Putting the pelvic floor first:

Pilates for clients with pelvic floor dysfunction

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Abstract

Many of us will experience pelvic floor problems during our life, such as incontinence, prolapse or pelvic pain. Women are more affected, with one in two women experiencing some symptoms in their lifetime. Pelvic floor dysfunction can have serious impacts on quality of life, through uncomfortable or painful symptoms and also through limiting the physical activity sufferers can safely perform.

Many common forms of exercise are unsafe for those with pelvic floor dysfunction. Pilates, with its awareness of the role of pelvic floor in movement, has the potential to benefit these people, complementing pelvic floor rehabilitation/management, and providing a safe outlet for movement. However, care must be taken to tailor individual programs and work with clients to prevent inadvertent worsening of their symptoms.

This paper explores guidelines for working with people at risk of or currently experiencing pelvic floor problems to help the instructor determine which exercises should be excluded, and how to modify or employ assists to avoid placing excessive strain on the pelvic floor. The paper details a case study of a new mother with mild pelvic organ prolapse and provides an example program for this intermediate-level client. It concludes that when instructed and practised with precaution, Pilates has the capacity to be an ideal form of movement for people living with pelvic floor dysfunction.
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The pelvic floor and floor dysfunction

**Figure 1: The pelvic floor as part of the core**

The pelvic floor is formed by deep and superficial muscles acting together as a hammock to support the pelvic organs. It works together with the other abdominal and back muscles to create intra-abdominal pressure, stabilising and supporting the spine.

Diagram: Continence Foundation of Australia 2013.

**Figure 2: Muscles of the pelvic floor (superior view)**

The musculature of the pelvic floor forms a sling-like structure that supports the pelvic organs, resists intra-abdominal pressure, and works as sphincters for the urethra, rectum, and vagina.

Diagram: Openstax College 2013.
Pelvic organ prolapse, a common symptom of pelvic floor dysfunction, can occur when there is a weakness in the support structure provided by the pelvic floor, allowing the pelvic viscera to descend and move through the weak point.

Common symptoms accompanying a prolapse include backache, abdominal pain, perineal pain, incontinence and "heaviness" or bulging in the vaginal area. Pain may be felt due to stretching of the ligamentous supports. In severe cases prolapsed tissues protruding from the introitus can abrade and cause pain. Symptoms may be relieved by lying down and exacerbated with prolonged standing, walking, coughing or straining.

Diagram: Merck 2008.
Introduction

Pelvic Floor Dysfunction (PFD) is very common, affecting up to one in two women (Physiopedia 2014). The term encompasses a range of conditions and symptoms, from urinary or bowel incontinence, to pelvic organ prolapse, to pelvic floor muscle overactivity (sometimes described as chronic tightness). Symptoms vary in severity, and it is possible to experience multiple symptoms at once.

Some exercise and daily activities can harm pelvic floor condition and worsen PFD. Contraindicated movement includes anything that worsens symptoms by straining an already-compromised pelvic floor. This includes high impact exercise (e.g. jogging, trampolining), exercises that create high intra-abdominal pressure (e.g. weight lifting, strong abdominal work), exercise that increases overuse of pelvic floor (contractions without sufficient release) and exercise that opens up the area and reduces support (e.g. weight-bearing exercises with a very open-legged stance) (Kenway 2009).

Pilates takes a special interest in the pelvic floor, particularly its role in core strength. Pilates professionals are thus ideally placed to tailor pelvic floor-safe programs for all clients, and in particular those experiencing or at risk of PFD.

This paper investigates how to develop pelvic floor-safe Pilates instruction, including:
- A brief outline of PFD,
- Groups of people at higher risk of having or developing PFD,
- General guidelines for working with these clients, and
- High risk Pilates exercises for PFD, and some modifications.

It uses the case study of an active 30 year old mother with PFD to illustrate how PFD can present in the studio, how to apply the guidelines for working with PFD clients, and benefits experienced by the client.

An overview of Pelvic Floor Dysfunction

PFD can occur when the pelvic floor becomes stretched, weakened or excessively tight (Pelvic Floor First, 2013). The term PFD encompasses many different symptoms, ranging from urinary or faecal incontinency to pelvic organ prolapse (see Box 1).

