

Chapter Twelve

Painful Intercourse

Millions of women suffer needlessly from intercourse pain. Today, we understand that there is no longer any need for most of these women to forego intimacy or undergo pain: especially at the times they should be experiencing pleasure.

- Belinda Wurn, PT

Is Intercourse Pain Normal?

Although few women speak of it, intercourse pain (dyspareunia) and sexual dysfunction impact the lives of millions of women. The journal *Urology* reported that 50% of all US women experience some form of sexual dysfunction during their lives.²² Over 70% of women surveyed in a large study in the *Journal of Family Practice*²³ reported painful intercourse, and 60% of US women reported intercourse pain at some point during their lives, according to the *American Family Physician*.²⁴ Yet despite the high prevalence, women frequently do not discuss their sexual concerns with their physicians, according to the journal.

Sexual concerns and dysfunction include intercourse pain, anorgasmia (the inability to have an orgasm or to reach a full orgasm), and decreased desire (libido), arousal, lubrication, and satisfaction. For many women, intense orgasms are a myth, a thing of the past, or something that will never be.

Many women feel that “sex hurts” or that it has never been the pleasurable sensation they thought it would be, from their very first experience. Others note an increase in pain, sometimes accompanied by a decline in desire and vaginal sensation as years go by. In this

chapter we will examine intercourse pain (dyspareunia) and treatments available.

Adhesions and Intercourse Pain

During the course of life, the vagina and female reproductive tract may be subjected to traumas or surgery. In addition, the opportunity for infection or inflammation can occur because the vagina is open to exposure from the outside environment via tampons, sexual partners, sexual abuse, and self-exploration. The dark, moist environment of the vagina is also a perfect environment to nurture bacterial growth – and bacterial infections.

When infection or inflammation occurs on the walls of the vagina, cervix, or nearby structures, the body's first response is to lay down collagenous cross-links, the building blocks of adhesions.

When adhesions form within the vagina, the delicate and sensitive tissues of the vaginal walls or opening can become restricted by tiny collagenous bonds with a strength of nearly 2,000 pounds per square inch. Bound down by small adhesive straight-jackets, these highly innervated tissues become much less mobile and pliable. During intercourse, they can be stretched beyond their ability to move. Fixed in place by tiny, glue-like bonds, they can pull on nerves and cause a significant amount of pain as intercourse begins.

For others, the adhesive process occurs much deeper in the vagina, at the cervix, and the pain occurs with deep penetration. This is experienced by some women as a broader, deeper pain. Other patients report that "it feels like my partner is hitting something." Some women have a combination of initial and deep penetration pain, sometimes accompanied (quite understandably) by pelvic and uterine cramping. We treat these conditions clinically every day as we have for twenty years. We have published solid data on effective treatment of this biomechanical cause of intercourse pain.

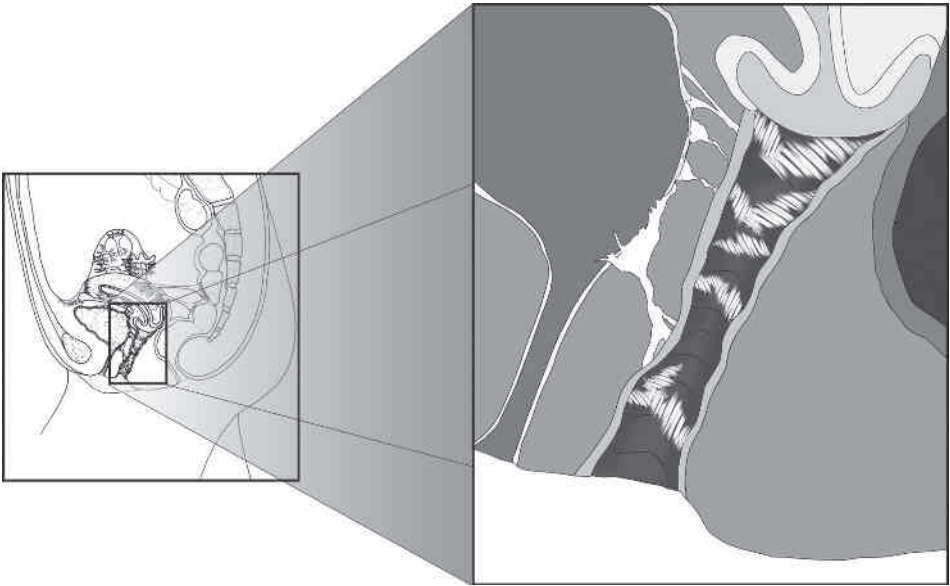
Our therapy is quite different from the psychological counseling that has been Western medicine's usual response for the last several decades. The "it's all in your head diagnosis" can be damaging to some women who then feel they must be crazy to be feeling pain. While we value psychological counseling, we find it necessary to physically address the mechanical causes of most intercourse pain

