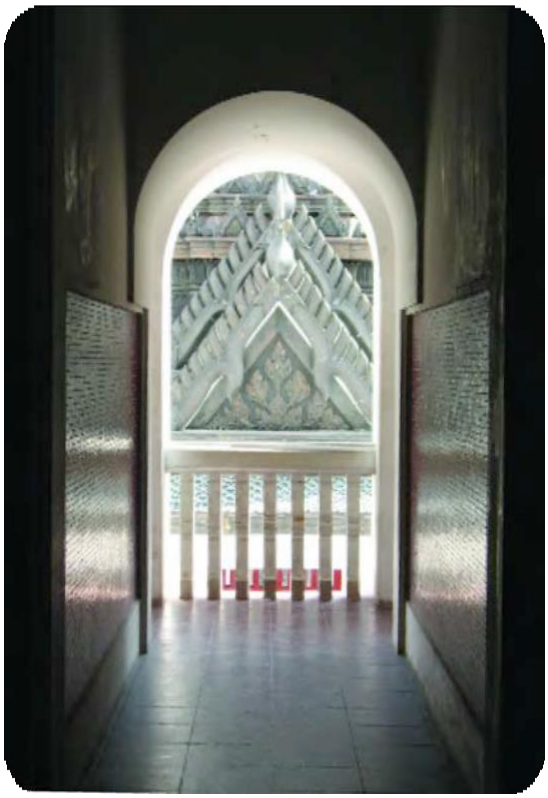
Perspective

Yoga Therapy in Neuropalliative Care: Specialization and Considerations

By Nathalie de Meyenburg

As yoga therapy increasingly rubs shoulders with mainstream medical practices, it stands astride a line that is, at times, blurry. Although yoga therapists are expected to have a high level of experience and be proficient in the applications of yoga as a therapeutic modality, they are also expected to have a knowledge base that is congruent with current medical practices and that permits them to converse intelligently and effectively with other healthcare providers. For this reason, some yoga therapists choose to specialize or to have a particular focus to provide yoga therapy founded on a distinct knowledge base. Specialization benefits practitioners (their practice is deepened and becomes more focused), clients (they are guided by a therapist with knowledge and understanding of their specific needs), and the healthcare community (providers can interact with yoga therapists and better understand what it is they do—and do not do).

As elaborated in a previous article,[1] it is all too easy to oversimplify one's focus as a practitioner, defining a client by a specific condition or disease rather than as a person on a continuum of life experiences: physical challenges, thoughts and emotions, relationships, a spiritual path. First and foremost, someone is asking for assistance; this must be acknowledged and responded to. It would, however, be negligent to act without first questioning our ability to help, dispensing care in an ad hoc manner rather than providing constructive support. Elementary principles of yoga, such as focus, awareness, and mindfulness, serve as fundamental building blocks and must be well placed. Once we have a sound foundation in yoga therapy, specialization serves to refine our approach and meliorate care of clients.



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Specialization as Enhancement

Specialization within yoga therapy is a source of much discussion among yoga therapists. Some regard yoga therapy as generally beneficial, provided that the therapist leads a session with care and observes basic physiological principles. Others perceive a need for a fundamental understanding of specific conditions in order to provide a benefit, rather than a possible hindrance, or even harm, to yoga therapy clients. These need not be divergent viewpoints. One can lose sight of the forest—the big picture—if all we see is trees; however, if viewing the forest results in not seeing the individual trees that comprise its vastness, we are being rather shortsighted. According to A. G. Mohan, a long-time student of Krishnamacharya and co-founder of Svastha Yoga, Krishnamacharya regularly emphasized the need for the appropriate practice and application of yoga, stating that yoga is best not done at all if it is going to be done without purpose and without "taking into account the structure of the body and the distortions in the body Practice without right knowledge of theory is blind. This is also because without right knowledge, one can mindfully do a wrong practice." Surely this should be taken to heart, not only by the yoga student but by the yoga teacher or yoga therapist. Further training that would help one avoid harm to clients and would give more benefit to those with specific conditions should not be perceived as superfluous or peripheral to one's knowledge base as a yoga therapist, but rather an enhancement.