<table>
<thead>
<tr>
<th>Lower urinary tract</th>
<th>Bowel</th>
<th>Sexual function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinary incontinence</td>
<td>Obstructed defecation</td>
<td>Dyspareunia (painful sexual intercourse)</td>
</tr>
<tr>
<td>Urgency and frequency</td>
<td>Constipation</td>
<td>Orgasmic dysfunction</td>
</tr>
<tr>
<td>Slow or intermittent stream and straining</td>
<td>Faecal incontinence</td>
<td></td>
</tr>
<tr>
<td>Feeling of incomplete emptying</td>
<td>Bowel/rectal prolapse (“bowel prolapse”/“rectocele”)</td>
<td></td>
</tr>
<tr>
<td>Bladder/urethra prolapse (“cystocele”/“urethrocele”)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vagina</th>
<th>Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uterine prolapse</td>
<td>Chronic pelvic pain / Pelvic pain syndrome</td>
</tr>
</tbody>
</table>

Box 1: Symptoms of PFD (from Herbert, J. (2009))
PFD can be experienced as one or a combination of symptoms. For example it is possible to have experience both pelvic organ prolapse and chronic tightness causing pelvic pain.
PFD is very prevalent. At least 50 percent of American women will experience incontinency during their lives (Mayo Clinic, 2002 quoted in Berzuk 2007). Childbearing is a major risk factor: mothers are nearly three times more likely to leak urine than those who have never had a baby, and one in three women who’ve had a baby leak urine (The National Continence Program 2011). Other risk factors include ageing, overweight and high impact exercise (see Box 2).

**Box 2: Groups with higher risk of having or developing PFD (Continence Foundation of Australia 2011)**

- Women who’ve gone through a pregnancy, including those who have miscarried;
- Women mid- or post-menopause;
- Women who’ve undergone gynaecological surgery e.g. hysterectomy;
- Men who’ve undergone prostate cancer surgery;
- Women who are overweight (BMI > 25);
- Chronic coughing or sneezing (e.g. through asthma, hayfever, smoking); and
- Elite athletes practising high impact exercise (e.g. runners, gymnasts, trampolinists).

PFD can have a huge impact on quality of life. Imagine feeling your organs bulging out between your legs, worrying about leaking faeces out in public, or suffering from chronic pelvic pain that prevented intimacy.

For such a prevalent and serious range of conditions, PFD is rarely discussed. The first many people hear of it is when they experience symptoms themselves. Understandably, many people experiencing PFD hide their symptoms due to embarrassment, and some suffer from lowered self-esteem and anxiety (Lowder et al 2011). They may also feel trapped into inactivity through fear of worsening their condition, as many forms of exercise are contraindicated and even everyday activities can aggravate symptoms.

**Are your clients are experiencing, or at risk of PFD?**

PFD is different from other injuries in that clients may be reluctant to talk about their condition, or realise that they have a PFD. Ideally, all new female clients would be referred to a pelvic floor physiotherapist to assess pelvic floor strength and function prior to commencing a Pilates program. A responsible Pilates practitioner will also always recommend the client consult a pelvic floor physiotherapist if any signs of PFD are reported over time. The physiotherapist would check that clients contracting the pelvic floor correctly, as pelvic floor exercises are commonly performed incorrectly; Bump et al (1991) found not only that 50% of women could not contract the pelvic floor correctly after a brief verbal instruction, but half of these were instead doing things that could promote incontinence in future.

If an assessment is not possible, the instructor must identify PFD symptoms and risk during the initial assessment, and cue clients to contract their pelvic floors correctly. Screening questions could include asking about common indicators of a PFD (see Box 3), such as whether the client ever leaks urine when they sneeze/cough/laugh, or feels heaviness in the pelvic floor area. Clearly, this should be approached with sensitivity and tact.
Box 3: Common signs that can indicate a PFD (Continence Foundation of Australia 2011)

- accidentally leaking urine during exercise, laughter, coughing or sneezing
- needing to get to the toilet in a hurry or not making it there in time
- constantly needing to go to the toilet
- finding it difficult to empty the bladder or bowel
- accidentally losing control of the bladder or bowel
- a prolapse
  - in women, this may be felt as a bulge in the vagina or a feeling of heaviness, discomfort, pulling, dragging or dropping
  - in men, this may be felt as a bulge in the rectum or a feeling of needing to use their bowels but not actually needing to go
- pain in the pelvic area, or
- painful sex.

