

Perceptions, acceptability and experiences of yoga to support long-COVID: a survey of people living with long-COVID

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Title page**Perceptions, acceptability and experiences of yoga to support long-COVID: A survey of people living with long-COVID****Anna Cheshire***

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Perceptions, acceptability and experiences of yoga to support long-COVID: A survey of people living with long-COVID**Abstract****Background**

The impact of long-COVID can be substantial for individuals, health systems and the economy, nevertheless, treatment and support options are limited. Yoga offers a potential solution to reduce the burden of long-COVID, demonstrating positive impacts on the biological mechanisms implicated in long-COVID, key long-COVID symptoms and associated mental health challenges. Yoga interventions can also be designed for people with limited physical ability, and online delivery can increase accessibility.

Aim

To understand the perceptions and experiences of yoga among people with long-COVID, and assess its potential benefits.

Methods

An online survey of PWLC, comprised closed and open response questions on: long-COVID symptoms, support needs, perceptions of a yoga intervention and its components, and yoga use. Participants

(n=171) were recruited via Prolific. Inclusion criteria were long-COVID (formal diagnosis or self-reported) and living in the UK. Inductive thematic analysis was used for open ended responses.

Results

We identified unmet needs among PWLC that align with the potential benefits of a yoga intervention, particularly in supporting symptom management, self-management and psychological symptoms. Additionally, an intervention could provide acknowledgment and support to PWLC who feel despondent about their condition and abandoned by health professionals. Participants reported a high level of interest in a yoga intervention, perceiving it could be of benefit. Barriers to yoga practise included anxiety regarding the group setting, fitting sessions into schedules, lack of energy and concerns about suitability for long-COVID. Those already practising yoga with long-COVID reported that yoga helped to manage symptoms and associated psychological challenges, as well as increasing flexibility and providing a safer alternative to exercise.

Conclusions

Many PWLC have positive perceptions of yoga and there is a good level of interest in a yoga intervention among this population. These findings suggest that yoga is a suitable intervention for study in future research as well as delivery in the community by qualified yoga instructors with a knowledge of long-COVID – provided that any intervention is appropriately tailored to fit the ability and address the concerns of PWLC. It should be offered in the context of health professional validation of symptoms.

Keywords

Yoga, Long-COVID, COVID-19, survey, qualitative, mixed-methods, long-term health condition

Word count: 4400

Introduction

Long-COVID is the commonly used name to describe symptoms of COVID-19 that remain after infection - also termed post-COVID condition by the World Health Organisation and post-COVID-19 syndrome by the UK National Institute of Health and Care Excellence (NICE). Long-COVID symptoms can last months and sometimes years (1); they are wide-ranging, heterogeneous, change over time and multisystemic (affecting any and all organ systems) (2). Key symptoms include chronic fatigue, breathlessness, “brain fog”, pain and post-exertional malaise (PEM) (3). Factors such as uncertainty of illness trajectory, traumatic intensive care stays and loss of identity can impact mental health (4). In April 2024 in England and Scotland, 3.3% of the population (two million) were experiencing self-reported long-COVID, with around three-quarters reporting the condition adversely effected day-to-day activities

(5). Whilst risk of experiencing long-COVID after COVID-19 infection is lower now compared to early in the pandemic, the estimated risk still stands at 3.5% (6).

The impact of long-COVID can be substantial for individuals, health systems and the economy, nevertheless, treatment options are limited, with care focusing on support and managing symptoms (2). In the UK, support for people with long-COVID (PWLC) varies from self-management advice for the more mildly affected, management in general practice for the moderately affected, and referral to specialist services where appropriate and if available for those who are more severely affected (7). However, experiences of healthcare are mixed, with reports of inadequate support and medical gaslighting commonplace (8). Research into the condition is hampered by a lack of a single definition of long-COVID and the multisystemic nature of the illness (9), as well as limited funding and investment into services and treatments (10,11).