Pain at the Vaginal Opening

Direct trauma

The most common cause we see of introitus (vaginal entrance) pain is a direct trauma earlier in life. Sometimes, this can be traced to a single traumatic event, such as a fall onto the pubic bones or coccyx (tailbone) [e.g. from playing on a jungle gym or slipping on ice and falling onto the buttocks] or sexual abuse. Trauma may occur later in life, such as a nearby surgery or a cut at the entry to the vagina such as an episiotomy, when the back of the vaginal opening is cut to aid vaginal delivery.

In other cases, we find that an injury which caused overstretching of the adductor muscle (on the inside of the leg attaching to the public bone) causes adhesions that pull directly into the vaginal entrance and perineum.



*We find tiny adhesions on the vaginal wall to be common.
These can bind pain-sensitive tissues, causing intercourse pain.*

In many cases, we find that pain at the vaginal entrance is a result of multiple traumas or events over life. Repeat traumas from gymnastics, bicycling, or horseback riding account for many instances of introitus pain we treat regularly.

Unfortunately, physical and sexual abuse are fairly common. Although the abuse or trauma may have ended years or even decades earlier, the effects remain in the tissues for a lifetime due to the cross-links, adhesions, and scars that formed to help the tissues heal so many years ago. We discuss this in further depth in Chapter Fourteen.

Infection/Inflammation

The entrance to the vagina is subject to bacterial infection, and we often see one or more vaginal or bladder infections in the histories of women who present with entrance pain or decreased sexual response. We surmise that as the body began healing from the infection

and inflammation, tiny cross-links formed in the area, binding some of the vaginal tissues. Unable to move freely and attached to nerves, these tissues can elicit significant pain at the entrance of the vagina when a woman attempts sexual intercourse.

Psychological trauma

Less common, but just as debilitating, we sometimes treat women whose vaginal muscles have been “guarding” against traumatic sex or pain for most of their lives. Whether the patient is protecting herself against a tormentor who is no longer a threat, or is holding onto beliefs taught in childhood that sex is dirty, bad, or a sin, or for a host of other reasons, the muscles of the vagina can shut tightly, in a state of near-constant spasm. This condition is referred to as “vulvodynia” or as “vaginismus.”

Early in our marriage, I suffered from discomfort and sometimes pain during intercourse... When I returned home (after therapy) I was eager to see my husband. We had a wonderful night, pain-free and pleasurable. I had a new intimate life with my husband!

- Jennifer, mother of one and currently expecting after struggling with infertility, intercourse pain and chronic urinary tract infections.

Over time, inflammation develops from the persistent spasm. The consequence generally includes adhesions that create, perpetuate, and even intensify the pain. This spasm can be so severe that it can prevent vaginal penetration by anything — a tampon, finger, gynecological exam, penis, or even the smallest dilator.