Not all incontinence issues are related to PFD, so it is important for clients experiencing these problems to see an incontinence specialist.

Guidelines for working with clients with PFD

Pilates and other forms of movement can contribute to pelvic floor problems in two ways; by overloading and stretching the muscles (through more downward pressure), or by creating too much pelvic floor tension without proper release of the muscles (Kenway 2011). However Pilates stands apart from many other guided exercises as given the attention to posture and the deep stabilisers of the core, the norm of small group sizes for equipment classes, the range of props and resistance setting available, and the ability of instructors to tailor sessions to the needs and capabilities of clients.

The guidelines in Box 4 have been compiled to help plan for pelvic floor safe Pilates programs.

Box 4: Planning for pelvic floor safe Pilates

- Refer clients who may be at risk of PFD or who reports any symptoms of PFD, including postpartum clients, to a pelvic floor specialist for assessment of pelvic floor function and strength. If dysfunction is present, gain client’s permission to discuss with their health professional.
- Start slowly and conservatively, adding new challenges gradually as clients gain strength (Kenway 2009) and as both you and the client gain confidence they can perform exercises safely.
- Tailor sessions to the capabilities of your client and err on the side of caution. In particular, avoid exercises that are higher impact (e.g. jumping), excessively load the pelvic floor (e.g. both legs in tabletop or Footwork with very high resistance), or require a wide/open stance (e.g. Hamstring Stretch Group) (Continence Foundation of Australia 2011, Kenway 2009). Modify stronger exercises to reduce pelvic floor load to safe levels.
- Monitor clients’ posture and help them become more aware of the postural changes they are striving towards, in particular the maintenance of a healthy lumbar curve and neutral pelvic position (Kenway 2009). Encourage clients to take this awareness into their daily activities.

Box continued over page
Box 4: Planning for pelvic floor safe Pilates continued

- Remind clients to regularly check they are maintaining pelvic floor tone whilst performing the exercise. If they lose control, feel their pelvic floor bulging down or their symptoms worsen during a session, they must stop immediately and be guided to an exercise that poses less challenge to pelvic floor (e.g. Pelvic Curls on the mat).
- If client’s symptoms worsen after an exercise or session, identify the exercise responsible and avoid or modify until strength increases.
- Modify sessions to reduce load when client is fatigued or tired (Kenway 2009).
- Schedule sessions for early in the day if possible, when the pelvic floor will not be as tired; this is more important for clients with prolapse.
- Always cue full relaxation of the pelvic floor after exercises to prevent chronic tightness from developing.
- Cue breathing, particularly exhalation on exertion and check clients are not excessively recruiting their rectus abdominis. This helps prevent ‘bearing down’ that can occur when effort is being made during a held breath and the generation of excessive intra-abdominal pressure (Kenway 2009).
- Remember that your client is a whole person and not just the owner of a pelvic floor! Ensure each session is sufficiently challenging and varied, and draw attention to progress so clients can feel improvements in their Pilates practice, even if their pelvic floor symptoms are not changing rapidly.

Whilst strong abdominal exercises are inappropriate, many exercises can be modified to reduce the pressure on or tension within the pelvic floor and make them safe for clients with PFD (refer to Table 1). Exercises with both legs raised in the air can be modified by raising only one leg at a time off the ground, or fully supporting both legs (e.g. on an exercise ball). Lower abdominal work by reducing the lever length (e.g. kneeling in Front Support rather than weight bearing through the feet) or adding a prop (e.g. Roll-ups using a Theraband stretched around the bottoms of the feet to reduce the abdominal effort to curl up from the mat).

Prudent exercise selection and modification needs to be coupled with good cueing to avoid breath holding and straining, and helping the client develop their awareness of where their own limits lie on that day. Clients should be cued to monitor their pelvic floor during exercises, ensuring they can maintain tone without losing it or feeling a downwards bulge. In addition, clients should be reminded to fully relax their pelvic floor, particularly after more intense abdominal exercises.