Yoga offers a potential solution to reducing long-COVID burden by supporting PWLC with symptom reduction, self-management and quality of life. Yoga is a holistic mind-body practice originating from India that has become increasingly popular in the West as an accessible approach to manage health conditions (12), and support health and wellbeing (13,14). Yoga is a multi-component intervention that typically incorporates physical postures, breathing techniques, and relaxation. Both cross-sectional population surveys and clinical trials suggest that yoga has physiological and psychological effects on health (particularly pain conditions and mental health), as well as being associated with positive health behaviours (14–19). Research on yoga for long-COVID is in its infancy. A UK Iyengar Yoga intervention for PWLC (n=55) that provided 10 individual sessions with three teachers, reported statistically significant improvements for physical and mental health for participants after the intervention (20). Trials have also shown yoga to be safe and to improve outcomes for patients with COVID-19 (21–23). Both a feasibility intervention (24) and RCT (25) that focused specifically on breathing techniques (a component of yoga) have shown positive effects for long-COVID. More robust evidence for the potential of yoga to improve long-COVID comes from research demonstrating the effects of yoga on the biological mechanisms implicated in long-COVID (e.g. dysautonomia and chronic inflammation (26,27)), related health conditions (e.g. chronic fatigue syndrome (28)), key long-COVID symptoms (e.g. fatigue (29–33), pulmonary issues (34–37)), and quality of life (38–40) and mental health (19,26,41–43).

Yoga interventions can be designed for people with very limited physical ability. Additionally, it can be delivered online compared to other services (44), increasing accessibility for PWLC, as well as being low cost (45,46). Yoga is already being provided on the NHS (e.g. acute mental health services) and via social prescribing for people with long-term conditions (47); our research has previously found that a 10-week

yoga intervention was acceptable to ethnically diverse NHS patients and supported self-management (47). Home-based interventions are recommended for PWLC (48) and online live-streamed delivery of yoga is acceptable in both patient and community populations (44). However, acceptability is often established through those already attending yoga interventions, less is known about acceptability among the wider population. This is important because yoga for PWLC is not without its challenges, given the low functionality of many PWLC and prevalence of post-exertional malaise (PEM) symptoms. Such issues have led to a backlash against planned exercise interventions in the United States (49), and are reflected in findings from a Spanish study which found both positive experiences of yoga and barriers due to long-COVID fatigue symptoms (50). A safe and tailored approach to yoga in this population therefore needs to be established. Additionally, long-COVID and related communities may prioritise biomedical approaches (51). Thus, more work is needed to understand the perspectives and experiences of PWLC on yoga.

In summary, the treatment gap for long-COVID, combined with emerging evidence to support the use and suitability of yoga for PWLC, suggests its potential value as an intervention for this population. However, existing research is limited and the perspectives of PWLC remain underrepresented in the literature. This research therefore aimed to explore the perceptions and experiences of yoga for long-COVID among PWLC - in order to establish its potential as a supportive practice. We examined these perceptions irrespective of participants' prior experience with yoga.

Methods

Design

The study was a cross-sectional anonymous survey design, collecting both quantitative (closed choice questions, n=21) and qualitative (free text questions, n=8) data, during September and October 2024. The survey was developed for this study (see Supplementary file 1).

Participants and recruitment

Participants were recruited via the online research platform Prolific. Using Prolific allowed sampling of a broader range of participants, compared to recruitment through channels such as support groups and charities, who may be more motivated to seek support. To identify participants, firstly Prolific's pre-screening questions were used (UK; long-term health condition/disability; formally diagnosed or self-reporting as having experienced Covid-19; and 90%+ approval rate) and these identified a possible 4296 possible participants. In order to identify those with long-COVID, we invited 3000 to answer a 10-option multiple choice question ('which long-term health conditions have you experienced in the last five years?'). One-hundred and ninety-eight participants reported they had long-COVID and were invited to

participate in the main survey; participants who reported they had long-COVID but also ticked a high number of the other response options were excluded as potential imposter participants (n=5). One-hundred and seventy-one (90%) of those invited completed the main survey. We did not request a formal diagnosis of long-COVID from participants, as some report challenges getting a diagnosis due to issues such as lack of COVID-19 testing early in the pandemic, health professional scepticism and limited medical understanding of the illness (52). This is particularly prevalent in ethnic minority populations who may experience mistrust in the healthcare system and barriers to service access (53).

