

This column is a forum for readers to share responses and insights to challenges in dementia care. Readers are invited to contact the editor at PO Box 39, #2107 Highway #215, Walton, Nova Scotia, Canada BOR 2R0; e-mail: csifton@ns.sympatico.ca with questions and concerns that have arisen in their practice with persons with dementia and their caregivers. Responses from the editor or other experts in the field will be printed in future columns. Insights and experiences in response to the questions raised are most welcome.

## Individuals With Dementia Learn New Habits and Are Empowered Through the Feldenkrais Method<sup>®</sup>

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Mary stood for a moment and looked me squarely in the eyes after our session. She smiled. Ah, what a wonderful feeling this was, for me to see this apparent moment of happiness. This was the first time I had seen her smile. This was the first time I had seen her with any expression of feeling at all, and certainly the first time I felt eye contact with her. However, this was not the first time I knew that we were communicating and this was not the first time that I knew she felt good. We had been communicating all along, but not verbally. Our dialogue took place through my hands and her response to my gentle touch, using the Feldenkrais Method of Somatic Education.

Mary is 96 years old, in the advanced stages of Alzheimer's, and is totally dependent on others for all aspects of her daily life. I started to see Mary because of problems sitting in her wheelchair. Both the nursing home staff and Mary's daughter were concerned that she was in pain, and traditional therapy was unsuccessful in helping alleviate the problem.

When I first met Mary, she did not give me any eye contact and she had a blank expression on her face. She did

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not speak to me, nor did she acknowledge that I was standing in front of her. I noticed that Mary constantly rocked her pelvis forward and backward while pressing her upper back hard against the back of her wheelchair and with her chin tilted upward. She wore a splint on her contracted hand, which she held with a bent elbow close to her body. I knew Mary was uncomfortable and possibly in pain, yet looking at her facial expression would not have given this discomfort away. Mary was resistant to movements such as hip rotations, lengthening her legs or arms, or rotating her head. When placed in her bed, she remained static in the position she was placed in.

During Mary's sessions, it was important to choose a position that reduced stimulation to the nervous system and allowed her the best opportunity to relax. In our first sessions together, I worked with Mary while she rested on her back, therefore reducing the muscular demands of gravity in an upright position. As she breathed, the rise and fall of her chest was barely noticeable, and most movement was taking place in her abdomen. Mary leaned on her left hip and left side of her ribs, with the right shoulder, ribs, pelvis, and hip lifted off the surface. Her head tilted back in extension causing her to lean toward the top back of the head. Mary leaned on her heels with both of her knees and hips bent slightly and tilted toward the left. A soft roller was placed under her knees and support placed underneath her neck. This would allow her tight muscles the opportunity to stop contracting because they would be supported by the surface she rested on. Once these muscles could rest, less used, forgotten muscles could respond to my guided movements and she would have access to more movements. These movements could then be translated into the more demanding upright position.

During each session, it was necessary to determine what Mary could do easily and to build upon this. I would sometimes place my palms underneath her shoulder blades and gently support them. Then, I might check to see whether I could move her shoulder blades in any direction and explore whether these movements would engage movement in her ribs or spine, and eventually in her pelvis and hips. I might also gently support her ribs with my palms and explore movements, checking to see whether I could engage movement in her spine and shoulder blades from her ribs. If I rolled her head side to side, it was done partially to see how much of the spine was engaged by this movement. Through the gentle movement process, we would work together to determine what she wanted to do and where her movements took her. What sets the Feldenkrais Method apart from other modes of movement, remediation, or traditional therapies is that I always look at the relationship

between one movement and another.<sup>1-9</sup> For example, if Mary was to turn her head and look toward an object, I would look at how that movement may cause her to shift weight in her chair or how her eyes would either enhance or inhibit optimal movement.

