

Increasing Orgasm and Decreasing Dyspareunia by a Manual Physical Therapy Technique

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Abstract and Introduction

Abstract

Context: Female sexual pain and dysfunction

Objective: To evaluate the effectiveness of a new site-specific, manual soft-tissue therapy in increasing orgasm and reducing dyspareunia (painful intercourse) in women with histories indicating abdominopelvic adhesion formation.

Design and Intervention: A total of 29 new patients presenting with infertility or abdominopelvic pain-related problems, and also indicating sexual pain or dysfunction, received a series of treatments (mean, 19.5 hours) designed to address biomechanical dysfunction and restricted mobility due to adhesions affecting the reproductive organs and adjacent structures.

Outcome Measures: Primary outcome measures were post-test vs pretest scores on: (1) the Female Sexual Function Index (FSFI) full scale, orgasm domain, and pain domain; and (2) 3 supplemental 10-point rating scales of sexual pain levels. Secondary outcome measures were post-test vs pretest scores in the other 4 FSFI domains (desire, arousal, lubrication, and satisfaction). The Wilcoxon signed-rank test was used for all statistical analyses.

Results: For the 23 patients available for follow-up, the paired FSFI post-test vs pretest scores were significant ($P \leq .003$) on all measures. Of the 17 patients who completed the 3 sexual pain scales, the paired post-test vs pretest scores were significant ($P \leq .002$)

Conclusions: Many cases of inhibited orgasm, dyspareunia, and other aspects of sexual dysfunction seem to be treatable by a distinctive, noninvasive manual therapy with no risks and few, if any, adverse effects. The therapy should be considered a new adjunct to existing gynecologic and medical treatments.

Introduction

In the course of treating female infertility with a manual physical therapy technique,^[1] several of our patients volunteered the fact that they were having "the best sex, the best orgasms ever." To determine the extent of this phenomenon, a question noting changes in orgasm intensity, frequency, and duration was added to the post-therapy outcomes section of the patient follow-up form. The response was sufficient to inspire further investigation.

The purpose of this study was to systematically assess the effectiveness of an innovative, site-specific, manual soft-tissue therapy in increasing orgasm and reducing dyspareunia (painful intercourse) in women with histories indicating abdominopelvic adhesion formation.

Assessing Female Sexual Dysfunction

Relatively recent investigations have found the prevalence of female sexual dysfunction (approximately 40%) to surpass that of males (approximately 30%).^[2,3] Despite the higher prevalence, there have been few investigatory studies of female sexual problems and fewer available treatments than for comparable male conditions.^[4]

Since the publication of the "Report of the International Consensus Development Conference on Female Sexual Dysfunction: Definitions and Classifications" in 2000, research has advanced. The committee built upon the existing frameworks (ie, the DSM-IV and ICD-10) and expanded its classifications to include both psychogenic and physiologic causes of arousal, desire, orgasm, and sexual pain disorders.^[5] Thus, despite the fact that dyspareunia had long been considered to be psychogenic, it is now included in "Sexual Pain Disorders" due to its solid biological base (eg, connective tissue, hormonal, iatrogenic, inflammatory, muscular, neurologic, and vascular causes).^[6]

Although there is still a lack of consensus regarding the definition and diagnostic framework for evaluating and treating female sexual dysfunction,^[4] it has traditionally included a variety of (overlapping) disorders of desire/libido, arousal, lubrication, pain/discomfort, and inhibited (or total absence of) orgasm.^[2] Many experts agree that the most authentic way of evaluating subjective sexual responses is in a naturalistic (ie, at home) setting, using a self-report technique.^[4] Although earlier measures were largely unidimensional scales (eg, Hoon, Hoon, Wincze^[7]), several newer multidimensional self-administered questionnaires have met the basic psychometric criteria for reliability and validity.^[8] The Female Sexual Function Index (FSFI) is one of these.^[4,8,9]

The FSFI, a 19-item questionnaire, assesses 6 key dimensions (domains) of sexual function in women, including orgasm and pain. The others are arousal, desire, lubrication, and satisfaction. The FSFI full score is obtained by adding the individual domain scores.

