

Scoops



The Newsletter of the Guild of Antenatal and Postnatal Exercise Instructors
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www.postnatalexercise.co.uk

AN & PN EXERCISE SHORT COURSE!

Firstly, thank you all for your support of the Guild and I am very glad to report that Guild membership has increased this year. We now have around one hundred members with over seventy-five listed on the web site. In fact, a number of people have joined specifically so that they can be listed on the website, as it is seen as the premier source to find a teacher qualified in pregnancy and/or postnatal exercise.

The study day on the pelvic floor given by Samantha Gillard was very successful and well attended, see the write up by Liesel Scrutton.

The Guild is offering a 4 day Antenatal Exercise Training Short Course and Postnatal Exercise Adaptations Short Course (3 or 4 day depending on whether you have already completed the theory day of the AN short course (see the enclosed flyer).

I hope to see all of you that are able to make it at the AGM which will be in at the study day on Sat 1st April at St Agnes Centre, North London. I am very pleased to report that Gillian Fletcher has agreed to act as Caretaker Chair as Marion Grant and Ruth Barrett are both retiring due to other commitments.

In the meantime, I trust you all enjoy

Christmas and have prosperous New Years!
MEG WALKER



Samantha Gillard explains the finer points of pelvic floor exercises to Sarah Allen and Liesel Scrutton.

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GUILD NEWS FROM MEG



The disappointment this year has been the fact that we were unable to run the antenatal exercise teacher training course, developed by Judy DiFiore and Gillian Fletcher. We had around 100 enquiries but when it came to the crunch only two applicants paid their deposit. This meant the course was not viable and had to be postponed. However, new dates are set 3rd & 4th June, 8th July and 16th September, subject to there being enough applicants who either want to upgrade their qualifications or keep up to date in the field of antenatal exercise. Dates are set for a 3 day course postnatal exercise course. **This is an ideal way to update existing PN teachers but also is designed for regular exercise to music teachers wishing to specialise in PNEX teaching.** We have made the decision

to are put on hold the full postnatal exercise teacher training course which was originally developed by Marion Grant and Gillian Fletcher designed for people who had never taught exercise to music before.

A sad note is that Marion Grant decided she had to step down as co-chair of the Guild because she is retiring from tutoring and her NCT work. She has been a key figure from the beginning; from our growth from the NCT into the Guild, supporting students in their journey through the courses and marked countless assignments along the way! Marion, Thank you for all your input over the years - you will certainly be missed.

We shall be looking for a new chair because Ruth Barrett is also planning to step down as co-chair of the Guild at the next AGM in 2006. This is due to a change in her career direction. She says "I'm considering teacher training, and have been working in a school since September 2005 as a teaching assistant". We shall be sorry to see you go Ruth, but in the meantime we have very much appreciated your support and input over the years.

On a more cheerful note, we had a really successful Pelvic floor Study day on 6th

November in Ascot. There were ten attendees and Samantha Gillard gave an enthusiastic session that was much enjoyed and very interesting.

Tricia Liggett will be presenting a Posture and PNEX study day on Sunday 22nd January 2006 specially designed for Guild members in Cricklewood, North London. . Early bird cut off date 31 December 2005.KEEP UP YOUR CPD.

The Guild AGM is 1st April to coincide with the next study day 'Inside Out' - a workout for new mothers with the baby in tow (literally).

If any of you would like to volunteer to be Chair of the Guild or would like to know a little more do contact me. I should be very happy to discuss it with you.

In the meantime I wish you all a happy Christmas and prosperous New Year.

megwalker@pnex.freeserve.co.uk

PS Do read the article by Moira Clarke on pages 6 & 7. it is an authoritative piece of work and summarises much research. It is to be published in two instalments, part 2 next issue . The full article is published on the Guild website if you would like to read it now!

PELVIC FLOOR STUDY DAY REVIEW

The weather may have been bleak outside but the atmosphere inside was nothing short of energetic and informal.

With this being my first attendance of a Guild study day I was particularly enthusiastic about meeting other trainers who were a mixture of midwives, pilates and aerobic instructors, exercise specialists and an obstetrician. It was fantastic to share experiences both professionally and personally relevant to PFM.



Serious concentration!

