WSH The Foundation

Women's Sexual Health Journal

Editorial

Women function sexually when all the parts involved come together as a healthy whole. Overall fitness, balanced hormones, mental well-being, and an emotionally safe relationship contribute to a woman's ability to participate in and enjoy sex.

This month's journal issue is all about the pelvic floor. Before I became a sex therapist, I couldn't have even told you what the pelvic floor muscle did, but once I learned, I understood its function and why it is so important. That one set of muscles pretty much holds up all the organs at the bottom of a woman's torso. With gravity taking its natural course, the pelvic floor needs to work hard to keep the organs optimally functioning.

Yet, like me in my naïve state, most women have no idea of the importance of the pelvic floor. When a woman has painful vaginal sex and I suggest a consult with a gynecologist and a physical therapist, she nearly always understands the first referral, but rarely the latter. It is yet another instance of the ways in which a woman's sexual anatomy are mysterious to her. The article "Female Sexual Dysfunction and Physical Therapy" by Stephanie Lutz, DPT and Amy Stein, MPT will help to enlighten readers.

Further enlightenment comes from material reprinted from Amy Stein's book Heal Pelvic Pain: The Proven Stretching, Strengthening, and Nutrition Program for Relieving Pain, Incontinence, IBS, and Other Symptoms without Surgery. Stein describes the role of the pelvic floor and what can happen when the muscle tone is too high. Then she offers exercises that are helpful in alleviating a variety of problems. Because men have pelvic pain, too, the book is written to help both sexes.

This is, sadly, my last editorial for the Women's Sexual Health Journal, and the last issue that will be produced. I have found the Journal to be very informative, and I hope you have, too. The Foundation will continue its role as an advocate for women's sexual health in a multitude of other forms. In a culture where women's sexuality is still a taboo topic for many, there is plenty of work left to do.

Editor—Stephanie Buehler, MPW, PsyD, CST

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Published four times yearly by The Women's Sexual Health Foundation, Cincinnati, Ohio. The Journal (WSHJ) is an educational service to provide valuable information to professional, student, and public members of the Foundation. Founded in April of 2003, and directed by Lisa Martinez, RN, JD, The Women's Sexual Health Foundation (TWSHF) is a nonprofit corporation. TWSHF supports a multidisciplinary approach to the treatment of sexual health issues and serves as an educational resource for both the lay public and healthcare professionals. The Professional Advisory Board: Yitzchak (Irv) M. Binik, PhD, David Ferguson, PhD, MD, FACCP, Jean Fourcroy MD, PhD, Marjorie A. Green, MD, MPH, Woet Gianotten, MD, Andre T. Guay, MD, FACP, FACE, Susan Kellogg-Spadt, PhD, CRNP, Michael L. Krychman, MD, FACOG, Talli Rosenbaum, PT, PhD, Lynne Shuster, MD, FACP, Mitchell Tepper, PhD, MPH, and Beverly Whipple, PhD, RN, FAAN.

Articles, letters, and questions may be submitted to Dr. Stephanie Buehler, at info@twshf.org.

Female Sexual Dysfunction and Physical Therapy

Stephanie Lutz, DPT and Amy Stein, MPT

Many women experience sexual difficulties at some point in their lives. Difficulties with sexual function can be extremely distressing to women and to their partners, especially if these difficulties persist. If you experience long lasting lack of desire or arousal for sexual activity, or persistent pelvic pain, you may have a form of female sexual dysfunction. Several factors, including psychological and physical conditions, should be considered in diagnosing and treating female sexual dysfunction.

What are the symptoms of Female Sexual Dysfunction?

Female sexual dysfunction (FSD) includes conditions such as decreased libido, decreased sexual response, or pelvic pain. Decreased libido can be described as a persistent lack of interest in sexual thoughts or activities. Sometimes the desire is present, but there is difficulty with arousal. Decreased sexual arousal or response can manifest as lack of lubrication or difficulty achieving or maintaining an aroused state. Decreased sexual response can also result in trouble achieving orgasm or inability to experience orgasm. Occasionally, a hyperarousal syndrome results, which is another form of FSD. Women with this condition experience constant arousal, but orgasm may be impossible or painful to achieve.

Pelvic floor dysfunction (PFD) and pelvic pain often leads to female sexual dysfunction. Sensitivity of the tissue at the opening or deeper in the vagina can make intercourse painful or impossible. A recent research article in JAMA (Journal of American Medical Association) found that one out of every four women suffers from pelvic floor disorders. In the Journal of Sexual Medicine, it is estimated that up to 21% of women experience dyspareunia (painful intercourse) at some point in their lifetime.

What can cause FSD?

It is important to remember that sexuality is complex and female sexual dysfunction can be caused by multiple factors that include psychological or social attitudes, hormonal changes, underlying medical conditions and musculoskeletal factors. For purposes of this article we are going to discuss the musculoskeletal components of FSD as it relates to pelvic floor dysfunction.

Various medical conditions can factor into female sexual dysfunction. Chronic yeast or urinary tract infections can lead to increased sensitivity of the vulvar and vaginal area. Other skin conditions, such as lichen sclerosis and lichen planus, can also alter the delicate tissue near the vaginal opening. Also, hormone levels, specifically estrogen, affect the skin around the vagina. When estrogen levels are low as in menopause or following childbirth, the sensitivity and lubrication of the vaginal tissues can be altered. Bowel or bladder dysfunctions are commonly seen in conjunction with FSD. This can add to the pain and discomfort, as well as the complexity of the problem.

