

As part of the client education, I would include addressing sitting in cars and other places where one is "forced" to sit. One can always do active sitting, sit on the edge of a chair, practice bracing, practice pelvic floor exercises, practice scapula retraction (and depression), seated (tall-sitting) marches, chair stretches, and etc. There are a host of things that even while seated, one may do (I am naturally squirrely in a chair).

Sleeping posture is important as one spends considerable time sleeping, as you mentioned.

General recommendations: The pseudo-myth

Sleeping on one's side is most recommended, with legs up a little (do not overdo) towards one's chest, and with a pillow between one's legs; also, avoid sleeping on one's arms in such a way as to cut off circulation or place the shoulder in an impingement position (ACA, 2011; DCC, n.d.; UCLA Ergonomics, n.d.). Also use pillows to maintain the normal curvature of the neck (ACA, 2011; DCC, n.d.; UCLA Ergonomics, n.d.). The idea is to try maintain a neutral spinal alignment.

ACA (2011), DCC (n.d.), and UCLA Ergonomics (n.d.) recommend side sleeping as the best way to reduce back pain. However, one may sleep on one's back, but one should try a small towel roll under the neck and a pillow under the knees to promote neutral spinal alignment.

Normand et al. (2005) noted that while positional sleeping techniques help, the mattress is equally important to consider. Body support provided by the mattress is a key contribution to being able to maintain good spinal posture. If the mattress is too soft, even the side-lying body position will do no good as the hip and shoulder will sink into the mattress, creating a lateral bend (spinal) away from the mattress; if the mattress is too firm, then the opposite happens (convexity) (Normand et al., 2005). In supine position with legs in neutral, Normand et al. (2005) noted that the psoas' tendency to pull promoted lumbar loading (increased lordosis). With a firm mattress, force is distributed to the pelvis and lower thoracic region, leaving the lumbar area less supported with increased shear and compressive forces (Normand et al., 2005). Normand et al. (2005) found that a lumbar support (little adjustable air-filled cushion) placed around L3 was beneficial in distributing forces more evenly for the individuals in their study.

The truth is...

Among all the "recommendations" and "research", the truth is: "It depends" (McGill, 2015, p. 151). Seeing as the spine runs from your "head to toe", it really depends.

Everybody has a different issue with a different "pain-free" or "less pain" positional solution. It depends on one's culture; it depends how one has slept from the time they were a child to the age they are now. It depends on all the other biomechanical considerations for that unique individual. There really is no "this is the position you should sleep in" recommendation, just as there is no "this is the best exercise" and no "best nutrition plan" (even for one individual, one's nutritional needs will change throughout every stage/milestone of one's life which could be 2 weeks away or 2 yrs away).

Gray Cook stated, "You got to do what the body needs" (Cook & FMS, 2007); and the needs of the body are dynamically driven. Cook also stated, "You deem an exercise functional by what it produces, not by what it looks like" (Cook & FMS, 2007). So, while there is the tendency to target "the core" with what looks to be "core" exercises, the author believes that taking a step back to get a bigger picture of the situation will aid in determining the most effective corrective exercise programming for a client at a specific point in time--which may or may not include the "obvious" "core-looking" exercises (McGill, 2010). Sleep positioning follows the same logic. Everything has a time and place that is more/less appropriate for each unique individual.

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