A 12 Step Programme for 21st Century Job Creation for Alexander Technique Teachers and Graduating Trainees

Monika Gross

Introduction

The goal of this programme, which I introduced in a workshop at the Congress, is to connect qualified Alexander Technique trainees and teachers to industry and population-specific jobs. It is a response to what I call the "Alexander Technique Anonymous" syndrome:

> "Hello. My name is Monika and I'm an Alexander Technique teacher."
> "Hello Monika. What's the Alexander Technique?"

Most professions mentor trainees into internships and ground-level job opportunities. Current AT training programmes sometimes offer professional development in starting a private practice, but do not often include curricula for training to work with specific industries or populations. Not all teachers are suited to entrepreneurship or managing a private practice. Some prefer salaried jobs and/or working in a communal setting.

Advances in neuroscience have lent scientific credibility to the processes behind AT and there is growing acceptance of innovative approaches in fields like education, business, and health and wellness. Building links with these areas of work in a strategic, organised way will lay the groundwork for employment opportunities for AT teachers into the future.

I believe the next decade is key. Enhancing credibility, creating demand, sorting out funding and delivery systems, designing job-training curricula for AT teachers, and introducing AT-principle-based continuing education programmes for other professionals must all happen concurrently or we will not be successful.

This initiative looks beyond our community of AT teachers to build new partnerships. Our students are underused as advocates. Also, many open-minded, forward-thinking professionals can help us bring our work to new industries and populations. Let's reach out to those who are eager to help. This initiative will be most successful if it is undertaken with a team approach that includes industry leaders, grant writers, media consultants and other professionals.

A primary motivation for this initiative is to make AT available to more socio-economically diverse populations than our current private-pay model allows. In addition, we will encourage more diversity in AT teachers if we work to ensure there will be a job with a living wage at the end of their training.

If you are interested in supporting this initiative in any way, I welcome you to contact me.

Current Employment Snapshot

The vast majority of AT teachers use a private practice model. A recent independent study sponsored by the Complementary Medicine Evaluation Group, Department of Health Sciences, University of York with a grant from the National Institute for Health Research[1] found that essentially 100% of UK AT teachers are self-employed (95% self-employed and 5% not working). 87% offer lessons in homes or in privately rented rooms.

23% of teachers hold post-graduate degrees. 8% are also members of statutorily regulated healthcare professions such as psychotherapy, nursing and physiotherapy. Additional trainings include cranial-sacral therapy, yoga, Pilates and massage. 51% combine AT teaching with other non-AT work. AT teachers teach AT for an average of 8 hours per week.

Only 12% teach at performing arts colleges or in a National Health Service clinic, but these also identify as "self-employed" meaning they do not hold full-time salaried positions and are probably coming in for workshops or as part-time adjuncts.

Only 3% of teachers work in corporate, office or workplace settings. 5% work in non profit settings, but the study doesn't indicate whether they rent space, are brought in to do workshops, or started an AT non profit.

23% work at AT training schools, making AT training programmes our largest, and essentially only, employers.

The median age of AT teachers in the UK is 58. 74% of UK AT teachers are women. Most are located in the south of England, in large urban areas.

As for our clients, only 3% come for neurological reasons, such as migraines, Parkinson's Disease or Multiple Sclerosis; only 5% for psychological reasons, such as acute stress, anxiety or depression; and only 2% for sport or other physical performance. Only 8% of clients come for performing arts reasons.

91% of people who take AT lessons pay for lessons privately. 4% receive lessons for "free or barter". Only 2% of lessons are paid for by employers or through a college, and only 1.4% through a private health insurance or the National Health Service.

The median age of AT clients is 48, although 76% of teachers say they do some work with clients under the age of 18. 66% of AT clients are women

[1] Eldred, J., Hopton, A., Donnison, E., Woodman J, MacPherson, H. *Teachers of the Alexander Technique in the UK and the people who take their lessons: A national cross-sectional survey* Complementary Therapies in Medicine (Volume 23, Issue 3, June 2015, Pages 451–461).for abstract: http://www.sciencedirect.com/science/article/pii/S0965229915000643 for full survey: http://tinyurl.com/oot6lhx

There was no information collected regarding ethnicity or economic status of either AT teachers or AT clients.