Musculoskeletal impairments can also contribute to female sexual dysfunction. For sexual arousal to occur, adequate blood flow must reach the genital tissues. Decreased circulation or restrictions in muscles and connective tissue can limit blood flow. The muscles of the pelvis, specifically the pelvic floor muscle group, are a big factor in controlling sexual appreciation and response. The pelvic floor muscles need to maintain proper tone throughout sexual activity. Weakness or hypotonicity (muscle laxity) of the pelvic floor muscles can limit sexual response. Hypertonicity, or 'overactive' tone, can result in disorders such as dyspareunia (pain with intercourse), vulvodynia, vulvar vestibulitis, vaginisimus, levator ani syndrome and more. These can also limit sexual response. The Section on Women's Health of the American Physical Therapy Association defines vulvodynia as pain and inflammation in the vulvar area, while vulvar vestilbulitis refers to pain at the vestibule of the vagina. Vaginismus is another pelvic floor condition that is defined as muscle spasm of the vagina that is persistent and disrupts normal sexual function.

What is happening with the Pelvic Floor Muscles?

The pelvic floor muscles and tissues form a sling that connects from the front of the pelvis (the pubic bone) to the tailbone and sacrum. They help support the pelvic and abdominal organs. The muscles and tissues also surround the urethral, vaginal and rectal openings, and they assist in bladder, bowel and sexual function. Therefore, if there is a disorder in the muscles, this can result in bladder, bowel and/or sexual dysfunction, whether it is a weakness issue or a 'hypertonic' issue.

How can physical therapy help treat FSD?

Female sexual dysfunction requires a proper diagnosis, appropriate care and follow-up. As mentioned above, female sexual dysfunction involves a myriad of physical and mental factors. Psychological stress, diet, and physical conditions should all be considered and treated by the appropriate healthcare provider when creating a comprehensive treatment plan for female sexual dysfunction.

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The good news regarding female sexual dysfunction is that natural treatment options exist to help alleviate sexual problems. After addressing any underlying medical conditions (hormone levels, infections, etc), physical therapy can be prescribed. Physical therapists skilled in pelvic floor function can evaluate and design a treatment program to address the musculoskeletal causes of FSD. For decreased libido and sexual response without pelvic pain, physical therapists can use massage and pelvic floor strengthening (sometimes known as kegel exercises) to increase blood flow and strengthen weak muscles. Biofeedback can assist in strengthening the pelvic floor muscles, or vaginal weights can be used. However, neither of these is required to do these exercises.

When pelvic pain is a factor in sexual dysfunction, pelvic floor muscles and connective tissues often exhibit hypersensitivity, tenderness, and spasm. Internal and external massage will reduce tender points and restrictions in connective tissue as well as relax and lengthen the pelvic floor muscles. Dilators may be issued, as part of the at home program, to assist in normalizing the tone of the muscles and to help with desensitization of hypersensitive tissues. Physical therapists can also use relaxation techniques and biofeedback to teach the muscles not to tense. Additionally, stretching the muscles of the hips, trunk and pelvic floor can assist in alleviating pelvic pain. Once pelvic pain symptoms have been eliminated, a physical therapist may carefully progress specific exercises to strengthen any weakness found in the core and pelvic floor, allowing for more stability. Behavioral training techniques are incorporated in the home program to help with relaxing the pelvic floor muscles throughout the day and especially during sexual activity. If the individual has had changes in bladder and bowel function, she may be given exercises and techniques to help return to normal function. Research has shown a significant improvement through physical therapy treatment in up to 87% of women suffering from pelvic pain disorders, such as vulvodynia.

Conclusion

Though female sexual dysfunction may include multiple factors, careful diagnosis and proper treatment can alleviate the problem. Treatment needs to be multidisciplinary and all factors need to be addressed. Talk to a health care provider that specializes in FSD if you are concerned about a persistent sexual difficulty. Physical therapy has proven to be an effective form of treatment for the musculoskeletal components of Female Sexual Dysfunction.

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A Self-Help Book to *Heal Pelvic Pain*, Increase Sexual Response and Cure Incontinence

Amy Stein, MPT, BCIA-PMDB

Amy Stein's *Heal Pelvic Pain: The Proven Stretching, Strengthening and Nutrition Program for Relieving Pain, Incontinence, I.B.S. and other Symptoms without Surgery* (McGraw Hill, 2008) takes an important step toward bridging the awareness gap; at the same time, it constitutes a practical prescription of natural healing aimed not just at those who suffer from the many disorders of pelvic pain but also at the healthcare providers who minister to them. Structured as a self-help guide, the book offers a program of exercises, massage, nutrition, and self-care therapies that can alleviate the pain and disorder so the patient can begin to heal.

Stein is a physical therapist who has specialized in pelvic floor disorders and their attendant pain since 1999. Her book ends the taboo on talking about this "delicate" subject—a disorder that is rarely diagnosed correctly. Aimed at both a general audience and healthcare providers, Heal Pelvic Pain begins by defining just what pelvic floor disorder is and how it

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can cause pain and further injury, can damage well-being, and can disrupt the quality of life. Stein then offers a series of therapies to alleviate the symptoms and begin the healing. These include two programs of physical exercise—one to end the pain, one to strengthen the muscles; massage techniques to address pain and relax the muscles; special nutrition tips; stress management; exercises to enhance the sexual experience well into old age; and advice on pregnancy and post-pregnancy. Special sections on pelvic floor disorders in men and in children round out the book's rich content.

