0.78)	-0.17 (-0.58 to 0.25)
Wellbeing (95% CI)	3.4 (2.9 to 4.0)	2.4 (1.9 to 2.9)	2.0 (1.5 to 2.5)	-1.00 (-1.38 to -0.62)	-1.36 (-1.85 to -0.87)	-0.34 (-0.72 to 0.03)
MYMOP profile (95% CI)	3.8 (3.4 to 4.2)	2.7 (2.3 to 3.1)	2.6 (2.1 to 3.0)	-1.02 (-1.32 to 0.72)	-1.14 (-1.56 to -0.71)	-0.09 (-0.35 to 0.16)

Across all MYMOP domains, service users recorded that their symptoms, activity and wellbeing had improved by about one point on a seven point scale. Again these improvements were maintained at three months. The most substantial improvement occurred with activity which included movement, sports, gardening and sleeping. The overall MYMOP profile score improved on average by 1.14 units (95% CI: 0.71 to 1.56).

Table 6

## MYMOP Wellbeing

Direction of change in wellbeing	Number of service users
Steady improvement	28
No change	8
Variable	4
Steady deterioration	2
No data	1

In looking at wellbeing, 28 service users had steady improvement from baseline to three months, defined as a trend towards a decrease in scores of one or more. Eight service users recorded no change in their wellbeing, however of those eight two rated their wellbeing as good as it could be (0) at baseline, six weeks and three months. Four service users reported variable changes in their wellbeing whereby their wellbeing scores initially went up at six weeks and then fell at three months. Two services users recorded a steady deterioration and for one there were no data.

Table 7 MYMOP Medication

Direction of change	Number of service users
Reduced	12
Stopped	10
No medication at baseline, 6 weeks or 3 months	9
No follow up data at 6 weeks or 3 months	8
No change	4
No medication at baseline & started at 6 weeks or 3 months	1
Variable	1
Not clear	1

Nine of the 43 service users did not take medication for pain throughout the time period of the evaluation. Of the 34 service users who were taking medication at baseline, two reported using alcohol for pain relief, one mentioned cannabis and one was taking a course of Chinese medical herbs. Prescribed medications taken for pain and pain related symptoms included diclofenac, solpadol, cocodamol, tramadol, meloxicam, gabapentin, morphine and codeine and named over the counter medications were paracetamol, ibuprofen and aspirin. Nine service users also mentioned taking prescription medications for mood and sleep such as amitriptyline (n=6), diazepam (n=2) and zopiclone (n=1). Interestingly, more than half of the service users (n=22) stopped or reduced their use of medications between baseline and three months.

### **EQ-5D**

To recap, EQ-5D is a quality of life measure that attempts to capture five dimensions: pain, anxiety/ depression, self-care, mobility and usual activities with three levels (e.g.

no, some, extreme/ great difficulties). Higher values for the summary score indicate better quality of life.

Figure 5      EQ-5D mean summary scores

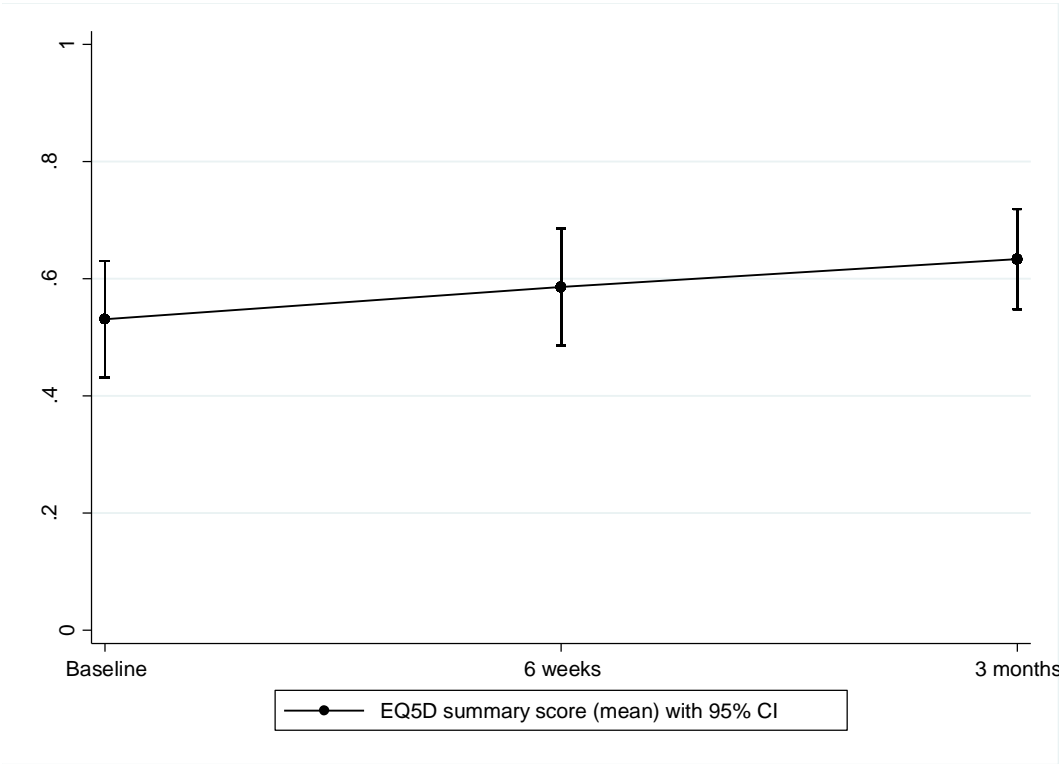


Table 8 EQ-5D summary scores 3

	Baseline	6 weeks	3 months	Difference baseline to 6 weeks	Difference baseline to 3 months	Difference 6 weeks to 3 months
Number	43	41	39	41	39	38
Summary score (CI)	0.53 (0.43 to 0.63)	0.59 (0.49 to 0.69)	0.63 (0.55 to 0.72)	0.04 (-0.04 to 0.13)	0.06 (-0.03 to 0.14)	0.0 (-0.06 to 0.07)

Although the mean EQ5D summary score in Figure 5 is shown to increase over time (suggesting an improvement in the average quality of life of service users) the changes are very small in magnitude. The 95% confidence intervals for the mean difference between time points all include zero which suggests that any observed changes may just be due to chance. The lack of evidence of an improvement may be because there was no underlying change in the quality of life of the service users or it could be because the EQ-5D is not sufficiently sensitive to respond to changes. The literature suggests that the EQ-5D is known as not being particularly sensitive to change.

### ***Client Service Resource Inventory***

The Client Service Resource Inventory captures NHS and personal costs, which for this study we calculated at a standard weekly rate (in £) and then compared across the three time points.

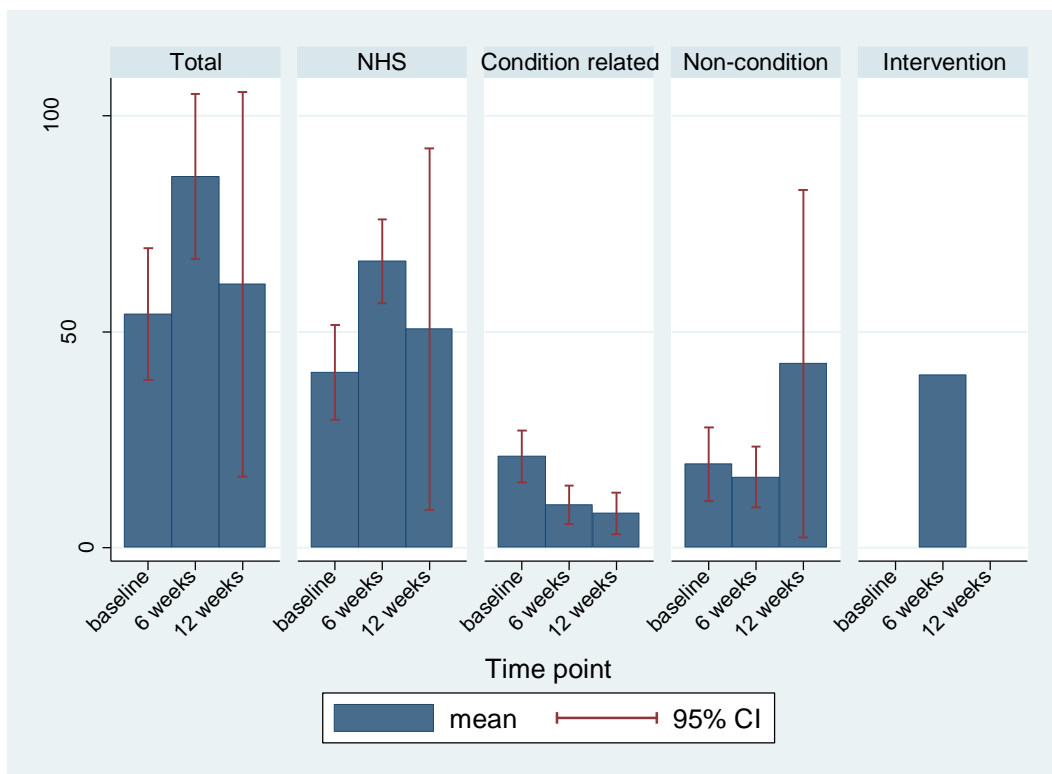
The figures and tables below include data for all patients, including returns with missing data, as we found that the pattern did not change. The data for total costs include

personal and NHS costs; the data for condition, non-condition and intervention costs are based on NHS costs only.

Table 9: Mean Weekly Costs (£)

Total Costs (£)					
Time point	mean	sd	n	upper 95% CI	lower 95% CI
baseline	54.06	46.3	38	69.28	38.85
6 weeks	85.88	55.6	35	104.99	66.78
12 weeks	60.96	121.4	31	105.50	16.41
NHS					
Time point	mean	sd	n	upper 95% CI	lower 95% CI
baseline	40.57	33.2	38	51.49	29.65
6 weeks	66.34	28.2	35	76.02	56.65
12 weeks	50.60	114.1	31	92.44	8.76
Condition related costs					
Time point	mean	sd	n	upper 95% CI	lower 95% CI
baseline	21.16	18.1	38	27.11	15.21
6 weeks	9.96	12.7	35	14.33	5.59
12 weeks	7.98	13.1	31	12.79	3.16
Non-Condition related costs					
Time point	mean	sd	n	upper 95% CI	lower 95% CI
baseline	19.41	25.9	38	27.91	10.91
6 weeks	16.38	20.6	35	23.47	9.29
12 weeks	42.62	109.6	31	82.81	2.44
Intervention costs					
Time point	mean	sd	n	upper 95% CI	lower 95% CI
baseline	0.00	0	38	0.00	0.00
6 weeks	40.00	0	35	40.00	40.00
12 weeks	0.00	0	31	0.00	0.00

Graph 1: Total mean weekly costs



Total costs (NHS + personal costs) over the course of the study remained relatively unchanged with a baseline mean of £54.06 (95% CI: £38.85 to £69.28) and a 3 month mean of £60.96 (95% CI: £16.41 to £105.50). At the six week time point, total costs are higher when Alexander Technique lessons are included (6 week mean of £85.88 95% CI: £66.78 to £104.99). Moreover, the wide confidence intervals suggest that there was substantial variation in this small sample.

In comparing NHS costs to total costs, the majority of the total cost burden falls to the NHS rather than the individual and the pattern remains stable. NHS costs follow the same pattern as total cost which is better understood by looking at the constituent costs (condition, non-condition and intervention). For example, the bulge in NHS costs at 6 weeks represents an additional £40 per person per week for the cost of Alexander Technique lessons. Whereas the increase in average NHS costs between baseline and 12 weeks represent an additional weekly cost of £25.21 per person of non-condition related costs due to 2 hospital admissions.

So non-condition costs rose from a baseline mean of £19.41 (95% CI: £10.91 to £27.91) to a three month mean of £42.62 (95% CI: £2.44 to £82.81). But condition related costs for this population of service users fell significantly from a baseline mean of £21.16 (95% CI: £15.21 to £27.11) to a

three month mean of £7.98 (95% CI: £3.16 to £12.79). In summary, the overall costs are relatively stable at all three time points and those costs directly associated with the referral condition of pain decreased significantly.

## **4.5 Discussion**

There were several limitations to the quantitative aspect of this evaluation. Apart from the lack of a control group which is to be expected when carrying out a service evaluation rather than an experimental trial, the principal difficulties concerned the Client Service Resource Inventory. We were completely reliant on service user self-reports, which can lead to recall bias. In addition, we had no other source of data to confirm resource use.