This is an excellent snapshot of our profession. What is disturbing is that we are attracting such a tiny percentage of the general population to AT - only people who can pay out of pocket and only as individuals - and we have essentially no institutional employment. We have not located funding and delivery systems to help pay for or subsidise lessons, such as non profits, employers, educational institutions, athletics programmes, governments or trade organisations. We are not creating AT-focused non profit models. And we are working in isolation, in private settings with little professional interaction with - or visibility to - the public.

If the median age of our teachers is 58, we are not attracting young professionals to AT as a career choice. Interestingly, AT teachers are mostly women, and women have historically earned less money than men and are more likely to work part time.

Our clients come to us mainly with musculoskeletal issues. We are not working with healthy children, adolescents and young adults and their teachers, parents and caregivers in institutional settings to help preserve poise before it's disturbed, but rather are engaging with adults much later, usually with a crisis as their entry point. We are not regularly employed where we are uniquely qualified to be of service, as in populations with neurological conditions or anxiety issues, or in sports and athletics.

Even within the performing arts community - where one would think we would have a stronghold - we are losing ground. Performing artists make up only 8% of our clients and performing arts training programmes are not seeking us for salaried employment.

In fact, there doesn't seem to be anyone hiring Alexander Technique professionals! Anyone entering "Alexander Technique Teacher" for an online job search service will quickly find this to be true.

The 12 Step Programme

The current method for AT principles to reach a chosen population is for an AT teacher to attract private paying clients, one-to-one or in workshops, or to approach an institution such as a school or business as an individual.

The initiative I propose takes a centralised team approach, including non-AT professionals and consultants. It would result in the creation of jobs for AT teachers as well as the creation of continuing education programmes based on AT principles designed for the education of targeted industries. Payment is drawn from a mixture of sources: private-pay, employers, non profits, government and non-governmental organisations and trade organisations. I plan to establish an independent non profit organisation devoted to funding and implementing this initiative, which will follow the 12 step method outlined below. This will provide an infrastructure for supporting and coordinating existing efforts of members of the international Alexander community.

We start by identifying a target population: "Whom do we want to help?"

Example: "Children, Adolescents & Young Adults"

We then:

1) Identify the industries that will connect us to the target population

   Industries with infrastructures in place and ongoing interactions with the target population

   > *Connecting Industries:* Early Education, Primary, Secondary & Tertiary Schools, Day Care, Health & Wellness Systems, Summer Camps, Performing Arts Programmes, Juvenile Justice Systems, Sports

2) Locate AT teachers already working in a connecting industry with the target population

   AT teachers who have specific expertise with this target population or are working within one of these industries. They will often have additional qualifications that have given them industry credibility. They are a primary resource for initial guidance in navigating the process.

   > *Connecting Industry:* Primary Schools
   > *AT Teachers:* Sue Merry & Esther Miltiadous from the Educare Small School in the UK[2]

[2] Educare Small School, 12 Cowleaze Road, Kingston Upon Thames, Surrey KT2 6DZ http://www.educaresmallschool.org.uk/

3) Locate an Advocate/Translator

A person with experience in those industries who also has personal experience or understanding of AT but who isn't an AT teacher. They essentially "translate" between AT language and point of view and the language and point of view of the specific field or industry. They offer guidance throughout the process.

Advocate/Translator: Elementary school principal who has benefitted from AT lessons[3]

4) Identify the industry's perceived needs

We often focus on needs that may not be actual concerns of a target population. We need to focus instead on the *perceived needs* that do concern the industry decision makers. We identify them with help from the Advocate/Translator and other industry professionals. If things go well and we get access to the target population, I hope to educate them later about needs they may not yet be aware of.

Perceived Needs:

- Support children diagnosed with ADHD
- Improve test performance
- New games for recess and PE
- Reduction of aggressive behaviors

5) Research the industry's current solutions for their perceived needs (i.e. our "competition")

What other professionals are they using? What programmes are already in place? How much do they cost? How much time do they allow for them? How effective have they been? How are they dissatisfied with their current solutions?