In these excerpts from Chapters 2, 3, and 4, author Stein defines and describes the various disorders that can come from pelvic floor dysfunction and sets forth the two main sets of exercises for dealing with them:

First are her end-the-pain exercises for urinary, bowel, or sexual dysfunctions—including urge incontinence, irritable bowel syndrome, urinary and/or bowel frequency, urgency or retention, pudendal neuralgia, prostatitis, endometriosis, pelvic inflammatory disease, and more. These exercises are geared toward easing the pain and discomfort of these dysfunctions as a way to start reversing "the cascade of pelvic floor disorder and pain."

Second, *Heal Pelvic Pain* offers strengthening exercises to correct pelvic floor muscle weakness and poor coordination that can produce incontinence, pelvic organ prolapse, and/or decreased sexual response. This exercise regimen can boost sexual pleasure, eliminate incontinence, and increase the body's core strength and pelvic stability.

Also included is the Symptoms Monitor, the book's key tool for dimensioning a starting benchmark of pain and other symptoms and for measuring progress as the program proceeds.

Of course, it's also possible to have just one distressing symptom. An avid runner with a weak pelvic floor may find herself leaking every time she goes for a run or coughs or sneezes or picks up her baby. But the distinctive character of pelvic floor dysfunction is that pain that starts in one small area from one single cause can spread throughout the muscles, tissues, nerves, and organs of your pelvis, up and down your body, and into your central nervous system, causing more irritation that causes further pain—and possibly confusing your doctor.

The Vicious Circle Of Pelvic Pain

So any kind of disorder anywhere in the pelvic floor can have an impact on any or all of the pelvic floor's other functions. Once a cascade of deterioration is set in motion, each new diffi culty makes it harder to cure the original disorder and/or alleviate the pain.

To get a more in-depth understanding of this cascade, let's start by dividing pelvic floor disorders into two major categories—mus-culoskeletal pain disorders and bladder, bowel, and sexual dysfunctions. The problem is that a dysfunction or an irritation or pain in one of the two types can cause a dysfunction or an irritation and pain in the other type. That is, a disorder in the muscles or skeleton can cause a bladder, bowel, and/or sexual disorder—and vice versa.

So a bladder infection might end up causing you terrible pain in your legs, while a strained groin muscle could lead to uncomfortable bowel retention and bloating. Bruise your tailbone at the stadium concert—a musculoskeletal disorder—and you may eventually experience bladder and bowel disorders plus sexual dysfunction. By the same token, something as simple as a case of constipation or diarrhea can cause spasm, tightening, or shortening of the musculoskeletal tissue in the pelvic floor, and that in turn can cause pain up and down your core, back, legs, genital area, groin, and hips.

What's particularly vicious about this is that as the infection or inflammation or injury gets worse, it may cause the muscles to tighten and shorten. And as that happens, the pelvic fl oor musculature gets overloaded and grows weak. With the capabilities of the pelvic floor thus limited, the symptoms of the original infection or inflammation or injury become even worse. As if that weren't enough, the infection and inflammation may also cause scarring in the tissue. The scar tissue can adhere around muscles, nerves, or organs, which may further decrease your mobility and lead to even greater pain. It's really a no-win situation.

So let's look at the different kinds of dysfunctions, irritations, and pain in each of the two main components of pelvic disorder— musculoskeletal disorder and bladder/bowel/sexual disorders—one at a time. (For detailed information on all the dysfunctions and disorders of the pelvic floor, see Appendix A at the end of the book.)

Musculoskeletal Aches and Pains

Musculoskeletal disorders range from bones being out of alignment to muscles feeling knotted, tight, tired, or weak to nerve irritation. The pain can be local, or it can radiate to other parts of the body. For example, pain from an irritated nerve might be felt all along the nerve. Misalignment of the back or pelvis can aggravate nerves which then aggravate the surrounding muscles and tissues. It may hurt to exert yourself—either in one spot or all over, or you just might feel you don't have the strength to do so. You might be sensitive to even slight pressure applied near the ache; it may feel tender or painful. Or maybe you feel the pain as a spasm when you move or as a dull, persistent nuisance.

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The pain might be in your lower back, thighs, abdomen, pubic area, genital region, groin, hips, butt, sit bone, or right in the pelvis. Tailbone pain is common; radiating to your gluteal muscles, it can make it difficult to sit. Or perhaps the pain has started in the tailbone but has spread throughout the muscles at the bottom of the pelvic fl oor to the rectum. That makes it diffi cult or painful to urinate or defecate.

A dull ache when you're standing up for a while may mean that the blood veins in your pelvic area are congested—that is, the blood has accumulated in the veins and doesn't flow well. In addition to the pain, you may feel either an urgency to urinate or difficulty emptying the bladder or bowel. Women may find it too painful to have sexual intercourse, while men may experience erectile dysfunction or postcoital pain.

Women can have some pelvic floor disorders that are particular to them. In addition to painful intercourse, women can suffer pelvic cavity infections and infl ammations that scar and adversely affect their reproductive organs. Endometriosis is one of the most common of these pelvic inflammatory diseases. In addition, women also suffer some very particular vulvar discomforts, including the burning and irritation known as vulvodynia and vaginismus, the inability to undergo vaginal penetration—during sex, with a tampon, or during a medical examination. With vulvar vestibulitis, the skin on the outside portal of the vagina becomes red and highly irritated; the slightest touch can cause severe pain.