Pain at Deep Penetration

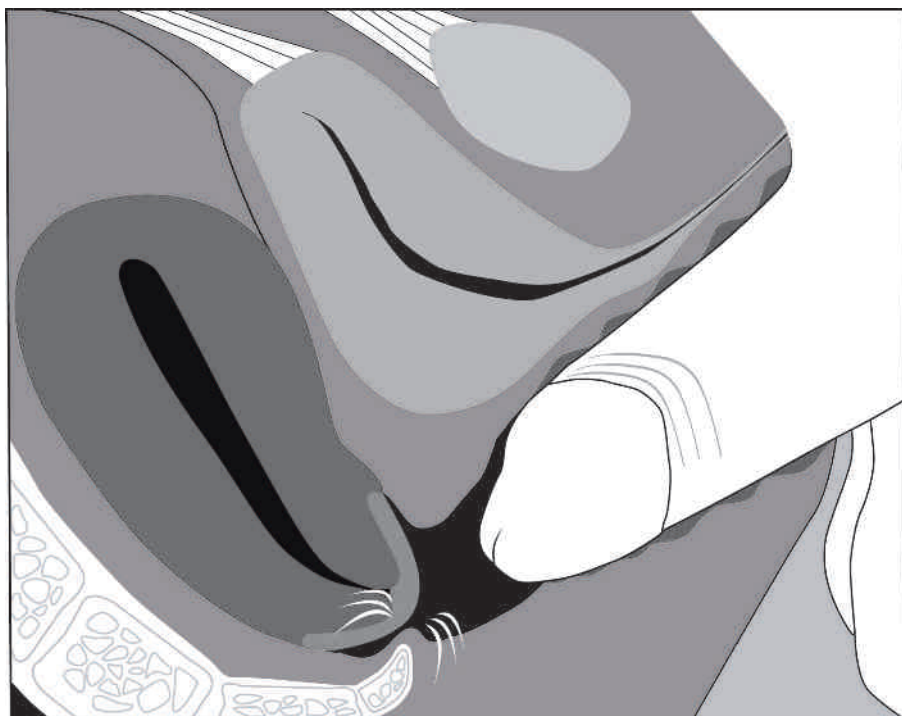
The Tailbone

Falls onto the buttock are common throughout life, and the coccyx (tailbone) is a common recipient of that trauma. The tailbone can be pushed forward or to either side by any fall in the area. If the fall is mild, the tissues generally recover and the tailbone becomes mobile

again. When it is mobile, it can move out of the way during a bowel movement, and during sexual intercourse. But if the tissues and ligaments around the tailbone have been sufficiently injured, they can pull the tailbone forward and it can heal in that abnormally fixed position with mechanical restrictions to its mobility. The tailbone can then become a physical block to intercourse and/or bowel movements.

***By the time I
left (CPT),
sex no longer hurt,
my appendectomy
scar felt completely
different, and my
tailbone was more
properly aligned.***

*– Ashley, mother of one after
struggling with infertility*



A fall or surgery can move the coccyx forward, causing a physical block to deep penetration.

When this happens, we hear such complaints as pain with deep penetration or bowel movements, chronic constipation, diarrhea (less frequently), difficulty sitting for long periods, and/or persistent headaches. These headaches often occur at the top or base of the skull or at the temples where the dura and spinal cord (which begins at the tailbone) attach to the skull. This phenomenon is explained more fully in Chapter Sixteen.

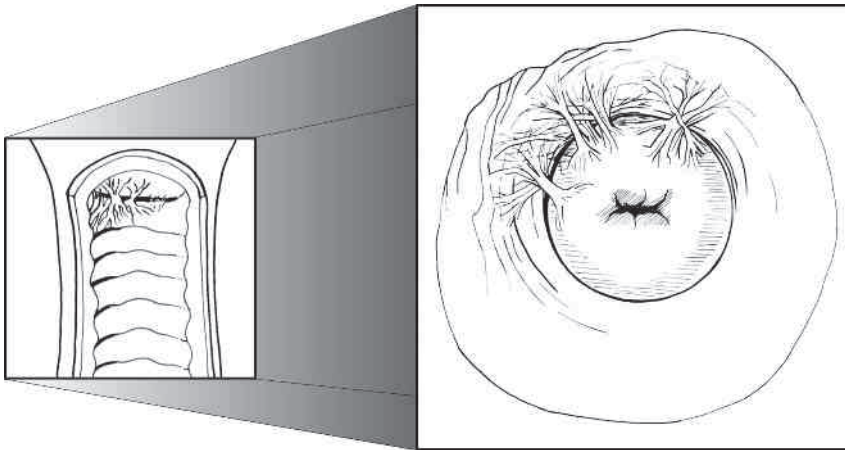
The Cervix

In its natural state, the cervix is situated midline in the vagina, at the entrance of the uterus. There, it comes in contact with everything

that passes by: tampons, sexual partners, infections, and inflammations. In its position in the center of the vagina, the cervix is also in the center of the melee when problems arise.

The cervix is held in its (preferably midline) position by ligaments that attach to it at the front, back, and sides. Because of its unique position, it is vulnerable to adhesive cross-link formation at the various ligaments designed to hold it in place whenever the vagina undergoes a healing event — be it from trauma, infection, inflammation, or surgery.

When healing occurs at or near the cervix or neighboring structures, powerful adhesive cross-links form as the first step in the healing process. This causes the cervix to be pulled from its mobile, midline position, as it attaches via adhesive bonds to structures that lie in the direction of the healing mechanisms.