Perceived Need: Support children diagnosed with ADHD
Current Solutions:

- Assistant teachers
- Special Education teachers
- Occupational therapists
- Pharmaceuticals
- Exercise/Movement programs
- Mindfulness practices
- Therapeutic arts programs

[3] This is a US example. Outside the US, terms and structures will be different, but the basic process will be the same.

6) <u>Create an industry-focused "AT Cultural Capital" credibility package</u>

To ensure a successful presentation, we will need to have a clear understanding of the industry's culture and language. What are their hierarchies? How do they interact? What are their basic beliefs? How is success measured? What will make AT credible to them? What makes AT the solution for their perceived needs? What do we offer that the "competition" does not? Is there data to support our solution?

In general, the three *solutions* that AT offers are: 1) improved performance; 2) pain and injury management, recovery and prevention; and 3) performance anxiety or stress management. The long-term *benefits* are enhanced self-perception, self-regulation, and critical problem-solving skills. I call these benefits collectively 'First Person Expertise'.[4]

Industry-focused "AT Cultural Capital" credibility package for Primary Schools can include:

- Approval process for an AT teacher in that school system
- Implementation process for the chosen intervention
- Expected costs
- Potential funding sources for the intervention
- Demographics of the children
- Our specific AT-based solutions - presented in primary school professional language, not in AT professional language

7) <u>Locate forward-thinking industry experts</u>

Open-minded people in the field, interested in innovation and curious about AT's potential. Good individuals to test the "AT Cultural Capital" credibility package and to help identify the best people for Step 8.

Industry Expert: The Executive Director of a local city schools foundation

8) <u>Identify the industry decision makers (i.e. "The Gatekeepers")</u>

Decision makers who can approve a pilot project or create a job. We need to prove to them that AT is the best solution for their perceived needs - and we will probably not get a second chance.

Decision Makers: Local or State Board of Education to approve AT teachers in ongoing positions in local government-run schools

[4] 'First Person Expertise' is a term I use for the practical ability AT principles teach to consciously and continuously perceive, interpret and navigate myself in my environment from moment-to-moment.

9) <u>Locate funding sources and delivery systems</u>

An economic system and organisational structure to support each pilot project, internship or job.

"For profit" structures include our current private-pay self-employment model, but can include limited partnerships or incorporated entities with other teachers, such as "AT clinics" that look like businesses the general public is already used to, or franchise-type models such as Shaw Method.[5]

"Non profit" structures are underused. Partnering with non profits or starting our own can bring AT principles to new populations and countries and can support the training of a more diverse teaching profession. An interesting model: US speech-language pathologists who are frustrated at the limited time they can spend with aphasia patients because of health insurance limitations, and knowing their clients can't afford private pay, have formed non profit 'aphasia centers' offering inexpensive group classes and using local university speech pathology students as interns. After a few years, they received enough funding to realise their goal to offer subsidised one-to-one sessions for their clients.[6] Worker co-ops are also potential models. There are also interesting hybrid models linking for profit and non profit entities.

'Pro bono' creates a professional context for us to offer services not 'for free' or as 'volunteers' but pro bono: "for the public good". Becca Ferguson has been teaching pro bono in a prison in Chicago[7] and Andrea Bruno in a Veterans Affairs hospital in New Jersey in its complementary medicine programme.[8] Their efforts become models for professional programmes to work with these populations.

I imagine that the majority of AT teachers are interested in making a living rather than a 'killing', and we can do so by blending for profit, non profit and pro bono models.