Instructors also need to emphasise and help clients work towards good posture, particularly achieving a healthy lumbar curve and neutral pelvic position where possible whilst performing exercises and loading the spine. An engaged lumbar multifidus – which requires a healthy lumbar curve - is essential for core stability (refer to Figure 1). If the multifidus is inhibited (e.g. by a flat or extended lumbar spine) it can also inhibit the activation of the pelvic floor (Sapsford et al 2007), leaving clients at risk of overloading and pelvic floor strain (Kennedy, 2014).

There is a broad spectrum of how much load someone with PFD can tolerate: clients with similar symptoms will have different thresholds for how much load their pelvic floors can take, and this may change for each client from day to day and over time. Be guided by feedback from your client and communication with their health professionals.
<table>
<thead>
<tr>
<th>Feature contributing to high load on the pelvic floor</th>
<th>Examples (not exhaustive)</th>
<th>Suggestions for modifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both legs and/or head lifted from floor</td>
<td>Hundred</td>
<td>Try standing rather than supine OR If can tolerate a chest lift, with one or both feet on floor/supported by a box</td>
</tr>
<tr>
<td></td>
<td>Double and Single Leg Stretch</td>
<td>Very strong. Double Leg Stretch can be lessened by supporting feet on exercise ball.</td>
</tr>
<tr>
<td></td>
<td>Teasers (all)</td>
<td>Very strong, avoid. Teaser 1 (Cadillac) can be modified by supporting feet/legs on Trapeze or an exercise ball</td>
</tr>
<tr>
<td></td>
<td>Arms Supine Series (Reformer)</td>
<td>Avoid as both legs in tabletop. Select alternative arms series.</td>
</tr>
<tr>
<td></td>
<td>Roll-up</td>
<td>Roll Up with RUB is the most suited; simulate on mat by stretching Theraband around bottoms of feet</td>
</tr>
<tr>
<td>Front support-type position</td>
<td>Front Support</td>
<td>Modify by keeping knees on ground.</td>
</tr>
<tr>
<td></td>
<td>Up Stretch Group excluding Up Stretch 1 and Elephant</td>
<td>Avoid, as these exercises contain front support position.</td>
</tr>
<tr>
<td>Wide legged stance</td>
<td>Footwork with wide stance e.g. Open V Heels and Toes</td>
<td>Stick to hip-width stance positions to begin; wider positions may be appropriate for some clients.</td>
</tr>
<tr>
<td></td>
<td>Hamstring Stretch Group</td>
<td>Very open stance. Choose alternate hamstring and hip flexor stretch (e.g. Ladder Barrel)</td>
</tr>
<tr>
<td></td>
<td>Side split</td>
<td>Avoid. If attempting, instruct client only to open legs to a narrow stance, and use high enough resistance to ensure client doesn’t feel they might slip into a full split.</td>
</tr>
<tr>
<td>Strong abdominal work</td>
<td>Short box series (most)</td>
<td>If introducing, keep movements very small and reduce levers with arms crossed over chest or hugging torso.</td>
</tr>
</tbody>
</table>

REMEMBER: Instruct client to relax the abdominal and pelvic floor muscles completely after having contracted them during a stronger abdominal exercise.
Case study: active 30 year old mother of one with mild-moderate prolapse

Age: 30

Occupation: Full-time mother of one child

Age of child: 21 months (still breastfeeding)

PFD symptoms:
Mild to moderate prolapse symptoms first experienced by client 6 weeks post-partum whilst carrying baby in a front-pack. Symptoms include heaviness and a feeling of bulging, local discomfort, and variable control over pelvic floor tone. These symptoms vary in severity from day to day, possibly linked to amount of child carrying and general fatigue/energy.

