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Original Research

Hypopressive exercises for diastasis recti and pelvic floor symptoms in postpartum women: A randomized trial

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ABSTRACT

Background: Diastasis recti abdominis (DRA) is a common postpartum condition that can persist for months, impair abdominal function, and negatively affect quality of life. Despite its prevalence, there is no gold standard treatment. Hypopressive exercises have been proposed as a therapeutic option, but evidence from randomized controlled trials is limited.

Objective: To evaluate the effects of a 12-week hypopressive training program on inter-recti distance (IRD) in postpartum women and its impact on body perception, abdominal function, and pelvic floor symptoms.

Methods: Forty-four primiparous or multiparous women, 45 days to 6 months postpartum, with DRA ≥20 mm at any point on the linea alba, were randomized into two groups. The hypopressive group (HG) underwent a standardized 12-week program, twice weekly, 30 min per session, under professional supervision. The control group (CG) received no intervention. The primary outcome was the change in IRD measured by ultrasonography. Secondary outcomes included abdominal muscle function assessed by bridge tests, body image perception, and pelvic floor complaints using the Pelvic Floor Bother Questionnaire.

Results: No significant difference was observed between groups in the change in IRD. There was a significant difference between groups in abdominal muscle function in the prone bridge [34 s (95% CI 13, 55)], right side [12 s (95% CI 3, 21)], and left side tests [16 s (95% CI 7, 25)], body appreciation [9 (95% CI 5, 13)] and pelvic floor dysfunctions complaints [-4 (95% CI -6, -2)].

Conclusion: Hypopressive training did not reduce DRA, but it improved abdominal muscle function, body image perception, and pelvic floor dysfunction complaints when compared to the control group.

Introduction

During pregnancy, a woman's body undergoes significant transformations to ensure balance and adaptation to maternal-fetal development.[1] One of these changes is the stretching of the rectus abdominis muscles, which leads to muscle distancing called diastasis of the rectus abdominis (DRA).[2,3]

DRA is a condition that affects 100% of pregnant women in the third trimester.[4,5] It is physiological during pregnancy and can persist in the immediate and late postpartum period, in up to 53% of cases after 24 h and 36% for up to 12 months.[4,5] Although there is no consensus in the literature on the cut-off point for DRA,[6] some studies suggest that a distance of 20 mm may be considered pathological diastasis.[3,6] In addition to being a postpartum-related condition, inter-rectus distance (IRD) can persist throughout life,[7] which can impair abdominal muscle performance,[8] impacting women's health-related quality of life.[4,9]

Due to the lack of a gold standard treatment for DRA,[10] new approaches have been tested, including hypopressive exercise.

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1413-3555/© 2026 Associação Brasileira de Pesquisa e Pós-Graduação em Fisioterapia. Published by Elsevier España, S.L.U. All rights are reserved, including those for text and data mining, AI training, and similar technologies.

Hypopressive exercise is a training technique created by Dr. Marcel Caufriez in the 1980s to treat urinary incontinence. This method involves rhythmic and chronological postures associated with breathing and apnea to tone the abdominal and pelvic floor muscles.[11] Therefore, it is possible that hypopressive training is a therapeutic option for the treatment of DRA and can work on the involuntary contraction of the deeper muscles of the abdomen and pelvic floor muscles.

Few studies have assessed the effects of intervention through hypopressive exercises in women with DRA. Some studies were non-randomized and had small sample sizes and observed positive results regarding the improvement of IRD.[12,13,14] However, despite the possibility of positive effects and its widespread use in clinical practice, no randomized controlled clinical trials on the subject were found. Therefore, this study aimed to investigate the effects of a 12-week hypopressive training program on IRD in women 45 days to 6 months postpartum, and its impact on body perception, abdominal function, and pelvic floor symptoms.

Methods

Design

The research consisted of an exploratory, parallel-group, randomized controlled trial, with concealed allocation, assessor blinding, and intention-to-treat analysis, following the Consolidated Standards of Reporting Trials (CONSORT) guidelines. After the initial test, all participants were randomized into two groups: the group that underwent training with hypopressive exercises (HG) and the control group that did not receive any intervention (HC). The randomization of the groups was carried out by an independent researcher. A list of random numbers was generated by a computer and placed in opaque, sealed, and numbered envelopes separating them into two groups. As soon as the volunteers arrived at the initial assessment, they picked one of these numbers and thus they were randomized into each group (1:1).