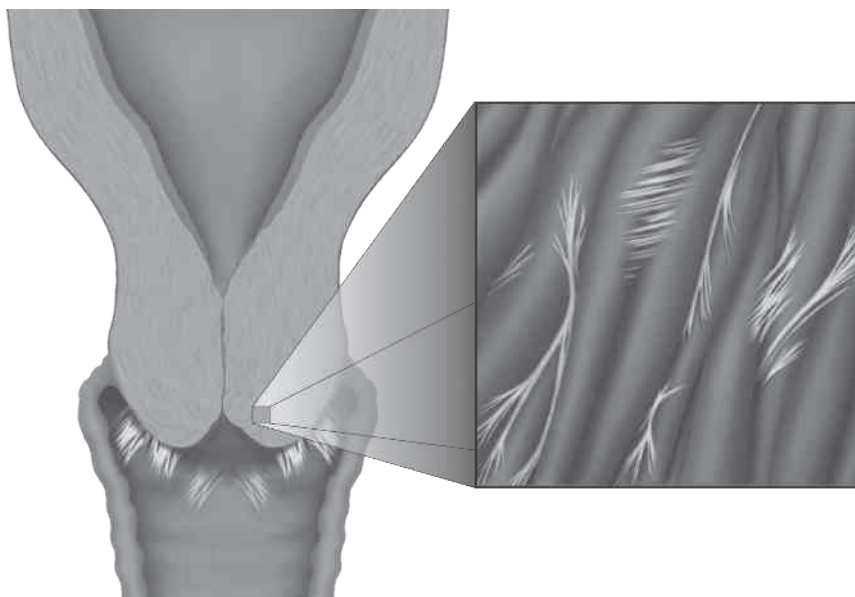


The cervix can become adhered to the vaginal wall, causing pain with deep penetration.

The cervix may be pulled towards the sacrum or tailbone by adhesions on the uterosacral ligament. In this position, it can tighten, close, or elicit pain with deep penetration. When the cervix is not in

a fixed position, it can easily slide out of the way during intercourse. But when it is fixed in position by adhesions, it can be hit by the penis during intercourse. Unable to move and fixed in position against a thrusting partner, deep pain can occur for the woman.

The cervix may be pulled (and often is) to one side of the vagina, where it can attach via adhesive cross-links to the vaginal wall. When parts of the vaginal wall are glued to the cervix or tightened by glue-like adhesive cross-links, they do not stretch. Unable to attain their normal pliable and mobile state, the nerves within the vaginal wall may elicit pain when they are impacted by deep penetration.

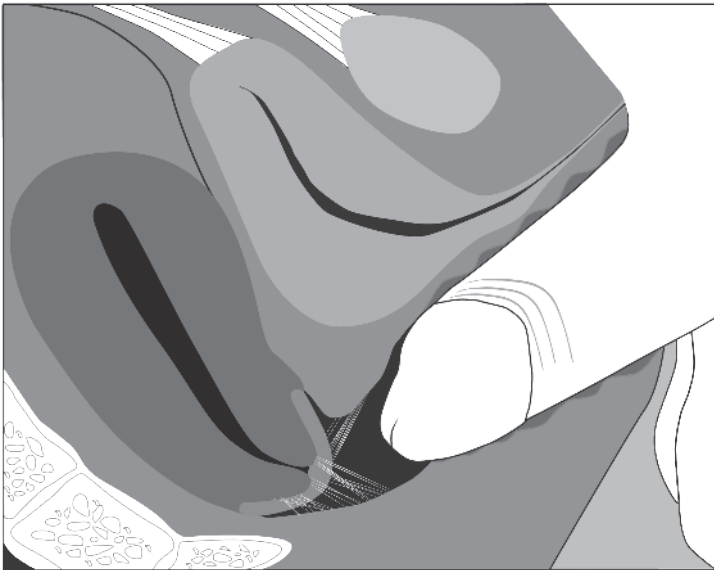


*Tiny but strong cross-links can stiffen the cervix,
or pull it out of a relaxed, midline position.*

The cervix may also be pulled forward. We commonly see this in women who have suffered bladder or vaginal infections, abuse, or trauma to the anterior vaginal wall. This position of the cervix is often

accompanied by additional sexual dysfunction, such as decreased desire, lubrication, or orgasm, due to its proximity to the G-spot and (through the vaginal wall) the clitoris. Some women also experience pain with urination due to adhesions between the anterior vaginal wall and the urethra.

