

Article

Multidisciplinary Pelvic Floor Intervention in Women over 55: A Comparison Between Supervised and Reduced-Supervision Models

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Abstract

This study aims to assess the impact of an 8-week multidisciplinary intervention on the physical and psychosocial health in active women over 55 years old, paying attention to the need of supervision. Eighty-one women were assessed for pelvic floor strength (using PERFECT's guidelines), body composition and satisfaction with life, and later blindly assigned to a supervised or reduced-supervision pelvic floor exercise program (i.e., therapeutic exercises guided by a professional, twice a week, or identical exercises performed at home). All of them received six additional educational sessions together, interspersed along the program, for nutritional and psychological counseling. Twenty-eight women of 36 [66.50 (4.68) years] in the supervised group, and another 20 of 34 [64.65 (5.12) years] (reduced-supervision) ended the intervention. Although both groups improved in all four dimensions of pelvic floor muscle strength, with endurance showing differences between-groups. Completion rate was lower in the reduced-supervision group (58.8% vs. 77.7%). Lack of motivation was their main reason to leave. No significant changes were found in body composition or life satisfaction. However, the results suggest that comparable pelvic floor strength benefits can be achieved with fewer resources when health awareness is emphasized. Ongoing supervision appears important to minimize dropout in these sensitive interventions. Multidisciplinary, movement-based programs show strong potential for public health promotion in older women. Pelvic floor training should be incorporated into preventive care for this population and supervised or follow-up formats seem essential to support adherence and long-term effectiveness.



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1. Introduction

Pelvic floor dysfunctions (PFDs) affect a large number of women, with prevalence ranging from 1.9% to 46.5% worldwide [1]. Among the four types of PFDs [urinary incontinence (UI), pelvic organ prolapse, fecal incontinence and pelvic-perineal region pain syndrome], UI is the most frequently reported, with a prevalence of 15.7% in the American population [2], 36.3% in the Saudi population [3], and 55.8% in the Spanish

population [1]. Moreover, according to these studies, the prevalence of UI increases with age compared to younger women due to hormonal, functional, and structural changes in muscle mass. When additional factors such as ethnicity, pregnancy, childbirth type, and body composition are considered, PFDs become even more limiting. The pelvic floor's ability to contract and counteract the effects of intra-abdominal pressure is altered and deteriorated [4]. The loss of both type I and type II muscle fibers reduces the capacity to sustain continuous contractions or perform successive intermittent contractions [5], leading to urgency, stress, or mixed UI issues.

On the other hand, quality of life is closely related to the problems caused by PFDs. In fact, it has been shown that higher scores in any PFD result in a decrease in quality of life [6]. Generally, this decline affects social, psychological, and sexual well-being [1]. It is estimated that only 25% of affected women seek medical consultation due to a lack of health education and the embarrassment associated with acknowledging any of the issues related to PFDs [7]. In this female aging scenario, exercise emerges as a powerful tool for improving PFDs [8], not only by enhancing pelvic floor contraction but also by contributing to better psychosocial and mental health, and quality of life. However, despite physical exercise being one of the most effective strategies for maintaining pelvic floor functionality, many older women neither practice it nor are aware of its importance. This lack of knowledge occurs within a sociocultural context in which female sexuality and intimate health have traditionally been silenced, limiting sexual education and body awareness [9].

Regarding exercise programs, a variable of paramount interest is whether the training needs to be supervised, because studies comparing exercises performed under professional supervision with the same exercises done at home, without supervision, have yielded mixed results [10–12]. Beyond the importance of the supervised vs. unsupervised approach when aiming to help a larger number of people, it is of outmost importance that women improve their knowledge on physical and psychosocial changes associated with their PFD, and maintenance, as they age. Awakening this self-care commitment is an additional main goal. This is why multidisciplinary interventions are emerging as an even more powerful tool to address the consequences of PFDs in a holistic manner [13]. Additionally, exercise programs have traditionally been implemented for women already experiencing PFD-related issues, although there are a lot of women who are asymptomatic but with low muscle tone.

Therefore, the main objective of this study is to assess the impact of a pelvic floor multidisciplinary intervention (MI) on the physical and psychosocial health of healthy women over 55 years old without any specific diagnosis. More specifically, it analyzed its impact on pelvic floor, body composition and satisfaction with life, comparing a multidisciplinary intervention supervised (MI-S) versus a reduced-supervision (MI-RS) pelvic floor exercise intervention, both combined with six training sessions focused on nutrition and psychosocial health (three each) interspersed among the 8 weeks to increase awareness. It deepens improvements and differences in: (i) pelvic floor muscle strength [power (P), endurance (E), repetitions (R), and fast (F)]; (ii) muscle mass, fat mass, and waist-to-hip ratio; and (iii) satisfaction with life. As a main hypothesis: 8-week MI might improve pelvic floor muscle strength in both the MI-S and MI-RS groups, with the expectation that the supervised model might yield greater magnitudes of improvement due to the higher level of professional oversight. Additionally, no significant changes are expected in body composition in either group due to the short duration and type of exercise, although we expect to improve satisfaction with life in both groups.