An independent blind researcher with more than 3 years of experience in ultrasound in assessing DRA performed the examinations on the selected participants. To ensure data reproducibility, an evaluator's test-retest reproducibility analysis was initially carried out. Fifteen nulliparous women were assessed for inter-rectus distance on two different occasions, separated by one week. The intraclass correlation coefficient (ICC) calculation was performed for all ultrasound variables.

Participants

The participants were recruited through university social media advertising, in addition to announcements on local radio and television programs. The inclusion criteria were: women aged 18 or over; between 45 days and 6 months postpartum and diagnosed with DRA, defined as 2 cm or greater separation at any point along the linea alba.[3,15,16,17] Exclusion criteria were history of previous abdominal cosmetic surgery; presence of musculoskeletal diseases that make it impossible to carry out the requested exercises; and diagnosis of midline abdominal hernia. The study was conducted from January to July 2023 at the Pelvic Kinesiofunctional Performance and Women's Health Laboratory facilities at the Federal University of Uberlândia, Brazil.

After the ultrasound evaluation, participants completed an electronic questionnaire collecting information about lifestyle habits, weight, height, and body mass index (Table 1).

Intervention

HG performed the hypopressive exercises training for 12 weeks, with two sessions per week, lasting 30 min per session, led by a qualified instructor. The activities were conducted in-person in groups of up to four participants. The exercise protocol was performed based on the method described by Caufriez[11] and is represented in Fig. 1.

Table 1
Baseline characteristics of participants.

Characteristic	Hypopressive Group ($n = 22$)	Control Group ($n = 22$)	Total ($n = 44$)
Age (y), mean (SD)	34 (5)	32 (5)	33 (5)
Body mass index (kg/m2), mean (SD)	25 (4)	25 (5)	25 (4)
Postpartum period (days)	116 (33)	112 (28)	114 (31)
Type of birth, n (%)	Vaginal: 5 (23%) Cesarean: 17 (75%)	Vaginal: 8 (36%) Cesarean: 14 (64%)	Vaginal: 13 (30%) Cesarean: 31 (70%)
Performed physical activity during pregnancy, n (%)	No: 12 (55%) Yes: 10 (45%)	No: 16 (73%) Yes: 6 (27%)	No: 28 (64%) Yes: 16 (36%)
PFMT during pregnancy	No: 20 (91%) Yes: 2 (9%)	No: 20 (91%) Yes: 2 (9%)	No: 40 (91%) Yes: 4 (9%)

PFMT, Pelvic floor muscle training.

The control group participants were advised against performing physical activities for 12 weeks. During this period, we maintained regular contact through conversations and weekly reminders in a group, where we provided updates on the progress of the research and emphasized the importance of not engaging in physical activity, as this could impact the expected results.

At baseline and after 12 weeks, all participants were evaluated for primary and secondary outcomes.

Primary outcome

Change in inter-rectus distance: An independent researcher performed the clinical examination before and after the intervention using a two-dimensional ultrasound diagnostic scanner. The PHILIPS EPIQ5 USA equipment was used, using a 5–12 Mhz linear probe and musculoskeletal preset. The participants were positioned in the supine position with knees and hips semi-flexed and feet on the examination table, with their arms resting at their sides. Markings were made 2 cm above and below the center of the umbilicus to standardize measurement locations.[7] Using conductive gel on the abdomen, the transducer was placed transversely at previously marked points, and two images were taken 2 cm above (ICC=0.90) and 2 cm below the umbilicus (ICC=0.84). Then, participants were instructed to flex their trunk during exhalation until the lower edges of the scapula no longer touched the examination table. The images were collected at the end of expiration at the supra-umbilical (ICC=0.93) and infra-umbilical points (ICC=0.84). The mean of two values collected during two attempts at each of the marked points above and below the umbilicus, both at rest and during trunk flexion, was used for data analysis.[6,12]