My expectations of the course were to bring my knowledge base up to date, to seek inspiration on how to re-invent the instruction of PFM exercises, its' location and to feel I was going to leave the day having gained some invaluable tools and information to pass on. Lastly to gain a perspective of how PFM education is reinforced in the wider scheme of the NHS, or not due as became painfully apparent to us due to tight resources and funding. This is where people like post natal/

specialist trainers can play a key role in bridging this shortfall.

Samantha Gillard led the day, beginning with a questionnaire to test our knowledge of PFM before going into supportive, clinical research for doing PFM exercises regularly. What shocked us the most was the statistics for incontinence were significantly higher than previously realized and that there were so many types. The psychological negativity associated with incontinence was also addressed and it's our responsibility to ensure people are not ashamed to admit and talk about it.

The afternoon focused predominantly on the ante/post natal populations as usually only then does a woman become aware of her PFM when it's overloaded with the internal pressures of pregnancy. In conjunction with targeting this muscle the TVA also can be trained in synergy, therefore significantly reducing the incidents of incontinence. Having given birth earlier this year I'm more passionate than ever in effectively educating women and men in the, 'use it or lose it.'

The afternoon enabled us to utilize the Biofeedback assessment with an electrode which measured both the strength and activation time of the muscle which was particularly informative. A useful tool to motivate and encourage women to work the

PFM. It provided us with a cause to smile so De Smit Medical Ltd may be inundated with orders!!!

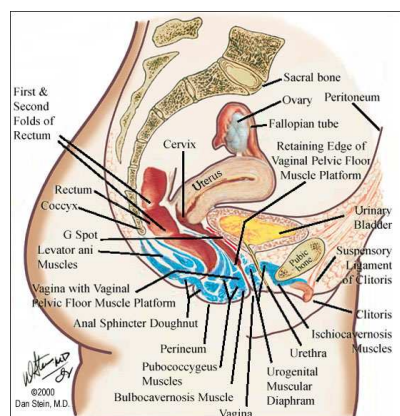
Practical components also covered tools to aid the location, optimal positioning and assessment of the PFM. The only criticism would be some felt there could have been more time allocated to exploring these to their full



Sue Deakin and Lynn Mayo trying out their teaching skills on a willing volunteer!

potential and more alternatives explored.

Overall the day completely exceeded all my expectations thanks to Samantha's expertise and deliverance, enhanced by Meg's organization of the day. I can't wait for the next study day as having come away empowered and on a mission to share my new found tools.



Snippets From the E-Group. Would you like to join in?



On the nature of the e-group.

The facility was set up to enable open discussion between Guild Members as well as providing a means of communicating study days and other relevant information to Guild Members. From a personal point of view I have found the flow of information regarding relevant courses, conferences and lectures useful.

However, I am wondering whether it is necessarily appropriate use of group mail to give what is effectively free advertising for commercially run training courses, as opposed to using this medium for information and questions of interest to our group?

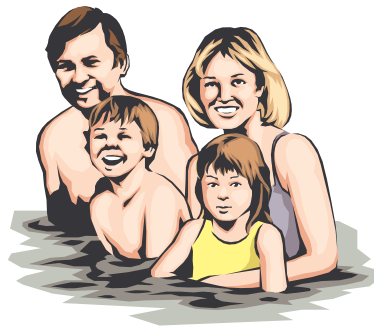
On aquanatal training courses:

1. You may want to look at Birthlight training courses. They run Aquayoga courses, amongst others. The

website is www.birthlight.com. If nothing else, it's an interesting website.

2. The best courses are from aquafusion that run courses for instructors and midwives - and they are acknowledged as professional development days for the NHS. The Speedo course isn't specifically aquanatal but to incorporate pre and post natal clients into your mainstream aqua courses. For aquafusion - contact Northern fitness and education (director Christine North)

I am a trainee tutor for aquafusion (aquanatal stage 1 for midwives) - I am not biased - I have been on Steph Toogood's 2 day course and it is good but as mentioned it only incorporates pre natal clients into mainstream classes as opposed to setting up



specific pre natal classes.

On C-sections:

A client experienced a sharp pulling sensation at both ends of her scar when attempting a half roll-back. Any ideas?