Procedure

Surveys were designed using Qualtrics software. A mixture of closed-response and open text questions collected demographic and other data including:

Long-COVID details: length of time with long-COVID, symptoms and severity. Key long-COVID symptoms were measured using PROMIS (Patient-Reported Outcomes Measurement Information System) (54) short form fatigue and physical function scales. Total scale scores range from 20 to 80. Recommended cut off scores are available to support interpretation of results i.e. fatigue: mild = 55-60, moderate = 60-70, severe = 70-80; physical function impairment mild = 45-40, moderate = 40-30, severe = 30-20 (55). PROMIS has previously been used with long-COVID populations (56) and it has established reliability and validity among patients with CFS/ME and fibromyalgia (57,58). Cronbach's alphas for this study were 0.91 (fatigue) and 0.86 (physical function).

Additional long-COVID symptoms/associated issues were measured using VAS scales (anchored 0 -none to 100 -as bad as could be imagined), including breathlessness, pain, light-headedness or unsteadiness, cognitive difficulties ("difficulty thinking clearly"), feeling anxious or worried, and feeling low or depressed.

Support needs: participants were asked 'Please tell us what kinds of support you would like to help manage your long-COVID symptoms?', as well as support received from long-COVID NHS services and non-NHS interventions attended.

Intervention perceptions: Participants were provided with a description of an online course (Figure 1) and were asked to rate how interested they might be in attending on a scale of 1 (very interested) – 5 (definitely not interested), as well their interest in each individual element of the course. Open text space allowed participants to explain their responses. Additionally, participants were asked '*Some yoga therapists are already running these types of programmes, how would you feel about attending if it was labelled as 'yoga' for long-COVID and why? (from our past conversations with people with long-COVID some have said they had concerns about yoga, whereas others liked the idea)*'.

Yoga use: Participants were asked about previous yoga practice, and those reporting yoga with long-COVID were asked to provide further details of their practice and experiences.

Analysis

Descriptive analysis was conducted for quantitative variables, including frequencies, percentages, means and standard deviations. For the PROMIS measures (fatigue and physical function), t-scores were calculated and then categorised by recommended cut-off scores to provide an indication of symptom severity (mild, moderate, severe) (55). In order to understand if interest in a mind-body intervention was related to symptom severity, one-way ANOVAs were conducted for all the symptom variables and rated interest in the programme. Qualitative data was typically subject to content analysis (59), but where data were richer (i.e. what are your support needs? Explanation of interest in the course), inductive thematic analysis was used (60,61). The thematic analysis was semantic, focusing on the explicit or surface meanings of the data, rather than latent analysis which seeks to identify hidden meanings or underlying assumptions that may shape descriptive accounts (62). A realist ontological approach was adopted (63). Both authors read through all open-ended responses independently. Open-ended questions were analysed individually in turn. AC independently coded, analysed and generated themes, which were then reviewed by TC and discussed to reach agreement (see Supplementary file 2 for thematic coding lists). In the results section qualitative and quantitative are presented together, where appropriate, being organised according to a topic area (rather than methodology) in order to address the aims of the study. Both authors are experienced mixed methods researchers, with research expertise and personal experience of living with long-term health conditions. This experience may have enhanced sensitivity to participant accounts of living with chronic illness, as well as brought awareness of the current controversies and debates within the field of long COVID.

Results

Demographics and illness characteristics

Participants were predominately female (61%), White (90%) and aged 31-50 (55%). There was a range of illness duration, with 2-3 years being most common (36%) (Table 1). The majority of participants had moderate to severe fatigue (80%) and challenges with physical function (59%) (Table 2). Cognitive difficulties were another key symptom for participants (52%), and around half were also experiencing mental health challenges (Table 3).