Other conditions we notice quite frequently include cervical stiffening (fibrosis) and narrowing or closing (stenosis). In these situations, the adhesive cross-links may form deep within the cervix, between the cells of this highly muscular structure, as shown on the preceding page. Upon palpation, the cervix may feel stiff, hardened or immobile. In some cases, the cervix may curl to the back, the front, or sides.



When a partner hits a stiffened cervix, deep pain is often the result.

The internal cross-links and scars within the structure of the cervix hold it in position. No longer pliable or mobile as it was during youth, the cervix becomes a fixed structure at the entrance to the uterus.

This can make it difficult for sperm to enter (naturally, or by catheter during IUI or IVF). In this position, it also becomes vulnerable to pain with deep penetration.

Adhesions attaching within the muscle of the cervix or attaching the cervix to the nearby structures, including the vaginal

walls, can also create an unnatural pull on the largely muscular uterus above. This can create spasm and inflammation when the woman has intercourse, walks, or has a period. Uterine spasm and inflammation are direct causes of infertility, and frequent causes of miscarriage in our experience.

When I returned home (after CPT), my husband and I were elated to find that there was no longer any pain with sex.

My husband joked that he would send me back for more treatment in a heartbeat.

— Madison, mother of one who struggled with endometriosis, pain, and infertility

When I told my therapist that the painful intercourse I experienced before treatment (at CPT) had gone away, she felt that adhesions were the likely culprit of that pain.

— Barbara, mother of two after struggling with infertility and intercourse pain

As the reader may know, intrauterine devices (IUD) were designed to prevent pregnancy by creating inflammation within the uterus. The same biomechanical process occurs when the cervix or uterus becomes inflamed naturally. Adhesions form within the uterus and can bind it to other structures, causing a pull with every step a woman takes. This pull can create or perpetuate

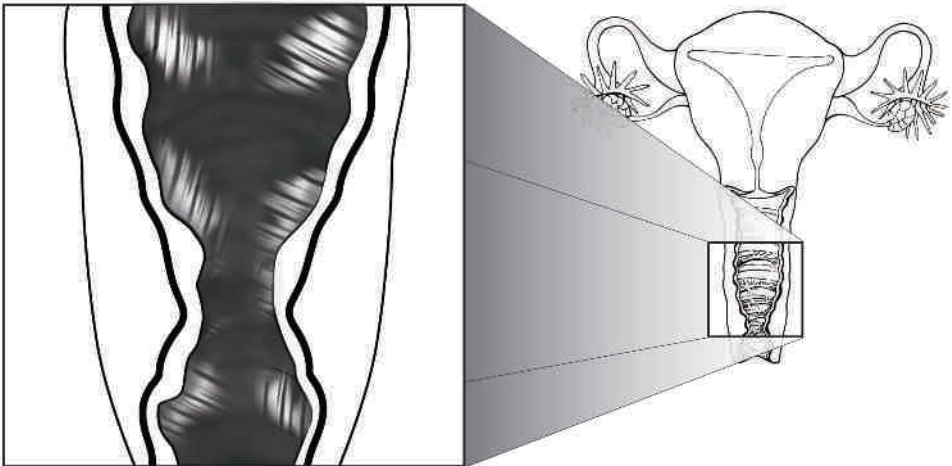
a cycle of adhesion-inflammation-adhesion as the woman proceeds through life.

The Vaginal Walls

As noted earlier, the vagina is subject to influences from the outside environment. Infection, inflammation, and trauma can cause adhesions to form, binding down areas within the highly innervated tissues of the vaginal wall.

In their natural state, the delicate tissues of the vaginal walls are pliable and mobile. But, when they become glued down by adhesions and collagenous cross-links, they lose their mobility and elasticity.

We often find tiny but powerful cross-links on vaginal walls of women with dyspareunia (intercourse pain).



Still infused with thousands of tiny nerve endings, the now adhered vaginal walls can be pulled or stretched during sexual intercourse, causing moderate to severe pain.