Moreover, unlike the EQ-5D, MYMOP and BPI which asked for information on current health and quality of life status, the Client Service Resource Inventory asked for data on resource use over the past two months. Because data were requested for two months, at the 6 week time point, there was an overlap of two weeks with data provided at baseline. Potentially this could have affected the final follow up at 3 month after baseline (12 weeks) as well. But when we looked at the dates for when follow up was conducted, all responses were received at least 14 weeks from baseline. So only the middle time point was affected.

In addition, by separating out the costs for referral and non-referral conditions and only including in the referral condition classification those items where the reason was clearly stated as pain related, we may have underestimated the resource use for pain-related conditions. For example, if a service user reported using glucosamine, which is often taken for joint pain, but reason for use stated 'because my doctor recommended it', we did not assume that the preparation was pain related. However, this ambiguity tended to occur with prescribed and over the counter medications, which were generally low cost and so the resulting underestimate is likely to be slight.

Nonetheless, this exploratory study of a small group of Alexander Technique service users (n=43) found that overall there was a general trend in the health outcome data (BPI and MYMOP) towards a decrease in scores of approximately one point between baseline and 6 weeks. This improvement was maintained at three months, once the service users were no longer attending Alexander Technique lessons. These changes were potentially clinically important as 95% confidence intervals (for the difference between 6 weeks and baseline) did not cross zero, they were also statistically significant at the 5% level. This suggests that the Alexander Technique service



provided some benefit in health status to this service usage population that carried on once contact with the service discontinued. However, the quality of life tool (EQ-5D) did not show statistically significant change, possibly because there was no change in quality of life or because the questionnaire itself was not adequate to detect any.

EQ-5D aside, the BPI and MYMOP results offer some intriguing possibilities. The BPI severity and MYMOP Symptom 1 scores, which attempted to capture the intensity of the experience of pain, showed some change. But the changes in wellbeing, activity and medications captured by MYMOP and the improvements in mood, walking ability, normal work, sleep and enjoyment of life reported with BPI interference scores suggest that the greatest changes were found in how service users managed their pain, for example more than half stopped or reduced their medication, and the impact that the pain had on their daily life. The service users still experienced pain, and that pain was quite severe for many. But their approach to coping with that pain and the extent to which the pain affected and limited their routine activities and movements may have eased.

Further complexity is added when the cost data are taken into consideration. The Alexander Technique teaching service was set up explicitly to address pain related conditions and all but one person stated an area of pain as their first priority for treatment in the MYMOP questionnaire. Costs overall remained stable during this time period, but the resources that these service users attributed to their condition decreased over time. As this study was observational and not comparison based, we do not know if this change would have occurred anyway. However the large scale, HTA funded randomised controlled trial for back pain mentioned previously was comparison based and found that six Alexander Technique lessons followed by exercise was more cost effective than usual care, exercise alone, massage (with and without exercise) or 24 lessons of Alexander Technique (with or without exercise) (Little et al. 2008).

Moreover the service users in this study reduced their costs, although they had experienced pain for many years (half of the service users for 5 or more years and a third for between 1-5 years). In comparison, a review of 36 papers found that 62% continued to experience back pain after a year compared to 90% of these service users at the start of the study (Hestbaek, Leboeuf-Yde, and Manniche 2003). Thus in consulting the wider literature, there is some suggestion that our finding that condition related costs decreased over time may be due to more than chance. However, this study needs to be tested in a future definitive study.

## 5. RESULTS OF ANALYSES OF QUALITATIVE DATA: INTERVIEWS WITH SERVICE USERS

### Report on the service user telephone interviews

In addition to the quantitative tools, this report draws on data drawn from semi-structured telephone interviews with 27 service users of the SEAT service. The interviews were conducted three months following baseline. The sample included a range of service users, including those who completed the majority or all six lessons and showed little or no improvement, minimal improvement at 6 weeks or 3 months weeks, and those who complete and show great improvement at 6 and 3 months. The sample did not include those who were referred and did not attend or those who dropped out after 1 or 2 AT lessons.

The interviews were facilitated by use of a topic guide (Appendix x) which comprised a variety of questions designed to prompt and guide the participants. Topics included the service users' experiences of the AT lessons, reasons for attending the service, impact and maintenance of AT technique, and benefits and drawbacks to the service. The interviews were tape recorded (with the service user's written consent) and transcribed in full. The data was analysed using a grounded thematic approach, coded to identify themes and categories, looking for similarities and differences across the accounts to identify patterns and search for 'deviant cases' (Strauss and Corbin 1998). Themes around the service users' relationship to and management of pain emerged in their accounts in analysis midway through the study and so we later incorporated questions about this to test the data and to seek alternative explanations. As such, thematic content analysis was used as an analytical tool as each of the interviews was different in content and length.

This report outlines the results of the thematic analysis of the data from the service user telephone interviews. Four key areas are addressed:

- routes into the SEAT service
- experiences of the AT lessons
- impact of the AT lessons
- post-service experiences and strategies for the future

### 5.1 Routes into the SEAT Service

This section discusses service users' initial referral patterns and reasons for taking part in AT lessons at the Pain Management Clinic. It explores service users' personal health history and long-term conditions, as well as their initial expectations of Alexander Technique lessons.

### 5.1.1 Reasons for taking part in SEAT

The majority of service users explained how they had decided to take part in AT lessons following consultation with either their GP for existing chronic back pain and had been referred, or they had been an existing patient at the Pain Management Clinic and the decision was made through the consultant,

*He [the GP] then referred me to the Pain Clinic at St. Michaels, where the women who saw me said that I would benefit from three things, there was a psychologist, a TENS machine and also, she said if I can get you a place on the Alexander then you can have it, so luckily one came up. (SEAT 147)*

As such the patients had often tried other treatment options first due either to their own or their GPs suggestions,

*At the time I was thinking about alternatives, and my Dr [GP] suggested Pilates, but I think that would be the wrong thing for me to do and Dr\_ [pain clinic] agreed with me on that. (SEAT 141)*

The decision to have Alexander Technique lessons also rested with the particular knowledge of the GP about their patients, with patients suggesting that GPs took an active decision in whether to recommend particular treatments,

*...what happened was he [the GP] wrote to the specialist in \_\_\_\_ who dealt with chronic back pain and leg pain, and he said that there was some injections that I could have. They didn't think that they were right for me to have them, so he [the GP] sent me off to the Alexander Technique. (SEAT 124)*

Those who had been referred to the Pain Clinic by their GP or who were existing patients at the clinic were mostly referred by the consultant to AT lessons if they thought the lessons would be

useful for that particular patient and if the patient was receptive,

*...[I] went to the pain clinic at \_\_\_\_\_ and the consultant just referred me onto that because he said about told me about the trial and asked if I would like to do it so... (SEAT 109)*

The majority of service users who were referred by the consultant were told that the AT lessons was one of a number of pain management treatments that were available and it was suggested that the service user had the final say in which one they thought they would like to try,

*I was offered a variety of different um opportunities...um one of which was the Alexander Technique so I said yes of the range of opportunities I had I chose that one. (SEAT 116)*

Service users talked about wanting to try 'anything' as they had been offered and tried other pain management related treatments before with little or no success, and so for some service users they wanted to try something other than medication; this was a significant strategy for some in their decision-making,

*The doctor at the Pain Clinic suggested I try the Alexander technique and I was happy to try anything really...they offered medication um but they didn't want to really go down that route again um so I want for the Alexander Technique really. (SEAT 127)*

...

*P: ...and um I've had injections and they only, excuse me, they worked short term, and then it was recommended um via the pain clinic*

*I: Right*

*P: ...that um sort of three options, more injections, Alexander technique or a use of a TENS machine.*

*I: Ok*

*P: So I um they explained the Alexander technique to me and I said well let's give that a try (SEAT 137)*

For those service users it was an active choice to try Alexander Technique lessons out of the available options, and for a significant number of those interviewed that had been offered the pain injections (either the first time or a subsequent time) had decided that they did not want that treatment,

*...that was one of the um options he was going to give me, it was basically going to be that or um further um steroid injections in my spine so I opted for that (SEAT 101)*

A few of the service users suggested that they had taken an active interest in what treatments had been offered at the clinic and had made the suggestion to the consultant based on what they knew. Others had been offered other treatments, such as psychological therapies, TENS, physiotherapy or acupuncture, but did not want to try those so felt the need to give something else a go,

*...they explained the Alexander technique to me and I said well let's give that a try... the way it was explained to me, I thought let's give it a try, don't knock it until you try it (SEAT 137)*

At the beginning of the AT teaching service and a few weeks before the beginning a poster was located outside of the main consulting office at the pain management clinic and some of the service users who noticed the poster mentioned it to the consultant and this helped to make the decision for them.

*...so I went to my doctor and I said I would like to try that and he said well you can't have that on the National Health Service I said that's all right but there are classes in St. Michaels because I saw it in the corridor so repeatedly I said the same thing and he said ok I will I will try so he contacted them and very quickly I got a response (SEAT 114)*

In the previous section we noted that over half of all service users (n=22) had a chronic back pain condition that had been experienced for over 5 years. As such this sometimes influenced how they perceived the AT lessons and also how they perceived taking medication or having injections for

the pain. Some of the service users talked about the pain in relation to other related chronic conditions that they suffered from, such as arthritis, osteoporosis and carpal tunnel syndrome (amongst others). One service user explained how the multiple conditions and long-standing nature of the pain condition made them very realistic about the potential of the AT lessons, even if they found them useful,

*I'm pretty bad actually, I've got terrible osteoarthritis and I'm also suffering from severe depression, so unfortunately I don't take much exercise or anything. I'm 78 years old and I'm going blind, so I've got rather a lot of problems. I've lost the sight of my right eye and my left eye's going, and I'm always at the eye hospital, so it's going...I've got degenerative conditions at my age, and so I'm in pain really all the time. (SEAT 128)*

### **5.1.2 Use and knowledge of other treatments**

The nature and extent of some of service users' other chronic limiting and long-standing conditions also influenced their understanding and perception of a range of therapeutic options. As such they had tried other options and considered themselves to be well informed,

*I've had constant treatment for about 3 years, including acupuncture, massage, physio, and mostly out of my own pocket. (SEAT 104)*

*I mean I have tried everything I have had acupuncture and reflexology and hot towels and you know the works. (SEAT 115)*

Frequently the alternative treatments that they had tried was through referral from their GP or privately as separate treatment, often involving a range of treatments such as osteopathy, chiropractic, massage, acupuncture, and physiotherapy, but not exclusively. Others had tried options through the pain management programme at the clinic and had found that they hadn't worked as well as hoped,

*...the first one didn't do much to me [the first treatment option at the pain clinic], that wasn't on that course, that was where you had all the pins and needles put in you (SEAT 113)*

A few service users had spoken about how they had very positive experiences of the Alexander Technique lessons and had wished they were available earlier so that they could have avoided other treatments. For those who had spent money privately on other treatments there was the sense that AT lessons were offered as a last resort and that given that lessons were free through the NHS pain clinic they more keen to try them, whereas as private paying clients they may not have done,

*I'd spent all my money on other things that didn't work and I was just at the end of my tether really, and I really just didn't want to spend any more money on anything, but it just came up. (SEAT 147)*

A few of the service users were more familiar with these alternative treatments (as opposed to conventional pain treatments), due mainly to their interest in trying CAM treatments for chronic pain or because of their professional background:

*I was actually a massage therapist anyway, so normally we are aware of alternative therapies. (SEAT 142)*

*...I have been interested in alternative methods as treatment... I had been to the chiropractor I have been to various others um various other um non NHS um treatments (SEAT 111)*

### **5.1.3 Expectations of Alexander Technique lessons**

Along with differing personal health histories and conditions service users also had varied expectations of the Alexander Technique lessons. Although many of the service users had tried other therapies and had heard of Alexander they did not necessarily know what they were going to get,

*I mean I have done a few other things but certainly Alexander... that was my... I've heard about the technique but I've never um done anything like that before. (SEAT 101)*

There were a few exceptions of those service users who had not only heard of Alexander but had read up on the approach and this was particularly for those who had some personal or professional interest in the therapies:

*My father was a doctor and he had books about Alexander Technique way back in the 1960's and so had also joined some courses at Glasgow University for it but I didn't only had sort of one or two sessions and then I came to Bristol...I read his life history and was interested. (SEAT 114)*

...