Table 1 – Participant demographics (n=171)

	Number	(%)
Age (years)		

18-30	34	20
31-40	52	30
41-50	43	25
51-60	23	13
61-70	15	9
70+	3	2
Missing	1	1
Ethnicity		
Asian or Asian British	9	5
Black, African, Caribbean or Black British	3	2
Mixed or Multiple Ethnic Groups	3	2
White	154	90
Other	1	1
Missing	1	1
Gender		
Female	105	61
Male	61	36
Non-binary	3	2
I use a different term	1	1
Missing	1	1
Is this the same gender you were assigned at birth?		
Yes	164	96
No	5	3
Missing	2	1
Length of time with long-COVID		
Less than 6 months	14	8
6 months – 1 year	21	12
1-2 years	33	19
2-3 years	62	36
3-4 years	25	15
4+ years	16	9

Table 2 - PROMIS scales, rating of severity by recommended cut-offs (55) (percentage of participants) (n=171)

	Normal	Mild	Moderate	Severe
	%	%	%	%
Fatigue	9	11	53	27
Physical function	15	26	56	3

Table 3 – Ratings of long-COVID symptoms

Symptom (0-100, ↑=worse)	Mean	Std dev
Cognitive difficulties (n=168)	52.0	29.8
Feeling anxious or worried (n=169)	52.8	32.1
Feeling low or depressed (n=170)	51.7	31.2
Light-headedness or unsteadiness (n=170)	44.8	29.3
Breathlessness (n=166)	41.7	26.0
Pain (n=165)	34.8	28.5

Many participants had received some kind of support from the NHS for long-COVID, but a significant minority had not received any support. The most common forms of NHS support were self-management (36%) or psychological support (26%); delivery in a one-to-one as opposed to group format was more common for all support (Table 4). Support was more likely to be reported by participants helpful than not, and pulmonary/breathing support, along with gentle exercise/activity, received more positive ratings. Qualitative responses on how helpful participants had found the NHS support they had received were too sparse for meaningful analysis, but several participants described waiting for extended periods of time to receive support.

Table 4 – What kind of support, if any, have you had from NHS Long-COVID services?

	Group		One-to-one	
	N	(%)	N	(%)
Self-management	21	(12.3)	40	(23.4)
Stress management/ psychological support	10	(5.8)	34	(19.9)
Breathing support	7	(4.1)	23	(13.5)

Gentle exercise/activity	11	(6.4)	16	(9.4)
Pulmonary rehabilitation	5	(3.0)	13	(7.6)
Other*	6	(3.5)	8	(4.7)
Nothing	58	(33.9)	45	(26.3)

* n=2: Cardiology clinic, CFS/ME clinic; n=1: Sick notes, occupational therapy, pain management, practice nurse, Long-COVID clinic, Memory improvement techniques

Multiple unmet support needs

Participants were asked what kinds of support they would like to help manage their symptoms. Key issues that emerged from participants responses included greater acknowledgment and support from the medical community, better access to their GP and specialist services for symptoms and associated psychological symptoms, self-management advice, and knowledge and information about long COVID. These are described in more detail below.

Participants' reporting a need for their condition (and the impact it had on their lives) to be acknowledged by the medical community was a dominant theme, with many saying they were struggling to get the recognition that they needed, requesting *"a doctor who listens to me and cares"*.

"It would just be nice if all medics believed the diagnosis and didn't try and pretend that long-covid was not a real thing." P10

Participants' narratives convey a sense of despondency characterised by descriptions of being left with little treatment, care, information or support. This sense of abandonment, represented by statements such as *"I'm being left to rot"*, meant some reported having *"little hope for any useful help"*. Participants expressed a strong desire to access support *"I would love to hear any solutions"*, whilst others reported uncertainty about the availability or suitability of support to address their symptoms: *"unsure what support would manage extreme fatigue and brain fog."*

Consequently, many participants said they wanted better and more regular access to their GP as well as access to specialist services like physiotherapy, rehabilitation or pulmonary support. Reporting they wanted help with symptoms, particularly fatigue, changes in smell/taste, cognitive issues, breathlessness/lung function and pain, including prescriptions of effective medication. Psychological support was also prioritised by participants, with some suggesting talking therapy, counselling or *"support with psychosomatic symptoms, anxiety, depression"*. A number of participants said they would like local support groups. Self-management support was also mentioned, including how to manage and monitor symptoms, undertake gentle exercise, pacing, diet, communication with medical staff or knowing what services they could request.