2. Materials and Methods

2.1. Study Design and Experimental Procedures

The study followed a quasi-experimental, quantitative and longitudinal design. Different women's associations and health centers were contacted for recruitment. After an initial meeting to explain the program, the volunteers were scheduled for an assessment of their baseline pelvic floor muscle strength. Later on, participants were anonymized and blindly distributed into the MI-S or MI-RS respectively, with the variable power as the reference outcome to create two equal groups (1:1 proportion). The intervention was then carried out over an 8-week period. This same process was repeated at three different time points to ensure a large sample size, spanning from 2023 to 2024 (first time point: September–November 2023; second time point: January–March 2024; third time point: October–December 2024).

All participants were informed and signed the informed consent form for both participation in the study and the physiotherapeutic assessment. The study complied with the ethical standards of the Declaration of Helsinki and was approved by the ethics committee of the responsible academic institution (FIS-2848346).

2.2. Participants

A total of 81 older women, with no prior diagnosis of any PFD, voluntarily participated in the study. The inclusion criteria were being a woman over 55 years old, having no condition that would prevent the assessment, not participating in any physical exercise program specifically targeting the pelvic floor, and attending at least 85% of the exercise sessions and nutritional and psychological counseling. As exclusion criteria: being unable to understand and/or complete the questionnaires, experiencing pain in the genital area, having a grade 3–4 prolapse, or having any diagnosed and medically treated PFD. After the enrolment, as described in Figure 1, seventy active older women were evaluated, and were blindly allocated to MI-S or MI-RS.

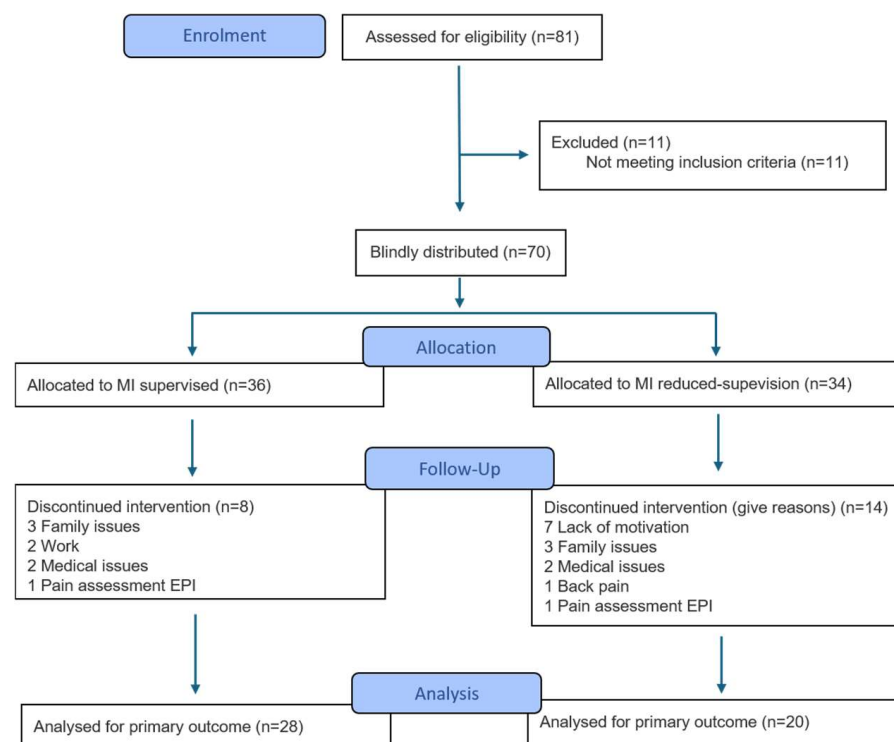


Figure 1. Flow chart. MI: Multidisciplinary intervention.

2.3. Instruments and Assessments

- Body composition and anthropometry: participants' height was first measured using the SECA stadiometer. Then, body composition was assessed with the Tanita DC-430MA (TANITA Corporation, Tokyo, Japan). To ensure accuracy, participants were instructed to have their last meal at least two hours before the appointment. Next, waist and hip circumference were measured. Participants were asked to stand with their feet together and arms crossed over their chest. A Lufkin metal tape was used for both measurements, which were conducted by an ISAK Level I-certified professional. Waist circumference was measured at the narrowest point, while hip circumference was measured around the most prominent part of the buttocks and, at the front, at the level of the pubis [14].
- Instrumental physiotherapy assessment: the Epi-No Delphine Plus perineometer was used for evaluation (Martimedica, S.L., Astigarraga, Gipuzkoa, España) [15]. The assessment was conducted by a pelvic floor specialist (physiotherapist) using the Modified Oxford Scale, following the PERFECT's guidelines (P = power, E = endurance, R = repetitions, F = fast, ECT = every contraction timed) [16]. Power was measured on a scale from 1 to 5. Endurance was assessed by requesting a continuous contraction for up to 10 s. repetitions and fast were evaluated with a maximum of 10 repetitions, adjusting contraction and relaxation times [Repetitions: 2 s contractions (4 s per repetition); fast: 1 s contraction (2 s per repetition)].