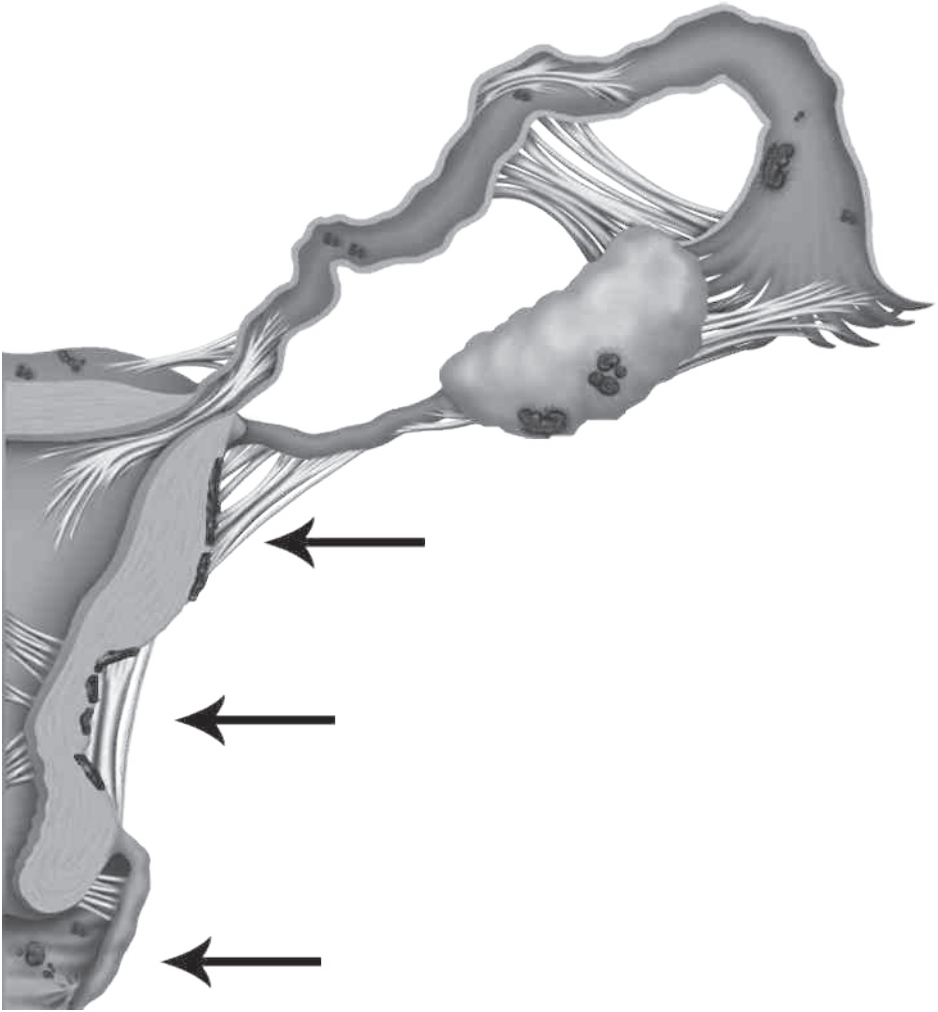
Prior medical procedures

Surgeries performed anywhere in the pelvis can cause adhesions as we heal from the trauma of surgery. After viewing countless medical histories of our patients, we have found that medical procedures such as IUD placement and removal, D&C, surgery to the cervix, and dilation of the urethra to diagnose or treat urinary problems may also cause adhesions to form.

Intrauterine devices (IUD) are placed inside the uterus to prevent pregnancy. Their mechanism of action is to create inflammation within the uterus. Often, they do their job all too well. Inflammation creates adhesions and adhesions decrease mobility, often pulling into the cervix. The consequent adhesions can cause pain with deep penetration, or infertility. A dilation of the cervix or procedure at or near the vaginal opening can cause inflammation in some women, creating microscopic adhesions to form affecting tissues near the clitoris, urethra, and vaginal opening. This can cause pain with intercourse or urination, and can decrease sensation, libido, and the ability to orgasm.

Endometriosis

Sexual intercourse pain is a common complaint among women with endometriosis. Endometrial tissue creates inflammation wherever it is found. Inflammation causes tiny adhesive cross-links to form, binding the endometrial tissue to the underlying structures. Endometriosis within the vagina causes the same adhesive reaction as any other inflammation. As the body heals from inflammation, adhesions form. Whether found on the vaginal wall, the cervix, the coccyx, the entrance to the vagina (introitus), or at surgical scars, these adhesions pull on nerves during intercourse, causing pain. A thorough discussion of endometrial pain is presented in Chapter Seventeen.



Endometrial adhesions cause tissues to contract, causing spasm or pain.

Treating Symptoms: A Major Problem with Modern Medicine

Until we stumbled upon and then expanded our work treating dyspareunia, modern medicine provided very few alternatives for women with intercourse pain. The most commonly prescribed modalities were:

- Pain killers (oral or topical)
- Desensitizing agents
- Psychological counseling
- Antidepressants
- Surgery

Pain medications and desensitizing agents have obvious drawbacks. Most women who are anticipating intercourse would like to be able to feel what's happening, especially if it is not painful. Pain killers and desensitizing agents remove the ability to feel in an area of the body that is very sensitive, and the most highly designed to experience physical pleasure.