Secondary outcomes

Pelvic floor dysfunction and complaints: The *Pelvic Floor Bother Questionnaire* was used to evaluate the presence and degree of pelvic floor discomfort. This is a questionnaire validated in Portuguese that evaluates nine symptoms related to urinary incontinence, urinary urgency, urination difficulty, pelvic organ prolapse, intestinal obstruction, fecal incontinence, and sexual pain.[13] The questionnaire is evaluated from 0 to 5 points for each question, which can vary from 0 to 45 points, with higher scores indicating more pronounced discomfort.[13] The questionnaire presents reliability and internal test-retest validity, in addition to high reproducibility (ICC= 0.98).[13]

Function of the abdominal muscles: Two different function tests were conducted by a trained physical therapist. For the prone bridge test the participants maintained a neutral and active posture supported only by their forearms and toes, with timing in seconds from the moment they

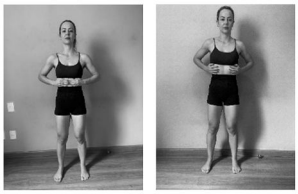
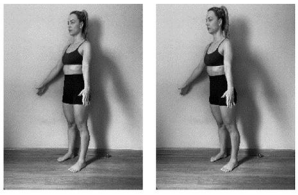
Exercise		Description	Images
Weeks 1 to 4: 5 cycles of 3 to 5 breaths were performed for each exercise.			
1	Breathing	Inhale through the nose for 2 seconds, expanding the chest. Exhale through the mouth for 4 seconds, bringing the navel towards the spine.	
2	Self-stretching	Light cervical spine straightening, accentuating the top of the head with the intention of touching the ceiling.	
3	Decompression	Intent of joint expansion with the idea of pulling the limbs away from the trunk.	
4	Anteposition of the Axis	With all feet on the ground, shift the body weight onto the balls of the feet.	
Weeks 5 to 8: 5 cycles of 3 to 5 breaths were performed for each exercise.			
5	Sitting Lying	Feet parallel, separated by the distance of one hand, feet in dorsiflexion; Head, dorsal spine, sacrum supported on the ground; Arms at a 30º angle from the body, palms of the hands resting on the ground with fingers extended. Knee flexion around 120º relative to the ground. With voluntary activation of the pelvic floor muscles.	

Fig. 1. Details of the exercise program.

maintained the correct posture until they voluntarily stopped the test or were unable to maintain the desired position.[14] Also, the side bridge variation test was conducted, in which the participants assumed the position of lying on their side, supporting themselves on their forearm and side foot, with their feet aligned one in front of the other. During this test, the participant keeps the body aligned, forming a straight line from head to feet. The test was conducted on both the left and right sides with timing in seconds from the moment they maintained the correct posture until they voluntarily stopped or were unable to maintain the position.[18]

Body Perception: Before and after 12 weeks, participants were asked to assess their body perception by responding to the question developed by the authors, "How do you feel about your body at this moment?" A Likert-type scale was used for this evaluation, ranging from 1 to 5, with lower scores reflecting reduced levels of body appreciation and acceptance.

Data analysis

Based on a literature study,[3] a minimum change of 10 mm (SD 9.2 mm) was considered for between groups IRD means. Considering a test

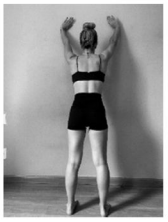
6	Aurora sitting on the wall	Sitting cross-legged, feet in dorsiflexion, back supported against the wall along with the head in self-stretching. Hands in dorsiflexion, shoulders internally rotated, with the heel of the hand resting on the middle of the thigh, fingers extended.	
7	Aurora on the Wall	Feet parallel, separated by the distance of one hand, feet in dorsiflexion one foot away from the wall; Head, dorsal spine, sacrum supported against the wall; Arms at a 30º angle from the body, palms of the hands resting on the ground with fingers extended. Knee flexion until the shins are at 90º from the ground	
8	Preparation for the Atlas	Hands supported on the wall, facing forward with internal rotation; Anteposition of the gravity axis. Hands open, activation of the glutes, quadriceps, erector spinae, and serratus anterior.	
Weeks 9 to 12: 10 cycles of 1 breath and 1 breath-hold were performed for each exercise.			
9	Aurora on the knees	On the knees, feet in dorsiflexion; shoulders internally rotated, in dorsiflexion, supported on the anterosuperior iliac crest, elbows flexed.	

Fig. 1. (*continued*).

power of 90% and a significance level of 5%, it was determined that at least 22 participants would be necessary for each treatment group, resulting in a sample of 44 individuals for the present study.