My gentle touch allowed a nonverbal communication with Mary. I could detect pleasure when her breathing became fuller, her chest rising and falling more, and when I could feel her muscles letting go as I supported them in my hands. After several sessions, Mary could stand momentarily, take a step, and sit more comfortably. She was able to move more easily, such as lengthening her legs, or turning her head in supine. In sitting, she reduced her rocking motions and she learned to shift her weight forward, and bend her spine and head. These improvements resulted in greater ease in the simple action of opening her mouth wider for eating, or transferring from sitting to standing.

What can we do to communicate with persons who are no longer verbal? How can we help them connect with the outside world or how can we relate to their world? These are some of the difficulties family members and health professionals face when caring for the individual with Alzheimer's disease and other dementias. We really need to listen creatively to what the person may want or need.<sup>10,11</sup>

Many older people, particularly nursing home residents, are often not exposed to gentle, pleasurable movements. They are used to being lifted and transferred, bathed, toileted, changed, and fed. They no longer experience the gentle caresses, hugs, and holding that they may have once enjoyed. The Feldenkrais Method communicates through this long lost touch. The individuals embrace it. They enjoy it. They experience warmth and loving attention.

#### **MEMORY AND LEARNING: PROCEDURAL LEARNING AND HOW LEARNED BEHAVIORS BECOME OUR HABITS**

Alzheimer's is an irreversible disease that slowly destroys brain cells and causes memory loss and loss of function. In the earlier stages, the individuals begin to get confused about familiar places, take longer to accomplish daily tasks, and begin to have mood and personality changes. Later, as these symptoms get worse, they begin to have difficulty with language, problem solving, conscious learning of new tasks, and recognition of their friends and family members. During the final stages of Alzheimer's disease, the individuals lose all ability to care for themselves, including feeding themselves.<sup>12-15</sup>

Although individuals in later stages of Alzheimer's disease appear to have little relationship to the outside world or comprehension of themselves, there is still a way they can learn and maintain the learning, through procedural memory. There are many different kinds of memory of which 3 will be mentioned here: declarative, nondeclarative, and emotional memory. *Declarative memory* is the ability to consciously remember events and facts. This type of memory becomes impaired early in individuals with Alzheimer's disease.<sup>16-18</sup> *Nondeclarative memory*, also called procedural memory, is learning by doing. This includes repetitive activity, habits, and motor learning. Procedural memory in an individual with Alzheimer's disease is preserved long after declarative memory is lost.<sup>15,14,16,19-21</sup> *Emotional memory* is the ability to recall emotional stimuli. The impact of this type of memory with individuals with Alzheimer's disease will be discussed later.<sup>22,23</sup>

## ABOUT DR FELDENKRAIS

Israeli scientist Moshe Feldenkrais DSc (1904-1984) was a nuclear physicist and engineer, and the first European to earn a black belt in judo. He received his doctorate in physics at the Sorbonne in Paris, and worked closely with Nobel Chemistry Laureate Joliot-Curie. During the 1940s, Dr Feldenkrais was barely able to walk due to a serious knee injury and was given only a 50% chance of improving his condition with surgery, which he could not accept. He began exploring movement patterns, and observed how people form movement habits, a subgroup of procedural learning. He mastered the sciences of anatomy, kinesiology, and physiology, and combined these with his knowledge of physics, engineering, and judo. Eventually, he restored his ability to walk and began his life's work of helping others improve their functional abilities and to move through life with grace and dignity.<sup>7-21</sup>

Any individual interested in becoming a certified Feldenkrais Practitioner<sup>®</sup> is required to complete 800 to 1000 hours of intensive training over a 3- to 4-year period.