Prior to the assessment, participants were instructed on the use of the Epi-NO device to familiarize themselves with it, as well as the evaluation method. A demonstration test was performed to clarify any doubts. The perineometer consists of a vaginal probe inserted in the gynecological position into the perineal cavity until a pressure of 20 mmHg is reached, as indicated in the manual. The women applied pressure to the perineometer, which was displayed on the manometer. Three measurements were taken to calculate the average for each of the evaluated variables. Subsequently, the values were extrapolated to tables of equivalencies between the Oxford scale and the pressure measured by the perineometer in mmHg, as Bustelo et al. [16] recommended.

At any point, the assessment could be canceled if the physiotherapist identified any signs that contraindicated the examination, or if the participant refused to proceed, whether due to pain, discomfort, or any other symptoms they might experience during the study.

- Psychosocial dimension, satisfaction with life: the Satisfaction with Life Scale (SWLS) [17] is an instrument that evaluates subjective well-being and measures overall life satisfaction. It consists of 5 items that assess the judgment of how satisfied an individual is with their current life, using a Likert-type scale with 7 response options, indicating disagreement or agreement with each statement. The score ranges from 5 to 35, with higher scores suggesting a greater presence of life satisfaction. The questionnaire was self-administered.

2.4. Multidisciplinary Intervention: Exercise Program and Educational Workshops

Along the eight weeks of pelvic floor exercise training, two educational talks were conducted by the physiotherapist specialized in this topic (weeks 1 and 5). Additionally, each week, all the women together also received educational training conducted by nutritionists and psychologists for a multidisciplinary approach and improvement of their health knowledge.

Three training sessions were conducted on topics related to nutrition during menopause, post-menopause, and foods that contribute to healthy aging, with the aim of providing nutritional education to the participants in the intervention. The sessions lasted 60 min. The talks followed a progression of concepts. The first session established basic

notions about food and its classification. The second session delved into dietetics and diet therapy, focusing on the properties of food and its use for health, particularly the type of diet adapted to the different changes women experience throughout their lives. Finally, guidelines were provided for creating a healthy diet, taking into account the participants' age, lifestyle, and health. During these sessions, the participants actively participated, answering questions about their habits, customs, and dietary mistakes in order to establish basic principles they could use when creating a healthy diet.

The three sessions led by psychologists (also 60 min) focused on well-being, identity, and strategies for coping with ageism, emphasizing the importance of embracing aging positively. The workshops also explored changes in sexuality during aging and provided tools for managing emotions more effectively, thereby promoting the overall well-being of the participants.

Regarding the pelvic floor exercises, the MI-S group participated in a weekly guided class with the physiotherapist, who provided the necessary materials for pelvic floor training. During the sessions, exercises targeting both the pelvic floor muscles and the lumbopelvic complex were explained and performed to improve pelvic stabilization [8], integrate pelvic floor contraction into daily activities, and encourage anticipation before any exertion [18]. The harmonious function of all these components ensures proper continence maintenance. The exercises followed a progression in difficulty, both in terms of the variables involved in the contraction and the elements contributing to pelvic stabilization [19]. Each session was complemented with postural exercises from Global Postural Re-education (GPR) to ensure that pelvic floor exercises were performed starting from a neutral pelvis position.

Before the start of the guided class, materials were provided to perform the exercises at home, including a booklet and audio recordings with precise instructions, adapting the materials used in the classes to other similar items that participants might have at home. They were asked to complete the exercises at least 3 times per week to reinforce the exercises (MI-S: once in a guided session and twice independently with audio recordings; MI-RS: all three times independently but also with audio recordings), following the repetitions per week proposed by Bø et al. [20]. To monitor the execution of the exercises at home, participants were asked to fill out templates registering the exercises performed, the number of repetitions, and any comments or questions they might have, so that the difficulty of the sessions could be adapted over time. Table 1 shows the progression of specific pelvic floor exercises conducted throughout the 8 weeks.

Table 1. Progression of specific pelvic floor exercises throughout the 8-week intervention.

Weeks	Description	Repetitions
WEEK 1	Teach how to contract the pelvic floor through respiratory and proprioceptive exercises in different positions.	
	Kegel (gentle contractions).	2–3 times/day, 15 rep.
WEEK 2	Contraction of the transverse muscle in supine and sitting positions.	15 rep.
	Contraction of the abdomen + PF.	15 rep.
	Kegel in lying down: Long and gentle contractions (5") + relaxation for 10".	2–3/day (2 × 15 rep.)
	Strong and fast contractions (1–2").	2–3/day (1 × 10 rep.)