“Coping strategies that can minimise long-term effects impact on daily life. How best to get through the working day etc when symptoms are bad.” P68

Some participant reported wanting access to knowledge and information about their condition – particularly around prognosis and treatment options, including complementary medicine and research trials: *“information on how it affects people and how things are moving forward with treatments”*.

Whilst others said they needed practical support to help with day-to-day living and understanding/flexible working arrangements from employers.

Acceptability of a yoga-based course to support symptom management for long-COVID

A description of an intervention including the components often found in yoga practice was presented to participants (Figure 1). This was not described as a yoga intervention to avoid potential bias associated with common preconceptions about yoga. Participant ratings indicated that the majority were interested in attending the intervention (64%), whilst 16% were unsure and 20% were not interested.

A one-way between-groups analysis of variance was conducted to explore the impact of symptom severity on interest in participating in the course. There was a statistically significance difference for cognitive difficulties ($F(4,163) = 2.7, p=0.031; \eta^2 = 0.024$) with a small effect size, suggesting that those with more severe cognitive difficulties may be slightly more interested in attending the course. No statistically significant differences were found for the other symptom or mental health variables. Chi-squared tests revealed no statistically significant effects of age or gender on interest in attendance. A Fisher’s exact test revealed a statistically significant difference ($p=0.015$) toward those from an ethnic minority background being less interested in the intervention, however, given the multiple comparisons conducted and the small subgroup sizes, this finding should be interpreted with caution. In relation to interest in the different components of the course, symptom management (80%) was most highly rated (definitely or might be interested), followed by relaxation (74%), breathing exercises (70%) and gentle movement (60%). Connection with others with long-COVID (47%) was of least interest.

Participants who rated themselves as interested in the intervention reported in their qualitative responses that they felt the course sounded potentially helpful, and a number expressed a willingness to *“try anything”* (*“I welcome any support for managing symptoms”*). Others said they liked the convenience of the online format or the course content– either specific activities (e.g. nervous system regulation) or the range of components included. Some reported liking the group setting, believing that connecting with others with long-COVID could help reduce their feelings of isolation.

"I would welcome this - being in an online environment is manageable as it wouldn't contribute to fatigue through travelling and having contact with other people who live with this would help me feel less alone. I want this very much. Gentle movement and stretching is something I don't know how much to try or do so this is important. Peer support is essential and I just don't have this at present. P47

However, participants expressed concerns about interacting in a group setting, primarily due to anxiety, and some reported disliking online courses: *"I'm a little nervous about interacting with people over livestream as it gives me anxiety"*. A more individualised approach was preferred by some to acknowledge the variability in symptom experience. These concerns were expressed across all ratings of participant interest in the intervention (with the exception of 'definitely interested') suggesting that concerns could lead to a range of reactions from complete lack of interest in the course, to apprehension without deterring participation entirely. Many participants also expressed concerns about managing the sessions alongside fluctuating energy levels or busy schedules.

"If it was something I could log into and just do when I feel like I have the energy, it would be perfect. But if it requires me to put X amount of minutes in a day - I can't know if I'll have the energy to do that." P155

Of those who rated themselves as having little interest in the course, a number felt they were mostly recovered or were self-managing effectively. Others indicated they had already tried similar techniques and had limited success. A smaller number reported feeling generally despondent or doubtful that such a course would be helpful. A few expressed scepticisms, viewing such of courses as tokenistic: *"I've seen a lot of LC support that just feels bare minimum to 'shut us up' but doesn't really help. I'm sceptical I guess."*

When asked if there was anything else they would like to see included, responses echoed the qualitative findings reported above around unmet needs, highlighting the importance of self-management support and relaxation. This included support to manage specific symptoms as well as broader self-management strategies such as pacing and brain retraining. Psychological support included positive thinking, building confidence, managing unhelpful thoughts and relaxation, whilst noting that some types of relaxation could exacerbate anxiety. Some participants said they wanted more information about long-COVID itself or diet and nutrition, with particular reference to loss of taste/smell. Finally, ensuring a positive tone of the course was perceived as important by participants, with some noting that being around others with more severe symptoms could be emotionally draining.