The focus of the training is to become observant in movement patterns in themselves and others, learn to teach individuals how to move more efficiently, and form new and more useful habits.<sup>5</sup>

The Feldenkrais Method is accomplished in following 2 ways:

Awareness Through Movement<sup>™</sup> (ATM) is generally taught in a group situation where the individual actively moves through a series of verbally led movements and variations in movements. Functional Integration<sup>™</sup> (FI) is an individualized, hands-on approach in which the individual is

taken through a series of movements that fit the particular needs of the person. During FI, most often the individual is resting in a comfortable position and passively moved by the Feldenkrais Practitioner. Since the individual with dementia is often unable to follow instructions, passive movement is a more effective option.<sup>2,3,5,7,24,25</sup>

Our habits, which are automatic behaviors, are formed through life experiences, and are extremely important. Without habits, we would spend too much time thinking about every movement we make, and it would be impossible to accomplish the daily tasks of life. Habits can either help us or hinder us.<sup>2,3,5-9,24</sup> When habits are formed as a result of illnesses or injuries, the immediate behaviors we adopt are helpful to us (such as protecting an injury), but long after we have recovered, these protective ways of moving are no longer useful. Let us take the example of walking and the potential of falling. Let us say that an individual is afraid of falling on ice during the wintertime. He or she may alter movements, such as taking smaller steps, stiffening up the torso, and/or leaning forward. This new way of walking can quickly become a new habit for the person. During the winter months when the potential for slipping on ice is a valid one, this change of habit may be useful. However, long after winter is over, the individual is likely to maintain this habit. Fewer movement options create more of a potential for falling.

In the case of individuals with Alzheimer's, it is these habits (or procedural memory and learned behaviors) that help them function longer. Because the motor ability is one of the last areas to be effected by Alzheimer's disease, individuals with this disease can often walk around long after reasoning and communication abilities are gone.<sup>19</sup> The longer they can remain ambulatory and physically active, the better. However, since they are often no longer aware of safety issues around them, it creates serious concerns and greatly increases the risk of falling and injury.

When I first started to work with people with Alzheimer's disease, I did not know the extent of the help I could give to persons who were apparently unaware of my presence (in the traditional sense), or if they were aware, would likely forget within minutes. In my literature review of procedural memory and learning, I discovered that it is not necessary to be conscious, able to remember, or recount how these skills are learned.<sup>14</sup> This information reinforced my anecdotal experiences working with individuals with dementia. Since the Feldenkrais Method changes an individual's habits, the results of this intervention can produce positive and lasting results through the individual's capacity for procedural learning.

## THE FELDENKRAIS METHOD® IS A WAY OF TEACHING THE INDIVIDUAL HEALTHY HABITS

It can also teach the individual to alter unhealthy and unnecessary movements and find more comfortable and efficient patterns. The results of these more efficient patterns can help the individual to move more freely (lessening the risk for falling), improve attention span, alertness and communication skills, breath easier, and sleep better. The individual, no matter what the diagnoses, begins to enjoy an enhanced quality of life.<sup>1-9, 21-27</sup>

### Eve\*

Eve, 92, was in the middle stages of dementia. She was always sleepy when I approached her, sitting with her eyes closed and her chin resting almost on her chest, and complained that she was too tired to move. My acknowledgement and empathy with Eve's complaints of fatigue set the foundation for trust between us. Even though she did not recognize me from session to session, she was willing to work with me, especially if I told her she could lay down. Eve was verbal, and could ask questions, which she would repeat frequently throughout our time together. A common one was to ask me why I was there with her, and if I told her it was to help her walk better, she would ask, "Why? Am I having trouble walking?"

For walking, Eve used her walker, hunched over and leaning on her elbows and forearms. She required moderate assistance in transitioning from sitting to standing, practically pulling over the walker trying to pull herself up. She was reluctant to let go of the walker when she needed to use her arms and hands for an activity, such as washing her hands. I began to see Eve because the nursing home staff was increasingly concerned at her risk for injurious falls.

Our first session, we worked together while she rested on her back in her bed, with one leg straight and the other bent at the knee with the sole of her foot on the bed. (Feldenkrais Practitioners commonly referred to this as the "standing foot.") I taught her how to push into her standing foot and feel the movement transmitted through her spine. Each time she pushed her foot down onto the bed, I positioned my hand under her spine in a specific area so that she could feel the movement there. We worked also on twisting in her torso and easier hip movements. After the session, Eve stood up from sitting with less effort and little

help from me. She stood upright and walked without resting her elbows on the walker.