Table 1. *Cont.*

Weeks	Description	Repetitions
WEEK 3	Transverse abdominal work in supine, sitting, and quadruped positions.	15 rep.
	Kegel in lying down and sitting positions: Long and gentle contractions (5") + relaxation for 10".	2–3/day (2 × 15 rep.)
	Strong and fast contractions (1–2").	2–3/day (1 × 10 rep.)
WEEK 4	Contraction of the PF, along with the transverse muscle and lower limb strength.	1 × 6 rep.
	Kegel in lying down, sitting, and prone positions: Long and gentle contractions (5") + relaxation for 10".	2–3/day (2 × 15 rep.)
	Strong and fast contractions (1–2").	2–3/day (1 × 10 rep.)
	Kegel exercises in the “elevator” technique in lying down (supine) position.	1–3/day
WEEK 5	Contraction of the PF, along with the transverse muscle and lower limb strength.	1 × 6 rep.
	Kegel in lying down, sitting, and prone positions: Long and gentle contractions (5") + relaxation for 10".	2–3/day (2 × 15 rep.)
	Strong and fast contractions (1–2").	2–3/day (1 × 10 rep.)
	Kegel exercises in the “elevator” technique in lying down (supine) position.	1–3/day
WEEK 6	Contraction of the PF, along with the transverse muscle and lower limb strength.	1 × 6 rep.
	Kegel in lying down, sitting, and prone positions: Long and gentle contractions (5") + relaxation for 10".	2–3/day (2 × 15 rep.)
	Strong and fast contractions (1–2").	2–3/day (1 × 10 rep.)
	Kegel exercises in the “elevator” technique in lying down (supine) and sitting position with unstable surface.	1–3/day
WEEK 7	Contraction of the PF, along with the transverse muscle and lower limb strength.	1 × 6 rep.
	Kegel in lying down, sitting, and prone positions: Long and gentle contractions (5") + relaxation for 10".	2–3/day (2 × 15 rep.)
	Strong and fast contractions (1–2").	2–3/day (1 × 10 rep.)
	Kegel exercises in the “elevator” technique in lying down (supine) and sitting position with unstable surface.	1–3/day
WEEK 8	Contraction of the PF, along with the transverse muscle and lower limb strength.	2 × 6 rep.
	Kegel in lying down, sitting, and prone positions: Long and gentle contractions (5") + relaxation for 10".	2–3/day (2 × 15 rep.)
	Strong and fast contractions (1–2").	2–3/day (1 × 10 rep.)
	Kegel exercises in the “elevator” technique in lying down (supine) and sitting position with unstable surface.	1–3/day

Rep.: repetitions; PF: pelvic floor.

Regarding the group that performed the MI-RS, they did the same exercises as the MI-S group, with the only difference being that they received the exercise booklet for the first 4 weeks during the initial meeting. In week 5, they met again with the physiotherapist to

receive the exercises for the remaining 4 weeks. Just like the supervised group, the women in the MI-RS group received reminders through phone messages with the same instructions.

2.5. Statistical Analysis

Data analysis was conducted using the SPSS statistical package version 23 (IBM SPSS Corp.; Armonk, NY, USA). Descriptive statistics for all variables were calculated, expressed as Mean and Standard Deviation (Mean [SD]). After determining the normality of the sample (Shapiro–Wilk test, $p < 0.05$), the Wilcoxon test or t -test was used to assess the differences in means between the variables of muscle tone, satisfaction with life and body composition, before and after the multidisciplinary intervention. Furthermore, the distribution of pelvic floor strength scores was strongly skewed toward the upper limit of the scale, further supporting the use of non-parametric methods. To assess the differences between both groups, (pre- and post-intervention), the Mann–Whitney U test was applied. To evaluate whether the magnitude of change differed between groups—acting as a non-parametric assessment of the interaction effect—we calculated the absolute change scores ($\Delta = \text{Post} - \text{Pre}$) for all primary outcomes and compared them between groups using the Mann–Whitney U test. The effect size for parametric data (d de Cohen) and for non-parametric data (the rank–biserial correlation, r) was calculated and classified following Cohen’s guidelines [21]: small size, $d = 0.20$ – 0.40 ; moderate, $d = 0.50$ – 0.70 ; or large, $d = 0.80$ – 2.0 . The p -value was set at $p < 0.05$.

3. Results

Finally, 48 older women finished the MI, where 28 belonged to the MI-S group [66.50 (4.68) years] and 20 to the MI-RS group [64.65 (5.12) years]. Completion rate was 58.8% in MI-RS and 77.7% in MI-S (Figure 1).

As reflected in Table 2, age at menopause did not show significant differences between groups. When analyzing educational level, both groups showed a higher percentage of women with a high level of education. Regarding the type of childbirth, six women were nulliparous (two in MI-S and four in MI-RS), and in both groups vaginal births were more common than cesarean births. In addition, each group included one woman who had experienced both types of childbirth. Although the participants did not have any diagnosed conditions, their scores on the Pelvic Floor Distress Inventory–20 (PFDI-20) [22] indicated the presence of distress, specifically related to urinary incontinence in the MI-S group and colorectal–anal symptoms in the MI-RS group. For that reason, we considered that our women were mildly symptomatic but undiagnosed.

Table 3 shows pre–post changes in anthropometric, body composition and psychosocial outcomes. Neither variable showed significant changes after the 8-week MI.