Perceptions of Yoga for long-COVID

After gaining participants views about the intervention, participants were asked *'Some yoga therapists are already running these types of programmes, how would you feel about attending if it was labelled as 'yoga' for long-COVID and why?'* Over half of participants (54%) reported positive attitudes towards using yoga, often mentioning previous positive experiences with yoga, or simply an openness to try a gentle form of exercise, reporting they *"would find this [yoga] reassuring"*. Several said they were attracted by the holistic approach and positive focus on health: *"I like the sound of yoga as it sounds healthy, proactive activity rather than something for sick people"*. A further 19% of participants reported feeling unsure about 'yoga' because of perceptions about how strenuous it might be (*"post exertional malaise is a massive concern"*), or if it would be suitable for their comorbid conditions or limited mobility (*"Yoga implies floor level and I can't get that low"*).

"I am hesitant because yoga feels like something quite advanced - I would be worried about pushing myself too much, and having some days where I felt too unwell to participate physically - I think if I knew I was able to do less or minimal on some sessions depending on fatigue and pain levels, I would feel more confident." P47

A significant minority (25%) indicated they would find the term yoga off-putting. Whilst many did not specify their reasons (*"I wouldn't like to attend yoga"*), several responded by indicating they were not interested in yoga (*"I don't really like yoga"*), disliked groups or perceived they were not fit enough for yoga. Additionally, two participants said they would feel offended by being offered yoga, as it implied their condition was not physical in nature. Another described it as a poor use of NHS resources.

"This is just minimising the severity and reality of the disease. Wellness techniques are not cures or help for medical conditions." P151

Experiences of yoga for long-COVID

Fifty percent of participants had practised yoga before they had long-COVID. However, only 14% (n=24) had practised yoga with long-COVID, the majority of whom (n=20) had previously practised. The most common styles practised with long-COVID were restorative (25%), hatha (21%) and yin yoga (17%). The majority of those practising rated its helpfulness for long-COVID symptoms 'a little' (50%), Table 5.

Table 5 - Overall, how much does practising yoga help with your long-COVID symptoms? (n=24)

Symptom response	n	(%)
It makes them worse	1	(4.2)
No difference	5	(20.1)
Helps a little	1	(50.0)
	2	

Helps a moderate amount	5	(20.1)
Helps a lot	1	(4.2)

Participants who had practised yoga with long-COVID perceived a range of benefits, with relaxation the most common. Several described it as a safe alternative to exercise, reporting that it allowed them to build strength, flexibility and fitness. Others noted benefits such as breath management (*“helped with dysregulated breathing”*), relief through distraction from symptoms, nervous system regulation, and overall symptom management.

In terms of challenges to practising yoga with long-COVID, by far the most common issue reported was fatigue, which could impact ability or motivation: *“might be too fatigued to even get started”*.

Additionally, flexibility, breathing problems, pain and stamina were also perceived as affecting ability to practise. Less commonly reported challenges were aggravation of symptoms, boredom, time, space, difficulty level and certain poses: *“stretching can aggravate, especially bending over if it’s a bad day”*.