In addition, menstrual pain, with its distinctive cramping, tends to tense a woman's muscles, and that in turn can signifi cantly restrict the muscles of the abdomen and pelvic fl oor.

Women also suffer a range of skin conditions that can result in or be a result of tightening or shortening of the pelvic fl oor muscles. Skin inflammations or eruptions that cause lesions and adhesions may scar and narrow the vagina, making intercourse even more painful.

There are also musculoskeletal pelvic fl oor disorders particular to men. In fact, the most common prostate problems, prostatitis and prostadynia, can result in, contribute to, or be caused by pelvic floor disorders—and can be alleviated using the natural healing methods described in this book.

Bladder and Bowel Disorders

Bladder and bowel discomfort seems to come in two different forms. There's the discomfort of fullness and the discomfort of excessive emptying out. With the former, you feel bloated. You might have gas or constipation. It's hard to begin to void. You may feel pressure and pain, and you have the sense that you cannot empty yourself—or it hurts when you try.

With the latter, it's almost the exact opposite. This time, the pressure is an urgency to go, and you fi nd you're going often. You might have diarrhea, or maybe you're getting out of bed multiple times during the night to race to the toilet.

Bladder Disorders. Bladder disorders—for example, interstitial cystitis—are common to both men and women, and in both, they can cause urinary frequency, urgency, retention, and recurring pain that may affect the genital area, the back, and the abdomen. Incontinence may eventually result from these bladder disorders.

What's going on?

What happens is that irritation in the lining of the bladder or in the muscle or nerve irritates the surrounding tissues as well, including the musculoskeletal tissue. That's the vicious circle at work again. If the irritation persists, the muscle tightens and shortens, and that in turn causes more irritation and more pain.

Typically, the person will try to relieve the irritation by urinating. If this happens enough, the brain learns to accompany the irritation with the need to urinate. Eventually, the person gets tired of the frequent trips to the bathroom and will try to hold it in. That tightens the pelvic floor muscles, and those muscles shorten and tighten even more. And that, in turn, acts like a belt tightening around the bladder, giving the person the feeling of needing to urinate even when the bladder is not full. So the vicious circle is simply exacerbated.

Bowel Disorders. Common symptoms of abnormal bowel function in both men and women sound a lot like bladder discomfort: frequency, urgency, retention, spasms, pressure, diffi culty with initiation, incontinence. But to these we must add gas, constipation, diarrhea, inflammatory bowel, and irritable bowel syndrome. The effect of these disorders ranges from the extremely unpleasant to the intensely painful. Inflammations of the bowel can affect all layers of the intestine and rectum, while the group of symptoms involved in irritable bowel syndrome can cause considerable abdominal pain.

What's more, most of these disorders can produce increased toxins in the gut, which in turn irritates the surrounding tissues, including the musculoskeletal tissue. As with bladder irritations, persistent irritation may tighten and shorten the muscles, which will create more irritation and more pain—not just in the pelvis but through the abdomen, back, legs, and buttocks.

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Of course, any of these disorders can limit your daily activity. And the worse the resulting pain, the less active and social you become, and the more homebound and inactive your life.

The Impact: What Pelvic Floor Disorders Can Do To You

Pelvic floor disorders can be painful, disruptive, and emotionally stressful and upsetting. If misdiagnosed, as they frequently are, they may lead to unnecessary and therefore destructive drug therapies or even surgical procedures. Even without such extreme effects, these disorders can cause life-changing results—including organ prolapse, incontinence, skin disorders, and sexual dysfunction.

Prolapsed Organs

Organ prolapse takes place when the pelvic fl oor musculature and tissues become so strained from irritation, infection, infl ammation, weakness, or trauma that the organs of the pelvis literally fall. In both men and women, the rectum may fall into the back wall of the pelvis. In women, the bladder may collapse downward and backward into the front wall of the vagina. The uterus can descend, and it can take the vaginal vault with it. The urethra may collapse as well. The pouchlike space between the rectum and the back wall of the uterus might be displaced, potentially causing pressure, pain, or the feeling that something is actually falling out of you.

Often with prolapsed organs, the pain is not immediate and not severe or nonexistent, so people may have no idea they have the condition.

Incontinence

Incontinence of both bladder and bowel can be a common result of pelvic floor disorder, mostly resulting from weakness or shortening of the muscle. It comes in several forms.

In urinary stress incontinence, a cough or sneeze, lifting, or running can cause sudden involuntary urine loss. As many as 38 percent of women engaging in high-impact athletics experience stress incontinence during the athletic activity.

Different from stress incontinence, urge incontinence is characterized by a quick warning that precedes the strong desire to void that results in the involuntary urine loss. A great many women and men also suffer from a combination of both stress and urge incontinence. And many also experience fecal incontinence, typically due to weak or shortened muscles in the pelvic fl oor.

Skin Conditions

A cascade of skin conditions, such as lichen sclerosus and lichen planus, can result in pelvic floor disorder, and pelvic fl oor disorder may contribute to the discomfort of such skin conditions. It's another case of the revolving door effect—the vicious circle of pel-vic floor disorder. These skin conditions may derive from a compromised immune system, from sexually transmitted diseases, and sometimes from the inappropriate use of vaginal creams. Or, the condition may be congenital—that is, you're just born with it.