Data analysis was performed using the Statistical Package for the Social Sciences (SPSS) software, by an investigator independent of the assessment and intervention process. Background variables were reported as means with standard deviations (SD) or numbers with percentages. Data were analyzed using the intention to treat analysis. All participants were reevaluated, and their data were analyzed, including those who did not fully complete the training.

Conformity with normal distribution was tested using the Shapiro-Wilk test. For the descriptive analysis of the quantitative and qualitative variables, Student's *t*-test and χ^2 test were applied respectively. An analysis of variance (repeated measures ANOVA) was performed to compare the variation between the CG and HG variables, followed by a post-hoc Tukey test to compare the intra- and intergroup variables.

10	Preparation for the Pim on the Wall	Feet parallel, separated by the distance of one hand, feet in dorsiflexion one foot away from the wall; Head, dorsal spine, sacrum supported against the wall; Arms at a 30º angle from the body, palms of the hands resting on the knee with fingers extended. Flexion of the cervical and dorsal spine with elevation of the hands in contact with the quadriceps.	
11	Aurora sitting unsupported	Head, dorsal spine, sacrum aligned; shoulders internally rotated, in dorsiflexion, supported on the anterosuperior iliac crest, elbows flexed.	
12	Aurora standing	In orthostatic position, hands on the hips with fingers pointed towards the iliac crest. Knee flexion, Anteposition of the axis.	
13	Horse	On all fours with feet separated by the distance of one hand, parallel and in dorsiflexion, knees at 90 degrees; Hands in line with the shoulders. Shoulders internally rotated, Maximum cervical flexion, Dorsal spine flexion, elbows flexed	
14	Sitting on the Wall + Mobility	Feet parallel, separated by the distance of one hand, feet in dorsiflexion one foot away from the wall; Head, dorsal spine, sacrum supported against the wall; Arms at a 30º angle from the body, palms of the hands resting on the ground with fingers extended. Knee flexion until the shins are at 90º from the ground. Inhale for anteversion, exhale for retroversion. With voluntary activation of the pelvic floor muscles.	

Fig. 1. (*continued*).

Differences in change between groups from baseline to Week 12 are reported with 95% CI. The established significance level was 5%.

Results

Flow of participants through the study

A total of 228 women signed up and were selected to participate in the screening and initial ultrasound assessment. One hundred and eighty-four (81%) were not includedmostly due to not meeting the IRD

inclusion criteria. Therefore, 44 participants were included in the study and randomized into the hypopressive exercises group (HG, $n = 22$) and the control group (CG, $n = 22$). The flow of participants through the trial is described in Fig. 2.

Baseline characteristics of the trial participants

Baseline characteristics for the participants included in the trial are presented in Table 1. The groups' characteristics were similar at baseline.

Adherence to the exercise program

A total of 24 exercise sessions were scheduled over a 12-week period. The adherence rate to treatment among participants was 72% (17 sessions) ± 20% of the scheduled sessions. Fifteen (68%) of the 22 participants in the intervention group attended over 70% of the sessions.

Change in inter-rectus distance

The data analysis revealed no significant group-time interaction for the IRD variable, as assessed at rest in the supra-umbilical region [$p = 0.183$] and the infra-umbilical region [$p = 0.070$]. Similarly, no group-time interaction was observed for IRD values measured during a curl-up above [$p = 0.936$] or below the umbilicus [$p = 0.594$].

A significant time effect was observed across all measurements, with the Tukey post-hoc test revealing a reduction in IRD values exclusively within the hypopressive group (HG) following the intervention. These reductions were identified in measurements taken at rest, 2 cm above ($p = 0.006$) and below ($p = 0.034$) the umbilicus, as well as during a curl-up, 2 cm below the umbilicus ($p = 0.041$). In contrast, no significant changes were observed in the CG, nor were there significant differences between groups (Table 2).

Complaints about the pelvic floor

A group-time interaction was observed for the PBQ questionnaire [$p = 0.001$]. A reduction in symptoms related to the pelvic floor was observed only in participants in the HG when the values before and after the intervention were compared ($p = 0.003$) and a difference between groups after 12 weeks ($p < 0.001$) (Table 3).