Discussion

This study explored the perceptions and experiences of yoga for long-COVID among PWLC, in order to establish the potential as a supportive practice. Findings suggest that yoga is a suitable intervention for study in future research as well as delivery in the community by qualified yoga instructors with a knowledge of long-COVID – provided that any intervention is appropriately tailored to fit the ability and address the concerns of PWLC. Specifically, findings highlighted the many unmet support needs of PWLC, particularly the need for validation and recognition of their condition and its impact from healthcare professionals - the absence of which left many feeling despondent, abandoned and desperate. We found alignment between several of these unmet needs and evidence-based potential benefits of a yoga intervention, namely support with symptom management, self-management and psychological impacts. This compatibility was also reflected in the high level of potential interest in a yoga-based intervention and perceptions that it could be beneficial. Additionally, reports from those already practising yoga with long-COVID support the idea that it can help manage symptoms and associated psychological challenges, as well as providing a safer alternative to exercise. A significant minority did express concerns, with key barriers including anxiety regarding the group setting, fitting sessions into schedules or lack of energy. Importantly, our findings highlight that yoga for PWLC requires tailoring for long-COVID to reassure individuals, avoid exacerbation of symptoms and PEM, and be sensitive to the physical and cognitive limitations experienced by those with long-COVID.

A key unmet need was the lack of acknowledgement of the condition and its impact by health

professionals, a finding supported by others (8,64,65). Lessons from treatment of individuals with ME/CFS have highlighted the importance of this basic level of care in the face of lack of treatment options (66) and guidelines on the management of long-COVID for health professionals have reflected this (2). Nevertheless, this research suggests that practice is not always achieving these standards, and these experiences may worsen further given the current uncertainty around the future of long-COVID-specific services in the UK and elsewhere (i.e. long-COVID clinics). Additionally, doctors may find it challenging to deal with the clinical uncertainty surrounding long-COVID, resulting in unhelpful or dismissive interactions with patients (67,68) or lack of empathy (69). A yoga intervention may help to provide some of the validation by a professional needed by PWLC but may also address other unmet needs, namely support with symptom management, self-management and psychological symptoms. Yoga interventions have been shown to improve key long-COVID symptoms such as fatigue (29–33), pulmonary function (34–37), pain (70–72), sleep (73–75), as well as support mental health and well-being (19,26,41–43). They may also address the biological mechanisms implicated in long-COVID (e.g. Dysautonomia and chronic inflammation (26,27)), or provide a ‘safe’ way to move which can be challenging with long-COVID PEM symptoms. It is also possible to integrate specific self-management techniques for long-COVID (e.g. pacing) into yoga interventions (47). The ability of yoga to address some of these issues was supported by reports from participants practising yoga in our study.

Our findings suggest that a tailored, online yoga intervention is likely to be acceptable to many PWLC and have a broad appeal to those with various severities of symptoms and demographic backgrounds, including men who are typically less likely to practise yoga (14). Other research has found that yoga interventions (including online) are generally acceptable to patients including those with ME/CFS (28,44,47,48) and PWLC (76,77). However, acceptability is typically established in existing studies among those already enrolled on a yoga programme, this research highlights there may be issues prohibiting wider uptake. For example, whilst a group format to connect PWLC to others with the condition was very appealing to some, more participants expressed discomfort at the group setting, particularly in relation to interacting with the group or being on video. In addition, ‘connection with others with long-COVID’ gained the lowest ratings of interest among participants (47%). Thus, online interventions that do not involve group interaction or require participants to have their video on may be more popular than previously thought, whilst options of face-to-face interventions or those that include group interaction also have a role (48).

Further barriers included fitting sessions into schedules alongside lack of energy on the day, suggesting the value of flexible online sessions. Interestingly, concerns around low energy primarily reflected

worries about ability to participate, rather than concern that yoga would exacerbate symptoms. Additionally, the lack of correlation between interest in the intervention and symptom severity, suggests that many PWLC are aware of and able to work within their energy limitations. Nevertheless, careful consideration should be given to how the intervention is constructed, with an emphasis on safety and appropriate modifications for PEM. This emphasis on safety and accessibility for long-COVID should be clearly conveyed to PWLC who may perceive yoga as strenuous physical exercise, when in fact it can be practiced in ways that are not physically demanding. The use of 'yoga' (78,79) is also important. The majority of participants in this study responded positively (or neutrally) to the term 'yoga', or it clarified for participants that this was not the right intervention for them. For others, it raised concerns that would require addressing when promoting such programmes, for example clarity regarding the suitability for individuals with co-morbidities or limited mobility. Importantly, yoga for long-COVID should be offered in the context of health professional validation of symptoms and research into biomedical treatments (64) to ensure individuals feel heard and their concerns are appropriately addressed.