Diagnosis:
When and since the prolapse symptoms first occurred, the client has consulted doctors, pelvic floor physiotherapists and a gynaecologist for further diagnosis and advice without obtaining a clear diagnosis. Pelvic floor exercises were started under the guidance of a pelvic floor physiotherapist as a preventative measure during pregnancy. Client’s pelvic floor muscle attachments are all still intact post-birth and pelvic floor strength was recently rated at 4 out of 5 (very good). Possible factors in developing the prolapse could include stretching of ligaments supporting internal organs during the pregnancy, delivery of after the delivery. Another factor could be the hormonal balance due to breastfeeding creating greater laxity in tissues; specialists have suggested she may see a further slight improvement in prolapse symptoms after cessation of breastfeeding.

Management:
The client was advised to continue both pelvic floor muscle strengthening and relaxing, to continue low-impact exercise, and to stop any exercise or activity when pelvic floor control is lost and/or if symptoms worsen.

Needs of client:
The client’s occupation as a mother comes with high physical demands, and she spends extended periods carrying a child over 10 kilograms, often coupled with lifting, bending over and carrying other loads such as the shopping. The client is conscious of the need to improve lifting techniques, shoulder use, and improve symmetry (which is challenged by holding child on one hip for extended periods). She has little time for (child-free) exercise, but a high desire to exercise and feel like she’s looking after her body.

Previous Pilates experience:
The client took group equipment Pilates classes during her pregnancy, and has taken a combination of weekly group equipment classes and physio-Pilates sessions since then. She had also taken a weekly mat class post-partum, however she discontinued as it included very strong abdominal exercises where she was unable to engage the pelvic floor and the instructor was not able to cater to her PFD-limitations.

Physical assessment of the client:
The client is of a healthy BMI and moderately active. She shows a postural tendency towards flat lower back with hinging at lumbar-thoracic junction but is working towards awareness and maintenance of a healthy lumbar curve. The client has tight chest and neck muscles from holding/breastfeeding child.
The client cannot safely maintain legs in table top or extended on an angle (although strap work is usually fine) as she feels a downwards bulge and/or lack of control over the pelvic floor in these positions. Many strong abdominal exercises feel unsafe. She is developing her awareness of pelvic floor control, and confidence to stop or modify exercises when pelvic floor tone is flickery or absent.