*P: Well I already had read about Alexander Technique, but I did go on the internet and just do a little bit of exploration, just really for my own...because I was inquisitive really.*

*I: And did that help?*

*P: It just made me realise that actually it wasn't really what I thought it was, if you like. (SEAT 142)*

This studying showed that the service users wanted to inform themselves more before embarking on a course of lessons. As such, service users who had not necessarily 'studied-up' had unclear or erroneous expectation of what they would receive,

*I can't say it was top of my list in the past because it seemed to me to be just about you know standing up straight. (SEAT 115)*

Moreover, some of the service users said that their expectations were unclear up until the first lesson.

*I had a vague idea that it was something to do with posture and I... I had... I didn't know that it was going to be helpful particularly for back pain I was quite surprised when I saw that leaflet. (SEAT 101)*

*Initially I had different expectations; I thought it would be a group session. (SEAT 106)*



Others were just glad that it was not carried out in a group, and this was important because as we shall see the positive experiences depended on the intense one-to-one nature and focus of the lessons,

*I thought it would be like just a normal exercise class thing, and I found out it was a one-to-one basis which has really helped me, because with a one-to-one session it was better than having lots of people in a room together.*(SEAT 124)

Service users reflected on their motivation for undertaking AT lessons and a clear theme emerged for many service users that it was something they had not yet encountered in their dealings with pain and that they were open and receptive to this; they had tried many other treatments and so many were pragmatic and realistic about what AT might have to offer. As such, this openness rather framed their expectations about what they thought they would encounter,

*I think I was just quite open-minded really...I didn't really think that much about it to be honest.* (SEAT 145)

Expectations veered between uncertainty, scepticism, and realism/pragmatism,

*I was sceptical to begin with that such small changes could make such big differences, you know, changing posture and things, and the way you move and how you move, but I was very, very pleasantly surprised.* (SEAT 108)

Some of them had talked about how they had unrealistic expectations before (e.g. the magic wand, with other treatments) and so they were more cautious about their feelings towards this approach,

*There's not a kind of magic wand, nobody can make everything better and take all the aches and pains away and stuff. So I had before sort of magic bullet expectations that things would be amazingly better overnight, just with a pill or a small tweak of lifestyle, and they weren't obviously.* (SEAT 121)

Others were just hopeful as well open-minded about Alexander, but cautious that they would expect too much,

*...my hopes were that it was going to alleviate my back pain um I don't know whether I expected it to help really because I had tried so many different things and I had had this problem for a couple of years um so I don't know whether I really expected it to help but certainly that was my hope. (SEAT 101)*

*I went in with an open mind. To be honest, I had to be a bit careful because I wanted it to work so much, but then I realised if it didn't work it wasn't anyone's fault. But, um, I kind of went in with an open mind. (SEAT 147)*

## **5.2 Experiences of Alexander Technique lessons**

This section discusses service users' experiences of AT teaching in the 6 lessons that were provided at the Pain Clinic. A range of themes emerged in relation to service users' experiences of the AT lessons; in particular, at the heart of service users' positive experiences of the lessons was the AT teacher. This was obviously central to their satisfaction and enjoyment of the lessons and a range of reasons were given as to why they felt this was important – such as being supportive, knowledgeable, making a good connection with the service user, having healing hands.

### **5.2.1 Positive experiences**

When asked about the service users' experience of the AT lessons themselves service users generally reported positively, expressing a high level of satisfaction,

*...the Alexander was first class, I can only praise it. It's certainly doing me some good. (SEAT 113)*

*I found it all really easy and relaxed and comfortable. (SEAT 124)*

Some particularly focused on the way it gave them a 'feel good' factor,

*I did feel incredibly mellow after the sessions... I felt like I was walking on air it was brilliant. I felt about 2 inches taller and I just felt that everything was at peace with itself, you know, there were no sort of aches and pains jangling for attention. (SEAT 121)*

Others found that similarly it gave them an energy boost for a time,

*I found it um... I found the experience, I don't know if this is the right word invigorating... (SEAT116)*

As such the service users explained how the primary reason for the enjoyment was that they found the AT lessons relaxing and that this was in some ways a 'pampering' experience for themselves,

*It's also a way of pampering yourself, but it's also beneficial. (SEAT 108)*

*The actual treatments I really enjoyed, I found them really relaxing, and I did feel better for a few days after the treatment as well really, so yeah that was good. (SEAT 145)*

This experience led some of the service users to focus on AT as a treatment and they expected some 'feel good' sensation following the lessons. One service user reflected on how this sensation of feeling good came from the dedicated focus that the AT teachers provided during the lessons,

*Having Alexander was very useful at the time. It's just you and the instructors and there is nothing else to take your attention. (SEAT 104)*

When asked if the service users had any uncomfortable or unpleasant experiences only one reported that due to their condition,

*...sometimes I was in some discomfort because obviously I had to lie down and at that stage I had bad sciatica... um so it was sometimes a little bit uncomfortable (SEAT 101)*

## **5.2.2 Views on and experiences of the Alexander Technique teacher**

Central to service users' positive experiences of the lessons was the AT teacher. A range of views was expressed about the teacher and particularly why they felt the teacher was important to their sense of satisfaction and enjoyment of the lessons. Some talked about how the teacher was good at helping the healing process,

*It was lovely [the AT], I loved the person who did it, she was really good. I wish it could have gone on for longer. I thought she had very healing hands. (SEAT 128)*

The hand contact factor of the teaching approach, as much as the educational approach, was clearly important as some of the service users explained how the gentleness of the way teachers work was very important. There was also an important issue for many about how the lessons, carried out in six consecutive weeks helped to build up this connection and rapport,

*...she [the AT teacher] was wonderful...we had a good rapport. (SEAT 114)*

*I think the duration of it was good enough to impart the wisdom and um build up the trust and um learn about the technique and as a complete um course... you also need to build up the techniques and the trust you have between the patient and the practitioner... (SEAT 111)*

In this sense the AT teachers were seen as very supportive, helpful and encouraging in terms of guiding the service user through the lessons but also dealing with service users who were perhaps lacking confidence because of their condition,

*I thought the practitioner was lovely um [...] was just amazing, she was so gentle um and perceptive and kind and supportive, she was really encouraging.*

*I: Can you give me an example of the ways in which she was supportive, was it something specific she did?*

*R: Um, yes so when I... I mean I tend to rush around a lot and she... I was... I thought I got something which I hadn't there was the picking up, bending over to pick up and I sort of went yes, yes I know how to do this and she was really gentle at saying, making me see that no I hadn't got it um just by um I mean she was very gentle at putting her hand on my*

*shoulder and was very reassuring and was very good at the start of each session of sitting me down, just putting her hands on my shoulders and enabling me to relax before the session began so that was really useful. (SEAT 115)*

What we see in the last service user comment is that a significant dimension to that helpfulness and supportive relationship was an emphasis on the learning process in Alexander Technique, and also that the AT teacher guided the service user and did not tell them what to do. Many of the service users commented on how knowledgeable the teacher was which was clearly important, as we see here, in terms of the practical aspect of explaining what was happening, but that also they were able to provide materials for the service user to study up on in advance of and after the lesson,

*We had a DVD at the end, and the lady who was doing my sessions puts her own books out and you could sit and browse them while you were waiting. Over the weeks I was reading a couple of chapters, but that sort of gave you a bit of background knowledge as you were going, and she gave pretty comprehensive handouts for us as well, which I found very beneficial, you know the background to it [AT] and stuff. I didn't know much about it before I went and I thought the handouts backed up and supported the sessions very well. (SEAT 121)*

But what was equally important, if not more so, was that the teacher played the role of the teacher and helped to tailor all aspects of the lesson to the service user,

*I thought the teacher was very knowledgeable um and she was very geared up towards my issues, so we diverted quite a lot but um there was always a story and an explanation and another technique that she'd sort of find on a different course that she could apply to me. So it was, it was very practical for my problems, if you see what I mean? (SEAT 134)*

*The way it was approached by the therapist was um very sound um and um explained it very well and each session I had, six sessions, it was um well explained what the objectives were you know what the outcomes should be. (SEAT 137)*

One service user reflected on how this knowledge and perception was about the intuitive strength of the teacher, and they were able to intuit aspects of the pain, the condition, which the service user was feeling,

*P: ...at the time I found um the practitioner helpful, understanding, intuitive um she was very knowledgeable, she was very helpful...*

*I: when you say intuitive can you say a little bit more about that?*

*R: Well I mean I got the distinct impression that I mean the woman I can't remember her name forgive me for that she seemed to be incredibly knowledgeable and as a result of her experience she was intuitive about what I could expect from it, how I was reacting um and the problems that I was having...for example this is going to sound very, very childlike however the way one stands up and sits down...and so she said well you know if you do this and perhaps this might work better for you. (SEAT 116)*

This reflected also in the terms service users gave for the AT teachers as 'teacher' or 'tutor', as opposed to practitioner or health professional.

### **5.2.3 Views on the clinic and the number of Alexander lessons**

Despite the project's emphasis on the Alexander Technique we were also interested in the service users' perception and experience of Alexander in the context of being provided at a pain management clinic, where other treatments were available as part of a programme. Service users were very positive generally about the pain clinic and the team of clinicians, a view represented by the following statement,

*I think that the pain clinic in general was absolutely brilliant. And because there were a group of people trying to find out what was wrong and trying to fix it, whereas before I kind of went around from one thing to another, and I didn't have a holistic answer. But the pain clinic's good because it gave you an answer. (SEAT 147)*

Service users had only good things to say about the consultants, who had referred them to the Alexander Technique lessons, only wishing in some cases that AT had been recommended earlier,

*It would have been helpful to me had this been offered beforehand and I think it would be interesting um you know I was offered physiotherapy for example... and I went to a couple of physiotherapy sessions within the hospital and the nurses and practitioners were very good. Um but it would have been more beneficial to me to have been offered Alexander as an alternative you know right in the very beginning. You know having come out as part of the process you know I have got a back problem what can you do to remedy it well here are the alternatives like you know physiotherapy well in my particular case I have had a long history of physiotherapy and some bright spark really should have said well obviously you have had a long history it hasn't work for you why don't we try something else. (SEAT 116)*

Service users were generally satisfied with the facilities of the clinic and the room that the AT lessons took place, although given that for the majority of the service users this was the first time they had experienced anything like Alexander, they did not have other similar experiences of approaches to compare it to. Also, most of the service users were happy with the six AT lessons, saying that this was just about right for them to learn the basics of the teaching and importantly, to build up the relationship and the trust,

*I think the duration of it was good enough to impart the wisdom and um build up the trust and um learn about the technique and as a complete um course the whole six treatments was about... was about right really um but because of course you get the diminishing returns on the excessive number of treatments but you also need to build up the techniques and the trust you have between the patient and... (SEAT 111)*

Other service users, knowing that being part of the NHS meant that they had realistic expectations of what to expect with the lessons,

*I think so I mean it was... it would have been nice to have carried on a bit more or to make it more of a kind of routine um but obviously with the NHS it's kind of difficult isn't it? It gave you enough insight to kind of show you what you know what you shouldn't be doing and teaching things. (SEAT 109)*

All of this is important in the context of a broader debate about best use of NHS resources when providing interventions, and particularly with Alexander Technique where there are differing views and evidence about the value of providing a certain number of lessons. One service user struck the

right note by suggesting that you could always add to the number of lessons, but given that the technique is about education then the key issue is about whether six lessons is enough to help the service user learn the right things and not feel dependent on the lessons and the relationship with the teacher,

*I think six weeks is good because it leaves you... I think you could go on forever you could go on seeing somebody every week and then you become dependent on them don't you so I think six weeks was about right. (SEAT 115)*

The main issue for some service users is that many of them wanted to take it further but were not in a financial position to do this, and so the six lessons only gave them a 'taster' of what it would be like,

*I mean it would obviously be good if it could go on a bit longer, but yeah I understand it can be quite expensive as well really. (SEAT 145)*

There was a feeling from some that they had a complex pain condition and that they wanted to continue the lesson so that the technique became further ingrained in their daily life; only regular sessions would have helped this process,

*...having started me off I was then left in a situation where I... I think um its a bit like yoga if you want to go further with it you have to be part of a group and be with the practitioner... so it's a bit like you know giving me a taste and then taking it away from me... the second thing was that I felt while I had a very, very, very, very limited start and understanding to it in order to move further forward um what... in order to move further forward in my particular case I would need to go and see somebody regularly so that it became part of my habit. (SEAT 116)*

### **5.3 Impact of Alexander Technique lessons**

This section highlights service users' accounts of the impact of the AT lessons on their pain and overall health and wellbeing. Several issues are addressed including the self reported improvements to their condition as well as perceived impact on pain. A key theme emerges which is about AT as a technique for managing the perception of pain and service user response to pain;



this also led to some behaviour change and changes in awareness and self knowledge from the service user, and these issues are reflected on. As such the wider impacts of AT lessons on participants are also discussed.