Adhesions of tissue layers are the most likely cause, they can cause some discomfort for many years for some patients

post-operatively. Some times the scar tissue can become quite tight, and scar tissue massage may be helpful - physiotherapists are the best people to speak to about this.

On femoral (groin) hernias:

Is AnteNatal Pilates OK for this client?

1. The British Hernia Centre say that this type of activity is unlikely to cause a problem, unless there is pain. Femoral hernias are rare but more common in elderly or obese women who have given birth several times

2. I can only think of it being a problem if too much Intra Abdominal Pressure but this shouldn't be a problem with pregnancy modified Pilates class.

On the post natal check and exercise:

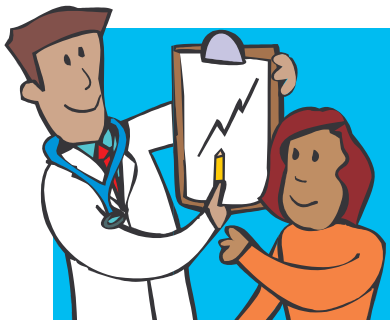
Can we accept clients before their postnatal check?

Although I'm pretty certain that the PN check is not a condition of insurance, we could be open to the accusation of negligence from the duty of care if a mum does not have this done before joining a class for which the instructor is responsible.

In my area the PN check is a pretty cursory affair. I frequently pick up problems with abdominal muscles,

caesarean scars and pelvic floors and have, in the last 4 years, referred 3 mothers for a blood pressure check by the GP resulting in those mothers being placed on medication - all after the so called PN check. It is rare for a GP to check for diastasis recti or ask about the pelvic floor.

I carry on insisting that mothers have had their PN check before joining my classes or seeing me in the gym at the Health Club, because I do not want to leave myself open to the accusation of negligence.



Waiting for the PN check also has the advantage of making sure that mothers wait a decent interval before starting to exercise formally. In my experience they need that time and especially after a C section (22% of mums in this area), just to let everything settle down, including breastfeeding. The PN check is a handy way of making mums wait a little - no bad thing. There is also the slight/rare risk of embolism or SPPH before the placental site has healed completely - this can take several weeks.

On thrombosis in a

previous pregnancy:

I am a midwife as well as a pre/ post natal instructor - from an exercise point of view shouldn't pose a problem - in fact if they are participating in gentle exercise this will help their circulation and be quite proactive and preventative if they have had a thrombosis previously.

From a pregnancy point of view they will more than likely/ should be under care of a consultant and local DVT clinic and on daily anti - coagulation injections, this is worth checking out that she is under appropriate professionals and for your safety in teaching maybe liaising with your local DVT clinic for advice. If it was a pulmonary embolism - she should aware of symptoms such as chest pain/ back pain and breathlessness and seek urgent advice.

The main complication is with any trauma/ bleeding or at birth with increase risk of haemorrhage which is carefully monitored in labour and birth (due to anticoagulant).

On exercise in first trimester:

No research suggests 1st trimester exercise can cause miscarriage - that is one of those old wives tales - dehydration can occur really easily though, due to the fact that thermoregulation changes and women will sweat a lot more so we need to keep reinforcing about good

hydration. This is nature's way of trying to keep internal core temperature down. The hormone relaxin peaks at 12 weeks so I wouldn't increase stretches - maintenance stretches only, and avoid sudden changes in direction that may potentially damage ligaments.

What could potentially be harmful is prolonged high



intensity exercise - this is thought of, in James Clapps studies as 60 - 90 minutes.

EDITOR'S NOTE:

Many thanks to Gill Tavner for submitting the above extracts.

JOIN THE EGROUP

If you would like to join the e-group, the procedure is this:- email Meg on megwalker@pnex.freemove.co.uk and she will contact Karen Boom who will place you on the egroup.

LOOK OUT FOR

The December issue of MIDIRS - The Midwifery Digest—Moiria Clark has an article published on post caesarean exercise.