Eve's ankle was slightly swollen at our second session. I continued to work with her lying on her back, and teaching her to push through the bottom of her feet in order to lengthen her spine, as in last session. After the session, Eve again walked more easily, and stood without holding onto her walker to use the toilet and wash her hands. Her ankle swelling was noticeably less.

During subsequent sessions, we explored shoulder blade movements and their relationship to her ribs underneath them. We also revisited the same themes from the first two sessions, incorporating how she used her ankles when her feet made full contact with the floor. Eve was learning to sit more easily on her sitting bones, therefore making it easier for her to support her upper body weight in both sitting and standing.

I began to see a pattern with Eve. Prior to sessions, she was always sleepy and required some assistance to stand up or sit down. After each session, she could always stand up or sit down with little or no assistance, and her alertness and energy level always improved. For one particular session, Eve was in a group activity where they were playing music and singing. Our session together that day was about being aware of the group while simultaneously doing a gentle hands-on lesson, helping Eve to sense and feel herself in the context of a social situation. As the session progressed, she became more alert, opened her eyes, sat more upright, and began tapping her foot to the music being played around her. According to the staff, that was a first time.

### Lee

An example of how procedural memory works can be illustrated by my experiences with Lee, a 92-year-old man with advanced dementia. Although I worked with Lee while he was sleeping, his waking actions and behavior changed. Because of Lee's constant need to "walk," coupled with his aggressive behavior, it was a challenge to initiate our work together. When I tried to get him to sit down or lay down, he complained and sometimes loudly told me to get away. Therefore, I decided to work with him during his frequent nap times.

Lee had a habit of walking constantly. He walked bent over with his feet and hips turned outward, and had a wide stance. He held both arms close to his sides, with his elbows bent and with no arm swing. He was unable to move isolated areas of his torso; therefore he did not turn his head to look at something next to him, but turned his

\*Please note that all names have been changed in this article to protect confidentiality.

whole body. Lee no longer had awareness of his personal safety or the ability to reason. Therefore, he would get up from his bed immediately after waking up and start to walk. He sat long enough to eat, and then stood up to walk. He would decide to sit down without looking to see whether there was a chair to sit on, partially because he did not have this safety awareness, and partially because he did not have the capability to rotate his body. As may be expected, Lee fell a lot.

### ***Learning to differentiate movement patterns***

If a healthy person wanted to look at an object next to him, he would have a choice to move in numerous ways. He may choose to turn only his head, maybe, move part of his shoulders as he twisted, or possibly he would pivot and turn on one foot. It is these choices that make movement "differentiated."<sup>2,5</sup> The choice made would depend on the situation. For example, if an individual is walking and sees someone he knows across the street, he can simply turn his head to look and greet the person, or also turn his shoulders toward the person. He can continue to walk on his path, or pivot to walk toward the person. Either way, a person capable of more differentiated movements will have the option to make the choice. Lee did not have these options available to him. His movement patterns were "undifferentiated."

Through gentle movements while Lee was laying on his back or side, the first several sessions we explored movement of his pelvis and spine. I focused on Lee's ability to move in diagonal patterns, to create a relationship between his right shoulder and left hip and vice versa, lengthening his spine and learning to twist his torso better. During our sessions, I could see that his breathing started to expand in his chest. I continued to explore upper torso rotations, including head turning, shoulder blade differentiation (improving the ability to move his shoulder blades independent of his ribs), and connecting movements of the ribs and chest to movements of upper spine, all while Lee was asleep.

After the third session, Lee stopped falling while walking. Although he still exhibited rigid movements and difficulty moving his arms away from his body, he shifted weight a little more easily and twisted better in both directions. Lee remained fall free for several months, until he stopped walking owing to a sore on the ball of one of his feet.

