Yoga Scotland
(incorporating the Scottish Yoga Teachers' Association)

GUIDELINES FOR TEACHING YOGA TO PREGNANT WOMEN

Pregnancy is a normal and natural part of a woman's life cycle. For the most part these will be young women who are fit and well. Many will suffer from one or two of the discomforts that come with most pregnancies. A minority will encounter a problem that may necessitate treatment by a qualified health professional.

Yoga is ideal for pregnancy as it allows women to practise both on a physical and spiritual level while at the same time developing confidence and self-awareness. A good number of women now do some form of exercise before they become pregnant. Yoga provides a perfect way to keep exercising to maintain health and fitness during pregnancy without strain. It encourages awareness of posture with attention to grounding, breathing, gentle stretching and relaxation. This is an excellent preparation for labour which requires a woman to have developed a certain flexibility of body as well as of mind.

Yoga is as much a philosophy and way of life as it is an exercise. Whilst many of the Guidelines for Exercise in Pregnancy are still relevant (NHS 2009), not all are necessarily applicable. The following advice should be considered in relation to Yoga.

1. ADVICE TO WOMEN:

1:1 Discuss with your midwife the most appropriate Yoga class to join if starting for the first time. Ideally you should join a class that is dedicated to pregnant women. Failing this, choose a beginners class or one with a slower pace, as more physically strenuous forms of yoga practice which involve fast flowing aerobic sequences, raising body temperature, prolonged use of breath retention are not recommended for pregnant women.

1:2 Continue your practice, if already practising Yoga asana. However, be prepared to slow down and modify the postures with reference to your Yoga teacher (Clapp 2006). Recognise that there may be some Yoga postures that you may no longer wish to practise because they feel uncomfortable.

1:3 Choose a gentle form of exercise such as walking or swimming to develop muscle tone, strength and stamina. This will complement your Yoga practice. Gradually increase this exercise to 2 or 3 times a week. Avoid overheating or any exercise where the maximum heart rate exceeds 140bpm.
Note that a moderate level of exercise may protect both mother and baby. Research into the efficacy and safety of exercise during pregnancy is currently being conducted for women at risk of Pregnancy-Induced Hypertension (raised blood pressure) and pre-eclampsia (Yeo 2006).

1:4 Maintain an adequate fluid intake. Bring a bottle of water to the Yoga class and eat something light beforehand e.g. banana, piece of toast. Bring a snack also for the end of the class.

1:5 Stop exercising or practising Yoga if feeling light-headed or fatigued. Sit or lie down and practise simple relaxed breathing.

RECOMMENDATIONS TO YOGA TEACHERS

2. GENERAL ADVICE

Reiterate all the recommendations and advice in Section 1 ADVICE TO WOMEN and in addition:

2:1 Direct women to a dedicated pregnancy Yoga class where possible.

2:2 Advise women joining a Yoga class for the first time to wait until 14 weeks or so. By this time the initial fatigue and possible nausea should be starting to lift. Pregnant women who already practise Yoga should be advised to slow down in their practice and be sensitive to the changes in their body. There is no evidence to suggest that Yoga causes women to miscarry. However, the most common time for miscarriages to occur is between the 6th and 10th week (NCT Information sheet)

2:3 Request women to inform you of any problems that might arise from week to week.

3. ON PRACTICE

Consider the following with respect to movement, joints and breathing:

3:1 Focus on finding the ground (grounding) and posture

3:2 Encourage women to move their legs regularly when standing (This is particularly important for women with low blood pressure or anaemia). Prolonged standing can result in pooling of blood in the lower limbs leading to a drop in blood pressure – dizziness, nausea etc. This is more common in the hot summer months.

3:3 Encourage women to move slowly from lying down to sitting, carefully keeping their legs together or parallel to avoid stress on the pelvic joints.

3:4 Encourage fluidity of movement with an emphasis on flowing rather than static movement

3:5 Focus on promoting core stability with attention to the pelvic floor.

3:6 Promote an awareness of optimal foetal positioning by including upright forward leaning positions e.g. all fours, every week (Sutton 2007)

3:7 Offer alternatives for women with pelvic girdle pain (PGP) (formerly known as SPD) – primarily alternatives that will promote core stability (Pelvic Instability Network Scotland).

3:8 Be sensitive to the fact that some women are uncomfortable touching other women. Offer alternatives for any partner work.

3:9 Note that pregnant women may have a tendency to hyperextend joints and that this should be avoided.

3.10 Take care when teaching any posture involving full flexion of the joints especially beginners. In the first instance modify the pose using props e.g. cushions for kneeling.

3:11 Jumping in and out of postures is not advised as this practice can put too much unnecessary stress on the pelvic floor, joints and ligaments and can exacerbate structural imbalances

3:12 Ask women to cease lying in the supine position for relaxation from about 30 weeks. About 10% of pregnant women suffer from supine hypotension – a condition consisting of a drop in blood pressure, slowing of the pulse, dizziness, light-headedness, nausea and even fainting if the woman remains in the supine position for any length of time. By rolling the woman on to her left side, the cardiac output can be instantly restored (Fraser and Cooper 2009).