Strengths and limitations

A key strength of this study was its inclusion of any individual with long-COVID, rather than those already accessing an intervention – as has been the case for previous research exploring yoga acceptability. Recruitment through Prolific enabled access to a broader sample than might be obtained through support groups who may be more motivated to seek help and be positively biased towards yoga. Nevertheless, this was not a random sample and participants using Prolific may have certain biases. The study relied on self-reported long-COVID status and we did not require a formal clinical diagnosis. While this may introduce some diagnostic uncertainty, we considered it important to include all individuals identifying as having long-COVID to avoid excluding key groups - such as those infected in the first wave and ethnic minority populations who find it hard to get a diagnosis. Indeed, this has also been the approach of other studies in the area (53). Nevertheless, minority ethnic groups are still underrepresented in our sample, comprising 9% of participants compared with 16% in the general UK population (80).

We chose a survey method collecting both quantitative and qualitative data, as we considered it the best fit for our research question and participants. This method allowed us to collect a larger number of responses than an interview study might have allowed, as well as recruit a broader and more diverse number of participants, so our findings are more representative of the broader population. Sample diversity is particularly important in long COVID research because symptom and severity vary greatly

between individuals. The method was also a good fit to answer our research question - short answers provided sufficient information to address our primary research aims, though we acknowledge that in-depth interviews could yield additional insights, as recommended for future research. In addition, the survey method was more appropriate for PWLC, who may tire easily or feel uncomfortable speaking with a researcher (81). Nevertheless, surveys do not allow researchers to clarify participant responses or probe deeper into the topic in question. Future research into this topic would benefit from more in-depth participant perspectives to build upon our findings by gaining deeper insights and perspectives on the topic.

Conclusions

Many PWLC have positive perceptions of yoga and there is a good level of interest in a yoga intervention among this population. Our findings suggest that yoga is a suitable intervention for study in future research as well as delivery in the community by qualified yoga instructors with a knowledge of long-COVID – provided that any intervention is appropriately tailored to fit the ability and address the concerns of PWLC. Given the narratives of struggle for recognition and treatment of long-COVID within the medical domain, any intervention should be offered alongside health professional validation of symptoms and situated within the broader context of research into biomedical treatments for the condition.

List of abbreviations

NICE - National Institute of Health and Care Excellence

NHS – National Health Service

PEM – post-exertional malaise

PROMIS - patient-reported outcomes measurement information system

PWLC – people with long-COVID

UK – United Kingdom

Declarations

Ethics approval and consent to participate: Ethical approval for the study was gained from the University of Westminster, College of Liberal Arts and Sciences ethics committee (ETH2324-2236). All participants were provided with a participant information sheet and consent form and gave consent prior to completing surveys. The study adhered to the Declaration of Helsinki.

Consent for publication: Not applicable

Availability of data and materials: The datasets generated and/or analysed during the current study are not publicly available due ethical reasons.

Competing interests: The authors report there are no competing interests to declare.

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Authors' contributions: XX conceptualised the study and led on study design, data collection, analysis and write up. XX contributed to study design, data collection, analysis and write up. Both authors reviewed and agreed upon the final manuscript.

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Figure 1

If you were invited to participate in the below course to support people with long-COVID to help manage their symptoms, would you be interested?

A course of online live-streamed, weekly practical sessions, over 8 weeks, specifically for people with long-COVID. Sessions lasting 45 minutes. Content includes breathing practices to improve lung function, gentle movement and stretching (from sitting or lying), nervous system regulation, information about symptom management (e.g. pacing), guided relaxation and peer-group support.

Optional home practice includes short videos of the practices covered in classes.

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