All muscle tone-related variables improved significantly, regardless of the group, with no differences between groups either before nor after the 8 weeks of multidisciplinary intervention (Table 4). The four pelvic floor muscle tone variables reflected a large improvement. Between-group comparisons of the change scores revealed no statistically significant differences between the MI-S and MI-RS groups for most pelvic floor muscle performance variables, except for endurance, where the MI-S group exhibited a significantly greater magnitude of improvement compared to the MI-RS group.

To evaluate the potential for attrition bias, we performed a comparison of baseline characteristics between completers and dropouts (Table 5). No statistically significant differences were found in baseline age, symptom severity or pelvic floor muscle strength, suggesting that attrition was likely random rather than systematic.

Table 2. Demographic data of each group at the start of the multidisciplinary intervention.

	MI-S (<i>n</i> = 28) Mean (SD)	MI-RS (<i>n</i> = 20) Mean (SD)
Age (years)	66.50 (4.68)	64.65 (5.12)
Level of study (%)		
Basic	7.1	20
Intermediate	32.1	10
High	60.7	70
Type of childbirth (%)		
Vaginal	78.6	55
Caesarean	10.7	20
Both	3.6	5
No birth	7.1	20
Age at menopause (years)	49.18 (4.95)	48.09 (5.41)
PFDI-20 (au)		
UDI-6	18.67 (14.24)	13.89 (13.57)
CRADI-8	9.37 (10.56)	18.82 (14.11)
POPDI-6	8.33 (11.54)	17.19 (19.67)
TOTAL	36.37 (24.98)	49.91 (36.01)

MI-S: multidisciplinary intervention supervised; MI-RS: multidisciplinary intervention reduced-supervision; PFDI-20: Pelvic Floor Distress Inventory-20 [22]; UDI-6: Urinary Distress Inventory; CRADI-8: Colorectal–Anal Distress Inventory; POPDI-6: Pelvic Organ Prolapse Distress Inventory.

Table 3. Differences between the sampling moments (pre and post) based on the group. Data are presented as Mean (SD).

		PRE	POST	<i>p</i> -Value	ES
Height (cm)	MI-S	158.21 (6.32)	158.09 (6.31)	0.14	−0.02
	MI-RS	158.71 (6.15)	158.53 (5.95)	0.13	−0.03
	<i>p</i> -value	0.90	0.85		
Weight (kg)	MI-S	67.28 (10.39)	67.47 (10.37)	0.31	0.02
	MI-RS	63.97 (7.91)	64.25 (7.99)	0.23	0.03
	<i>p</i> -value	0.37	0.38		
Body fat mass (%)	MI-S	35.19 (5.22)	35.33 (5.05)	0.34	0.03
	MI-RS	33.77 (4.49)	33.48 (4.32)	0.51	−0.08
	<i>p</i> -value	0.21	0.09		
Lean mass (kg)	MI-S	40.98 (4.19)	41.05 (4.39)	0.62	0.02
	MI-RS	40.36 (4.55)	40.47 (4.47)	0.31	0.02
	<i>p</i> -value	0.67	0.68		
Waist-to-hip ratio (au)	MI-S	0.84 (0.07)	0.84 (0.07)	0.42	0.00
	MI-RS	0.87 (0.07)	0.86 (0.08)	0.26	−0.13
	<i>p</i> -value	0.18	0.69		
Satisfaction with life (au)	MI-S	24.29 (6.99)	24.87 (6.96)	0.34	0.08
	MI-RS	25.70 (6.17)	27.15 (3.55)	0.34	0.29
	<i>p</i> -value	0.44	0.49		

MI-S: multidisciplinary intervention supervised; MI-RS: multidisciplinary intervention reduced-supervision; ES: effect size; cm: centimeters; kg: kilograms; au: arbitrary units.

Throughout each week, all participants were advised to perform the exercises three times (24 workouts). The MI-S group completed an average of 18.35 (5.28) workouts, and the MI-RS group, 17.76 (5.14) workouts. That is, the workout completion rate was 76.49% and 74.01%, respectively.

Table 4. Medians and interquartile ranges between the sampling moments (pre and post) for pelvic floor strength.

		PRE	POST	<i>p</i> -Value	ES ^a	Δ	ES ^b
Power (au)	MI-S	2.82 [2.50–3.00]	3.00 [3.00–3.50]	<0.01	0.53	0.56 (0.96)	0.11
	MI-RS	2.68 [2.12–3.81]	3.00 [2.75–4.00]	<0.01	0.80	0.63 (0.70)	
	<i>p</i> -value	0.97	0.65				
Endurance (s)	MI-S	2.59 [1.89–3.32]	9.33 [7.67–10.00]	<0.01	0.84	5.72 (2.72)	0.30 *
	MI-RS	2.26 [3.16–5.17]	9.21 [6.71–10.00]	<0.01	0.90	4.64 (2.52)	
	<i>p</i> -value	0.19	0.91				
Repetitions (rep)	MI-S	6.33 [3.42–8.33]	10.00 [9.33–10.00]	<0.01	0.83	3.32 (2.51)	0.17
	MI-RS	7.00 [5.08–8.92]	10.00 [7.83–10.00]	<0.01	0.73	2.32 (2.31)	
	<i>p</i> -value	0.44	0.41				
Fast (rep)	MI-S	2.67 [1.75–4.83]	8.50 [5.50–10.00]	<0.01	0.84	4.27 (2.26)	0.16
	MI-RS	2.17 [1.33–7.67]	9.17 [3.75–9.17]	<0.01	0.82	3.47 (3.20)	
	<i>p</i> -value	0.52	0.96				

