Yoga for Women With Hyperkyphosis: Results of a Pilot Study

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The thoracic region of the spine is normally kyphotic, or anteriorly concave. Hyperkyphosis, colloquially called “dowager’s hump,” refers to excessive kyphotic curvature; however, there is no criterion standard, nor are there any outcome-based definitions of the condition. A kyphosis angle ≥ 40°—the 95th percentile value for young adults—is currently used to define hyperkyphosis.12

Hyperkyphosis may be associated with physical and emotional limitations3–11 and may have multiple precipitants.4,12–14 Yoga could be an optimal intervention for hyperkyphosis in that it may improve physical and emotional functioning as well as combat some of the underlying muscular and biomechanical causes. We conducted a single-arm, non-masked intervention trial to assess the effects on anthropometric and physical function of yoga among women with hyperkyphosis.

METHODS

To be included in the study, which was conducted in Los Angeles during September 2000 to September 2001, women had to meet the following criteria: presence of physician-diagnosed hyperkyphosis, age 60 years or older, absence of angina and uncontrolled lung disease, cleared for participation by primary care physician, and able to pass physical safety tests (e.g., able to rise from the floor to a standing position safely and independently). The intervention involved hatha yoga, a type of yoga incorporating a combination of breathing and movement.

As a means of ensuring the safety of the participants, the study took place in a closely monitored environment involving one-on-one supervision and hands-on adjustments and corrections. The women were divided into 2 separate small classes (n = 11 and n = 10), each of which involved 12 weeks of yoga consisting of twice-weekly 1-hour sessions.

The program included 4 series of poses modified from the classical forms of yoga to accommodate the physical constraints of kyphotic women. More challenging poses were introduced every 3 weeks, and muscles and joints particularly affected by hyperkyphosis (shoulders, spinal erectors, abdominals, neck) were targeted. Figure 1 briefly summarizes the 4 series and illustrates an example of 1 pose from each.

Anthropometric outcomes, assessed at baseline and follow-up by 1 of the investigators (A.M.) by means of standard protocols, were (1) height without shoes (measured with a stadiometer), (2) distance from tragus to wall (a measure of forward curvature), and (3) Debrunner kyphometer angle (an estimate of degree of thoracic spinal curvature; higher values indicate more curvature).15 At baseline, this investigator performed same-day repeated measurements of each anthropometric characteristic for 6 of the participants. Intraclass correlation coefficients were .98, .61, and .34, respectively.

Timed physical performance measures were chair stands (standing up and sitting down, with arms folded across chest, using an armless chair),16 functional reach,17 the “penny test” (picking up a penny from the floor),18 the “book test” (placing a book on a high shelf),18 and an 8-ft (2.4-m) walk.19 At baseline, all participants underwent spinal radiographs; radiographs were read by a skeletal radiologist.20

We used pretest–posttest scores to compute changes in each anthropometric and performance outcome. Because our sample size...
was small, we computed mean change scores (matched t tests) as well as median scores (Wilcoxon tests). We also conducted analyses that stratified by presence or absence of vertebral fracture (n = 12 women) and by yoga class. Results were not substantively different; thus, we present pooled results.

Participants completed daily diaries that were independently coded by 2 of the researchers. In making entries in their diaries, the women provided responses to semistructured questions and added comments regarding the program. We conducted content analyses of diary entries.\(^\text{21}\)

**RESULTS**

At baseline, the mean age of the 21 participants was 75.0 years (range: 63.3–86.0 years). Mean height and mean weight were 156.9 cm and 61.5 kg, respectively. Nine women (43%) had no thoracic or lumbar vertebral fracture, 7 (33%) had at least 1 thoracic fracture (median = 2), and 5 (24%) had both thoracic and lumbar fractures (all of the women with lumbar fractures had at least 1 thoracic fracture).

Nineteen women (90%) completed the study; losses were due to unrelated medical problems. Among those who completed the study, session attendance averaged 80% (range: 52%–96%), and the daily diary completion rate was 100%. There were no adverse events.

Measured height increased and distance from tragus to wall diminished; no changes in
TABLE 1—Baseline and Follow-Up Physical Characteristics and Physical Performance Measures

<table>
<thead>
<tr>
<th>Physical characteristic</th>
<th>Baseline Mean Value</th>
<th>Follow-Up Mean Value</th>
<th>Mean Change</th>
<th>t</th>
<th>Median Change</th>
<th>Wilcoxon test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height, cm</td>
<td>156.28</td>
<td>156.81</td>
<td>0.52</td>
<td>0.039</td>
<td>0.30</td>
<td>0.056</td>
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<tr>
<td>Tragus to wall, cm</td>
<td>17.43</td>
<td>15.41</td>
<td>-2.02</td>
<td>0.000</td>
<td>-2.00</td>
<td>0.001</td>
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<tr>
<td>Kyphometer angle, degree</td>
<td>60.89</td>
<td>59.79</td>
<td>-1.11</td>
<td>0.748</td>
<td>-2.00</td>
<td>0.111</td>
</tr>
</tbody>
</table>

| Physical performance    |                     |                      |             |    |               |               |
| Chair stand, s          | 16.54               | 15.23                | -1.317      | 0.034 | -1.32 | 0.033 |
| Penny test, s           | 2.78                | 2.47                 | -0.350      | 0.037 | -0.46 | 0.039 |
| Functional reach, cm    | 28.23               | 33.09                | 4.863       | 0.002 | 5.60  | 0.005 |
| Book test, s            | 3.24                | 2.87                 | -0.345      | 0.129 | -0.52 | 0.102 |
| 8-ft walk, s            | 2.60                | 2.38                 | -0.222      | 0.116 | -0.21 | 0.073 |

Note. Five participants were missing data on one test each; results were unaltered when the analysis excluded these 5 individuals.

kyphometer angle were apparent. Improvements were evident in the case of timed chair stands (faster), the penny test (faster), and functional reach (longer) (Table 1).

In terms of diary entries, 63% of the women reported increased postural awareness/improvement (e.g., “I feel I am standing straighter; because I’m more aware of my posture the more I do yoga, the more I remember to stand and sit correctly” and “I still bend over, but I am catching it more often”), 63% reported improved well-being (e.g., “nonfracture” hyperkyphosis include poor posture and muscular weakness, factors targeted by the yoga intervention.44

The present intervention was not randomized, and investigators assessing outcomes were aware of the study hypotheses, limitations that must be acknowledged. Nonetheless, this pilot study suggests that the use of yoga among women with hyperkyphosis is safe and acceptable and may produce better posture. The mechanisms by which postural improvements occurred among our participants may have included increased strength and flexibility (attested to by improvements in physical function measures) and heightened attention to alignment (as reflected in women’s diary entries). The contemplative state encouraged by yoga’s mind–body approach may also lead to enhanced well-being,22 a benefit noted by the majority of our participants.

DISCUSSION

Some clinicians perceive hyperkyphosis as the irreversible product of vertebral fractures, leading to greater anterior convexity. However, in 1 study involving 500 participants, only 42% of variance in kyphosis was explained by vertebral wedging.13 Similarly, another study showed that only 50% of 132 women with hyperkyphosis had vertebral fractures,4 about the same percentage as in the present pilot study. Postulated causes of hyperkyphosis include poor posture and muscular weakness, factors targeted by the yoga intervention.44

Acknowledgments

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Human Participant Protection

Ethical clearance for the study was obtained from the institutional review board of the University of California, Los Angeles.

References

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