3:13 Be aware that prior to 30 weeks women lying on their backs should place some support beneath the thighs. This will bring the lumbar spine to the ground if the woman wishes to remain on her back for relaxation. This is particularly important when the psoas muscle is tight. Alternatively women can lie with the knees bent and resting together, with the feet placed on the floor a little wider than the hips.

3:14 Avoid any breathwork/pranayama that involves breath retention. Focus on developing an awareness of the breath and then on the benefits of extending the outbreath. Use of sound can be particularly helpful in encouraging extension of the outbreath and can also bring a calming quality e.g. gentle bhramari. Practices such as Kapalabhati and Bhastrika are not recommended in pregnancy.

3:15 Emphasise and teach relaxation and breathing. Pregnant women benefit particularly from a longer relaxation at the end of a class with plenty of cushions and props for support

4. POSTURES/ASANA

Consider the following in relation to specific postures/asana:

4:1 Focus on teaching narrower versions of the classical wide angle standing postures such as Trikonasana (Triangle), Virabhadrasana (Warrior) etc. These postures can over-stretch ligaments (particularly within the sacro-iliac (SI) joint), create a twisting of the knee joint, collapsing of the arch of the foot and do little to promote core stability (Blackaby 2008).

4:2 Take care when teaching side bending postures e.g Trikonasana (Triangle) which should be taught with caution as they can create a sheering force on the softened sacro-iliac joints and lumbar spine of pregnant women. Wide standing with feet parallel will offer some protection to the SI joints.

4:3 Recognise the difference between high and deep squatting (either on the balls of the feet or with heels down). In general, unless the woman finds squatting easy, deep squats should be supported (by partner) or practised using props (e.g. roll/blocks under heels/supported against a wall/sitting on a low stool/leaning forward on to support). Great attention should be taken to the position of the feet in relation to the knees to maintain alignment. In addition care should be taken in teaching how to come in and out of the pose to avoid excess loading on the knee joints, e.g. by rocking back and forth from all fours. Consideration also should be given to avoiding deep squatting under the following circumstances:

- History of premature labour
- Knee problems where hyperflexion is contraindicated
- Haemorrhoids
- Recent unexplained bleeding

- Baby is in the breech position in the last 6 weeks of pregnancy
- The woman feels very uncomfortable
- Pelvic Girdle Pain
- Placenta Praevia

4:4 Be aware that kneeling involves hyperflexion of the knee joint and hyperextension at the ankle. Pressure on the calves can aggravate varicose veins, and can also impede the venous return from the lower limbs leading to light headedness, particularly if blood pressure is low. So do not hold for too long.

4:5 Take care when teaching twists. Avoid strong twists as these can increase separation of the rectus sheath.

4:6 Avoid teaching full inversions e.g. Sirsasana (Headstand) and Vrikshasana (Handstand). However, a few women with a strong established Yoga practice, may like to continue these into the second trimester – perhaps close to a wall for reassurance. Partial inversions such as Adho Mukha Svanasana/Sumeru Asana (Dog Pose), and supported Vipareeta Karani Mudra (Half Shoulderstand) may be taught. Most women will appreciate some support of the lower back and hips e.g. using a wedge or cushions, when legs are up the wall to avoid lying flat on the back. This will help increase the angle at the hip which will further help to relieve congestion in the legs. Adho Mukha Svanasana/Sumeru Asana (Dog Pose) and knee chest pose can be used to encourage a baby in the breech position to turn. However, once head down, the mothers of these babies (usually from 37 weeks or so) no longer wish to practise these partial inversions in case the baby turns back again.

4:7 Avoid the more advanced backbends e.g Ustrasana/Ushtrasana (Full Camel) and Urdhva Dhanurasana/Chakrasana (Wheel), as they tend to create further compression of the lumbar spine and to over-stretch the abdominal muscles (Robin 2002). As an alternative, include postures that open the upper body but also release the psoas muscle, both of which are characteristics of a backbend, and beneficial to pregnant women e.g. Virabhadrasana I (Warrior I) and modified Eka Pada Rajakapotasana (Pigeon).

4:8 Note that postures that strongly tighten the abdominal muscles e.g. Navasana/Naukasana (Boat Pose), are contraindicated as these tend to further separate the rectus abdominis. Choose a flowing Cat sequence (Cakravakasana/Marjariasana) instead for abdominal and core stability.

4:9 Take particular care when teaching balances. Balancing postures in themselves promote strength, concentration and a deepening of internal focus. However, pregnant women tend to lose their balance more easily and feet may be swollen, arches less supportive etc. Practising close to a wall may be helpful.

4:10 When teaching Sethu Bandhasana/Dvipada Pitham (Bridge Pose), pelvic tilts, Apanasana (supine squat) or any posture that involves lying on the back, these can be continued for short periods after 28 weeks as long as the woman remains symptom free and the practice is not static (see 3:11) (Clapp 2007)

For Help, Support and Further Information Please Contact

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