### ***Connection between procedural memory and emotional memory***

Individuals with Alzheimer's disease recall positive emotional stimuli.<sup>22</sup> It would stand to reason that the positive

emotions encountered through the gentle touch of the Feldenkrais Method would create a positive emotional memory and help establish trust, even if the emotional stimuli could not be consciously recalled in the advanced stages of the disease. Although most of the clients I see with Alzheimer's disease seem to retain new movement patterns from session to session, some of the movements that seem to be lost are quickly regained in the next session. I believe this is possible, in part because of the link between mind and body, aided by the individual's emotional memory. Any time we work with our body it affects our mind, and when we effect changes in the mind, it affects the body.<sup>5,6,22,25,28,29</sup> For this reason, although procedural memory and emotional memory are different skills, they cannot be separated. I believe that the procedural learning capabilities and the emotional memory work together to allow these individuals to build upon past sessions.

Initially, when Lee would wake up and I was with him, he told me to get away from him and only his private care specialist could convince him to let me continue. This would happen several times during a session, and then he would go to sleep again. After several sessions, if he woke up while I was working with him, after he was reminded of what I was doing, he would go back to sleep instead of getting angry. He clearly did not remember who I was or why I was there, however after a while, I could ask him to lie down for our session, and he would do this with minimal encouragement. As soon as I began to touch him, he would settle down and remain quiet for most of the session. I believe that he liked these new movements.

Lee's ability to feel increasing comfort with my presence and touch is an example of learning through his emotional memory. I believe that this emotional memory accounts for this consistency of the feelings and behaviors the touch brings up. As with Lee, I am often able to see a person who is combative initially and through repetition will gradually accept my gentle presence because of the trust that can be established.

### ***How is the Feldenkrais Method different from traditional therapy?***

Studies have shown that individuals who participate in the Feldenkrais Method are more likely to obtain better balance, relief of negative symptoms such as pain, and gain a better sense of well-being and confidence than groups receiving traditional therapeutic interventions.<sup>4,6,8,9,26,27</sup>

There are many areas that distinguish the Feldenkrais Method from other interventions. It is not an exercise

program, stretching, massage, or considered therapy (remediation of a health problem). The individuals we work with are our “students” because of the learning that occurs during sessions. The body’s movement stimulates the individual’s brain, whether the person is moving actively or passively. The learning occurs when new patterns of movement are formed, keeping in mind that learning is not always conscious.<sup>2,3,6-21</sup>

Learning happens instantaneously under the right circumstances. For example, have you ever struggled with learning something new, only to put it aside and when you return to it, you are successful? Ah ha! That is how it is done, you may say to yourself, and after that you wonder how you had not understood before. The awareness of the learning has happened at that moment and once this happens, the individual can stop thinking about it. From now on, the learned information can become habitual.

Another distinction is that a traditional therapist measures and treats joint range of motion and muscle strength deficits by isolating particular joints and muscle groups. Many individuals who experience pain or range of motion deficits are actually experiencing movement limitations in areas other than that of the deficit. *Range of motion*, which is performed by therapists, is often stretching the individual and can cause discomfort. Although we work with the individual’s range of motion, we do not stretch muscles. To the contrary, using gentle movements, we move the person in the direction and within the range that he or she is able to move, keeping it pleasant, so that muscles can allow him or her to release unnecessary and chronic tensions. The increased range of motion occurs because the entire body is sensing and acting as a more integrated whole self.<sup>1,2,7</sup>

Dr Feldenkrais emphasized that our skeleton was meant to support us and our muscles and connective tissues were meant to move us from place to place and not intended to be in a continual state of contraction.<sup>5,11</sup> The Feldenkrais Method provides kinesthetic experiences that teach the individual to distribute movements of the skeleton more evenly, resulting in better range of motion. For example, if a person is hunched forward in his walking, he would be unable to let go of certain muscle groups because he would have the constant need to use these muscles to hold himself erect. However, if the same person were to learn to allow his skeleton to support his weight, less muscular contractions would be necessary. This would allow the person to move more powerfully with less muscular effort and less wear and tear on all connective tissues.<sup>2,9,25</sup>

Keeping it pleasant and in the present moment are also unique to the Feldenkrais Method. The person at

the advanced stages of Alzheimer’s disease has no memory or retrieval of past events or people. They also have no future in their awareness. All they have is the *present* and their present needs to make sense to them! There are times when traditional therapies may be too painful or demanding, leaving the person feeling afraid, frustrated, or defeated. The individual with Alzheimer’s disease cannot comprehend these goal-oriented sessions.