Abdominal muscle function

Group-time interaction was observed for the variables prone bridge [$p < 0.001$], right side bridge [$p < 0.001$] and left [$p < 0.001$] tests. The post-hoc test demonstrated an increase in the test holding time only for the HG after the intervention with large effect sizes for all three tests ($p < 0.001$). Compared with controls, the hypopressive exercise group increased prone bridge endurance by 34 s (95% CI 13–55) (Table 3).

Body perception

There was an improvement in body appreciation in the HG with an average increase of 30% compared to the control group (Table 3).

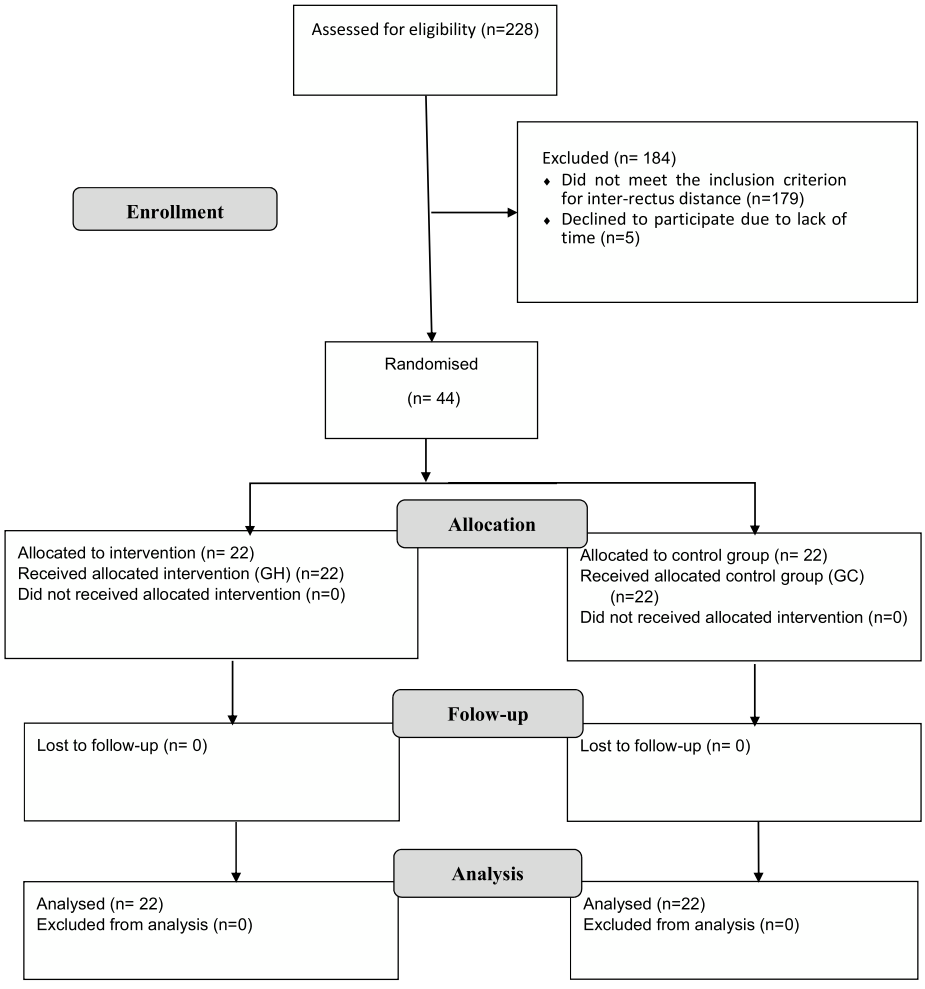


Fig. 2. Flow of participants through the study.

Table 2
Mean (SD) of groups, mean (SD) within-group difference and mean (95% CI) between-group difference for width of inter-recti distance under various conditions.

