

THE WRIST & PELVIC FLOOR GUIDE

The two places where women over forty most often stop. Neither is a reason to stop.

HOW TO USE THIS

This expands two pages of your book: **A3 Wrist Prep** on page 15 and **E1 Breathing and Pelvic Floor Connection** on page 51. Nothing here replaces them – the sequences are identical. What is added is how to make each one lighter or harder, what to check when it is not working, and when the answer is a professional rather than another attempt.

Read it once. Come back to it in week two, which is when both of these usually announce themselves.

THE WRISTS

Bodyweight training asks the wrist to hold your body weight while it is bent back toward ninety degrees. For most women over forty this is not an old injury complaining. It is a load the joint has not been asked to carry in decades, arriving all at once.

Your book calls tightness at the wrist check very *common* and says to expect improvement over several weeks. Both halves of that matter. It is common, and it is slow – which means the women who quit over it usually quit in week two, three weeks before it would have resolved.

A3 is the answer, and it is two minutes. Before every upper-body day and again at the end of the session. On recovery days, all eight mobility movements.

THE FOUR POSITIONS

Identical to page 15. What follows is what each one is for.

Palms down, fingers forward · 20 seconds

The position you will actually be in during every push-up. Start here so the rest has a reference.

Palms down, fingers turned back toward your knees · 20 seconds

The one that talks loudest. It lengthens the forearm muscles on the palm side, which are the tight ones in almost everybody.

Backs of the hands down · 15 seconds

The opposite direction. Skipping it is why some women stay tight for months while doing the other two diligently.

Open and close both fists · 20 times

Circulation and grip. Two minutes of the first three, then this, and the hands feel like hands again.

Never push into pain. Tightness that eases as you hold is the work. Sharp is not.

MAKING A3 LIGHTER OR HARDER

The four positions never change. What changes is how much of you is on your hands.

If the version on page 15 is too much on day one, you have not failed the warm-up — you have started one rung too high. Work down this ladder until the positions are uncomfortable but not sharp, hold there for a week, then move up one.

- 1 Standing at a table or kitchen counter, hands flat on the surface**
Almost no load. Lean in only as far as is comfortable.
- 2 The same, leaning further forward so the arms take some weight**
Light.
- 3 On all fours, weight shifted back toward your heels**
Moderate.
- 4 On all fours, weight neutral**
Full load. This is the version printed on page 15.
- 5 On all fours, weight rocked gently forward over the hands**
More than full.

Rung 1 is also the answer on days you cannot get down to the floor. Same sequence, same two minutes, standing at a table. Nothing is lost.

Rung 5 is not a goal. Most women never need it. It is there because a few will find rung 4 easy by week four and should have somewhere to go.

AND THE PUSH-UPS THEMSELVES

Wrist load in a push-up drops as the surface rises. This is the ladder your book is already built on.

B1 Wall p18 → **B2** Counter p19 → **B3** Chair p20 → **B4** Knees p21 → **B5** Floor p22

Alongside it runs a second track that removes wrist extension almost entirely.

B6 Fist Push-Up, page 23. Fists, knuckles down, wrist near neutral. It costs nothing in difficulty and it is the version the book designed for exactly this. On **B3**, gripping the sides of the seat rather than the flat does the same job.

And the rest of the book barely involves your wrists. Every movement in D — Legs is wrist-free. So are E1 to E4, E6 to E9, and F1 to F5. On a bad wrist week you still have more than thirty movements available without a single modification.

WHEN IT DOES NOT IMPROVE

Your book's wrist check gives three results. The third is the one that matters here.

Sharp pain, or numbness. Use fists and forearms throughout, and speak to a doctor or physiotherapist before attempting floor push-ups. **Numbness in particular deserves a proper look** — it is a different kind of signal from tightness, and no amount of wrist prep is the right response to it.

And the book's own rule, from page 13: if the same movement hurts three sessions running, that is worth a conversation with a professional rather than another attempt.

WHAT E1 IS ACTUALLY DOING

Most women meet the pelvic floor as an instruction to squeeze, given without explanation, usually after childbirth and usually once. E1 is not that.

Your diaphragm and your pelvic floor move together. Breathe in, and the diaphragm drops while the pelvic floor lengthens underneath. Breathe out, and both return. They are the top and the bottom of the same container, and they work as a pair whether or not you are thinking about it.

E1 trains the coordination, not the strength. That is why the effort is light, why the breath is the exercise rather than the setting for it, and why releasing counts as much as lifting. A pelvic floor that has learned to move with the breath is doing something a pelvic floor that has learned to clench cannot do.

This is also why page 51 marks it a key movement, and why Day 5 of every week in the program opens with it. Always.

HOW TO DO IT

Identical to page 51.

1

Lie on your back, knees bent, feet flat. One hand on your chest, one on your lower ribs.

2

Breathe in slowly through your nose. Your **lower ribs widen sideways** under your hand. The hand on your chest barely moves.

3

Breathe out slowly through your mouth. As you do, gently draw up through the pelvic floor.

4

The feeling is of **stopping wind, or lifting a marble**. Effort around **three out of ten** — light.

5

Fully release as you breathe in again. Eight to ten breaths, about two minutes.

Releasing matters as much as lifting. If you only ever practise the lift, you are training half a movement — and it is the half most women already over-use.