Whether a contributing cause of pelvic floor disorder or a result of it, these conditions can be unpleasant, painful, and disfi guring.

Sexual Dysfunction

Pelvic floor disorders cause a range of sexual dysfunctions. To begin with, these disorders can greatly decrease libido in both men and women. If arousal does happen, both men and women may find it difficult or even impossible to achieve orgasm due to weak or overly shortened muscles.

In a condition known as dyspareunia, women may feel pain during intercourse. This pain is in the initial penetration, or with deep penetration, or from the thrusting motion, or from a lack of lubrication. Superficial scarring, adhesions, skin irritation, or muscle tenderness may all contribute to the pain and discomfort.

In men, erectile dysfunction can be a direct result of pelvic fl oor muscle tension, weakness, or pelvic congestion. Or it may result from experiencing pain during or after intercourse.

Healing Your Pelvic Floor Disorder

It is essential to get a proper diagnosis from a specialist in pelvic floor dysfunction, because, as you can see, the list of things that can go wrong with your pelvic floor is a long one, covering a varied range of complex signs, symptoms, and dysfunctions. I've included such a list as Appendix A to this book. Consult it about any sign or symptom that you think may be related to or radiating from the core of your body—and take action accordingly.

Whatever kind of pelvic pain you're suffering, and whatever the particular pelvic floor disorder that afflicts you, I'm certain you're eager to start the natural healing that can ease the pain and alleviate the disorder.

There are two separate exercise programs, depending on whether your problem is pain—and the accompanying bladder or bowel discomfort—or weakness. Each of these programs consists of different exercise routines, and each progresses in phases.

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The first program is the End-the-Pain routine, a three-phased course that focuses on what I'm sure is most important to you right now—your pain. The entire End-the-Pain routine must also be accompanied by the external and internal massages described in Chapter 5. Do these two therapies together to ensure an end to your pain.

The second exercise program addresses the problem of weak-ness—specifically, bladder and bowel incontinence and decreased sexual pleasure. The Strengthen-the-Muscles routine is in four phases.

For both exercise programs, you'll progress from one phase to the next only after you've become comfortable with the earlier phase and have begun to feel its benefits. The Symptoms Monitor at the end of this chapter is your tool for assessing when it's time to move on.

If you have symptoms of both pain and weakness, begin your healing with the End-the-Pain routine and the massage therapies of Chapter 5, and move on to the exercises of the Strengthen-the-Muscles routine only when you are 100 percent pain-free—and assuming you still have an incontinence problem. It is very often the case that the exercises of the End-the-Pain routine will end your incontinence as well, so you may not feel the need to do the other strengthening routine. Or, you may decide to do just some of those exercises in order to keep your muscles strong and stave off a return of incontinence.

If you succeed in healing your pain through the End-the-Pain routine and the self-massage you'll learn in Chapter 5, then begin the Strengthen-the-Muscles routine only to find that some pain symptoms have again surfaced, stop! Go back to the End-the-Pain routine. In other words, it's important to be pain-free when you undertake the strengthening exercises to address problems of incontinence.

Be sure also that you take note of any negative responses as you change exercises or increase the intensity of any exercise—for example, by doing more repetitions or by adding resistance—or as you move from phase to phase in a routine. By negative responses, I mean an increase in the level of pain or a worsening of the disorder's symptoms. If such responses do occur, first check your posture and alignment; that is, make sure you're doing the exercise correctly. Then, cut back on the intensity of the exercise: do fewer repetitions or use less resistance. If you still feel the negative response, go back to the earlier part of the End-the-Pain routine. If none of this helps, you should by all means contact your health-care provider.

Chances are you won't have any negative responses. If you follow the phased programs carefully, your healing will progress. The pain will diminish and then end, and your weakness will turn to strength.

I'm sure you're eager to get started. Task number one is to fill out the following Symptoms Monitor. It's a questionnaire that asks you to pinpoint where it hurts, how much it hurts, and what effect the pain or incontinence and other symptoms are having on your life. You'll use this Symptoms Monitor over the next weeks and months as a guide to advance from phase to phase in each program. With today's assessment, you'll create a baseline. Come back to the Symptoms Monitor four weeks from now to reassess your symptoms. If your symptoms have improved by 50 percent or more, you are ready to move to the next phase of the program. If your improvement is less than 50 percent, wait another four weeks, then try again. Keep reassessing your pain and symptoms every four weeks as you do the natural healing exercises and other therapies of this book; you'll see as well as feel the improvement.

Symptoms Monitor

The following questionnaire is reproduced with permission from the International Pelvic Pain Society, www.pelvicpain.org.

For each question, circle 0, 1, 2, 3, 4, or 5 where, for pain, 0 no pain and 5 severe pain, and for non-pain symptoms, 0 no symptoms and 5 severe symptoms.