## Dina

The principles of *keeping the present pleasant* and working within the comfort level for *range of motion deficits* can be demonstrated with Dina, an 83-year-old woman with advanced Alzheimer’s disease, Parkinson’s disease, depression, and cataracts. I started to see her due to her swollen knees, which she was unable to straighten past 90° for the past 2 years.

Dina had been receiving traditional therapy in which the intervention included straightening the knees and placing weight on top of them. Dina would cry from the pain of these treatments. She could not make any sense of it. Only that she was in pain! It should be no great surprise that Dina made little progress and the nursing staff believed I could be of benefit to her.

Dina sat in a wheelchair pushed by others. She required 2 staff members to transfer her to and from her wheelchair. When staff members would transfer her, they held under her arms and Dina would immediately lift her legs and hand over her total body weight. She did not rest her feet on the floor, even in sitting. Dina had difficulty lying in all positions. When she lay on her back, her lower body twisted to the side. When she lay on her side, her upper body twisted behind her, and with her legs bent, only her heels touched the bed, the rest of the foot pointing toward the ceiling. She stayed where she was placed and in the position she was placed in. Dina was unable to point to a body part and say it hurt her.

When I began to work with Dina, I had to wonder what would be the best course of action for her? I did not know whether I could get her to straighten her legs after so much time had elapsed. It was possible that she could walk, but her dementia was so severe that she would walk without regard for her safety. It became evident within the first session that this woman needed to be able to rest more comfortably in all positions. This would allow muscles that were habitually contracted to release and allow for new movement possibilities during subsequent sessions.<sup>2,7</sup> I began to focus on exploring possibilities for more mobility in her ribs and spine.

After the first session, she was able to lie more fully on one side. After another session, Dina was able to rest her shoulder blades and pelvis more evenly when she was on her back. With her knees resting on a roller, she bent them at about 150° of extension.

After subsequent sessions, Dina could rest more fully and easily on her back with her knees bent and her feet standing (feet weight bearing more fully underneath her). Depending on the day, she began to follow simple directions to change positions while in bed. Dina began reaching with her arms more easily, and wheeling herself in her wheelchair using her feet. After the 4th session, later that same day, staff at the nursing home told me that she stood up by herself and stayed standing for about a minute. Five months after our sessions were completed, Dina still assisted in transfers by standing with verbal and physical cues and some assistance.

It was several sessions before I even attempted to move her legs around. I knew she would be too guarded and afraid. However, the progress she made in her ability to straighten out and weight bear on her legs when I did not even touch them is an example of how the area of perceived involvement is not always the root of our problem.

Dina sometimes thought I was her daughter or her daughter's friend, and I let her believe this. She would talk about things with me that only made sense to her, but I happily responded to her questions, which did not necessarily make sense to me. I kept her engaged, in any way that I could. This was her reality. I would not be able to convince her that it was not reality, so I did not try. If she asked me how the party was, I told her it was great. If she asked me how long people were there, I told her what I thought would make her happy. Often, making up answers seemed to calm her down. For me, the purpose was to keep her engaged and comfortable and present so that I could work with her. Regardless of the content or the logic of our conversation, it was her way of reaching out and offering her trust.