Table 2: Session tailored to case study client

<table>
<thead>
<tr>
<th>Block</th>
<th>Exercise (&amp; equipment)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warm up</td>
<td>Roll down</td>
<td>Invite the client come into their body and leave other responsibilities behind.</td>
</tr>
<tr>
<td></td>
<td>Breathing (on roller)</td>
<td>Cue client to check in with pelvic floor and begin engaging, holding and relaxing with the exercises.</td>
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<tr>
<td></td>
<td>Pelvic tilts (on roller)</td>
<td>Encourage client to activate pelvic floor first in exercises and stop if lose control during an exercise.</td>
</tr>
<tr>
<td></td>
<td>Single leg lifts (on roller)</td>
<td>Watch client’s posture, ensuring they can achieve a healthy lumbar curve and correct asymmetry. Lying along foam roller opens chest, releasing tightened pectoral muscles.</td>
</tr>
<tr>
<td>Foot Work</td>
<td>Foot work (Wunda Chair)</td>
<td>Position client side on to a mirror to monitor and correct her own posture (e.g. hinging at lumbar-thoracic junction).</td>
</tr>
<tr>
<td>Abdominal Work</td>
<td>Chest lift (Step barrel)</td>
<td>Exercises counteract shortening and rounding through the chest. Challenge client to keep lower ribs from flaring, and to keep lower abdominal muscles cinching in the waist.</td>
</tr>
<tr>
<td></td>
<td>Overhead stretch (Step barrel)</td>
<td></td>
</tr>
<tr>
<td>Stretching</td>
<td>Shoulder stretch lying side (Step barrel)</td>
<td>Opens and mobilises chest and shoulder joint, to balance kyphotic tendency and shortening of pectorals and biceps.</td>
</tr>
<tr>
<td>Hip Work</td>
<td>Basic leg springs series (Cadillac)</td>
<td>Keep movements small at first; increase range of movement if pelvic floor control maintained. Watch pelvic-lumbar stability.</td>
</tr>
<tr>
<td></td>
<td>Frog</td>
<td></td>
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<tr>
<td></td>
<td>Down circles</td>
<td></td>
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<tr>
<td></td>
<td>Up circles</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Walking</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bicycles</td>
<td></td>
</tr>
<tr>
<td>Spinal articulation</td>
<td>Bottom lift (Reformer)</td>
<td>Safe spinal articulation exercise for client. Cue open chest, and returning to neutral spine with each repetition.</td>
</tr>
<tr>
<td></td>
<td>Bottom lift with extensions</td>
<td></td>
</tr>
<tr>
<td>FBI 1</td>
<td>Knee Stretch Group (Reformer)</td>
<td>Keep movement small at first, client can increase range if safe and can maintain lumbar stability.</td>
</tr>
<tr>
<td></td>
<td>Scooter</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Round back</td>
<td></td>
</tr>
<tr>
<td>Arms</td>
<td>Arms kneeling series (Reformer)</td>
<td>This series challenges the posture whilst working the upper girdle. Cue client to relax neck, and remind about the importance of posture during lifting. Check whether arms are internally rotated, as this is client’s tendency.</td>
</tr>
<tr>
<td></td>
<td>Chest expansion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Circles up</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Circles down</td>
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<tr>
<td></td>
<td>Triceps</td>
<td></td>
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<tr>
<td></td>
<td>Biceps</td>
<td></td>
</tr>
<tr>
<td>Additional FBI</td>
<td>Elephant (Reformer)</td>
<td>Focus on lengthening hamstrings. Ensure springs are heavy enough so the abdominal work of in-phase is not excessive.</td>
</tr>
<tr>
<td>Exercise Type</td>
<td>Exercise Description</td>
<td>Notes</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Additional legs</td>
<td>Single leg skating (Reformer)</td>
<td>Keep focus on maintaining posture in this exercise, as tendency is towards excessive lumbar extension.</td>
</tr>
<tr>
<td>Lateral flexion and rotation</td>
<td>Side stretch (Wunda chair)</td>
<td>Good for activating deep stabiliser muscles in back and stretching through side of trunk. Check pelvic floor can be maintained in extended position, and reduce lever length by crossing arms over chest if needed.</td>
</tr>
<tr>
<td>Back extension</td>
<td>Swan on floor (Wunda chair) (Rest position)</td>
<td>Prepare for this exercise by doing pelvic tilts on stomach first, to find neutral spine.</td>
</tr>
<tr>
<td>Warm down</td>
<td>Roll downs</td>
<td>Emphasise broad shoulders. Finish with some mindful breathing to help client take calm into the rest of her day.</td>
</tr>
</tbody>
</table>

Benefits felt by the client from Pilates practice:
The client feels that through her Pilates practice she is developing a greater awareness of her pelvic floor function and how it varies. This is directly applicable in everyday life, as the client feels more confident in judging what is ‘safe’ and what might worsen her PFD. The client is gaining awareness of the types of movements that generate greater loads on pelvic floor, and how she might modify them to avoid risk. This lowers her risk of worsening PFD through daily activities (e.g. lifting loads that are too heavy).

Another important benefit to the client is the contrast of being able to do Pilates and progress in her practice to the restricted, ‘I can’t do anything!’ feeling of no longer being able to do high-impact exercise like running or jumping.

This case study demonstrates that with careful planning and good communication it is possible to teach clients with pelvic floor dysfunction and that Pilates can form a valuable, valued part the lifestyle of clients with PFD.

Conclusion

Pilates is ideally placed as an exercise to benefit those with PFD, given its awareness of the role of the pelvic floor, its broad repertoire and an accompanying range of assists and modifications, and its low impact nature. However Pilates also has the potential to worsen symptoms of PFD, if it is performed or instructed incorrectly. All Pilates instructors need to be aware of risk factors predisposing their clients to PFD and common symptoms, to help them identify when clients may be experiencing or at risk of PFD.

Instructors also need to know how to design appropriate programs that ensure they do not overload clients’ pelvic floors or increase chronic tightness, and to monitor clients to ensure they perform exercises safely. Key within this is working with the client (and their pelvic floor health professional) to develop the awareness of pelvic-floor safe movement for their own body, and avoiding contraindicated movements beyond the capacity of the individual client.
Reference List