More than Intention

As a yoga therapist specializing in neurological and neuromuscular conditions, I believe that intention and right mind/right action must be present to help in the healing process. However, just as Krishnamacharya stated that one can mindfully do a wrong practice, so can a yoga therapist or yoga teacher have good intent yet be ineffective, or even cause harm. Herein lies the merit of specialization—knowing what is helpful and beneficial, or even possible, without causing negative repercussions. For example, we would turn to a neurologist for a neurological condition, yet we would also certainly hope that they specialize in their field and are able to differentiate among multiple sclerosis (MS), Parkinson's, and Huntington's as opposed to focal dystonia, essential tremor, or the effects of a transient ischemic attack.

I recently spent time at the University of Colorado Anschutz Medical Campus neurosciences center in Denver to observe the neuropalliative care program directed by Benzi Kluger, MD, MS. Neuropalliative care is long-term care for those with progressive neurological conditions. The approach is not so much to target symptoms as it is to provide full-spectrum care, support, and access to resources. Although Kluger specializes in neurological conditions and movement disorders, he recognizes that intention alone on the

part of a practitioner does not suffice. In an interview[2] he uses MS as an example, saying, "Neurologists are very skilled with MS and with disease-modifying therapies, but may not have specific training in pain management or fatigue or depression or constipation or other complex symptoms common to MS." For this reason, the neuropalliative care team—comprised of neurologists, a registered nurse, a social worker, and a chaplain—works together to treat and support patients physically, mentally, and spiritually, yet the team also refers patients to a network of specialized resources in the community, including a yoga therapist.

Context: In-Clinic or Local Resource?

The efficacy and long-term benefits of one-on-one therapy sessions or small-group yoga therapy classes should be considered in the context of location and accessibility, as well as patient engagement and acceptance. Finding an available space in a clinic or hospital setting is challenging, at best. Assuming physician and administrative support, the logistics of setting aside a quiet, clean, and accessible room can be enough to make a class setting impracticable. Kluger makes the point that asking a patient to drive to a hospital, find parking, get to the building, and then navigate to a particular floor and room is not feasible for most neuropalliative care patients. His viewpoint is readily supported by clinical reviews.[3]

I advocate for in-home sessions when possible as a means to avoid client stress, fatigue, and the outright anxiety that can be evoked by the mere thought of organizing a ride, ensuring that a caregiver is available, and the time involved (easily 3 hours with getting ready/dressing, driving to the session or class, time parking and in class, and driving home). The majority of my clients, whether referred or inquiring about an alternative to conventional therapies such as physical or occupational therapy, are motivated first by pain or a growing lack of mobility, and then by cost. On first contacting me, they are often quite blunt in that they wish to have a speedy, cost-effective, and durative solution to their problem. After an initial intake session, most recognize that a class setting (their initial inclination because of monetary concerns) would not be possible due to their level of ability and the energy output required, combined with the logistics of getting to class. In addition, they appreciate the personalized attention and interaction possible in a one-to-one session. Perhaps most importantly, the long-term relationship built between yoga therapist and client is more likely to lead to a steady practice and progression, rather than transient, episodic classes that may or may not be offered depending on grant funding, space availability, or administrative decisions. If you are providing a yoga therapy class in a clinical setting, be mindful of bright lights (particularly problematic for those with neurological conditions), sudden or unexpected noise, and ambient temperature (preferably cooler but not cold for those with MS and warmer but not overheated for those with Parkinson's).

Know What You Do—And Do Not—Know

If dyskinesias or brain-fog are the manifestation of the day for people with Parkinson's disease, asking them to stand with their eyes closed is perhaps not the best approach—or is it? In this case falling abruptly would be the expected outcome, yet having them place their hands, palms down, on the therapist's upturned hands will usually reduce (if not stop) the dyskinesia. If the eyes are open rather than closed, the somatosensory input from touch is less clear, and there is little effect. Let us go further: Is the dyskinesia due to Parkinson's or to extended levodopa (L-dopa) treatment? It is certainly necessary to know, as the former can be helped by yoga therapy, whereas the latter is unlikely to improve without adjusting medication and/or dosages.