THE THREE THINGS THAT GO WRONG

Page 51 names all three. Here is how to catch each one.

Squeezing hard. If you could squeeze harder and you are, you are past three out of ten. A pelvic floor that is always clenched is not a strong pelvic floor — it is a tight one, and tightness can produce exactly the symptoms people assume mean weakness.

Using the glutes or inner thighs instead. Rest a hand on one buttock. It should stay soft throughout. Same for the inner thigh. If either fires, the pelvic floor is not doing the work and you are practising the substitution.

Forgetting to release. Count the in-breaths, not the out-breaths. It reverses your attention and the release stops being an afterthought.

And one more: holding your breath. If you find yourself bracing and stopping the air, the exercise has inverted. The breath is not the container for the movement. The breath is the movement.

THE FIVE STAGES

Page 51's harder box says the real progression is adding this connection to the exhale of every other exercise in the book. This is the staircase to it.

Do not move up until the current stage is unremarkable – not perfect, unremarkable.

- 1 Lying**
Page 51 as written. Knees bent, hands on chest and ribs.

- 2 Seated**
In a chair, feet flat, sitting tall. Identical pattern, and gravity is now involved.

- 3 Standing**
Feet hip-width. The hardest of the three static positions, and the one that matters in ordinary life.

- 4 Attached to one movement**
Connect on the lifting exhale of D6 Glute Bridge, page 43. One movement, every rep.

- 5 Attached to everything**
Every push, every squat, every plank. The exhale is when you connect.

Page 51 lists seated as the easier option, and for a woman who cannot lie down comfortably that is exactly what it is. It is also stage two. Both are true – the position is easier to get into and harder to do.

WHEN IT DOES NOT WORK

I cannot feel anything.

Common, and not a verdict on you. Give it two full weeks of daily practice. If you still cannot find the connection after that, **talk to a pelvic health physiotherapist – do not push harder.** That instruction is on page 51 of your book and it is the single most important line in this guide. Squeezing harder at something you cannot feel does not build it. It builds the substitution.

I can feel it, but it is exhausting.

The effort is too high. Three out of ten. If two minutes of this leaves you tired, you are doing something considerably more strenuous than what is on page 51.

I leak during the conditioning days.

Information, not failure. Your book's conditioning block is built with no impact for exactly this reason. It also means one of the three questions on page 8 is a yes for you now, whatever it was on day one – which puts the next page in play.

I feel heavy or dragging at the end of the day.

That is one of the three questions. Same answer: the next page.

I have been doing pelvic floor exercises for years and nothing changes.

Worth knowing: an over-tight pelvic floor produces symptoms that look identical to a weak one, and more squeezing makes it worse. This is not something to work out at home from a PDF. It is one of the clearest reasons to get an assessment.

WHEN TO SEE A PELVIC HEALTH PHYSIOTHERAPIST

Your book puts it plainly on page 8: most women have never heard of one, and it is often the single most useful appointment they ever make.

GO BEFORE YOU START IF

- Two or three of the pelvic floor questions on page 8 were a yes
- You have any sense of bulging or heaviness in the pelvis
- The abdominal check found more than two fingers, softness, or doming
- You have been on the general **see a doctor first** list on page 8

CONSIDER GOING IF

- One of the three questions was a yes
- You cannot find the connection in E1 after two full weeks
- You have practised pelvic floor exercises for years without change
- Something started during the program that was not there before

And the ordinary reason, which is the most common of all: you have symptoms you have been quietly managing for a decade and have never told anyone about. Leaking when you cough is common. Common is not the same as normal, and it is not the same as untreatable.

WHAT ACTUALLY HAPPENS

The barrier for most women is not knowing what they are walking into.

Expect a conversation first — symptoms, history, what you have tried, what you want to be able to do. Expect to be asked about things nobody has asked you about before, by someone who asks them every day.

An assessment may include an internal examination, because it is the most direct way to see what the muscles are doing. **It requires your consent, it can be declined, and useful work can be done without it.** You are allowed to say no, or not today, and it will not end the appointment.

You should come away with an individual plan — not a leaflet.

FINDING ONE

United Kingdom. Ask your GP for a referral. Some NHS services accept self-referral for pelvic health directly. The professional network for this specialism is POGP — Pelvic, Obstetric and Gynaecological Physiotherapy — which maintains a directory of practitioners.

United States. The Academy of Pelvic Health Physical Therapy maintains a locator for qualified practitioners.

Anywhere. Search *pelvic health physiotherapist* or *women's health physiotherapist* with your area. The specialism exists in most countries under one name or the other.

WHAT TO TAKE, AND WHAT TO ASK

Take the book. Open it at page 8 and at page 51.

Then ask the specific question, not the general one: **what should I modify?** Page 8 of your book makes the point and it is worth repeating — professionals give far better answers to a specific question than to *is exercise okay for me*.

You are not asking permission to train. You are asking what to change while you do.

This guide is general educational information. It is not medical advice, diagnosis or treatment, and it cannot rule anything in or out.

It expands two pages of *Military Calisthenics for Women Over 40* and adds nothing clinical to them. If anything here raises a concern, the correct next step is a qualified professional — not this document and not the book.

Stop and seek medical attention for sharp pain, numbness or tingling, dizziness, chest discomfort, or any sense of bulging or heaviness in the pelvis.

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