### ***Expectation and exploration: Goals and quality of life. Who decides on quality of life?***

In traditional therapy, based on a specific evaluation, the therapist generally determines the goals and makes recommendations as to the goals or outcomes they would like to see occur. In the case of an individual with Alzheimer's disease, since the person often cannot communicate these goals, the therapist and team decide them. In the Feldenkrais Method, we think about improving function and the quality of life, but the persons determine what is

important to them, nonverbally, maybe not even in their conscious awareness.<sup>7,25</sup>

I was made aware of this early on in working with the people with Alzheimer's disease. My first thought about what I could do to help these individuals was to help them move better, improve their balance, and decrease the risk of falling. I quickly learned that even without goal setting, each individual received a personal experience and got out of it what he or she needed.

### **Gail**

When I first saw Gail, I worried about her possibilities, but Gail is a good example of a person's ability to determine the outcome that was important to her. She was 76 years old, had suffered a stroke 2 years prior, and had a diagnosis of anxiety, depression, Parkinson-like symptoms (became worse with anxiety), and dementia. Gail had severe contractures (deformity in the joints causing inability to move them) in both ankles and wrists and severe tremors in her left leg and left arm. Gail had no visible independent functioning. She was wheelchair bound, unable to bring her hand to her mouth, unable to swallow or speak, and she relied on a feeding tube. Gail required head support in sitting, and her head remained rotated slightly toward her left. She did not turn her head, and responded very little to the outside world. Gail's daughter had been given little hope about the possibilities for her mother, but remained optimistic and became enthusiastic when she learned about the Feldenkrais Method.

Gail's response to me varied depending on the day. On one day, she might like when I gently moved her shoulder blades and upper spine because when I did this, I could see that her breathing changed and her ribs started to expand more. At other times, she clearly preferred that I explore movements in other areas.

It became evident that she welcomed my visits, although what she responded to changed from session to session. Gail's contractures did not change much, however, she was able to control her tremors with a verbal cue and gentle hand on the leg or arm that was trembling. She gained the ability to turn her head slightly past midline to the right. She answered questions with a nod and eye contact. Gail learned to communicate in a way that staff and family could understand and they could communicate with her.

I could never have planned that outcome with Gail. She was able to accomplish a goal that was her priority and important to her.

There is not always a pattern or traceable way to predict the outcomes of a session. Generally, when a person's

strengths are recognized and built upon, then positive changes happen. However, what if the person we are working with does not want to make changes? What if our good intentions to help someone are really causing that person more distress? I really began exploring this question after working with Alan.

## Alan

Alan, 92, with Parkinson's disease needed total care. He hardly moved, had little apparent energy, and when he spoke, he was difficult to understand because he was barely able to move his lips. I worked with him 3 times for very short periods, twice while he sat reclined in his wheelchair and once when he rested on his back, in his bed. The nursing home staff was excited about his progress. He was his old ornery self again and able to speak more clearly. However, staff was disappointed when he refused further sessions. He said that I had hurt him. (Alan did not have dementia and was able to make all of his own decisions regarding his care.) Maybe Alan had accepted his condition and limitations and he did not want change. Maybe, the change happened too fast. Maybe, he learned to feel things again and that was too painful. I began to question what a person wants and needs in the later stage of his life and at a later stage of a disease. This made me really think about how we must be careful not to put our own values onto another person, even if we are intending to help them. Our goals for them may not be their goals. Alan taught me a lot.

Perhaps, we cannot help everybody, but we can make a big difference to some people. Harvey told me that he could breath more easily after our sessions. Lucy said that she "can breath for the first time," and felt "so relaxed." Jean said, "it feels like a massage in slow motion," and that her knee no longer hurt her. Mary smiled at me. Lee stopped falling. Eve could get up and stand by herself. Gail could nod. Dina could propel herself in her wheelchair. Not one person responds like another. Despite what we may see on the outside, when we look at an individual with Alzheimer's disease or dementia, it is not necessarily what the person is experiencing inside. If we can find a way to allow a person to communicate his needs, desires, pleasures, or discomforts with us, we have made a tremendous difference in that person's life!

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