'Delivery Systems' connect AT teachers to target populations. For 'Children', a day care center that brings in an AT trainee as an intern would be a delivery system. For 'Occupational Therapists', AT-based continuing education curricula designed for OTs and approved by the American Occupational Therapy Association would be a delivery system. Presentations and AT sponsorship booths at professional conferences are delivery systems to many target populations. Anikó Ball presented at the 2015 36th

[5] The Shaw Method, The Factory, 407 Hornsey Road, London N19 4DX UK http://www.shawmethod.com/

[6] A conversation with speech-language pathologist and aphasia specialist Molly Secrest of Westboro MA, 5 July 2015

[7] From panel presentation 13 August 2015 at 10th International Alexander Technique Congress in Limerick Ireland: Ferguson, Becca; Cranz, Galen; Freeman, Caitlin. “Diffability vs. Disability: Reframing Personal Definitions of Self”

[8] From presentation 20 October 2015 at Alexander Technique International Annual Conference in Philadelphia PA USA: Bruno, Andrea. “Working with Veterans at a VA Hospital”

Australian Dental Congress in Brisbane, which had over 4500 attendees.[9] Candace Cox presented at the 2013 World Parkinson's Congress in Montreal, which had close to 3500 delegates from 64 countries.[10]

10) Locate AT Training Programme Directors interested in additional Industry and population-specific training

Working on solutions with training programme directors becomes a vital part of our professional development. How will we position industry and population-specific training? As additional elective hours in their training course? As a fourth year of graduate training? As post-graduate courses? As onsite trainings?

11) Design and implement industry-focused curricula for trainees and post-graduate trainings for AT teachers

Curricula created from information previously gathered, with input by experts in their respective fields and training programme directors. We can also connect trainees and teachers to existing industry-specific certification courses.

12) Final Goal: Connect industry-qualified trainees & teachers to internships & jobs

Currently the only internship-style option for most graduating trainees is as assistants in AT teacher training courses. At this final step, there will now be many interesting internships, as well as jobs for more experienced teachers. Working in day care centers could be internships for trainees. Assistant teachers in primary schools could be entry-level jobs for recent graduates. However, handling the design and implementation of AT principles for an entire public school system would require teachers with considerably more senior experience and training.

The final outcome must be job security. We do not want to waste all this hard work because a friendly principal, CEO or sheriff moves on to another school, corporation or district and those who remain don't recognise the value of an AT professional. We want our AT professionals to be ongoing, integrated, vital parts of an industry's culture.[11]

9 Ball, Dr. Aniko, "Overcoming Back and Neck Pain in the Dental Surgery" and "Well-Being and Ergonomics for the Dental Team" 36th Australian Dental Congress, Brisbane. http://www.adc2015.com/speaker/dr-aniko-ball/

10 Cox, Candace, "Long Term Effects of Alexander Technique in Managing Motor Symptoms of Young Onset Parkinson's Disease" 2013 World Parkinson's Congress, Montreal. https://drive.google.com/file/d/0BzbY4ZvnzS0WRTZTTGxxdmN6TlU/view and http://themillatpipercreek.ca/parkinsons/

11 For examples, see this 2011 report published by the Spanish Foundation for the Prevention of Occupational Hazards, which gathered data from multiple onsite projects that used AT principle based solutions to improve worker health and safety: "Alexander Technique: training for the self-management of workers to prevent musculoskeletal disorder" Foment Prevención de Riesgos Laborales. Data gathered by Mireia Mora i Griso with funding from Fundación para la prevención de Riesgos Laborales. http://www.vanschuylenburch.nl/Uploaded_Files/439_Research.pdf

CONCLUSION

The German word *Zugunruhe* (pron. *tsuk' un roo he*), combining *Zug* (move, migration) and *Unruhe* (restlessness, anxiety), is a scientific term for migratory restlessness prior to a journey central to a species survival. In his 2010 book of the same name[12], Jason McLennan, co-founder of the green building movement, explains how the serious realities of climate change adjust the timeline for environmental action:

> *"Nature provides us with wonderful examples of how not to get stuck in habitual patterns of behaviour, as change is necessary for survival. As a tree grows, it adjusts constantly to respond to external forces... In essence, the tree redefines its process and structure continuously at every moment because of ever-changing inputs. If only human-made systems were so elegant. ... Once we create a system our tendency is to fall in love with it! ... [The system] becomes a signature - part of our identity - and then it blinds us. We begin to look for anything that justifies how our process is correct and ignore signs that it is not... Somehow, our movement must shed the weight of the paradigm of the last thirty years and take bolder action if we are to succeed ... Our baby steps must now turn into giant leaps and our processes must accommodate this new pace and the urgency behind it."*[13]