### **5.3.1 Condition improvement and pain outcomes**

In the interviews participants were asked how things had progressed with their condition and their pain since the last AT lesson. Some service users noted overall improvements to their condition, although it was common to find that service users had periods where there were setbacks and changes to the condition or pain that made the improvements seem less noticeable,

*Although recently I've had a little set back, overall things have improved. (SEAT 106)*

It was also noticeable that some had felt that although there were improvements soon after the start of the Alexander Technique lessons these improvements plateaued so that the effects do not improve incrementally every week,

*I'd say I've reached a level now [3 months on] where it's staying as it is, it hasn't got any more improvement but there's a definite improvement over when I started the course. (SEAT 121)*

Few of the service users reported no changes at all to the condition or pain levels, indeed many reported having an initial impact but the longer term impact lessened over time, and for them it was the level of pain that they were hoping to reduce,

*I: Had the pain improved during that time?*

*P: It definitely did while I was receiving the treatment, yeah. But there wasn't much change apart from that really.....the main thing is that the pain has not really improved that much and I've sort of become resigned to it really. (SEAT 145)*

For those who felt that the levels of pain had not reduced (a minority view), they took something from the AT lessons that they could apply to other aspects of their life and they still often reported finding the technique useful,

*In general terms it's pretty much been the same I would say. It's been no changes, but it's something I can apply in some areas of my life, but in terms of the symptoms it's pretty much the same I'm afraid. (SEAT 131)*

However, for the majority who reported significant change, they felt that the Alexander Technique was something they had been hoping for

*I found the Alexander Technique the most effective thing I have ever tried. (SEAT 127)*

*With the help of the Alexander Technique my back has improved a great deal to make my life a lot easier, with the things I've been shown and helped...It's provided some relief – getting out of bed easier, getting in bed easier, getting out of my chair easier and stuff like that, relaxing more. (SEAT 126)*

As suggested, some had tried many different treatments and the Alexander Technique was something they were favourable to and wanted to work, as such many reported continuing to use the techniques and procedures even as they were in a lot of pain, and often this strategy would work,

*I've been trying to do the exercises but I'm still in pain. (SEAT 103)*

*When she did the exercises on my back and legs I felt the back pain went, I wasn't in pain up until about now, so the pain only started to come back in the last month or so. It's been quite effective. (SEAT 124)*

Service users also talked about the changes not necessarily being very noticeable or large ones, that sometimes there was a subtle change to the pain, small differences that made a difference to them,

*I guess you never know completely um but I suspect it might have something to do with it just as I say the change... they are very subtle small changes but um that I've made but I*

*mean I have not had another crisis point since then so it looks as if it would be down to that.*  
(SEAT 101)

### **5.3.2 Impact on relationship to pain**

Although overall pain levels had decreased or had leveled off for most, for some the pain had not changed significantly and they talked about how AT lessons had an impact but mostly in terms of how they experienced the pain – the relationship to the pain, given that for many the conditions were long-term, was a crucial dimension to what they saw as important to them. Being able to use the Alexander Technique to be able to deal with the pain was important given its chronic nature, and it meant that they had changed their perception of what the pain meant to them. As such service users talked about how Alexander Technique lessons helped them to manage the pain,

*I am managing the pain much better now... with the tools given to me I feel more in control.*  
(SEAT 147)

For some this was about how they used the technique to help with the pain, such as being able to breathe through it. This does not stop the pain from coming but it provides relief for those that want to be able to deal with the pain when it comes,

*It's possibly helped me to breathe through the pain, rather than...the Alexander Technique woman was telling me that I kind of close down with the pain, I just shut down to it, so I've learned to breathe through the pain. I've been doing the exercises she's taught me to do but I wouldn't say the pain has stopped at all... She said [the AT teacher] I just had to go in on myself and don't help with the pain, she'd just more helped me to breathe through the pain, cos I was like holding my breath when the pain come so it would hold the pain longer, so it just helped me to breathe through it, which was obviously a big relief in itself. I had high hope hopes of stopping the pain but I'm happy with the helping breathe through it, and helping to manage it. (SEAT 144)*

This is also evident in the following quote, where the service user explains, using the metaphor of a jumble sale, that it is important to take what you can from the technique, but not everything will be useful to you,

*No it didn't reduce my pain, I have to say. But what it did do is made me aware of maybe how I could stop the pain from escalating, you know, if I've felt...cos I clench my jaw a lot and I know I do, which gives me headaches, and when I found myself doing that I just did the breath technique and I still do that, so it made me aware of that which was incredibly helpful. It's just that deep breath, aahh, and just let it out, and oddly it's one that my son does exactly the same and I just said to him, you know. I think what happens, and I think with any therapy, is you actually take from it what is relevant to you, you know, what you find you can use, and I find even you know clients who have come to me I think do the same thing. You know if you go into a jumble sale there's usually one thing that you know will pertain to you. (SEAT 142)*

Others were more explicit in saying that their relationship to pain had changed, and that they had some agency in terms of being able to influence that. This meant that they had moved on from thinking about the Alexander Technique in terms of being able to change their levels of pain,

*...it meant that there was a significant shift in my relationship with my pain... it's going really well actually because I was describing it to somebody recently um and the big shift like I said has been my relationship with the pain and acknowledging that when it's there I have then got a choice to carry on having pain or I could just breath and relax and let it go and quite often that's the thing that makes the difference... and acknowledging that if there is pain then is it... you know how am I sitting how am I standing and what am I doing because quite often I take on a lot and it's been a really good... it's almost like a... it's not constant meditation I am not that good (laughs) but you know every now and then I check in and go oh ok slow down um and that's been just fantastically important to me. (SEAT 115)*

Other service users also provided some clear examples about their relationship to pain had changed because of the AT lessons and this had led to better techniques for managing the pain,

*P: Because like I was saying it doesn't make the pain go away, it just gives you a greater degree of control when it does come on as to things I can try um to ease it.*

*I: Can you give me an example?*

*P: Yeah, I'll give you an example, um I'm trying to think of um my um I have difficulty, a lot of difficulty bending slightly forward, for example like you're washing up or something like*

*that...and there are few tests that I need to do and work that you know I've got to watch my position and also sitting long periods of time and when it does bite in, then um things like the monkey [an AT way of standing] and things like that do help because I can look at my position. I can look where I'm standing, I can think about whether my knees are locked or not or where the stress is going...and try and take it off my back and through my legs. Um things like that um help big time. Especially if I'm stood long periods talking, I suddenly have to um re-position the stress through the back. So that, you know it doesn't make the pain go away; it makes it more manageable to cope with at the time. (SEAT 134)*

In the next example we see the service user explaining how these ways for managing the pain and changing their relationship to the pain stemmed from a realisation that Alexander Technique lessons would not provide a miracle cure for the pain, and once they had dealt with this then they were able to focus on how it would benefit them,

*P: Well, so it helped me deal with my pain and my back, and whilst it's not completely gone away I know now how to control it. And I think psychologically it's helped as well.*

*I: Are you saying you're finding it easier to manage the pain or the condition that causes the pain?*

*P: Both really. And I know what causes the pain; I know certain things that I do cause it. But then, I know how to um...what's the word...stop it from getting any worse.*

*I: Stop the pain from getting worse?*

*P: Um, well for instance now, I've done some cleaning this morning and it's made my back hurt. So now I'm sitting properly using the Alexander technique making sure that the pain won't get any worse, and by worse I mean it won't last for two weeks or whatever....Not in terms of getting...because my pain is strange, it wasn't as bad as like breaking your arm or anything, in fact it wasn't that bad, it's just that it was there all the time, preventing me from doing certain things...And to be honest the Alexander technique seemed to be the only thing that understood that. Everyone else is trying to find a quick fix... Because I know that it's not a miracle cure or anything, but I know that I've got some tools to help me. And psychologically that helps as well because I know that the pain won't be there forever...I know it comes and goes, and it's annoying when it's there, but I had two good weeks and that's just lovely to have that. (SEAT 147)*

### 5.3.3 Wider impacts: awareness and self knowledge - 'changing direction'

Service users talked about the lasting impact that Alexander Technique lessons had in terms of remembering key changes to the way they went about their everyday activity. Their discussion focused on an increased self-awareness and self-knowledge of what they were doing and many of the teachers 'directions' on this had a long-term impact in helping them to change and get relief from pain. At the time the slogan for the AT team was about 'changing direction' and you can see how this rubbed off onto some of the service users' approaches and attitudes to their everyday habits,

*It was a good start; you know it made me change direction. (SEAT 115)*

The AT taught approach instilled mindfulness to their everyday activities. Also, it's important to mention that over half of those interviewed said they were continuing to practice the technique and some of the directions on a regular basis, with some of them mentioning very positive effects about how they had progressed with this and had slotted it in to the day. Some of the service users spoke about the ways in which the teachers' teaching methods had made them change some habits in the day or had made them respond differently,

*I remember a lot of what she said. It's hard to explain really. Well, sometimes when I'm walking along I remember what she said about turning the head...I'm also continuing with the semi-supine, although sometimes I wonder why I'm lying there. (SEAT 106)*

*I've been continuing with the exercises, thinking I didn't have to do it this way, with things like standing and moving. It's coming very naturally, although I have overdone it with the walking recently. (SEAT 107)*

In particular the emphasis was on the teaching aspect of Alexander Technique and that those who perceived themselves more as a 'student' and less as a service user (expecting treatment) seemed better able to make use of AT and make it fit their perception of their condition and the pain. This was about them wanting to establish some control over their condition and AT offered a way of doing this,

*It's the fact that I have control over my own body and I can learn about my body and that I realise that I hunch my shoulders... lift my shoulders and tense up before any even minor situations, even waiting for the bus getting impatient and then I can think of what [the AT teacher] taught me and I get relief. (SEAT 114)*

*...you know it was kind of um you know it made you aware of what you were doing wrong... and I think that until someone kind of shows you what you shouldn't be doing... um because she had... it was quite good she had a little skeleton model that she was showing you what kind of movements that I did was actually doing to my back and I thought that was quite good, just kind of points out how (laughs) how normal things that you do are wrong. (SEAT 109)*

A common theme therefore when thinking about the future was that for many they were filled with a realism but it was also optimistic – they had seen how they could fulfill certain activities they wanted to do by using the AT and this allowed them to think carefully about how their habits could change to help their back pain. The benefit of the teacher was clear but for many they could not at that stage think beyond the teacher-student relationship into a more independent self-management approach. As such this particular service user spoke about the way it was important once the behaviour had been changed to keep up the habit, as without this they had found less incentive to keep it up,

*In order to move further forward in my particular case I would need to go and see somebody regularly so that it became part of my habit... my living habit if that makes sense to you. I am 100% sure that the way that I stand, the way that I walk and things like that I have not taken on board the regiment, the regime and I have gone back to my old ways. However had I continued to see somebody either singularly or in a group then part of the dynamics of Alexander technique would have become part of my daily routine and I would have benefitted that much more. (SEAT 116)*

Others had taken this on board realising that to benefit from Alexander Technique lessons required not just a change in habits and behaviour but also a lifestyle change that required more commitment but also a different perspective on the condition and an active approach to self improvement and education,

*Well, I felt like, if I had gone along thinking here we go again, this is just another thing I'm going to try and it probably won't work, maybe it wouldn't have worked. But I don't know how it did exactly, but I got it straight away for some reason. I'm trying to think how. I think it's because it's a lifestyle thing, rather than something you just do for half an hour in the evening...maybe it shouldn't be advertised as a solution exactly, because people might put too much hope to it. If it's clear about what it is doing um...because I understand that it's good for rehabilitation and things like that and that makes sense, because if you've got something wrong like you've broken your arm or something and you do the Alexander technique to make you better, but if you've got a long running problem like mine...um, you don't expect a quick fix. And Alexander technique isn't a quick fix; it's a lifestyle change that you make to help...that's how I view it anyway, to just help you along a little bit. I've been reading books and things. I want to kind of keep it...I don't want it to go away, and I want to keep it there, so I know about it. Um, and I sort of don't want it to get...I want to keep it fresh in my mind. So yeah I try and get books on it occasionally. You see I've benefitted and I just want to get it out there really so other people benefit as well. (SEAT 147)*

In addition, although most gave examples from home and spoke about practising the technique at home, a few reported how the AT lessons had helped them to evaluate their work space and do things differently there as well,

*My boss is very good and she has bought loads of stools for everyone at the minute at work and everyone's... everyone loves it now so um... I mean that's a big positive that's come out of it... I definitely, definitely improved with having a stool at work. (SEAT 109)*

## **5.4 Post-lesson experiences**

In this final section we explore the extent to which service users continued to employ the AT and some of the directions for their condition and pain, and we also take into account other strategies that were expressed. In addition, we go on to highlight service user perceptions of some of the challenges and barriers to continuing the AT self-management at the three month follow-up period.