MI-S: multidisciplinary intervention supervised; MI-RS: multidisciplinary intervention reduced-supervision; au: arbitrary units; s: seconds; rep: repetitions; Δ = Post-intervention – Pre-intervention. ES^a: Within-group effect size (Wilcoxon signed-rank test). ES^b: Between-group effect size (Mann–Whitney U test); *: $p < 0.05$.

Table 5. Baseline characteristics comparison between completers and dropouts.

		Completers (<i>n</i> = 28) (<i>n</i> = 20)	Dropouts (<i>n</i> = 8) (<i>n</i> = 14)	<i>p</i> -Value
Age (years)	MI-S	66.50 (4.68)	68.17 (3.54)	0.36
	MI-RS	64.65 (5.12)	66.86 (7.48)	0.06
PFDI-20 (au)	MI-S	36.37 (24.98)	55.03 (23.41)	0.26
	MI-RS	49.91 (36.01)	60.42 (48.23)	0.36
UDI-6 (au)	MI-S	18.67 (14.24)	29.17 (9.86)	0.14
	MI-RS	13.89 (13.57)	24.40 (23.89)	0.52
CRADI-8 (au)	MI-S	9.37 (10.56)	11.98 (4.15)	0.34
	MI-RS	18.82 (14.11)	21.43 (22.06)	0.37
POPDI-6 (au)	MI-S	8.33 (11.54)	11.89 (12.93)	0.41
	MI-RS	17.19 (19.67)	10.01 (14.35)	0.54
Power (au)	MI-S	2.69 (0.70)	2.85 (0.44)	0.71
	MI-RS	2.74 (1.14)	2.48 (0.78)	0.77
Endurance (s)	MI-S	2.87 (1.58)	2.19 (0.54)	0.24
	MI-RS	3.71 (2.37)	3.47 (2.02)	0.66
Repetitions (rep)	MI-S	6.05 (2.71)	5.88 (2.70)	0.88
	MI-RS	6.72 (2.68)	6.90 (2.36)	0.93
Fast (rep)	MI-S	3.38 (2.19)	2.67 (1.33)	0.61
	MI-RS	3.80 (3.62)	2.35 (1.42)	0.59

MI-S: multidisciplinary intervention supervised; MI-RS: multidisciplinary intervention reduced-supervision; PFDI-20: Pelvic Floor Distress Inventory-20 [22]; UDI-6: Urinary Distress Inventory; CRADI-8: Colorectal–Anal Distress Inventory; POPDI-6: Pelvic Organ Prolapse Distress Inventory; au: arbitrary units; s: seconds; rep: repetitions.

4. Discussion

The main finding of this study is that, under this multidisciplinary approach, both the supervised and the reduced-supervision PFD exercise program (home-based exercise supported with materials designed ad hoc to match the supervised training) were effective in improving pelvic floor muscle strength in all its four domains (power, strength-endurance,

stamina, and resistance to speed). Our main hypothesis regarding PFD training was thus only partially right, as both groups improved equally and significantly. This is promising, as our sample is around 65 years, and many women over this age, even without specific problems related to PFD, experience a decline in muscle tone due to structural and hormonal changes leading to more severe issues in the future. Additionally, maintaining good muscle tone in the perineal area may allow them to continue performing activities of daily living with confidence. To note, endurance was the only pelvic floor strength variable to exhibit significant between-group differences, with slightly larger improvements in the MI-S group. On the other hand, and as expected, body composition remained unchanged, but contrary to the hypothesis, we found no differences in satisfaction with life.

As previously introduced, the need of pelvic floor exercises supervision has led to mixed results. In Felicissimo et al. [10], where the supervised group followed a training program under professional guidance, while the other group performed the same exercises without supervision, both groups showed short-term (8-week) improvements in stress incontinence. Conversely, Hung et al. [11] observed greater benefits in an experimental supervised group that followed a specific training program focused on diaphragmatic retraining exercises, deep abdominal activation, and pelvic floor muscle strengthening, based on Sapsford's design compared to a control group which only received guidance on UI pathology, hygiene, and general pelvic floor exercises. Halfway, a recent study with the same objective showed that women guided by a professional achieved greater improvement in objective tests, whilst subjective outcomes indicated similar benefits between the supervised group and the unsupervised group performing exercises at home [12].

According to our data, when a multidisciplinary team collaborates to create a good protocol, including supporting exercise materials, and educational training to enhance awareness, lower human and spatial resources are required to achieve benefits in perineal muscle strength, similar to those achieved following a once-a-week supervision. Indeed, this latter protocol (once a week supervision) might be considered cost- and time-saving, per se. One aspect that may have been decisive in the success of this MI is that the women in the reduced-supervision group—by attending weekly educational training, submitting their weekly exercise diaries, and receiving exercise reminders via text messages—may have felt more supported than in other interventions where they had no further contact with the physiotherapist or other professionals after the first month [12].