McLennan suggests that "instead of despairing over a lack of progress towards change, reach out and find others who are also working to create change. Look for people in other disciplines and for ways to bring your ideas and expertise together. This collaboration will inspire you and keep you positive, grounded and moving forward. Seek common understandings and solutions and make the cornerstone of your vision one that is inclusive, synergistic and open-source."[14]

We can certainly draw parallels to our own situation. I know I am not alone in these concerns. Do you feel as I do that we are in a period of "*Zugunruhe*" in the AT community? Do you sense that the time has come when we can end this puzzling, persistent "Alexander Technique Anonymous" syndrome? I hope you will find inspiration in these models and join in this initiative. With persistence and a team approach, I believe we can prepare the way to be of true service in the 21st century.[15]

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12 McLennan, Jason F. (2010) *Zugunruhe: The Inner Migration to Profound Environmental Change*, Perfect Paperback.

13 Ibid pp. 238-241

14 Ibid pp. 273-274

15 Two appendices for this paper ("Current Employment Models for AT Teachers" and "Sample Target Populations, Connecting Industries & Decision Makers") can be downloaded at: http://tinyurl.com/nvnob9w

Monika Gross is a senior teacher of the Alexander technique, and has taught postural integrity and performance skills for over thirty years. She had her first Alexander lesson in 1976 at age 19, and was certified in 1985, training with Lydia Yohay (ACAT). She participated in the First and Second International Congresses in 1986 and 1988. Monika taught in New York City for 25 years and is now the co-owner of *Form Fitness & Function* in Asheville NC. She was on the faculty of the Hayes School of Music at Appalachian State University (2011-12). She is a professional theatre director, playwright and performer and holds a BFA from the University of North Carolina School of the Arts. In 2009, Monika, Belinda Mello and Lindsay Newitter co-founded *Studio AT Large*, where Alexander teachers and their students provided information and free AT "tastings" in a variety of indoor and outdoor locations in NYC, promoting awareness of AT to a broader population. She is a member of the Western North Carolina collaborative teacher consortium Alexander Teachers of the Mountain Region (ATMR).

Monika presented the ideas in this article in a workshop on 14 August 2015 at the 10th Alexander Technique International Congress at the University of Limerick in Limerick Ireland. This article is being published by The Society of Teachers of the Alexander Technique in the collected 10th Alexander Technique International Congress Papers in 2016.

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APPENDIX A

CURRENT EMPLOYMENT MODELS FOR AT TEACHERS

1. Private practices in home offices or going on site with private pay clients
2. Private practices in rented office space or going on site with private pay clients
3. Private practices in shared office spaces with other types of practitioners, such as Pilates or yoga instructors, massage therapists, Rolfers or cranial-sacral therapists, where all services are paid for by private pay clients
4. Private practices in the offices of insurance-covered practices, such as chiropractors, physical therapists, or social worker therapists, where AT is paid for by private pay clients
5. Private practices in informally shared office space or going on site with other AT teachers where AT is paid for by private pay clients
6. AT as secondary to a primary business identity requiring qualification from another professional degree or certification such as physical therapy, social work, psychotherapy, physical education or exercise science
7. Employment by a performing arts academic or conservatory training program, where again AT certification is generally secondary to another professional degree for job qualification, such as a masters degree or doctoral degree
8. AT teacher training program directors, teachers and assistants in for profit models with private pay trainees (Variation: The School For FM Alexander Studies in Melbourne Australia has government accreditation, which allows overseas students to apply for student visas and can help students with seeking educational funding)
9. AT teacher training program directors, teachers and assistants in non profit models with private pay trainees (Example: ACAT NYC)
10. For profit legal business partnerships with one or more AT teachers and perhaps other types of practitioners, where AT is paid for by private pay clients or by some corporate consulting or by organizing retreats or professional conferences (Example: Hite Ltd. in UK; Michael Frederick's Alexander Technique Workshops International, or the Alexander International Congress Board of Directors)
11. Corporate consulting services or motivational speaking and team building programs (Examples: Priska Gauger-Schelbert, Rosa Luisa Rossi, Philippe Cotton, Michael J. Gelb)
12. Trademarked niche businesses based on AT principles (Examples: Steven Shaw's Art of Swimming Ltd - The Shaw Method, Malcolm Balk's Art of Running, Jessica Wolf's Art of Breathing, Jeremy Chance's BodyChance, Peter Grunwald's Eyebody, Ilana Rubenfeld's Rubenfeld Synergy Method)
13. Creating and/or publishing AT-related products for sale such as books, DVDs, cushions, tables, chairs or magazines. Often this has a non profit educational component with funding coming from grants or other philanthropic sources.