### **5.4.1 Continuing practice**

The service users were asked about how much they had practised the technique after the six AT lessons and what other strategies they were implementing in order to improve. Most service users



focused on discussing how they had tried to carry on the AT directions and technique, with the majority of those who said that they did carry on, that they practised every day,

*...in the supermarket if I am waiting in a queue so yes I do that I would say I do that several times a day. (SEAT 101)*

*I do it [the AT] everyday (SEAT 126)*

And for others it was every two or three days (2-3 times a week),

*Some of the lying exercises I still practice on a regular basis, and um yes probably not daily, but at least 2 or 3 times a week. (SEAT 131)*

Some service users talked about keeping the momentum going and explained that in the course of the day other events prevent them from remembering to keep the directions or technique going, and so this brings to light earlier comments about trying to make a habit of it,

*I do the exercises every day sometimes, but I also forget to do them. (SEAT 108)*

*I have on my own I... you know whenever I remember it I put it into practice. (SEAT 114)*

As well as forgetting, service users discussed how they needed the teacher to remind them of what they were doing. Some felt that in the time between the last lesson and the follow up interviews that they had lost some of this momentum (see also 'challenges and barriers to momentum' below),

*I try to do them in the evenings but without her (the AT teacher) doing it with you it's quite difficult. (SEAT 124)*

Others had mentioned how they were looking to keep up the momentum by visiting the Alexander Teacher as a private paying client, although obviously not all service users were in a position to do this,

*I have been doing these, um, this Alexander Technique you know, so um and I have got her address so if I want to continue with the Alexander Technique I can sort of ring her up and she will book me in you see... (SEAT 127)*

A few mentioned difficulties doing the activities or adopting certain procedures due to existing pain or emergent conditions that set them back or prevented them from doing it properly,

*I have been practising the exercises, but recently I have had a slight relapse so it is more difficult. (SEAT 106)*

Others also expressed difficulty about their present condition but were still keen to see that they could continue the practical benefit of some of the procedures,

*Because I've got so many problems with my back I can't do a lot of the exercises that she wanted to do for me. She done like the very basic exercises because obviously it causes me a lot of pain to go through with them, but at the moment I'm doing like a semi-monkey [knees bent, arms dangling down] and things like that, just to try and release the pain a bit more, cos obviously otherwise I stiffen up and if in don't do anything I stiffen up, so it's good to know how to do the certain things. She taught me how to set my chair right and things like that, so it makes it easier to get up from a seated position. So it was more just helping on that side of it. (SEAT 144)*

When explaining what they continued, service users mentioned a variety of strategies and activities. The majority who did continue said that they were using the 'semi-supine' approach, that is commonly used in AT lessons and which requires some time in the day to put in into practice,

*I've been doing um you know how the resting bit um at the end of the day she told me to lie on a flat surface with like the books underneath my head. (SEAT 111)*

Others referred to the use of a breathing technique which required less time taken out in the day, but instead required more of a mindfulness in its use. Part of the difficulty in terminology stems from the fact that these service users had attended only six lessons, which it could be argued is not

enough time to learn what ‘the technique’ amounts to and how to refer to the various activities. ‘The technique’ is the mindfulness part and is applied throughout each activity.

*Well, I still use some of the techniques, and the one technique that I really use is the breath, breath work, and really being aware of my shoulders and actually just let them drop, and when I’m walking - I don’t know why it’s one that I held on to – but just being aware of your surroundings really, being aware of yourself in space I guess. (SEAT 142)*

*Yes I’m still doing some of those, and the ‘ah’ [whispered ah] , you know, the breathing, especially in intense situations I do find that really beneficial, you know when you can feel yourself tensing up, and I tended to really clench my teeth quite badly, not even realising that I’m doing it and it really hurts...during the day when I’m stressed I just sort of sub-consciously clench my teeth without realising, and then I kind of realise I’m doing it and I’m in a lot of head and neck pain, so I’ve had a less neck and face pain there as well really. (SEAT 121)*

Some talked about their use of a ‘monkey position’ when standing, which had very beneficial results,

*Well, she [the AT teacher] taught me one thing. I’ve been having a dreadful pain in my side and I’ve had CT scans, MRI scans and X-rays and I don’t know what, and they found about my osteoporosis being so bad, but nobody knew what that was. And I had some deep tissue massage which improved it a bit, but I play a lot of bridge and usually during the course of an evening because you’re sitting there for three hours I have to roll myself up against the wall and everyone says ‘oh \_\_\_’s ironing her back’ and when there’s about a hundred people it’s quite embarrassing. However, \_\_\_\_\_ taught me a thing called monkey, and it’s incredible, it’s more or less the opposite to what I’d been doing and it’s far more effective, and in fact I can do it more or less secretly you know, I can do it just looking as if I’m bending over a table, and she taught me that and it’s really made such a difference. (SEAT 146)*

#### **5.4.2 Other strategies**

As well as continuing to practice the activities and directions and use the Alexander Technique, service users remarked on other ways that they were focusing on the present and the future. And

so they mentioned other strategies as well as ones connected to the AT. Other strategies included staying positive and not letting things get them down, despite continued pain,

*I'm a very positive person despite the pain. (SEAT 104)*

*I try to keep cheerful, it's not always easy. (SEAT 106)*

Also, from the MYMOP data we know that a high proportion of service users thought that reducing medication was important or very important to them. Many of the service users mentioned this as a strategy or at least a goal, and continuing to use the Alexander Technique was something that they thought would help achieve that, which was enough of a motivation for them. Returning to the BPI data we could say that the perception of pain had increased due to service users taking less of their medication. There is overlap here with the earlier theme about avoiding injections and medication as a route into choosing AT lessons.

Comments here reflect a general theme about personal responses to medication and the perception that reducing medication was a positive step,

*I don't like taking medication, and in fact I've stopped a lot of my medication now. (SEAT 108)*

*At the moment I'm not taking any pain killers, trying to avoid them...what with all the other medications I'm taking at the moment for cholesterol and high blood pressure, I'm trying to avoid it. (SEAT 128)*

For the service users who did not feel that they benefitted from the AT lessons in terms of their pain levels the discussion became focused on if and when they would return to the pain clinic, either for the conventional treatments such as injections, or to try other options such as acupuncture,

*At the moment I'm looking to go back to the clinic for injections; recently I had some physio at the clinic (SEAT 104)*

*I went back to see the Doctor at the pain clinic, and he's arranged to do the injection into my back again so I don't know...I don't know. I've got mixed feelings about it. (SEAT 122)*

#### **5.4.3 Challenges and barriers to momentum**

Service users offered a range of explanations in terms of what impacted on momentum in keeping up the AT activities – some quoted a change in their condition (sometimes worsening), other related health problems, or acceptance that things would not change significantly enough for them,

*I stopped about a month ago because I was starting to get my back pain again. Because I'm on my feet at work, I work in a cafe, I'm on my feet 17 hours a week, and I'm always carrying heavy things, and it just puts my back out again when I start carrying heavy things and on my feet for so long. (SEAT 124)*

Other explanations included energy and/or motivation, which they largely put down to not having a teacher to regularly motivate and monitor them, a theme we have explored already in relation to looking at what might improve their chances of continuing with the activities,

*With the exercises I need to be pushed to do them, I need to constantly remind myself. (SEAT 103)*

Space was also an issue for some in terms of where they could lie down for the semi-supine activity, and as previously suggested issues at work were mentioned, although a few service users had managed to have their work-space changed in some meaningful way following AT lessons. In addition, time (lack of, fitting it in) and money were oft-quoted as reasons for losing momentum, despite the desire to keep it up; the following statements suggested a desire to keep things going but practical considerations meant that challenges of everyday life often intervened,

*...it's quite difficult to do it in everyday life (laughs) um because I think you know when you are rushing around and you know it's very hard. (SEAT 109)*

*So the question then becomes did I want to shell out £35/£45 whatever practitioner costs a week and the answer is of course well you know its difficult to have that sort of money to hand. (SEAT 116)*

## 5.5 Conclusion

As we will go on to see in the following section, service users of the pain management programme at St. Michaels are at the end of the line in terms of options for dealing with their pain. They attend the pain management clinic through GP referral because they are unable to cope with their pain and they seek a range of other treatment options. The service users made an active choice to undertake Alexander Technique lessons and to some extent this referral process suggested they were more receptive to this and more likely to find it acceptable, as opposed to those who would favour medication or injections.

Service users on the whole reported that the AT lessons were enjoyable, but those that seemed to gain the most from the lessons also took away important educational and self management benefits about how to manage the pain. As such, although for some the pain levels had not significantly reduced they said that they used the AT activities to help them cope with and manage the pain, and it changed their relationship to the pain. These impacts were sometimes reported as subtle as opposed to dramatic, but they made a difference and helped the service user to change their awareness of their pain, and also to change their behaviour in relation to particular habits that may have been exacerbating the pain levels.

The one-to-one nature of the AT lessons was very important to the positive nature of the experience, which may not have occurred with group-sessions, and is likely to have helped foster a self-management approach for service users. As such the service users who undertook a more active self management approach saw the long-term goals and benefits, whereas others that perceived AT as treatment struggled outside of the formal teaching period when there was no longer an Alexander teacher present.

## 6. RESULTS OF ANALYSES OF QUALITATIVE DATA: ALEXANDER TEACHERS AND PAIN CLINIC STAFF

Semi-structured face-to-face interviews were conducted with 4 Alexander Teachers that took part in the service. Three of the interviews were conducted half-way through the project and one was completed at the end of the project. In addition, three clinical staff (two consultants and one specialist nurse) at the pain management clinic at St. Michaels took part in face-to-face interviews once the results from the quantitative and qualitative analysis of service user generated data had been written up.

### 6.1 Alexander teachers' accounts

Five Alexander teachers took part in the teaching service at the pain clinic, although only four took part in face-to-face interviews. The AT teachers were experienced teachers and the majority had previously taken part in the RCT of AT lessons (Little et al. 2008). As such the teachers were aware of what to expect from the teaching service in some respects, and what the expectations were of a research project.

The teaching service had been set up after some long standing discussion with the pain management team at St. Michaels and the approach and attitudes of the consultants and other staff were viewed as positive by the teachers, and the consultants could see the potential benefits to their service users:

*There was a real openness and a real interest on the part of the clinic... they were really working hard to try to see what they could do for their patients and that's why they were open minded, so the fact that they were open minded meant that it just had you know the historical coincidence of, you know, I am thinking this is a really important thing to get into the NHS seemed to coincide with their really trying to find ways of helping their patients.*  
(Teacher 1)

The teachers spoke about being able to help people with severe chronic pain, and teaching a patient that they would rarely come across in private practice:

*...[it is] a big shift because you know I might have one person like that, you know one person with extreme chronic pain maybe out of every 15 people I see. Um, people with you*

*know histories... I was teaching here somebody with 30 year history of pain um from old injuries that kind of you know, kind of constant chronic pain over decades I would not meet very often. So to actually work in a kind of setting where everybody presented with a very complex in Alexander terms use their whole being, their whole pain history but their whole who they are that person that has that much pain you become... you know you become a different person, of course it shapes you. So um I would say I have met very complex people um in this setting at the pain clinic. (Teacher 2)*

Other teachers were explicit about how their motivation to take part in the study was guided by wanting to see how Alexander teaching worked in an actual NHS pain clinic service, used as they had been to private clinic practice,

*...[it was] guided by a desire to see Alexander in the mainstream of NHS...that was my driving motivation. (Teacher 3)*

One of the biggest challenges for the teachers was setting up the Alexander teaching service for the pain clinic. As there was no existing service at the clinic, the AT teachers spoke about the time and energy to set up a service and integrate this into the existing pain management programme in the NHS. No monies were available to set up the service (the costs funded only paid for the teachers' time during the delivery) so the setting up relied on goodwill and effort from each of the teachers. A key dimension to this process was establishing relationships with other clinical and non-clinical staff at the pain clinic:

*...you know establishing relationships with the pain clinic and...with the staff members, um you know finding out how they organise themselves, how they work here, the room use and all of that. So a huge amount of skill and work went into actually setting up the service, that was a whole thing and I hadn't anticipated that, so we went along as each kind of stage kind of developed to set up an Alexander Service which means for instance there was no awareness of the technique. I was aware that every time I come in here into the pain clinic here at St Michaels every time I would talk to anybody at Reception or I would talk to any of the doctors, I was... I was you know setting up... I was trying to kind of make links and build something into which you know I could come in whenever the day would arrive to teach my first lesson. So I was very aware that from the very beginning if you want to set up a service it's not just systems or organisations it's actually the relationships building. (Teacher 2)*



Alexander teachers were not so used to working in team situations, apart from what they might have experienced in training colleges, and so were more used to working independently and in an entrepreneurial way. This lack of familiarity with team working meant a lot more effort at helping the organisational side of the delivery:

*...there have been I suppose on a daily basis in the last 10 months there has been something to do with the project. Whether it be emails, mobile phone calls, meetings, paperwork, sometimes several times a day, hugely time consuming, energy consuming. Um and at times very challenging because of the difficulties within the team that emerged but just purely on the set up because we had no set up you know we had no service and so we had to go from...zero, rock bottom. (Teacher 3)*

As such there were some challenges with setting up an AT teaching team in the NHS, where mostly the AT teachers came from practices where they worked individually. Some of these challenges were organisational, due to the amount of unforeseen work the teachers had to do in setting up the teaching service, and that relied on a considerable amount of goodwill, particularly as the setting up of the service was not costed for. As such the AT teachers had expectations that the study would take less of a time commitment than it ended up taking, partly due to organisational challenges of setting up the service, but also due to NHS processes:

*I kind of assumed that that was in place so that was very naïve, um the set up as you know was quite time consuming and um a huge amount of input in terms of time and meetings and emails and phone calls and so on and I also assumed that my commitment would be all done and dusted within six months but because of the referrals coming in more slowly because of various things that were going on at the hospital and the consultants being away and asbestos in the roof and you know the referrals came through much more slowly. (Teacher 3)*

Other organisational challenges included managing the questionnaire completions within the allotted teaching time slot, but once the service was established most of these organisational issues became less problematic. Some of the challenges were more about the culture of practice; that is to say, how mostly working in individual private practice made working together as a team more difficult. Issues such as payment for teaching sessions became problematic as the ownership and management of the budgets were not clear from the beginning and lines of communication were not always straightforward. Other issues such as roles and responsibilities within the teaching

team were not clearly defined at the beginning of the process and as such affected how the team worked together:

*There weren't clearly defined roles and the roles emerged as the project went on and it had changed and they evolved and they, you know, it was this constant sort of dance of having to be on our toes. (Teacher 3)*

However, such organisational and management issues were resolved over time and the AT teachers were in some ways on a steep learning curve, working uniquely not only as a team, but also alongside two large-scale organisations: the NHS and the University. For future delivery of Alexander Technique lessons in this kind of setting, one solution was to think about separating out the work, so that the roles and relationships within the clinic are clearer,

*I think you need to have um I think there has to be very clearly probably a business structure set up and that the teaching as separate from the administering or the business side of things... I definitely would have had a budget for the time that it took to set something up, to administer it. I mean to get... because we had I mean how many meetings; we've had 30 meetings. (Teacher 1)*

Teachers spoke in-depth about a range of challenges such as the room allocations for teaching in the NHS buildings. The NHS buildings were clearly not designed for that purpose, so teachers had to be creative in terms of altering the space to their liking, and this contrasted with their private practice space,

*We are very creative; we bought flowers in. We kind of came in and created the space as much to our liking as we could. We brought our um, teaching tools in, table and chair and um you know the pain clinic responded in storing these and helping us with the rooms and so forth. (Teacher 2)*

There were other notable challenges, such as working with people with extreme difficulties that were not just pain related, but the teachers enjoyed the challenge and felt privileged to offer their help in this environment,

*So the actual lessons as I say was very, very challenging and rewarding in the sense that I had to ask myself as an Alexander teacher how can... how does this work, how can I apply myself on all levels thinking with my hands conducting each lesson, how can I be as effective, as adaptable, as precise as um you know warm to meet that person in front of me and as I say I had people where there was such immobility that I didn't think that I could actually do my work whether they could even get onto the table. (Teacher 2)*

Also, the teachers were acutely aware of the difference in patients and spoke of the privilege of being able to work in this context,

*I would say it's been a real privilege you know for me to work with um people who perhaps couldn't afford to have Alexander lessons who wouldn't afford to come and see me in the clinic in Bristol and feeling that in a way that's where I would really like to work with people who can't access this kind of service. (Teacher 3)*

One teacher mentioned how her previous work with the 'A team' randomised controlled trial had prepared her for the kinds of patients they might work with and she was more pragmatic about this:

*No I think just the level of problems and the pain they work in, I think that was the only challenge, but again even at the back pain Trial we already got some of those also social problems you know people being really poor... you know even things going against them in that way, but particularly I think the level of pain in some of them and not only back pain but they were having serious other problems as well, at least some of the ones I had. (Teacher 4)*

They also spoke about some of the problems with setting up the service and the challenges that were posed in terms of ensuring that the clinic worked around their needs, and that they adapted to how the clinic worked. There were initial difficulties with referral and with ensuring the time for each lesson was enough for the teaching work to be effective. For example,

*Referral was much, much slower and there were a lot of delays. Um the extra timing in terms of the lessons... I remember in a discussion I absolutely fought for having 40 minutes lesson or 45 for each person so there was a little bit of a write up time. I think that is the amount for an Alexander lesson to squeeze into half an hour and you know particularly for*

*this patient group...I have to also say that I was um you know one lesson I didn't do any Alexander work because that person just wouldn't let me near her. (Teacher 2)*

Alexander teachers taught six consecutive weekly lessons but a few of the teachers felt that six was not quite enough, particularly for those with complex pain problems. However, they were also realistic about the number of lessons the limited funding could provide,

*I mean six are not enough, sorry I shouldn't say. In the back trial I had two people and after three lessons the pain went away they were really well um and they had sorted whatever was the reason and they did apply the Alexander Technique but um of course to some extent but it was also they had been taught the wrong things and they were doing the wrong things so um... but whatever it somehow its way out and with those ones six it was fine. Um I think the people from the pain clinic quite a few of them are really having a lot of issues not just one, most of them but I think six lessons is better than nothing. (Teacher 4)*

Another particular challenge was in trying to provide a different kind of service in the pain clinic, which was dealing with patient-professional relationships. One of the teachers spoke about how to change the service users' mentality so that they would see themselves more in terms of Alexander relationships of teacher and student, and this was difficult to achieve with some of the patients in the six lessons allocation,

*Well I always treated them equal on a student basis like they come here to learn, so yes I think we always do that as the teachers very much aware of not getting people into the patient mode because otherwise they want treatment. So actually in our teaching training that is part of...it's a big challenge to not get drawn into the patient and all their symptoms, and you know you have to respond sort of listen to some element of their symptoms because their whole fear and anxieties maybe trapped there but at the same time you don't want to get drawn into it you need to give them something else to start thinking...So part of our teaching is actually to not get into being patients, that they are not our patients. I am not sure in those six sessions if they have had the time to really... well I think so... because they are so wrapped up in all their illnesses. (Teacher 4)*

Overall they were positive about being located in an NHS service, despite the challenges, and on reflection the process was more straightforward than some of them feared:

*I actually found it quite positive the whole thing experiencing how we were able to get into a system into the NHS and I was thinking its giving me more courage... and I think the way we integrated into the hospital setting in the NHS I think actually went quite good. (Teacher 4)*

Referrals started off slowly, more slowly than expected and the teachers spoke about how the consultants needed a clearer idea of what the AT might be good for, but overall there was a sense that the consultants had showed a clear willingness to engage in the service and encourage it to patients for whom it seemed appropriate.

## **6.2 Clinician Accounts**

Face-to-face semi-structured interviews took place at the Pain Clinic after the teaching service delivery, and once all the data had been collated and analysed from the service user questionnaires and interviews. Two consultants were interviewed, including the lead consultant, as well as the specialist nurse. Each of the interviews lasted approximately 30 minutes and addressed a range of issues from their interest in Alexander Technique, the referral process, the profiles of the patients at the Clinic, to their perceptions of the Alexander lessons and interpretation of results.

The lead consultant and specialist nurse spoke initially of how one of the AT teachers had approached them about the role of Alexander lessons for helping patients with chronic pain, and this led the lead consultant to seek out new information about the randomised controlled trial that had taken place (Little et al. 2008), and expressing an interest in the clinic being involved in a service evaluation. All those interviewed expressed some tentative interest in AT prior to the service in that they had heard of it and had remembered the trial, but knew no more than that at the early stage. The lead consultant explained that had he read more into the results of the trial he would have expressed a keener interest.

One of the key themes in the interviews with the clinicians was about the teething problems with the referral process. Although the lead consultant was keen to ensure patients were referred in to the service, this was more complex than it appeared at first glance:

*The main thing about referring people into the service was that, at the start, was remembering to do it or not, because initially we didn't have something to prompt us, so I*

*think it took a while and it was only when we met again with the teachers that I realised that it was actually going on and I'd forgotten to refer people in. So we put a poster up in the office, initially there was one in the corridor and some of the patients mentioned it, and then when we put one up in the office and I saw people with low back pain or neck pain, and offered the various options, because there's no specific treatment for lower back pain that helps everybody, so the kinds of things we generally offer, you know usual treatment if you like, are physiotherapy, Tens, sometimes acupuncture, or depending on how severely the patient's lives are affected by it, sometimes psychological intervention is appropriate. So patients often get given the options of a variety of treatments, and then it's up to them to choose which they want. (Lead consultant)*

The lead consultant provided the most referrals but as he explained even this does not tell the whole story, as there were periods early on in the AT teaching service when referrals took a while to get going. During the time period of the Alexander service the pain clinic was also going through some organisational change and flux, including consultants moving on and others coming in to the clinic, so referrals in to the service were unpredictable, but the use of a poster helped to provide a cue for the consultants as well as provide information for interested patients.

Also, an important issue here was the nature of the sample referred into the teaching service. Unlike a trial, in a service evaluation the sample were those who expressed an interest in Alexander Technique and those referring play a role in that process:

*...with a Trial like this where it's not all randomised it is a self-selecting group. But I think that's the same for all pain treatments in the real world setting, which is what this study is about. It's not supposed to be a clinical trial, and I think patients are like that anyway, they come and they get offered a variety of options and it's up to them to choose what they want. (Lead Consultant)*

This leads us to be cautious about some of the findings, as the patients were mostly self-selecting. In addition the clinicians made individual judgements about who might benefit from it, based on what they knew about the service users and what treatments they had already been exposed to:

*Primarily for me it's whether they brought it up, or whether, so if it got mentioned or if its posture related really that helped me make the decisions. It was fairly uneducated knowledge that led me to refer people in. (Consultant)*

Those who were considered suitable for AT, and who expressed some interest in it, were then referred to the teaching service. Typically this might be a patient who is less keen on taking drugs for pain for example, or those who did not want injections, but not exclusively, and the consultants were keen not to generalise on the basis of this. Others were chosen on the basis that they felt that the patient was more inclined to take a self-management approach to their pain:

*I think the majority need to be encouraged to do self-management, I think the majority come to us to fix them, and part of our job is to encourage them into a more self-management approach to it. And obviously the ones who are less keen on drugs etc are easier to encourage down that road than the ones that want to be fixed with an injection or a tablet. It's such a diverse bunch the people who get referred to pain clinics that it's difficult to generalise. Often by the time they've been referred here they've tried lots of stuff, and if they've been on lots of tablets and they either haven't worked or there's side effects that outweigh any benefits that they get from them, they're then keener on trying something that's less traditionally medical. (Lead Consultant)*

The issue of self management is important here as we have shown earlier in the report that Alexander teachers encourage users into this approach and attitude; from the findings we see that those who had a more favourable perception of Alexander Technique and its impact in many ways adopted a self management and educational approach to their pain.