CHAPTER 3

End The Pain

Do this program of exercises to treat any musculoskeletal pain in the abdomen, back, thigh, hip, genital, or pelvic region and/or any pain or abnormal symptoms associated with urination or defecation, or with sexual activity. This may include the following:

In Both Men and Women

- Tailbone pain: spasm or tension in butt or pelvic floor muscles
- Pudendal neuralgia: irritation or pain that typically worsens with sitting and is felt along the nerve pathways from the lower back to the rectal area, the genital area, and/or the bladder
- Pain in the lower back, sacroiliac joint, hip, groin, and/or pelvis
- Interstitial cystitis/painful bladder syndrome
- Irritable bowel syndrome and/or colitis (including constipation and diarrhea)
- Urge urinary or bowel incontinence (strong, sudden need to evacuate with leakage)
- Urinary or bowel urgency, frequency (including nighttime frequency, or nocturia), retention, or diffi culty with initiation
- Feeling of fullness, abdominal pressure and/or pain

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- Urethral or rectal spasms, burning, pain, or itching
- Pelvic pain from muscle spasm, nerve irritation, or adhesions
- Decreased libido due to pain and/or contracted or tight pelvic fl oor muscles
- Difficulty achieving orgasm due to pain and/or contracted or tight pelvic fl oor muscles
- Genital hyperarousal
- Any other disorder listed in Appendix A that causes any of the symptoms listed here

In Women Only

- Vaginal pain
- Vulvar vestibulitis: irritation and/or inflammation of vestibule to the vagina
- Vaginismus: muscle tension preventing penetration of the vagina
- Dyspareunia: pain during intercourse, superficial or deep, or postcoital pain
- Prenatal or postpartum pelvic pain
- Endometriosis or other pelvic infection or infl ammation
- Dysmenorrhea (painful menstrual periods)
- Difficulty with conception: infertility due to pelvic congestion or scarring

In Men Only

- Erectile dysfunction or postcoital pain
- Prostatodynia or nonbacterial prostatitis (pain in or around the prostate)

The main key to healing your pelvic floor disorder the natural way is to end the pain or discomfort. The program for doing so is in three parts and must be accompanied by the massage therapies described in Chapter 5.

In Part 1 of the End-the-Pain routine, you'll learn to let go—to relax your muscles, relieve them of any tension and strain, let them pause and come to rest. A routine of 11 simple exercises will help you do all that—the essential first step toward healing the disorder at your core.

In Part 2, you'll concentrate on strengthening your core with four other exercises added to the routine.

In both Parts 1 and 2, you'll also undertake some basic cardiovascular activity as a way of maintaining overall fitness and keeping your immune system strong.

Then in Part 3, you'll begin integrating some of your normal recreational or athletic activities back into your life, monitoring how it feels and what impact, if any, it has on your pain or symptoms.

How long will each part last? That depends entirely on you—on how bad your pain and other symptoms are, on their underlying cause, on your general level of health and fitness, and of course on how you respond to the program of exercises. Keep in mind that you are an absolutely unique individual in every way, including in what works for you in terms of your body.

In general, however, it might take anywhere from one month to as many as four months for the Letting Go exercises of Part 1 to make a difference. That sounds like a long time, but the truth is that it isn't easy to learn to relax the muscles, especially muscles that you may have automatically been clenching for some time. In other words, it took a long while to tighten and shorten those muscles, and it's going to take some time to loosen and lengthen them as well.

Still, once you do achieve the letting go and begin to feel relief from your symptoms, things move more swiftly. You'll start seeing the benefits of the strengthening exercises of Part 2 in one or two months. *Do not do the advanced exercises in Part 2 until you are free from pain and need a challenge.*

And so long as you ease back into your recreational activity and keep a close watch on your progress, you may feel the rewards of Part 3 in a matter of weeks. If, however, your symptoms do not improve or if they improve but are still present after six months of this routine, see a specialist in pelvic fl oor dysfunction.

I know you're eager to begin, so let's start letting go.

Part 1: Letting Go

You have to work at relaxing. That sounds ironic, of course, but it's true.

The reason is that tensing our muscles may be an automatic reaction. We do it so often, so spontaneously, for so long that the tension settles into our bodies and the tightness becomes the norm. We don't even know we're tense.

Ever have one of those days when you didn't even realize how keyed up you were till your friend or spouse or maybe a considerate coworker started kneading your neck and shoulder muscles? Wow! You could almost feel the tension flowing out of you, and it felt delicious.

The truth is you tend to tense your muscles throughout the course of the day. We all do. It's a subconscious response to the various stresses, strains, and annoyances we encounter—to the sheer tumult of daily life. Maybe you tense your shoulders and end up with a stiff neck and clenched jaw. Maybe you feel the

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stress in your lower back. Or maybe, like so many of us, the tension tends to settle in the bottom of your core, right in the muscles of the pelvic floor. The tensing shortens the muscles, and that weakens them. Result? That vicious circle of pelvic floor pain and dysfunction is set in motion.

The key to healing, therefore, is to let go of the tension so we can stretch and elongate the pelvic floor muscles, then strengthen the muscles around them. This strengthening of the surrounding muscles provides support to the pelvic floor muscles so they don't have to work so hard. That's why most of the Letting Go exercises are about stretching, and it's why most of the stretches focus on the external muscles of the hip, back, pelvic, and abdominal areas. The reason?

Tightness and weakness in these muscles can make it difficult to do the simplest activities—walking, for instance—and that, in turn, can throw you off balance. Being off balance, of course, just tightens and weakens the muscles further, and pretty soon, you're caught in the vicious circle of pelvic floor pain and disorder.

Stretching increases the flexibility of the tissues being stretched. It helps to loosen the tension in your muscles, de-stresses them, and thus helps you manage your mental stress as well. But there is a right way to stretch and a wrong way, and it's essential to do the stretches of the Letting Go exercises the right way.