Etiology of Dyspareunia and Inhibited Orgasm

Painful sexual intercourse and inadequate (or absence of) orgasms are among the most common complaints of women seeking gynecologic care.^[4,10]

Although psychological and interpersonal factors can contribute to all types of sexual dysfunction, physiologic factors play a large role in dyspareunia and orgasmic dysfunction. The causes of dyspareunia include a variety of organic factors, such as condyloma, ectopic pregnancies, endometriosis, pathologic conditions due to childbirth, pelvic inflammatory disease, postoperative scarring from gynecologic surgery, vaginal atrophy, vaginitis, and vulvar lesions.^[10] Other etiologies include adnexal pathology; cystitis and interstitial cystitis; inadequate lubrication; pelvic adhesions, congestion or infections; urethral disorders; vaginismus; and vulvodynia (vulvar vestibulitis).^[11]

Genital pain during vaginal intercourse may occur upon initial or deep penetration, or both. Inadequate lubrication [pelvic floor dysfunction], vaginal atrophy, vaginismus, and vulvodynia are associated with painful entry. Deep pelvic pain occurs with the other conditions cited above^[11] and may be due to the partner's thrusting, which hits pain-sensitive structures. Myofascial restrictions and trigger points in the pelvic floor muscles can cause pain and may also serve as a trigger for neurogenic inflammation of the bladder wall.^[12] We believe that many causes of dyspareunia (eg, clitoral and postsurgical adhesions, endometriosis, episiotomy scars, interstitial cystitis, vaginitis, and vulvodynia) may also affect orgasmic capability and overall sexual response.

Value of the Intervention

Clinically, we have observed that site-specific, manual soft-tissue therapy improves soft-tissue mobility, elasticity, and distensibility. Theoretically, mobilization of the soft tissue appears to break

down the collagenous cross-links and adhesions that cause pain and dysfunction,^[13] including dyspareunia and inhibited orgasm.

Adhesions and Female Sexual Dysfunction

Adhesions are deposits of fibrous tissue that form as a natural response to tissue injury after infection, inflammation, surgery, or trauma. In essence, they are bands of scar tissue with the potential to bind organs to other structures, which leads to multiple symptoms including organ dysfunction and/or pain. Wherever they occur, adhesions distort the anatomy and can cause decreased mobility and function.^[14] The pelvic organs and bowels are both common sites of adhesion formation, and many patients describe their pain as "pulling" or "stabbing."

In addition to being a common outcome of pelvic or abdominal surgery, adhesions are known to accompany related conditions such as bowel obstruction, chronic abdominopelvic pain, endometriosis, pelvic inflammatory disease, pelvic spasms, polyps, and tubal obstruction.^[15-17] It is presumed that some of these conditions cause, or are caused by adhesions. It is also presumed that some cases of dyspareunia and orgasmic problems may be due to the formation of pelvic adhesions imposing on pain-sensitive structures or altering pelvic biomechanics, including the positions of the pelvic support structures and viscera.

Adhesion Formation

Adhesions begin with a fibrin matrix that is formed as the body responds to tissue injury. In the first days following injury, multiple cellular elements become encased in this matrix. These are gradually replaced by vascular granulation tissue, containing fibroblasts, macrophages, and giant cells. Four days post-trauma, most of the fibrin is gone and more fibroblasts and collagen are present. From Days 5 to 10, the fibroblasts align within the adhesions. By Day 14, the predominant cells present are fibroblasts. These fibroblasts anchor to adjacent collagen fibers and contract, shrinking the tissue.^[18-20]

As the fibroblasts align within the structure, collagen is laid down in a haphazard manner, and cross-links begin to form. The result is the formation of a fibrinous adhesion, which may cause a subsequent adherence of the adjacent serosal surfaces. Tissue shrinkage leads to decreased movement of the area that, in turn, creates more mechanical irritation, thus perpetuating the cycle.^[18-20] Four to 8 weeks after tissue damage, the collagen fibrils organize into discrete bundles. Eventually, the adhesion matures into a fibrous band. These mechanical components have been proposed as the underlying mechanism of adhesion-related pain.^[21]

Manual Physical Therapy and Female Sexual Dysfunction

A search of the literature revealed a dearth of research in the use of manual physical therapy for treating female sexual dysfunction.^[1] Most dyspareunia studies focus on its prevalence; treatment information is generally limited to surgical options and psychosocial components.^[10] Thus far, we have found only 1 relevant case report. In this instance, the therapist employed soft-tissue mobilization, myofascial release, muscle energy techniques, biofeedback, strengthening and stabilizing exercises, and an orthotics consult to successfully treat dyspareunia in a 42-year-old woman (who also reported abdominal and low back pain). The patient was seen for a total of 31 hours over 1 year.^[10]

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