Although the consultants did not come across the AT teachers much during the teaching service (partly due to allotting different slots in the week at the Clinic from the consultant sessions) the perception from the clinical staff was that the teachers fitted in well to the clinic and could rise to the challenge of working in an NHS pain clinic. For the consultants the main challenge here was the different kinds of patients that Alexander Teachers would see, and which represented a significant change from the private pain patients that Alexander teachers might normally teach. For example,

*Everything's just easier in the private sector, because you just do what you want when you want, whereas in the NHS it's also a matter of fitting in around limited space, resources and just all the usual hassles of working in a big organisation. But because that's what I spend my life doing that's what I'm used to, whereas people that are used to working in the private sector are amazed at what a nightmare all the bureaucracy and nonsense there is, that you have to put up with working in an organisation as vast as the NHS... they'll be used to, I imagine, much more straightforward patients, and the other big difference I would imagine, if you're capable of paying £40 a week or whatever it is to go and have Alexander lessons that's a relatively small percentage of the population that fall into that category, whereas we see everybody and anybody. I imagine the vast majority who went through the trial wouldn't have done it had they had to pay for it. So it's a completely different patient group. It's like that when you do private medicine or private pain it's a completely different patient group in the private sector, they're much more self-motivated, one because they sort it out themselves, and two because they're parting from money for it, that in itself makes it more likely that it will work. (Lead Consultant)*

For the consultants the NHS patients would represent a challenge to the Alexander teachers, partly due to the broad range of service users at the Clinic from all socio-economic groups. It was suggested by the consultants that approximately 50% of the pain clinic patients would not be working, partly due to the nature of the pain and the condition, and earlier in the report we saw some of the implications for that in terms of service users not being able to afford to continue lessons after the trial service. But more importantly the unique patients referred to the teaching service were more challenging in terms of the nature of their pain complaint:

*The other minor problem with our patients, because they don't just have pain but they often have other pathologies but other problems in their lives, its just the attending six appointments in a row isn't it, and that's bound to be a bit of a hassle... (Specialist Nurse)*

Also, recommendations were made about the best kind of environment for the AT teaching service, and that the clinicians realised that administratively and in terms of the physical space of the Pain Clinic that there would be teething problems early on:

*It's the matter of having the right facilities and a lot of pain clinics are kind of stuffed in cupboards around the back somewhere because they're not particularly sexy services, and you haven't got the space to do it [the Alexander teaching] in. And obviously they [the*



*teachers] need a quiet private room where they've got plenty of time to do something free of interruptions. We don't have that problem here, but if your pain clinic was stuck in a busy outpatient department which I think some of them are, you're not going to have any of those things, it's going to be noisy and people are going to be interrupting and all that stuff that they wouldn't want. So probably the most important thing is having the correct environment in which to do it. (Lead Consultant)*

The clinicians spoke about their own awareness of the problem of the space and the environment, one of the problems being about where to store the equipment that the AT teachers wanted to use, as well as the issue of how much a suitable environment benefits the service user:

*Even in the NHS we really struggle because although we have reasonable floor space here, it's not very well set up, so even with our own Physios we tend to fight for couches. So for example we've got couches in rooms that we don't use because of the way that they are in the rooms and that's just poor set up because we've borrowed space from other people. So as soon as you bring in somebody from the private setting who potentially has designed their clinical space much more thoughtfully, I mean let's face it this clinic is not particularly beautifully set up for people who are in pain, so that does put a lot of pressure on the system I think. (Consultant)*

Overall the lead consultant was very encouraged by the results, had seen initial drafts of the report, and thought through the implications of this. In particular AT teaching was compared with other psychological therapies for chronic pain where there are similar favourable results:

*I'm pleasantly surprised about how good it is...they're [service users] not massively better in terms of pain, but they seem to have enjoyed the experience, and they seem happier.... they're wellbeing is improved despite the fact the pain isn't much different...if more than half of them have significantly reduced their medication and they're happier, and their pain is unchanged or slightly better, then that's a very good result...to get either no change in pain or a slight improvement in pain on half as much drugs makes the difference in pain scores much more meaningful. If the pain scores were as it is but the drugs were the same or higher, then that wouldn't be nearly as good. So the fact that their pain is the same or slightly better on half as much medication is an enormous improvement I think. If you look at psychological interventions for pain there is lots of evidence, and it's almost always positive, but it doesn't usually improve the actual pain scores very much. It will improve all*

*the things like this has shown like quality of life and general wellbeing and health care utilisation and drug use, all those things are improved rather than the actual pain itself. Most people think if you go to a pain clinic, what do you want - you want your pain reduced, but in the majority of times that probably doesn't happen, but if people's function and feeling of wellbeing and quality of life and all those other things are improved then that means we've done a good job. (Lead Consultant)*

The clinicians spoke about the AT service users who had returned to the Clinic due to not being able to cope with their pain, and overall even those that returned spoke favourably of Alexander Technique approach both in terms being a good (positive) experience, but also being able to give them something else to help them in the management of their pain, even if at the moment they were not coping. Regarding re-referrals, the clinicians explained it was too early to tell what long term impact AT lessons had on service users as the time period between lessons and the interviews was too short, but the clinicians had seen a handful of AT service users, particularly those who were the first to undertake lessons at the clinic.

Overall the clinicians suggested that having an Alexander Technique service as another approach, amongst myriad options, would be the right approach for the pain clinic. There was the awareness that it would not be right for everyone, but those who were not able to manage their pain, and who had been favourable towards and/or had tried other non-pharmacological options, may benefit from trying Alexander lessons:

*I've had at least two patients since then who have asked whether we offer it as a service, and it's just such a shame that it's not there, because I think we have relatively few NHS resources at our fingertips, and a lot of people are coming to us who have already tried Tens machines and or have tried acupuncture and they don't want to take medicines, and I think that it would be a very good thing if we did have it here. I don't think I would refer hundreds of people into it... the nature of chronic pain patients that come into secondary care anyway are people who are really struggling to manage and so I see Alexander as an adjunct. (Consultant)*

*I think it's got a definite place and in an ideal world where there was finance for it, I think it would be really nice to have that as another option that we could refer on to for many of our patients, to have another tool in our armamentarium, but I'm sure it's not the thing that all of*

*our patients would want to take up...it couldn't replace anything [at the clinic] because you still need to have all those options available. (Specialist Nurse)*

Clinicians were asked about their views as to whether the NHS Pain Clinics (secondary care) are the right place to have the Alexander Technique service and what they could envisage for the future. The clinicians were equally interested in the idea of broadening it out to primary care where GPs are dealing with a potentially bigger population of patients:

*We're expecting patients to come up from Weston on a motorway, which is often painful and stressful for them in a car, and come for a session which is supposed to be, you know, generally increase their wellbeing. So I think something local to patients would be much better, take it out into a community setting. There's no pain clinic in Weston. They have a musculoskeletal led service but they don't interact with us. But I know some of the big GP practices that work out of consortia's would have the space, some of the ones that have come out of health centres might well have the space to offer that service and you could have a big group of two or three practices that share that space, using you, and thereby get a bigger population of patients... I suspect you'd get less complex patients given to you in the primary care setting, because we are... we don't see anybody who manages their pain well, we see people who are really out of control. (Consultant)*

However, although the idea appealed, there was also the notion that hospitals may provide additional benefit for the patients for whom hospital environments are preferred, but again it was important to see how different the Pain Clinic service users could be. Future research could be conducted to explore this issue and the relative benefits those different locations and services might provide:

*It doesn't need to be provided in secondary care, you can provide it anywhere. That would probably be a better way of doing it. You should have asked the patients that, if they would have gone and if they would have liked it if it had been provided in a different environment. Different patients who come to pain clinics like different things, I think for some the idea that they're coming to a proper hospital, they like that, and they think that we must know what we're doing because we're experts, because we work in a proper hospital, whereas if they were getting it in some private house or something like that they might not think it was likely to be as good. Others might think the exact opposite. (Lead Consultant)*

## 7. CONCLUSIONS AND RECOMMENDATIONS

Overall the findings of this study suggest that the Alexander Technique teaching service is feasible, acceptable, and beneficial in terms of improving service users' health outcomes and management of pain, although there is some suggestion in the data that the study population were self and other selected on the basis of their likelihood to embrace and be receptive to a more educational and self-management approach to pain management. The data suggests that service users of this AT teaching service for pain found that their pain decreased and their relationship to their pain changed. Moreover, resource data suggest that these AT service users reduced their NHS costs related to pain by half. This has important implications for the future use of Alexander Technique lessons in pain clinics.

There were limitations to the quantitative aspect of this evaluation. The study lacked a control group, which is to be expected from a service evaluation, and there were small numbers, but the principal difficulties concerned the resource use questionnaire: Client Service Resource Inventory (CSRI). We were reliant on service user self-reports, which can lead to recall bias, and we had no other source of data to confirm resource use. Moreover, the CSRI requested data on resource use over the past two months, but because data were requested for two months, at the 6-week time point, there was an overlap of two weeks with data provided at baseline; essentially the middle time point was affected. In addition, by separating out the costs for referral and non-referral conditions and only including in the referral condition classification those items where the reason was clearly stated as pain related, we may have underestimated the resource use for pain-related conditions. Qualitatively the study would have benefitted from face-to-face interviews (as opposed to telephone) and it would have been useful to follow up with a second interview on some of the themes that emerged from the study; the theme of relationship to pain could have been returned to with service users in a subsequent interview. We were also unable to contact those who had dropped out of the study

However, the mixed methods approach has been beneficial and instructive in this study, drawing on both quantitative and qualitative research. As a recent systematic review of Alexander Technique lessons suggested, 'Such methodologies may elucidate the patient's perspective and experience of the intervention and the trial...leading to a better understanding of the processes and outcome of an RCT, as well as providing means for improving the intervention' (Woodman and Moore 2012: 111).

In summary, we can conclude:

- There is already a strong level of evidence for the effectiveness of Alexander Technique lessons for chronic and recurrent back pain, as indicated by two well-conducted RCTs (Little et al 2008; Vickers, Ledwith and Gibbens 1999). This study aimed to address a gap in knowledge, exploring the role, acceptability and impact of Alexander Technique lessons for service users at an NHS outpatient Pain Clinic.
- In the study there was a general trend in the health outcome data (pain scores and wellbeing) towards a decrease in scores of approximately one point between baseline and 6 weeks. Any improvement in health outcomes made by service users was maintained at three months.
- The greatest changes were found in how service users managed their pain: e.g. more than half of the service users (n=22) stopped or reduced their use of medications between baseline and three months.
- Condition related costs (those related to pain) decreased over time.
- Over time participants' relationship to their pain may change as a result of Alexander Technique lessons and they become more aware of how pain interferes in their lives. This is an important process encouraged by NHS pain management programmes.
- Awareness and increased understanding of pain also led to some behaviour change and changes in self-knowledge from the service user. The educational nature of the lessons led to service users maintaining long-term benefits where the technique and associated procedures were used in daily life. However, more research needs to be conducted to better understand the mechanisms underpinning this.
- Alexander Technique lessons can be seen as a useful adjunct to other pain management services provided in secondary Pain Clinics.
- It is too early to definitively rely on referral data for signs of encouragement, but those that do return to the clinic, although they are not coping with their pain, they claim to have benefitted from the experience of AT lessons.

We can conclude that the results, both quantitative in terms of outcomes, and qualitative in terms of experience and impact, were encouraging, and clinicians have clear ideas about the potential for an AT teaching service more long-term within a pain management clinic. Pain clinics that focus on a more medical model of understanding and controlling pain would not find a role for AT, but pain clinics working with a more psycho-social model of pain would be more sympathetic to AT and it could play a clear role within a multi-disciplinary and multi-professional team approach. The AT teachers approached the teaching service with enthusiasm and energy, and clearly gained a lot from the experience, despite not inconsiderable challenges of working with more complex NHS patients, and working in the NHS with minimal costs provided for set up.

Most service users liked the AT lessons, and found some benefit in terms of their day-to-day relationship to their pain, even if this did not impact on reducing levels of pain. It is possible the service users and others might benefit more if, at the end of their six one-to-one lessons, they had access either to group Alexander Technique lessons or to booster lessons so as to keep up the self-management approach, as some found there were significant barriers to continuing the technique and activities. Group sessions in particular would cost less per service user than individual lessons, they would help to encourage the disheartened and foster beneficial interactions between service users, e.g. through discussion, observation, support and inspiration. Well-timed group or booster lessons may have helped service users change behaviour; clearly further research is needed here.

Based on the results of this uncontrolled evaluation, we found that an Alexander Technique teaching service in a pain clinic can make a difference to how people manage their pain and reduce their pain related NHS costs including medication, tests and investigations and consultations with GPs and hospital doctors. Therefore we would suggest that AT lessons should be considered by commissioners who are interested in providing a useful, cost saving addition to pain clinic service provision, particularly as a useful service for a targeted population of those who are seeking a long-term educational approach.