The Continence Foundation
307 Hatton Square, 16
Baldwins Gardens, London
EC1N 7RJ Tel 020 7404 6875
HELPLINE 0845 345 0165

Group Resistance Training in Pregnancy

Part 1 – Considerations and Benefits

The aim of this article is to present group resistance training as one possible method of exercise in pregnancy for **normal, healthy women with no medical conditions experiencing a normal, health pregnancy with no problems or discomfort.**

Formal, structured exercise is now a common part of many people's lives. Normal, healthy adult women who are already regularly exercising may, naturally, wish to continue their usual activities when they become pregnant. Some women may only think about exercise after becoming pregnant in an effort to control their weight gain, or to "be fit" for labour and birth. Some women stop all forms of activity completely, or at least for the first few months when they may feel nauseous and/or very tired.

Myth and anecdote about exercise in pregnancy are very common and up until relatively recently, research has been limited.

General benefits of exercise in pregnancy can include improved postural and body awareness, strengthening of specific muscle groups, reduction of fatigue, fewer discomforts and problems with weight control, enhanced physiological wellbeing, reduction of stress and anxiety, improved confidence and encouragement of social interaction. A study published in 2002 on 98 pregnant women participating in a structured antenatal aerobic type class concluded that "women who participated in regular physical activity tended to have protection against reduction of psychological well-being" as well as "no indication of any risk to the pregnancy or the baby". James F. Clapp states that "**Regular, sustained, weight bearing exercise is the best type of exercise for pregnant women... however the proper frequency, duration and intensity will vary from woman to woman**". The benefits of regular physical activity are many and varied, however exercise prescription in pregnancy

is very individual and it is possible that some benefits, especially psychological ones, may come from regular contact with other pregnant women in a properly structured pregnancy exercise class.

It is common to hear the suggestion that women should avoid exercise for the first 12 to 16 weeks of pregnancy as this period is thought to be the most vulnerable. Brayshaw¹ suggests that women should be at least 16 weeks gestation before beginning to exercise. This is also the time when many women feel nauseous and tired, although there is anecdotal evidence that some women find activity helps alleviate this. There is also a general belief that pregnancy is not a time to start a new physical activity. James F. Clapp's research³ has shown that "there is no evidence ...that healthy women need to change their exercise habits... during early pregnancy." "**Beginning an exercise programme at this time is unstudied, but it appears that it should be safe as long as the duration of each session is limited to 20 to 30 minutes**".

Resistance training classes consist of weight bearing, sustained activity and therefore may offer one type of activity thought to be beneficial in pregnancy. Women who were already participating in and enjoying classes may wish to continue when they become pregnant; others may want to start for the first time. For any resistance training instructor asked to agree that a pregnant woman continue, or start participating in, a class, general considerations should include awareness that:

- The individual concerned may not have been individually screened for general health, medical history and pregnancy in particular. There may be issues or potential problems that are relevant but not disclosed. Even there is disclosure, is the instructor competent, experienced and knowledgeable enough to realize the relevance and potential risk involved and adapt accordingly?

- It is sometimes suggested

that a pregnant woman obtain her doctor's consent before participating in an exercise class. It is as well to be aware that usually a midwife will be the main health care provider in pregnancy and therefore it may be more appropriate to ask for the midwife's written consent. However, midwifery knowledge and experience of exercise in pregnancy may vary considerably and it may be debatable as to how useful this permission is in practical terms.

- **Professional instructor liability insurance may not cover instructors to teach special populations for which they have not been specifically trained. Some insurance policies do not cover pregnancy at all.**

- Women may need to be asked to consider whether continuing participation during the first 12/16 weeks of pregnancy is right for them, and, for complete beginners, whether resistance training is the best choice of activity in terms of type, intensity and duration for them as an individual.

- The A.C.P.W.H. have stated that the legal position on advice on exercise in pregnancy may be unclear and that "liability might be based on negligence, where lack of appropriate advice prevented the woman from making an informed decision about exercising"

Research into resistance training in pregnancy is limited. Clapp's research mainly relates to cardiovascular training, so for the purposes of relating to resistance training his conclusions can only be used in general terms.

A.C.O.G. guidelines for exercise during pregnancy state that "pregnant women are encouraged to engage in 30 minutes or more of moderate exercise on most, if not all days of the week" and that "participation in a wide range of recreational activities appears to be safe".