Another example: A client with Parkinson's is "frozen" in place and unable to move their feet. How might we guide them to unfreeze and step forward safely without falling? Those with Parkinson's face basic issues like this one daily, yet knowing how to help is often not self-evident, to the individual or the therapist. In a recent exchange with Paul Zeiger—who taught yoga until recently to persons with Parkinson's and who has himself been learning from his own experiences of the disease—observes that, "Keen awareness of the body, viewed from the inside, enhances the effectiveness of all

HOW WOULD YOU RESPOND?

Following are examples of questions that might point a yoga therapist toward additional education.

- If a client or patient with MS stands with their eyes closed, in which direction will their head—and usually the body—eventually turn? And for Parkinson's?
- Is it easier to walk forward, or backward, for those with Parkinson's? And for those with MS?
- Yoga has been shown to reduce tremor in those with Parkinson's, yet a client seems to be having much more difficulty with tremor than usual. In fact, the tremor is getting worse with each passing moment. Should you stop the yoga therapy session or continue?
- In a hypothetical yoga therapy session with three clients present, the client with MS repeatedly laughs uncontrollably, and then bursts into tears. The client with Parkinson's stares ahead in stony silence, unsmiling. The client with Huntington's is highly agitated and begins to shout at you. You know that all three clients are usually engaged, articulate, and able to take part in a 45-minute yoga therapy session. Why might they be acting in a markedly different way today? Hint: The causes are not related to the class scenario (e.g., unfamiliar location or new therapist), and each behavior is particular to each client's preexisting condition.
- A client with MS, one with Parkinson's, and another with cerebral palsy (CP) have just finished a yoga therapy session. They are pleased because they were able to do more stretching than usual. However, upon standing, they feel shaky and are unable to remain standing, let alone walk. The client with MS bounces up and down slightly, the client with Parkinson's experiences body-wide rigidity (note: rigidity, not spasticity), and the CP client is no longer smiling because of notable joint pain. Can you explain the reason for each person's reaction? There is a common cause.

therapeutic exercises and turns more of one's activities of daily living into therapeutic exercises. The body is a pretty important piece of your life, and without a certain amount of mindfulness, you are not even going to notice it."

Some years ago, a yoga therapy instructor was demonstrating what they felt was the best overall approach to therapy for Parkinson's—high-amplitude movements. Although this approach can be helpful with bradykinesia, it is far from one-size-fits-all in my experience, so I asked for the instructor's perspective on a common difficulty for those with Parkinson's: gait freezing when walking through doorways or turning a 90-degree corner. To my surprise, the instructor emphatically stated that the client should be instructed to "take big lunges" (as in warrior II). Such an approach may be possible in the early stages of Parkinson's, but if a client is frozen to the ground, with the sensation that a tangible, physical barrier is issuing from the doorway, attempting a lunge would result in tipping forward and falling, or quite simply becoming increasingly rigid to the point of outright inability to move as a result of high anxiety. From my perspective and time working with neurological and neuromuscular conditions, the most direct and effective approach to this visuomotor response is to have the client lightly touch the door frame on both sides (haptic perception), or put their arms over their head, then attempt to move through. Another possibility is to have the client (slowly) turn and step backward through the doorway. Because gait-freezing is attributed to a complex group of factors ranging from cognitive- and motor-based to affective state (depression/anxiety),[4] this phenomenon is an excellent example of a situation wherein we must know whether to emphasize physical, emotional, or awareness-based principles of yoga to support a client with Parkinson's.

These examples (in addition to others mentioned in the sidebar) underscore the need for a comprehensive scope of training within yoga therapy, as well as in-depth knowledge of particular conditions. Our responsibility to our clients is manifold: Informing oneself is commendable; however, gaining depth of understanding is vital and fundamental to our work as yoga therapists. Know what you do—and do not—know. YTT

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