Inter-recti distance (mm)	Groups				Difference within-group		Difference between groups
	Baseline		Week 12		Week 12 minus Week 0		Week 12
	HG (n = 22)	CG (n = 22)	HG (n = 22)	CG (n = 22)	HG (n = 22)	CG (n = 22)	HG minus CG
At rest 2 cm above umbilicus	29 (7)	30 (7)	25 (8)	28 (5)	−4 (−8.6, 0.6)	−2 (−5.7, 1.7)	−3 (−7, 1)
At rest 2 cm below umbilicus	10 (10)	7 (10)	5 (5)	7 (8)	−5 (−9.9, −0.2)	0 (−5.5, 5.5)	−2 (−6, 2)
During a curl-up 2 cm above umbilicus	21 (7)	23 (6)	19 (7)	21 (5)	−2 (−6.3, 2.3)	−2 (−5.4, 1.4)	−2 (−6, 2)
During a curl-up 2 cm below umbilicus	7 (8)	5 (9)	2 (3)	2 (3)	−5 (−8.7, −1,3)	−3 (−7.1, 1.1)	0 (−2, 2)

HG, hypopressive group; CG, control group.

Table 3
Pre and post intervention values by group, difference within and between groups, and point estimates with 95% confidence interval.

Outcome measure	Groups				Difference within-group		Difference between groups
	Baseline		Week 12		Week 12 minus Week 0		Week 12
	HG (n = 22)	CG (n = 22)	HG (n = 22)	CG (n = 22)	HG (n = 22)	CG (n = 22)	HG minus CG
PFQ score (0 to 45)	8 (8)	6 (5)	3 (4)	7 (7)	−5 (−8.8, −1.1)	1 (−2.7, 4.7)	−4 (−6, −2)
Prone bridge test (s)	25 (20)	25 (16)	65 (45)	31 (20)	40 (18.8, 61.2)	6 (−5.0, 17.0)	34 (13, 55)
Right lateral bridge test (s)	15 (14)	16 (13)	29 (16)	17 (12)	14 (4.8, 23.1)	1 (−6.6, 8.6)	12 (3, 21)
Left lateral bridge test (s)	15 (13)	17 (13)	32 (18)	16 (9)	17 (7.4, 26.6)	−1 (−7.8, 5.8)	16 (7, 25)
Body Apreciation (1 to 5)	33 (8)	28 (8)	38 (6)	29 (8)	5 (0.7, 9.3)	1 (−3.9, 5.9)	9 (5, 13)

HG, hipopressive group; CG, control group; PFQ, Pelvic Floor Bother Questionnaire # Tukey post-hoc test.

Discussion

The findings of this study suggest that there was no significant difference in changes in IRD between the hypopressive and control groups after 12 weeks. To our knowledge, this is the first randomized controlled trial to investigate the effects of hypopressive training in postpartum women with DRA.

It has been hypothesized that hypopressive exercises may help reduce IRD, as observational studies suggest that contraction of the transversus abdominis muscle can create tension in the linea alba and facilitate force transfer across the midline of the abdomen.[19,20] This tension may, in turn, lead to tissue remodeling, contributing to a reduction in IRD.[21] Hypopressive exercises, which combine specific postures with targeted breathing techniques, are thought to strengthen deep trunk muscles, including the transversus abdominis,[11] thereby promoting the reduction of diastasis in postpartum women. However, this hypothesis was not supported by the present study.

Few studies with less robust methodologies have investigated the effects of hypopressive exercises in women with DRA. Ramírez-Jiménez et al. conducted a case series involving 12 women with DRA.[22] All participants underwent a four-week intervention using hypopressive exercises with a similar progression of exercises. Following the intervention, the authors reported a reduction in supra-umbilical IRD, measured by digital calipers. However, it is well known that digital calipers are a less reliable method for measuring IRD,[23] which may account for the discrepancies between their findings and those of the present study.

Gómez et al. [24] also reported positive outcomes from hypopressive training. Their study included only eight primiparous women who participated in a 10-week hypopressive training protocol. DRA was assessed via ultrasound before and after the intervention, and the results indicated an improvement in DRA. However, the small sample size significantly limits the generalizability of their findings.

The studies by Ramírez-Jiménez et al.[22] and Gómez et al.[24] implemented a different number of sessions compared to the present study, which may have influenced the outcomes. Additionally, it is important to highlight that neither study included a control group, which is critical for adequately comparing the observed improvements to either minimal intervention or the natural progression of IRD. In the present study, the HG also demonstrated a reduction in IRD following the intervention. However, the magnitude of reduction in inter-rectus distance was similar between groups, with confidence intervals indicating no meaningful between-group difference. These findings suggest that hypopressive exercises do not provide additional benefit over natural recovery for reducing DRA in postpartum women.