Psychological counseling and antidepressants may help a woman cope with the fact that she cannot have intercourse without pain, but in most cases they do very little to actually decrease the physical pain. When there is a physical, mechanical reason for the pain, the best counseling or strongest antidepressant does not treat the cause of that biomechanical dysfunction. Thus, the condition persists as a permanent problem in the life of (literally) millions of women.

In rare cases, physicians find a reason to believe that surgery may help. We have found that surgery is a possibility for deep pain at the tailbone, such as coccydynia (tailbone pain), and some patients have told us that they received good relief after having the coccyx removed. However we have also treated many patients who underwent surgery for tailbone pain with terrible results. These patients

came to us with much more debilitating pain than they had ever experienced prior to surgery. Most of these patients were on heavy doses of daily pain medications, including ibuprofen, narcotics, or morphine, when they arrived at our door. Some of them couldn't even get out of bed without experiencing severe and debilitating pain.

In other areas of the vagina or cervix, surgery can certainly cut adhesions. But scars left from surgery in this most sensitive area of a woman's body can leave a woman with debilitating, permanent pain. We have found that most gynecologists encourage women to try a more conservative option rather than opting for surgery for tailbone or intercourse pain.

Treating the Cause of the Pain

When we employ manual physical therapy to address sexual intercourse pain, we start with a thorough, physical evaluation of the external and internal vaginal tissues and structures. The examining team consists of two people — the therapist and the patient. Working together, slowly, gently, and with respect and sensitivity, the therapist

first examines every centimeter of the opening of the vagina. We check the mobility in all directions, like the hands of a clock, examining the quality, mobility, and pain sensitivity of the structures.

She notes any areas of pain, and together, they judge the amount of pain in each location on a scale of 0 to 10. We want to be certain that each patient leaves that evaluation with a thorough

I had always thought the pain I experienced with intercourse was normal. I experienced a great reduction in intercourse pain (after CPT).

— Sydney, mother of two after struggling with infertility and intercourse pain

understanding of the precise areas causing her pain and the amount of pain each area elicits. As we proceed further into the examination we move deeper into the vagina if we are able to at that time, in order to check the cervix, pelvic floor, and pelvic wall muscles. If we are not, we will continue with deeper examination as we are able to during the next and subsequent sessions.



Thorough assessment and treatment of intercourse pain includes addressing all attachments into the medial pelvis.

We examine attachments into the legs, especially the adductors (the muscles on the inner thighs) which attach to the pubic symphysis (the bones at the front of the pubic mound). We have found that if a tear or trauma has occurred in this area earlier in life, it can create adverse consequences over time for the nearby vaginal and perineal tissues. When we examine this area, we note if any of the areas are tight, of if they replicate or increase the patient's pain. If they do, we know we must add that area to our focus of therapy. Thus, together with the patient, we thoroughly evaluate the full geography of the areas in and around the patient's vagina and perineum (crotch).

***It didn't hurt
anymore to go
to the bathroom
after therapy
and sex was
less painful.***

*– Kimberly, who struggled
with chronic pain
and endometriosis*



The adductors of the inner legs have strong fascial attachments into the urogenital area.

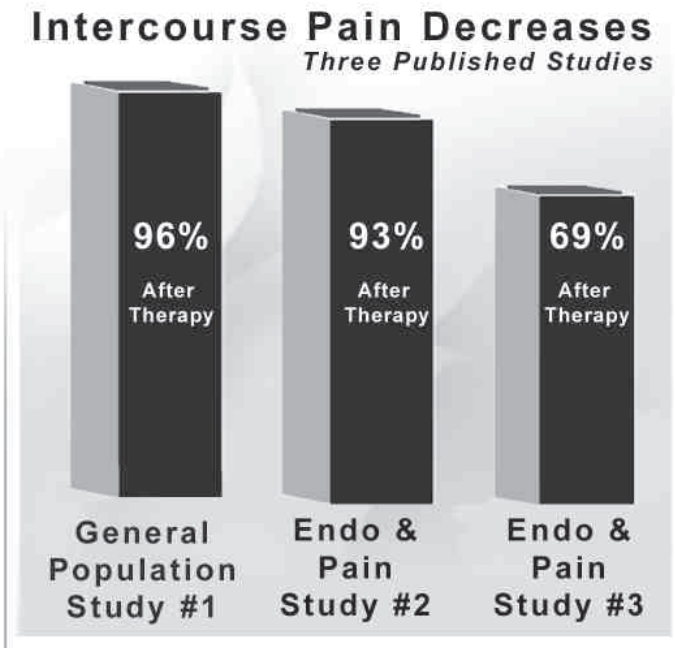
By the end of the week (at CPT), intercourse pain was completely gone – it was amazing!