## 8. REFERENCES

- Connell, J., Senior Clinical Psychologist at the Pain Clinic, Bristol. Personal communication, 16 December 2009.
- Bodenheimer T, MacGregor K, Shafiri C. (2005) *Helping patients manage their chronic conditions*. California: California Healthcare Foundation.
- De Silva D. (2011) *Evidence: Helping people help themselves*. London. The Health Foundation.
- Department of Health. (2001) *The expert patient: A new approach to chronic disease for the 21<sup>st</sup> Century*. London: Department of Health.
- Gelb, M. (2004) *Body Learning: an introduction to the Alexander Technique*. London: Aurum Press.
- Hestbaek, L., Leboeuf-Yde. and Manniche, C. (2003) Low back pain: what is the long-term course? A review of studies of general patient populations. *European Spine Journal*, 12(2): 149-165.
- HMSO (1994) *Epidemiology Review: The Epidemiology and Cost of Back Pain*. Clinical standards Advisory Group.London: HMSO
- Hollighurst,S., Sharp, D., Ballard,K., Barnett, J., Beattie, A., Evans, M., Lewith, G., Middleton,K., Oxford, F., Webley, F. and Little, P. (2008) Randomised Controlled Trial of Alexander Technique Lessons, exercise, and massage (ATEAM) for chronic and recurrent back pain: economic evaluation. *British Medical Journal*, 337(112) a2656.
- Little, P., Lewith, G., Webley, F., Evans, M., Beattie, A., Middleton, K., Barnett, J., Ballard, K., Oxford, F., Smith,P., Tardley, L., Hollinghurst, S. and Sharp, D. (2008) Randomised controlled trial of Alexander technique lessons, exercise, and massage (ATEAM) for chronic and recurrent back pain. *BMJ*, 337:a884: 438-452.
- Maniadakis N. and Gray A. (2000) The economic burden of back pain in the UK. *Pain*, 84: 95-103.
- NICE clinical guideline 88 (2009) *Low Back Pain*. Available from <http://www.nice.org.uk/CG88>

Strauss, A. and Corbin, J. (1998) *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. London: Sage.

Vickers, A.P., Ledwith, F. and Gibbens, A.O. (1999) *The impact of the Alexander Technique on chronic mechanical low back pain*. Westmorland General Hospital, Kendal, UK. Unpublished Report, pp.1-19.

Woodman, J.P. and Moore, N.R. (2012) Evidence for the effectiveness of Alexander Technique lessons in medical and health related conditions: a systematic review. *The International Journal of Clinical Practice*, 66(1): 98-112.

Wye, L., Sharp, D. and Shaw, A. (2009) The impact of NHS based primary care complementary therapy services on health outcomes and NHS costs: a review of service audits and evaluations. *BMC Complementary and Alternative medicine*, 9:5.



## APPENDICES

Appendix 1a	Confirmation letter of ethical approval
Appendix 1b	Topic Guide for Service Users
Appendix 1c	Topic Guide for Teachers
Appendix 1d	Topic Guide for Clinicians
Appendix 1e	‘Spending on your health’ (Client Service Resource Inventory)

Our ref: SE/lt

Dr Stuart McClean  
Rm 2G09  
UWE  
Glenside Campus  
Blackberry Hill  
Bristol BS16 1DD

Dear Stuart

**Application number:** HSC/10/03/26

Application title: Taking Charge; Choosing a New Direction: A Service Evaluation of Alexander Technique for Pain Clinic Patients

Your ethics application was considered at the School Research Ethics Sub-Committee and based on the information provided was given ethical approval to proceed.

You must notify the committee in advance if you wish to make any significant amendments to the original application.

Please note that all information sheets and consent forms should be on UWE headed paper.

If you have to terminate your research, please inform the School Research Ethics Sub-Committee within 14 days, indicating the reasons for early termination.

Please be advised that as principal investigator you are responsible for the secure storage and destruction of data at the end of the specified period. A copy of the 'Guidance on Managing Research Records' is enclosed for your information.

We wish you well with your research.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Simon Evans', with a stylized flourish underneath.

Simon Evans  
Chair  
School Research Ethics Sub-Committee

## Alexander Technique Patient Interview Topic Guide

[Questions will depend on status of patient – attend/not-attend, improvement/not improvement, etc]

Openers:

1. How did you find out about the AT service?
2. Why did you choose to take part/not take part in AT?
3. Had you tried anything like that before?
  - a. Did you like the idea of it?
  - b. What were your initial expectations of AT?

### For those that took part...

4. What has your involvement meant for you practically? What have you found easier/ more difficult than you expected?
5. What were your experiences of the service?
  - a. What's been good about it? What have you enjoyed?
  - b. What have you not enjoyed?
6. Overall, has AT been a success for you?
7. What has happened since the AT sessions? Are you doing any more AT? Practising AT, exercises, etc? Semi-supine? How often?
8. Do you have any suggestions on how this service might be improved in the future?
9. Would you take part in the service again?
10. Would you recommend it to others?
11. Is there something else that you think it's important to discuss that I haven't asked about?

## Alexander Teacher Interview Topic Guide

1. Why did you choose to get involved?
2. What were your initial expectations of the AT service? What were your initial expectations of working in the NHS?
3. What did your involvement mean for you practically?
4. What are your experiences of the service?
5. Overall, do you think the service been a success? What do you think are the strengths and weaknesses of the service?
6. In what ways has the service been beneficial to the patients?
7. Is there any other evidence (apart from that produced as part of the study) that you're aware of about the benefits of the service?
8. Have colleagues at the clinic supported it? If so, in what ways have they been supportive?
9. How did you (as AT teachers) work together? Were there any challenges with that?
10. Do you have any suggestions on how this service might be improved in the future?
11. Is there something else that you think it's important to discuss that I haven't asked about?

## Clinician Interview Topic Guide

1. What led to your involvement and/or interest in AT in the Pain Clinic? What did your involvement mean for you practically?
2. What were your initial expectations of the AT service and how this might work in an NHS Pain Clinic? Do you think those expectations were met? Did anything surprise you about the service or how expectations were met?
3. **[specific to consultants]** Did you refer? How often? What led to a referral decision for patients? Was it primarily your decision or did the patient or their GP play any part in that? Did any of your patients actively ask for AT (e.g. seeing the poster) and how did you respond? Taking into account different 'services' (e.g. physio, acupuncture, clinical psych, and AT), how did you come to a decision about who to refer to?
4. How did the AT teachers work in the pain clinic? What the successes and limitations of that? Are there any issues or observations you'd like to make?
5. Overall, do you think the service been beneficial to patients? What do you think have been the strengths and weaknesses of the service?
6. Is there any other evidence (apart from that produced as part of the evaluation) that you're aware of about the benefits of the service?
7. Do you have any information about AT patients who have returned (re-referral) to the clinic? It would useful to have info about what happens longer-term. Any data either way?
8. Do you have any suggestions on how such a service might be improved in the future?
9. Is there something else that you think it's important to discuss that I haven't asked about?



### *...taking charge - choosing a new direction*

Alexander Technique Service Evaluation (SEAT)  
@ the Pain Management Clinic St Michael's Hospital

### **SPENDING ON YOUR HEALTH**

Today's date \_\_\_\_/\_\_\_\_/\_\_\_\_

Participant Number

### **HOSPITAL INFORMATION**

1. In the last 2 months, have you gone to hospital? YES or NO

2. Please give details of any visits to A& E in the past 2 months.

	<i>Reason for visit</i>	<i>If paid for travel, how much did it cost?</i>
1 <sup>st</sup> visit		
2 <sup>nd</sup> visit		

3 <sup>rd</sup> visit		
-----------------------	--	--

3. Please give details of any times you have been admitted to hospital for an overnight stay in the past 2 months.

<b>Admission</b>	<b>Hospital name, <u>plus</u> department or type of ward</b> (e.g. BRIs, neurology)	<b>Reason for admission</b>	<b>Total days</b>
1 <sup>st</sup> admission			
2 <sup>nd</sup> admission			
3 <sup>rd</sup> admission			

4. Please give details of any outpatient visits you have made to hospital in the past 2 months (e.g. neurology, rheumatology, orthopaedics, day surgery).

	<b>Speciality</b>	<b>Who did you see eg doctor, nurse?</b>	<b>If paid for travel, how much did it cost?</b>
1 <sup>st</sup> visit			
2 <sup>nd</sup> visit			
3 <sup>rd</sup> visit			
4 <sup>th</sup> visit			

5. In the last 2 months, have you had any of the following investigations or diagnostic tests?

<b>Type of test</b>	<b>Reason for test</b>	<b>Number of times you've had this test in the last 2 months</b>	<b>If paid for travel, how much did it cost?</b>
A. Magnetic Resonance Image (MRI)			
B. CT / CAT scan			
C. Ultrasound			
D. X-ray			
E. Electroencephalogram (EEG)			
F. Blood test			
G. Other (please describe)  _____  _____			

6. Have you gone to hospital for your health for the past 2 months for any other reason? If so, please give details here.

---



---



---



## MEDICATION

7. Please tell us about the pain medications you have taken in the last 2 months that were prescribed by a doctor.

	Name	New or repeated medication	Reason for use	How often do you take it?
Medicine 1				
Medicine 2				
Medicine 3				
Medicine 4				
Medicine 5				
Medicine 6				
Medicine 7				

8. Do you pay for your prescriptions? YES or NO

9. Please also tell us about any medications that you are taking that are not prescribed by a doctor, for example supplements (e.g. evening primrose oil, vitamins), herbal (e.g. feverfew) or other over-the counter products for your health that you have used in the last 2 months.

	Name	Cost	Reason for use	How often do you <b>buy</b>	How often do you <b>take</b>

				this?	it?
Item 1					
Item 2					
Item 3					
Item 4					
Item 5					
Item 6					
Item 7					
Item 8					

#### GP AND COMMUNITY HEALTH INFORMATION

10. In the last 2 months,

<i>Care provider</i>	<b><i>Have you had any contact (face to face or telephone) with</i></b>	<b><i>How many times have you seen in past 2 months?</i></b>	<b><i>Reason for use</i></b>	<b><i>If paid for service, how much did it cost?</i></b>	<b><i>If paid for travel, how much did it cost?</i></b>
A. General practitioner (GP)	No Yes				
B. Practice nurse	No Yes				
C. District nurse	No Yes				
D. Community mental health worker eg nurse or doctor	No Yes				
E. Acupuncturist	No Yes				
F. Pharmacist	No Yes				

G. Psychologist / therapist	No	Yes				
H. Counsellor	No	Yes				
I. Physiotherapist	No	Yes				
J. Osteopath/ chiropractor	No	Yes				
K. Occupational therapist	No	Yes				
L. Social worker	No	Yes				
M. Home help/ home care worker	No	Yes				
N. Care attendant	No	Yes				
O. Community support worker	No	Yes				
P. Voluntary worker (incl priest etc.) Specify _____	No	Yes				

11. Have you seen anyone else for your health for the past 2 months? If so, please give details.

---



---



---



---

## OTHER COSTS

12. Have you had to stop or reduce work due to your state of ill-health? Yes or No

*If yes:* How many days in the last 2 months?

\_\_\_\_\_ days

or: How many hours per week less?  
hours

\_\_\_\_\_

13. Did you need a sick note from your doctor? Yes or No

14. In the past 2 months, have you lost any earnings because of this time off work? Yes or No

*If yes:* How much gross income (ie before tax) have you lost in the last 2 months?

£

15. In the past 2 months, has anyone in your family lost any earnings to take care of you? Y or N

*If yes:* How much gross income (ie before tax) did they lose in the last 2 months?

£

16. In the past 2 months, have you had any other extra costs of childcare or care of other dependants because of your illness? Yes **or** No

*If yes:* How much extra costs were incurred for childcare or care of other dependants in the last 2 months?

£

17. In the last 2 months, have you received any help from **friends or relatives** for any of the following tasks, because of your ill health?

<b>Type of help</b>	<b>Circle</b>	<b>Average number of hours help per week</b>	<b>Who helped eg partner, friend, mother, father, brother/sister, child</b>
Child Care <i>(circle 'No' if you have no children)</i>	No    Yes		
Personal care <i>(e.g. washing, dressing etc.)</i>	No    Yes		
Help in/ around the house <i>(e.g., cooking, cleaning etc.)</i>	No    Yes		
Help outside the home <i>(e.g., shopping, transport etc.)</i>	No    Yes		
Other	No		

ISBN: 978-1-86043-502-7

Faculty of Health and Life Sciences  
UWE, Bristol  
Glenside Campus  
Blackberry Hill, Stapleton  
Bristol. BS16 1DD  
United Kingdom