APPENDIX B

SAMPLE TARGET POPULATIONS, CONNECTING INDUSTRIES & DECISION MAKERS

1) Children, Adolescents & Young Adults

Connecting Industries:

1. Day Care, Early Education, Primary Schools & Secondary Schools
   Decision Makers: School Administrators, Teachers, Parents, Caregivers, Teacher Training Program Directors, Government Agencies, Advocacy Groups and Partnerships Staff (see "Sports" below as well)
2. Health & Wellness
   Decision Makers: Pediatricians, Hospital Administrators, Speech Pathologists, Occupational Therapists, Physical Therapists, and Dieticians
3. Juvenile Justice System
   Decision Makers: US Dept. of Justice - Office of Juvenile Justice and Delinquency Prevention Administrators, Social Workers, Psychologists, Vocational Rehabilitation Directors
4. Performing Arts Programs
   Decision Makers: For Profit Program Directors, Not-for-Profit Program Directors, Instructors
5. Summer Camps
   Decision Makers: Camp Directors, Counselors, Parents
6. Sports
   Decision Makers: Community Recreation Program Directors, Coaches, Parents, School Athletic Directors, After School Program Directors, Private athletic program directors, Exercise Science & Physical Education Training Programs, Sports Medicine Doctors

2) Neurological Disorders Patients (Parkinson's Disease, Multiple Sclerosis, Cerebral Palsy, etc.)

Connecting Industries:

1. Health & Wellness
   Decision Makers: Neurologists, Movement Disorder Specialists, Support Group Directors, Physical Therapists, Occupational Therapists, Caregivers
2. Related Research Institutions
   Decision Makers: Foundation Directors, Medical Research Centers, Neurologists, Clinical Health Practitioners, Academic Professors and Laboratory Directors
3. Support Groups
   Decision Makers: Community Center administrators, Senior Centers, support group leaders, Professional Health Providers, Center for Disease Control (to approve "Evidence-Based Exercise Programs" example: Tai Chi programs)

3) Health & Wellness Workers (Doctors, Nurses, Dentists, Occupational Therapists, Physical Therapists, Speech Pathologists, Massage Therapists, Chiropractors, Aides, Technicians, Hygienists)

Connecting Industries:

1. Hospital systems
   Decision Makers: Hospital CEOs, Department Heads, Discharge Directors, Insurance Company Directors
2. Professional Membership and Licensing Organizations
   Decision Makers: CEOs, Directors of Services, Membership Directors, Curriculum Committees
3. Private clinical practices
   Decision Makers: Practice Administrators/Directors, Members
4. Rehab Centers
   Decision Makers: Program Directors, Department Heads, Caregivers

5. <u>Medical Schools</u>
   Decision Makers: American Medical Association, University administrators, Goverment Licensing professionals, Professors, Curriculum and Textbook Development Managers
6. <u>Continuing Ed programs:</u> *Decision Makers:* Curriculum Development Managers

Additional Target Populations:

Elders; Office Workers; Factory Workers (Union & Non-Union); Physical Laborers (Union & Non-Union); First Responders (Police, Fire Fighters, Paramedics/EMS); Military; Athletes; Prisoners; Autism Spectrum Disorder & Sensory Processing Disorder; Post Traumatic Stress Disorder; Obesity; Chronic Pain; Drug & Alcohol Addiction; Cosmetologists; Academics (other than Performing Arts departments)

<u>Remember: Please use every pilot project or new market to gather data</u>
Save everything from simple case studies to full protocoled research projects
Always be prepared to record "before and after" outcome measurements
Share information in an archive such as Alexander Studies Online (ASO)