Although hypopressive training did not reduce IRD when compared to the absence of intervention, an improvement in abdominal function was observed exclusively in the intervention group following the intervention. This result is consistent with the randomized controlled trial of Moreno-Muñoz et al., who evaluated the impact of hypopressive training on postural improvement and activation of the deep trunk muscles of 117 women.[25] The training protocol consisted of two weekly 30-minute sessions over 8 weeks. Although the hypopressive exercise group showed greater improvements in abdominal muscle activation and function than the control group, the between-group differences were small. Considering the role of the abdominal muscles in trunk movement, lumbopelvic stabilization, and breathing,[26] hypopressive training may represent a complementary strategy to support abdominal function in postpartum women. Although the present study did not directly assess pelvic floor muscle activation, previous research has demonstrated that hypopressive exercises can activate the pelvic floor muscles.[27,28,29] Therefore, the findings of this study suggest that such activation during hypopressive exercises may contribute to reducing pelvic floor dysfunction complaints in postpartum women with DRA. Similarly, studies by Molina-Torres et al.[30] and Soriano et al.[31] reported improvements in pelvic floor muscle contractility and tone, along with a reduction in symptoms, following hypopressive training in incontinent women compared to those who did not receive any intervention. These findings are consistent with the results of our study. However, the practice of other physical exercises, including pelvic floor muscle training, was not systematically monitored during the study period, and the potential contribution of unreported cointerventions to changes in pelvic floor–related symptoms cannot be fully excluded.

It is worth noting that the baseline PFQ scores were low, suggesting that participants likely experienced mild symptoms. This underscores the need to further investigate the effects of hypopressive exercises on symptom reduction in women with more severe pelvic floor dysfunction complaints. Additionally, further research is essential to compare the effects of hypopressive training versus pelvic floor muscle training, the gold standard for treating pelvic floor dysfunction,[32] in postpartum

women with DRA.

The various training methodologies that permeate hypopressive training make intervention with this method heterogeneous, which may have contributed to the disparity in the results observed in our study. In this study, we chose to follow the approach proposed by Marcel Caufriez,[11] known as a precursor in the development of the hypopressive method. The scientific literature lacks a clear specification of the training approaches adopted, making it essential for research to detail interventions according to the principles of each training methodology.

Despite the findings regarding IRD following the intervention, an improvement in the participants' body image perception was observed. A randomized clinical study with a sample of 129 participants divided into a control and intervention group investigated the impact of hypopressive training on the quality of life of women in the postpartum period.[33] The study results showed significant improvement in these women, especially in body image and self-evaluation, resulting in a positive impact on the participants' self-esteem.

Based on the results found, it is worth reflecting on the significance of IRD, as muscle function, body perception, and self-evaluation are the variables that truly impact women's health. The study results suggest that movement professionals should not focus solely on bringing the muscle portions closer together, as there is a natural recovery process of this separation within 8 weeks.[34] Therefore, management should be guided by muscle function and women's satisfaction, contributing to a better quality of life.

The moderate adherence of the participants to the intervention is a limitation of the present study. However, it is believed that this fact mimics clinical practice with women in the postpartum period. It is known that less than 28% of women are physically active, and this number decreases during pregnancy and the postpartum period.[35] Many women do not return to physical activity postpartum, and it may take 3 years to fully return to physical activity.[36,37,38] This is because the postpartum period is a period of high demand and the mother's dedication to the new routine makes it challenging for women to attend the program.

Strengths of this trial were IRD measurement using ultrasound, considered the gold standard,[39,40] the randomized and assessor-blinded design with concealed allocations, and intention-to-treat analyses. Thus, the results offer valuable analyses to guide clinical decision-making in strategies for intervention in postpartum women with DRA.

Conclusion

In postpartum women with diastasis recti abdominis, changes in inter-rectus distance were of similar magnitude in the hypopressive exercise group and the inactive control group after 12 weeks. In contrast, compared with the inactive control group, hypopressive training was associated with greater improvements in abdominal performance, body image perception, and pelvic floor–related symptoms, although the magnitude of these between-group differences was modest. These findings suggest that hypopressive exercises may be more relevant for functional and symptom-related outcomes than for reducing inter-rectus distance in postpartum women.

Declaration of competing interest

The authors declare no competing interest

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