The right way is the simple way. The key is to stretch in a relaxed manner—as you breathe. You want to be relaxed because overstretching or stretching too hard may actually injure the muscles further and can even irritate the nerves, causing even more pain. This is especially true if your muscles are knotted to begin with; in that case, your best bet is to massage away the knots first—see Chapter 5. In all cases, you want to breathe as you stretch in order to increase the blood flow and the supply of oxygen to the tissues of the muscles you're stretching.

As you continue to do these stretches, you will begin to notice that you are able to stretch farther. It means your muscles are loosening and lengthening. It means the exercises are working and the healing is beginning.

Getting Started on Letting Go Exercises

Done in sequence in a relaxed manner, the Letting Go exercises take less than half an hour. Do the exercises in conjunction with the sore points self-massage you'll learn in Chapter 5; this will only add a few minutes to your total time. Start every day with this routine, making it as automatic a part of your morning as brushing your teeth.

In addition, repeat the exercises at intervals during the day. Two of the first four—deep breathing and the pelvic drop—can be done

CHAPTER 4

Strengthen The Muscles

Do this program of exercises if you are suffering either bladder or bowel incontinence—or both—as a result of pelvic floor muscle weakness or pelvic organ prolapse, or if you have a feeling of heaviness or a falling-out feeling in the pelvic region with no accompanying pain. These exercises may also mitigate a decreased libido or an inability to achieve orgasm; men who suffer erectile dysfunction due to weak muscles may also benefit from these exercises. Do not do them if you feel any urgency, pain, constipation, or retention, if you must relieve yourself frequently at night, or if you have any of the symptoms described in Chapter 3. You must wait until those symptoms are 100 percent improved through the End-the-Pain routine before you undertake them. Only then should you begin to slowly integrate these exercises into your normal daily routine. If the previous symptoms return, stop these exercises and return to the End-the-Pain routine only. Symptoms indicating the use of these exercises may include the following:

In Both Men and Women

- Stress urinary or bowel incontinence (involuntary leakage due to an increase in abdominal pressure, as from sneezing, coughing, running, etc.)
- Pelvic organ prolapse
- Decreased libido due to weak pelvic floor muscles
- Difficulty achieving orgasm due to weak pelvic floor muscles

In Women Only

- Prenatal and postpartum stress incontinence
- Cystocele (descent of anterior vaginal wall)
- Rectocele (descent of posterior vaginal wall)
- Enterocele (descent of intestine)
- Uterocele (descent of the uterus)
- Urethrocele (descent of the urethra)

In Men Only

- Erectile dysfunction
- Rectal organ prolapse

Incontinence is the involuntary leaking of urine, feces, or gas. Often, people only become aware of the problem when they note staining on their underclothing.

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But incontinence is really just a symptom. It signals a weakness in the muscles of the pelvic floor. Strengthen those muscles, and you very likely will end the incontinence.

How do the muscles of the pelvic floor grow weak? There are any number of possible causes. Childbirth can certainly weaken the pelvic floor. So can surgery; for example, we frequently see this muscle weakness and the resulting incontinence in men who have undergone prostatectomy for the treatment of prostate cancer. Injury or trauma, an illness that decreases the immune system, fatigue, or hormonal changes can also diminish the strength and elasticity of these muscles. If you lift heavy weights all day long and are straining your pelvic floor muscles as you do so, if you're excessively overweight or obese, if you have very poor posture, if you find yourself straining against a condition of constipation, you can weaken your pelvic floor. And, unfortunately, these muscles also lose strength as we age and grow less active.

And while incontinence is perhaps the most evident of the symptoms of this weakness, there are others. One is organ prolapse— when a part of the bladder or another organ literally slips out of place, producing a feeling of fullness as if something is falling out of you. Prolapse happens when the muscles and connective tissue have become so weak they are no longer holding up the organ; with no "floor" to support it, the organ simply sags.

Sex is another area where muscle weakness can be telling: individuals may have difficulty achieving orgasm when the pelvic fl oor muscles are weak, for those are the muscles that work to increase blood flow, stimulation, and satisfaction.

Clearly, the way to address all these symptoms is to strengthen the muscles of the pelvic floor, and that's just what the Strengthen-the-Muscles routine sets out to do. It proceeds in four parts. The key to all the parts of the Strengthen-the-Muscles program is the Kegel exercise you'll learn in Part 1. But perhaps just as important as learning to do Kegels correctly is to learn to relax the pelvic fl oor muscles between exercises.

Relaxing The Pelvic Floor To Strengthen It

One of my first patients many years ago was a Pilates instructor— I'll call her Sandy. As I'm sure you know, Pilates is a wonderful program of exercises geared precisely to enhancing core strength and flexibility. Sandy, in her mid-50s, was a sweet and delightful woman who was a living example of Pilates' strengths.

So I was surprised that she had come to my physical therapy studio complaining of a gradual onset of urinary urgency and frequency along with difficulty achieving orgasm. The urinary urgency had recently developed into urinary urge incontinence—that is, Sandy would feel a strong urge, would rush to the bathroom, but would invariably end up leaking before she got there.