S.O.G.C guidelines detail studies into strength training exercise programmes which have shown no adverse results in terms of

pregnancy loss or outcome and recommends that "all women without contra-indication should be encouraged to participate in aerobic and strength conditioning exercises as part of a healthy lifestyle." **However, this is limited by the recommendation that the chosen activity should be in 30 minute sessions up to 4 times per week. The issue of session duration relates to individual capabilities and the possibility of hypoglycaemia. Pregnant women experience a progressive increase in insulin resistance to ensure that maternal blood glucose circulates for longer to ensure adequate glucose absorption by the baby. In pregnancy regular food intake and hydration are vital.**

A further S.O.G.C. recommendation is that "women should choose activities that will minimize loss of balance and foetal trauma". As pregnancy progresses the maternal shape changes, weight increases and the centre of gravity shifts forward. The pelvis will commonly tilt anteriorly, increasing lumbar lordosis and the sacrum may tilt forward within the pelvis at the sacroiliac joints. This may place additional load on the lumbar spine. As the uterus grows and rises out of the pelvis there is additional loading on ligaments which are relaxed under the influence of the hormone relaxin. If, in addition the deep trunk stabilizing muscles Transversus Abdominis, Multifidus and the Pelvic Floor are weak they will not be able to cope with the additional demand placed upon them and this may result in pelvic and back instability and pain. Lumbar and/or sacroiliac pain may be felt from early on in pregnancy, possibly due to hormonal changes relaxing ligaments in the pelvis rather than necessarily changes in pelvic alignment. The effects of relaxing hormones (principally relaxin) may not be solely confined to laxity of the pelvis and it is common to also see ankle, knee and shoulder misalignment and instability. A wider pelvis may result in an increased Q angle (hip/femur/knee) affecting the knee joint. Heavier breasts

and altered posture may result in thoracic kyphosis and shoulder girdle instability, especially if shoulder stabilizing muscles (rotator cuff and possibly lower trapezius) are weak or have poor recruitment. All these changes combined with an inability to see the feet late in pregnancy can result in clumsiness and loss of balance.

Both A.C.O.G. and S.O.G.C. recommend that women should not exercise in the supine position after the first trimester (approx 14 weeks) and 16 weeks respectively. It is thought that the increasing weight of the baby may compress the inferior vena cava, thus impeding blood flow and resulting in loss of blood pressure. This is called supine hypotensive syndrome. There is some debate over this subject and the possible consequences for mother and baby. Hammer, Perkins and Parr suggest a prudent guideline of 1 minute or less. Clapp suggested that the supine position may be possible if the lower limbs are moving and A.C.E. suggest "short periods of time (60 to 90 seconds) interspersed with exercises performed in a side lying position" However, some midwives advise their clients to avoid the supine position, even when sleeping, and advice from a medically trained professional should not be contradicted. In practice some women find that the supine position is not a problem, whereas some feel uncomfortable or even very unwell. Possible problems from pressure of additional weight on the vulnerable sacroiliac joints should also not be disregarded, nor should the difficulties of transition from the supine position to sitting or standing in a heavily pregnant state.

A.C.O.G. adds that women should avoid standing motionless for too long. The hormone progesterone relaxes the blood vessel walls to accommodate an increased volume of blood. This reduced vascular resistance commonly results in reduced venous return and blood pooling in the lower extremities, and pregnant women can feel dizzy or faint if asked to stand motionless, or rapidly change position from lying or

sitting to standing. This is called postural hypotensive syndrome.

Specific benefits Resistance Training in pregnancy may include:

Strength development of muscle groups used in performing functional activities such as lifting, carrying, walking and climbing stairs.

Strength development, or at least prevention of disuse atrophy, of muscle groups used to assist, maintain and improve posture and stability of pelvis, spine, shoulders knees and ankles.

Improved circulation and endurance by using low resistance with higher repetitions (the usual suggestion in pregnancy) adding an element of weight bearing cardiovascular training.

Improved endurance and strength of muscle groups used to adopt active positions during labour and birth.

Improved body awareness and feeling of confidence as strength does not diminish.

In the past there has been a school of thought that resistance training is not suitable in pregnancy for those new to exercise, and that for experienced participants it is preferable to train on machines rather than with free weights, and one to one rather than in a group situation. However it should not be forgotten that pregnancy is, per se, a form of progressive resistance training and that there may be important psychological and motivational benefits to training in a peer group.