However, it is also noteworthy that the reduced-supervision group showed a lower completion rate after the 8-week intervention than the supervised group (59% vs. 78%), despite the quality of the home-based materials. The main reasons for withdrawal in the MI-RS were work schedule, household responsibilities and/or a lack of motivation. Several women reported that they needed someone to “push” them to perform the exercises, as they often found something more important to do at home. Although participants received psychological counseling and health education, behavioral engagement appears to benefit from ongoing professional supervision, which may reinforce motivation and accountability throughout the intervention. Additionally, since both groups attended to the workshops, a positive atmosphere and sharing pelvic floor exercise experiences may increase motor engagement and enjoyment of the exercises, likely increasing self-care commitment once a woman has decided to take care of herself.

Already, Dumoulin et al. [23] noted that group or individual interventions with supervision and prior knowledge provided by professionals always lead to better adherence and more awareness when correctly performing the exercises. On the other hand, given that the supervision of the physical exercises was the only difference between groups, the results suggest that educational content alone may not be sufficient to motivate women to engage in exercise independently, underscoring the importance of supervised physical

activity in this population, even on the short term (8 weeks). Our results align with those of a recent systematic review, where all supervised interventions showed positive outcomes after interventions directed at pelvic floor muscles [24].

Our findings also confirm that strengthening pelvic floor muscles is associated with minimal side effects and constitutes a cost-effective intervention. Moreover, this 8-week MI provides substantial benefits relative to the costs of medical consultations or even surgical treatment for PFDs [25], reinforcing the value of preventive programs targeting older women at risk of developing PFDs. A recent study has shown that suffering from any PFD can cause women to withdraw from social activities and physical exercise, leading to a decline in their physical and psychosocial condition [26]. The fact that women in the reduced-supervision group improved, contrary to studies suggesting that these interventions should be supervised [11], further enhances the value of this multidisciplinary approach, as the social support and widening of knowledge provided by other professionals complementary to the physiotherapist (nutritionist, psychologist and sports scientist) may have played a role.

Enhancing pelvic floor strength variables is very encouraging because the loss of muscle fibers decreases contractile capacity due to the aging process. A more pronounced improvement in endurance may be attributed to the continuous real-time feedback provided by the instructor, which helps ensure that contraction duration is strictly maintained throughout the training sessions, and may be additionally relevant because keeping longer contractions after the intervention might help to easily maintain a minimum unconscious pelvic floor tone to cope with daily living activities. However, it is of outmost importance that endurance improved in both groups, likely leading to a better quality of life by more effective urine control, as they can all maintain a contraction of the urethral sphincter for longer. At the same time, the improvement in the fast variable allows for the anticipation of sphincter contraction during physical exertion. This means women can preemptively contract the pelvic floor to prevent potential urine leakage during activities that create abdominal pressure. Furthermore, the fact that women were evaluated using the Epi-No instrument adds more value to the results since it is an objective measure, and few studies employ it. In fact, only five studies out of 32 used this instrument to assess pelvic floor muscles [24]. The most common method for assessing muscle tone is through digital palpation, but this can lead to errors, despite the professional's years of experience, due to the subjectivity of the measure [27].

Contrary to the initial hypothesis regarding the psychosocial variable, women did not exhibit a statistically significant increase in satisfaction with life. It is worth noting, however, that participants already reported high baseline levels of life satisfaction, likely due to the fact that the sample consisted of healthy women and the intervention was preventive in nature, aimed at reducing the risk of future PFD. Generally, quality-of-life concerns tend to become more pronounced when individuals face considerable discomfort from PFD. Moreover, many women remain unaware of PFD, often perceiving it as a normal aspect of aging, which contributes to the normalization of symptoms and a reluctance to seek help—a pattern previously documented in the literature [28]. Several factors may explain these findings. The lack of significant changes in Satisfaction with Life Scale scores is likely explained by a ceiling effect, as participants already reported relatively high baseline scores, leaving limited room for improvement. Furthermore, life satisfaction is considered a relatively stable construct, particularly in older adults, and therefore may require longer interventions to produce measurable changes. In addition, the intervention lasted only eight weeks, which may have been insufficient to influence a global cognitive evaluation of one's life. Finally, the SWLS assesses overall life satisfaction rather than more proximal

psychosocial outcomes, such as perceived coping, aging attitudes, or health awareness, which may have been more sensitive to the effects of the multidisciplinary intervention.

Despite the lack of quantitative change in satisfaction scores, qualitative feedback highlighted that the integration of sessions led by a nutrition expert and a psychologist was particularly valuable. Women reported that these components significantly contributed to improving their coping strategies regarding aging, suggesting that the intervention may have had meaningful psychosocial benefits not fully captured through quantitative measures alone.