Both Sandy and I were puzzled that a Pilates practitioner, who regularly worked the muscles of her core, could have a weak pelvic floor. In fact, on that first visit, Sandy enthusiastically demonstrated for me some of her Pilates teaching. She lay on her back, engaged her abdominals, and lifted her pelvic floor muscles as she slowly raised one leg and smoothly did leg circles in the air. She switched legs. She showed me the signature Pilates 100, challenging the abs and back. All the while, Sandy kept repeating what she told her students during a teaching session: "And, tighten those abdominal muscles and lift the pelvic floor. And tighten. And lift. Tighten. And lift."

Watching and listening, I suddenly had an insight into what the problem was. "Sandy," I asked her, "do you ever have your class relax the pelvic floor—or are you always tightening and never resting those muscles?" She replied that since the aim was to keep the students' heart rate relatively high during class, she limited the resting to three times during the one-hour session.

I was pretty sure that was the key to the diagnosis of Sandy's problem. "By resting so rarely," I suggested, "you're never really relaxing the pelvic floor muscles. The result is that they have probably shortened and are now pulling on your bladder and urethra, and that's what's causing your urinary urgency and frequency. Moreover," I explained, "shortened pelvic floor muscles have a diffi cult time contracting and going through their full range of motion. That's why you're having trouble coming to orgasm and with leaking."

The answer, I suggested, was to reeducate Sandy's pelvic fl oor muscles to relax—basically, to do the End-the-Pain routine of Chapter 3. For although in her case the muscles were probably not weak, their inability to relax certainly diminished their power—with the resulting incontinence and sexual dysfunction.

The bottom line? Relaxing the muscles between exercises is as important as the exercises themselves. Your muscles won't function with strength unless you learn how to relax them, so be sure to follow carefully the instructions to relax the muscles in these exercises. In addition, it's a good idea to relax altogether between each set of exercises.

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Also, don't forget to breathe. As you learned in the End-the-Pain routine, not breathing—holding your breath—while you exercise is completely counterproductive. Breathe deeply before each exercise, then start to count as you begin the exercise—whatever it is. This forces you to breathe while doing the exercise. After a while, this becomes automatic.

So take a breath, and let's begin those exercises now.

Part 1: Your Strength Foundation—Doing Your Kegels, Tightening Your Abs (2 Weeks)

10-second slow Kegels	10 reps 3 times a day
2-second fast Kegels	10 reps 3 times a day
Tight abs	10–30 reps, once a day

Part 2: Intermediate Exercises—Hips, Bridge,Tilt with Kegels (4 Weeks)

Hip external rotation	10–30 reps, once a day
Hip adduction	10–30 reps, once a day
Bridge	10–30 reps, once a day
Pelvic tilt	10–30 reps, once a day

Part 3: Challenging Exercises—Standing Kegels (4 Weeks)

Slow standing Kegels	5–10 reps, once a day
Fast standing Kegels	5–10 reps, once a day
One-foot squat with Kegel	5–10 reps, once a day
Two-foot squat with Kegel	5–10 reps, once a day
Sit-and-stand with Kegel	5–10 reps, once a day

Part 4: Advanced Exercises—Action Kegels (4 Weeks)

Marching in place	10 reps, once a day
Small jumps	10 reps, once a day
Big jumps	10 reps, once a day
Lunges	10 reps, once a day

Vulvodynia

Marjorie Green, MD, MPH
Instructor Harvard Medical, Director of Mt. Auburn Menopause and Sexual Medicine Institute

Vulvodynia is vulvar pain that has no known cause and strikes randomly. It has grown increasingly common over the past few years. Nowadays, between 3-15% of women suffer from it, at various times to varying degrees. A women with vulvodynia can be tall or short, young or old, and of any ethnicity. Unfortunately, many women suffer in silence.

A woman with vulvodynia may suffer from pain, burning, itching, tingling, and throbbing of the vulva. She has probably visited several physicians who attempted many treatments, sometimes vulvar biopsies, but she is still suffering. These symptoms occur all over the vulva and nothing that is obvious provoked it. This is known as generalized unprovoked vulvodynia.

Another woman who is suffering from vulvodynia may have different symptoms. She may only feel pain with attempted penetration during intercourse, use of tampons, or during a speculum exam. This is known as localized and provoked vulvodynia because, unlike generalized vulvodynia, it is confined to one area and causes pain when something is attempted to be placed in the vagina.

The etiologies of the condition are unknown. Generalized unprovoked vulvodynia is, perhaps, nerve pain which can be incited by various conditions such as allergies, too much anti-fungal creams, perfumes, fibromyalgia, etc. Localized provoked vulvodynia is thought to be myofascial in origin, caused in some cases by entrapped nerves.

A single treatment is difficult to find because not one treatment will work for all women. These treatments are mostly for relieving pain. For localized unprovoked vulvodynia, staying away from anything that will sensitize the vulva (i.e. perfumes, nylon underwear, vaginal creams, etc) is a good start. Using ice, not more than twenty minutes, helps acutely. Lidocaine jelly may work as well. Medications that have been successful are tri-cyclic anti-depressants, gabapentin, Lyrica, and Cymbalta. All of these are off label and used in clinics for chronic pain. Localized provoked vulvodynia can also be treated with pelvic floor physical therapy, lidocaine, and often, trigger-point injections. Surgery is the last resort.

It is important for all women to know that vulvodynia can remain silent for a prolonged period of time and can become a chronic condition. Nevertheless, it is manageable. If you suffer from any of the symptoms associated with vulvodynia, it is very important for you to visit your physician and talk about your symptoms. Before you diagnose yourself with vulvodynia, make sure there is no other cause for your pain.

Announcements

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