

When sex is a pain in the butt

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While usually not a topic of conversation in polite company, bowel problems are a part of life. Bowel problems can include constipation, diarrhea, bloating and/ or gas, and when they occur, sexual activity is often curtailed. When everything works normally, these symptoms generally occur infrequently and therefore, should not affect one's sex life. However, chronic anal, rectal, or bowel problems can certainly affect intimacy and the reverse may be true as well, in that certain sexual activities may be a trigger, or be a cause, of ano-rectal or bowel dysfunction.

Some women experience rectal urgency or gas during sexual intercourse. This may occur because of a rectocele, a condition in which the rectum has dropped slightly towards the vaginal canal. Penetration during vaginal intercourse then stimulates the bowel, which sometimes causes discomfort or a strong urge to defecate. In these situations, it is best to engage in sexual intercourse after a bowel movement, when the rectum is empty. It is also advisable in the event that occasional flatulence is triggered by sex, to relax and greet it with a sense of humor.

Irritable Bowel Syndrome, (IBS) is a condition characterized by chronic bouts of abdominal pain, constipation and diarrhea. Women and men with irritable bowel syndrome (IBS) often experience difficulties with sexuality and intimacy. Long hours spent in the bathroom, inability to allow any pressure on the abdomen, and fear of constantly expelling unpleasant gaseous odors are only some of the factors that can inhibit intimacy. In these cases, it is best to stick to intimate activities which are pleasurable and relaxing and

avoid activities which may cause anxiety, discomfort or pain for either partner.

Other ano-rectal conditions affecting sex include levator ani syndrome and proctalgia fugax. The former condition refers to tightness and tension of the pelvic floor muscles which contribute to constipation as well as the difficulty relaxing the sphincters, which can make vaginal penetration difficult. The latter refers to a condition of sharp, fleeting pains in the rectal area, which is related to contractions of the smooth muscle of the anal sphincter. In people who enjoy anal sex, both these conditions can severely limit the ability to enjoy painless penetration.

Whether the receptive partner in anal sex is a man or a woman, it is important to keep in mind the physiological differences between the anus and vagina. The anus is comprised of an internal and external sphincter which contract in order to prevent fecal incontinence. With penetration, the internal sphincter immediately closes. In order that penetration not be painful, the receptive partner must be able to control the pace and depth of penetration. Furthermore, injury to the anal sphincters from repeated penetration against a contracted anal sphincter can lead to fecal incontinence and chronic anal pain.

Chronic anal pain appears to be a common condition amongst men who receive anal sex. This condition has been referred to in the literature as ando-dyspareunia and some studies have suggested that its incidence is as high as 14% amongst gay men. Several possible causes for anal pain during sex have been suggested. Physical causes include anal fissures, which are tiny cuts in the skin around the anus that occur from overstretching, large partner penis size, lack of lubrication, insufficient arousal, or uncomfortable positioning. Irritation during penetration of a pelvic nerve known as the pudendal nerve may cause anal and pelvic pain. Anismus, a condition of increased tension of the muscles of the anus is a condition that can cause physical pain as well as constipation, but may also be related to psychosexual causes, such as anxiety or fear. Some studies have suggested a higher incidence of anal pain in gay men who are ambivalent about their sexual identity or are in the closet. Other possible psychosexual factors may relate to imbalance of power in the relationship or relationship dissatisfaction.

Psychoanalytic or somatic mind/body approaches may draw a parallel between the physical findings of anal muscle tension and anal retentive behavior.

Treatment for all these conditions should be multidisciplinary. Medical possibilities such as infection or disease should be ruled out and treated by a physician. Musculoskeletal aspects, such as tight and tense pelvic floor muscles can be treated by a pelvic floor specialist with techniques such as stretching exercises, trigger point massage, pelvic floor relaxation and biofeedback, as well as general relaxation and breathing techniques. Relationship and psychosexual factors should be explored and addressed as well.