Regarding the duration of the program, improvements in muscle strength were achieved with just eight weeks of multidisciplinary intervention—shorter than the 12 weeks or more typically reported in previous studies [29]. While these results may be partly influenced by the characteristics of the sample, they contribute meaningfully to the field of prevention. In terms of the type of multidisciplinary intervention applied, it is noteworthy that, to date, similar interventions have predominantly been implemented in clinical contexts, where they have demonstrated high completion rates [30,31]. In contrast, the present study involved community-based preventive strategy-seeking for selfcare commitment, delivered by a team comprising physiotherapists together with nutritionists, psychologists and sport sciences professionals. To the best of our knowledge, this is the first study to implement such an ecological model in a non-clinical setting and given its highly satisfactory outcomes, it shows strong potential for future applications in public health promotion.

When interpreting the PFDI-20 results, although participants had not previously sought professional help, aging often leads to discomfort that can affect quality of life. Despite relatively high total scores, these were far from the maximum value (300), suggesting that this intervention may serve a preventive purpose. Consistent with previous literature, cultural factors often delay specialist consultation until symptoms become severe. Moreover, since the PFDI-20 assesses symptoms over a three-month period, it may lack sensitivity to short-term changes. Therefore, instruments with shorter recall periods, such as the International Consultation on Incontinence Questionnaire–Urinary Incontinence Short Form (ICIQ-UI-SF), which refers to the previous four weeks but focuses exclusively on urinary incontinence, may be more suitable for brief interventions.

The fact that no significant changes were found in body composition may be due to the fact that the sample started with an acceptable weight, as these were active women, most of whom had a higher education, and therefore have greater awareness of the benefits a healthy weight has on their health. Additionally, it is important to note that the exercise protocol in the multidisciplinary intervention was not aimed at reducing anthropometric characteristics but rather focused on working the pelvic floor muscles. As the literature describes, at least 3 months are needed to improve body composition in older active adults, in addition to a program aimed at improving overall fitness.

The present study has certain limitations that should be acknowledged. First, all participants received comprehensive multidisciplinary intervention, including pelvic floor muscle training (PFMT), educational sessions, nutritional counseling, and psychological support. Consequently, the specific contribution of PFMT cannot be fully decoupled from the effects of behavioral monitoring, professional attention, or educational reinforcement. Furthermore, the lack of a “no-intervention” or “education-only” control group means that the massive within-group improvements observed must be interpreted with caution. While these results reflect the real-world clinical effectiveness of our multidisciplinary protocol, the absolute isolation of the exercise effect remains a challenge. In addition, this study should be considered preliminary/exploratory due to its sample size. While the observed effect sizes provide encouraging evidence for the efficacy of the reduced-supervision

model, these findings should be interpreted with caution and require confirmation in larger, adequately powered multicenter trials. However, we acknowledge that our results rely on a per-protocol analysis, which may overestimate the treatment effect compared to an intention-to-treat approach. While per-protocol analysis is appropriate for assessing the physiological efficacy of the intervention in compliant participants, these findings should be interpreted with caution regarding their generalizability to real-world populations with lower adherence. As for future lines of research, one question is whether an even shorter duration of intervention (6 weeks) would be enough to achieve the same improvements. On the other hand, using the same intervention in a clinical setting could help determine whether the effectiveness of the multidisciplinary team is due to the absence of pathology in the sample, or if the holistic approach to PFD genuinely improves different population groups. It should consider a dismantling design or include an education-only control group to further isolate the impact of PFMT from the broader behavioral and educational support provided. Finally, future studies should explore whether age-related barriers influence adherence to reduced-supervision programs.

5. Conclusions

In conclusion, eight weeks of multidisciplinary intervention improved the strength of the pelvic floor muscles, as measured by the PERFECT scheme, in both the supervised and reduced-supervision groups, while body composition and psychosocial outcomes remained unchanged. The multidisciplinary team (physiotherapists, sport and exercise sciences professionals, psychologists, and nutritionists) provided a holistic perspective, addressing the complex factors that influence these women's quality of life through an ecological approach.

Our results indicate that structured exercise protocols can promote physiological adaptations in pelvic floor muscle performance. While these gains are encouraging, they should be interpreted as improvements in muscle capacity rather than direct clinical prevention of pelvic floor disorders, as symptom-based outcomes were not assessed in this study. The markedly lower adherence in the reduced-supervision group underscores the necessity of professional supervision to reinforce motivation and accountability throughout the intervention. Incorporating pelvic floor assessment and education into routine geriatric care could help mitigate the growing burden of pelvic floor dysfunction in older populations.

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Abbreviations

The following abbreviations are used in this manuscript:

CRADI-8	Colorectal–Anal Distress Inventory
GPR	Global Postural Re-education
MI-S	Multidisciplinary Intervention—Supervised
MI-RS	Multidisciplinary Intervention—reduced-supervision
PERFECT	Power, Endurance, Repetitions, Fast, Every Contraction Timed
PFD	Pelvic Floor Dysfunction
PFDI-20	Pelvic Floor Distress Inventory
POPDI-6	Pelvic Organ Prolapse Distress Inventory
UDI-6	Urinary Distress Inventory
UI	Urinary Incontinence

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