Potential Risks of resistance training in pregnancy:

Over balancing, falling, trauma to abdomen

Tripping over obstacles or equipment due to reduced vision by anterior bulk, and altered centre of gravity.

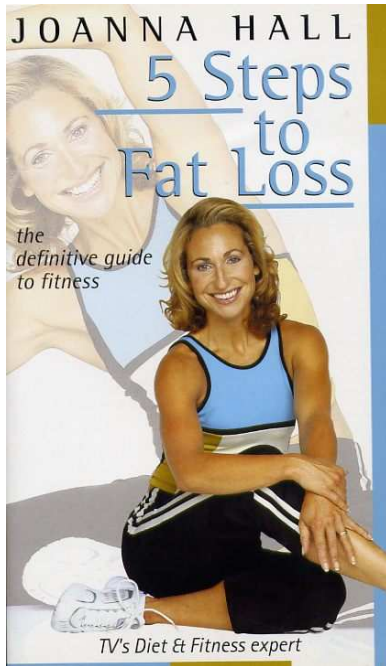
Injury due to vulnerability of joints and soft tissue.

Fainting from prolonged standing, inadequate nutrition or hydration, rapid change of position.

Increasing pelvic instability resulting in low back problems.

Joint misalignment – resulting

5 Steps to Fat Loss by Joanna Hall



Price £11.95 Also used copies available on Amazon for £0.90! This is not a new video, produced in 2001, and it is not a pregnancy or PN video either, but the teaching techniques that Joanna Hall demonstrates and her ideas for good body alignment, especially in the aerobic component are useful and worthy of a good quality postnatal exercise routine. She uses the idea of lights shining from strategic parts of the body, which remain constant whilst you are working and so help to keep the body in good posture. It is for this reason that I am reviewing it for the Guild because as a teacher it is useful to dip into videos for ideas and revitalization. At the beginning Joanna spends 10 minutes on motivation. She introduces two companions, Emma who offers a 'beginner'

adaptation (in the cardio section with arms mostly on the hips) and the other, Mairi, showing an 'advanced' option including impact work - Joanna herself takes a middle course and often breaks off to find out how the others are doing. She is giving teaching points almost constantly and her motivational work is helpful.

She demonstrates Emma and Mairi's fat loss in terms of blocks of lard and it is presented in a way to show that weight loss should and does take time - through increased level of exercise and healthier plus slightly reduced level of eating. Emma had a baby 2 years before the video was filmed.

Step 1 is a Postural Body Warm up, done at a pace which should enable the average newcomer to get good alignment and it promotes body awareness.

Before starting **Step 2**, Joanna suggests new participants look at the 20 minutes section before they actually do the workout. She introduces the concept of 'extra effort' which is a 1 minute section at a slightly harder intensity, and this is repeated every two minutes. Most of the moves she uses are compatible with postnatal exercise, although I would suggest that mothers up to five months postnatal should take all the low impact moves offered, so keep the eyes on Emma rather than Mairi and be extra careful on the 'repeater' knee lift, for very good quality technique is needed here.

Step 3 is the Chair Workout, Nice ideas and good technique but use of the transversus muscle could be explained.

Step 4

I was disappointed to see that Emma's tummy domed during the abdominal work and when Mairi & Joanna came into table top knees the transition was not outlined in preparation for a challenging toe tap exercise.

Step 5

The lying hamstring stretch is performed with a bent knee, and 'rolling like a ball' is used as a transition without any previous teaching or outline of technique, so uncharacteristic of the rest of the video. Otherwise a useful, high quality, motivational video. MW

DON'T FORGET DATES FOR YOUR DIARY:-

Posture & PNEX Sunday 22nd January 2006 with Tricia Liggett—North London easy access M1 Junction 1.

Inside Out—an exercise programme for new mothers with their baby in tow Saturday 1st April 2006 with Judy DiFiore, Sol Fluge Faull, and others—North London

Inside Out—repeat of above in the West Country—Stroud M5 easy access Sat 13th May

Teaching Pregnancy Exercise—4 day course 3rd & 4th June, 8th July and 16th Sept- North London

Teaching Postnatal Exercise—3 or 4 day course 17th Sept (theory), 14th & 15th Oct and 2nd Dec—North London. Great chance to refresh your teaching!