- Katrina, who struggled with chronic pain

After assessing all of the adhered areas, we proceed slowly and gently into treatment. As we do, we detach adhesive cross-links, link by link. We describe what we are feeling in each area, and we ask our patient what she is feeling, "Is the pain right there where my hand is? Does it radiate to other parts of the body?"

What is the quality of the pain (deep, piercing, sharp, burning, aching, etc.)? Now is it dissipating?"

Our published studies in this area have shown that the effects of this approach can be quite profound. Decreasing intercourse pain is definitely one of our highest areas for success. In fact, we have found that over the course of therapy, we have been able to decrease or eliminate intercourse pain in nearly every woman we treat. This encouraging outcome is supported by scientific data, published in highly respected medical journals. In fact, in two different studies, all but one patient received relief from intercourse pain after this therapy.²⁵



*Three pioneering studies and citations
examine our results treating intercourse pain.
Medscape General Medicine (2004) and Fertility and Sterility (2006)*

Unbearable Pain During Sex

- Emily's Story

When I was 27, I married my husband, Trevor. As a Christian, I had never had sex before I was married. I thought sex might be a bit painful the first couple of times, but on my wedding night and thereafter, it was awful! I felt like my husband was hitting a wall inside of me. I kept thinking, "We can work this out. If we can just push past the pain, it will be okay." However, he was just too nice to do that and he didn't want to hurt me.

Soon, the constant attempts and subsequent pain created a cycle. I would tense in anticipation of the pain to the point that it became both a physical and mental issue. I was so tight that at times he could not enter me at all.

***It was awful!
I felt like my husband
was hitting a wall
inside of me.***

After a couple of years, I went to see my doctor. She gave me some small rubber dilators, but they did not help. At the time, I did not know other treatment options existed and I felt very discouraged.

About four years into our marriage, my husband and I decided we wanted to have children. However, he could not enter me fully and the pain was now almost unbearable. We tried to have sex more often, and the stress of trying to push past the pain was making my menstrual cycles irregular.

My doctor suggested I try Clomid, a prescription drug that aids ovulation. I knew that was just her way of trying

to help me, even though the real problem was the painful intercourse.

After three months of Clomid and no pregnancy, she suggested I see a reproductive endocrinologist. I didn't think my doctor had evaluated me or truly listened to the heart of my problem to merit spending the money on a fertility specialist.

About that time, a friend at my church had returned from treatment at Clear Passage Therapies (CPT). Although they were treating her for endometriosis pain and infertility, she told me that the clinic also used manual physical therapy to relieve intercourse pain.

I was glad there was a place I could go to find help, but I didn't know what to expect. I decided to apply for a one-week intensive therapy regimen. My husband came with me for support.

I felt very comfortable at CPT, and in control of the treatment. At

***The pain was 90% gone!
It's been over six months since
treatment now, and my libido
and desire are still increasing.***

times, it was uncomfortable because they were treating a very pain-sensitive area, but I could

tell the difference as the pain decreased with each session, morning and afternoon.

My husband and I had intercourse a few times that week, and I noticed that the pain was less. Once I returned home and the temporary soreness from treatment dissipated, my husband and I had sex again. He had no problems entering me and the

pain was 90% gone! Before treatment he had never been able to enter me fully, and finally he was able to! No one knows but me, my husband, and God. What a miracle this is!

It's been over six months since treatment now, and my libido and desire are still increasing. My husband and I have been having sex more often and I am still amazed at the difference.

My menstrual cycles also became regular after therapy. Before treatment, sometimes I would go 40 days between cycles. After treatment, they went back to 26-28 days each month . . . but that didn't last long. I thought I was five days late, so I took a pregnancy test and it showed I was pregnant! I took four more that weekend before returning to the doctor to confirm that I am indeed pregnant!

Although I could not get my doctors to listen to me, I always knew my "infertility" was due to the painful intercourse I experienced. I am glad I found a clinic that actually listened to me and offered a non-surgical solution.