Pelvic Floor Dysfunction: How Tight, Weak or Poorly Coordinated Pelvic Muscles Can Affect Sexual Pleasure, Comfort and Reproductive Health

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Understanding the Pelvic Floor: An Important Part of Sexual Health That Is Often Ignored

When patients think about sexual health, they usually think about hormones, erections, vaginal lubrication, sperm quality or reproductive organs. Very few think about the group of muscles lying at the bottom of the pelvis.

Yet these muscles—the **pelvic floor muscles**—play an important role in bladder control, bowel function, support of the pelvic organs and sexual response.

A woman may come to me saying:

"Doctor, intercourse has become painful and I feel as though my body tightens automatically."

Another patient may report:

"I want intimacy, but penetration feels difficult or uncomfortable."

A man may say:

"I have pelvic tightness, urinary difficulty and pain after ejaculation."

Another man may have erectile problems despite otherwise normal desire.

In some people, pelvic-floor muscles are **too weak**.

In others, they are **too tight or overactive**.

And in many patients the main problem is not simply strength but **poor coordination—the muscles do not contract and relax at the correct time**.

This broad group of problems is often described as **pelvic floor dysfunction**.

Cleveland Clinic defines pelvic floor dysfunction as difficulty correctly relaxing and coordinating the pelvic-floor muscles. The muscles support pelvic organs including the bladder, rectum, uterus and prostate, and problems with their coordination can contribute to bowel, urinary, pelvic-pain and sexual symptoms.

From the perspective of sexual medicine, this topic is particularly important because the pelvic floor participates in **arousal, erection, vaginal function, orgasm, ejaculation and comfortable penetration**. A 2024 systematic review and meta-analysis in *The Journal of Sexual Medicine* found a meaningful association between pelvic-floor muscle function and women's sexual function, with the muscles involved in both arousal and orgasm.

My message to patients is therefore simple:

The pelvic floor should neither be permanently tight nor simply "as strong as possible." Healthy pelvic-floor function requires strength, relaxation, flexibility and coordination.

What Is the Pelvic Floor?

The pelvic floor is a layer of muscles and connective tissues forming the lower support of the pelvis.

An easy way to imagine it is as a **muscular hammock or supportive sling** stretching from the front of the pelvis toward the tailbone and from one side of the pelvis to the other.

These muscles support important organs.

In women, they contribute to the support of the:

- bladder,
- uterus,
- vagina,
- rectum,
- and associated pelvic structures.

In men, they support structures including the:

- bladder,
- prostate region,
- rectum,
- urethra,
- and surrounding pelvic tissues.

The National Institute of Diabetes and Digestive and Kidney Diseases describes the pelvic-floor muscles as supporting the bladder and rectum and, in women, the uterus. Pelvic-floor muscle training may improve bladder and bowel control and may also improve sexual function.

But these muscles are not simply a passive support.

They continuously:

contract, relax and coordinate with breathing, abdominal muscles, bladder function, bowel movements and sexual activity.

Why Does the Pelvic Floor Matter During Sex?

Sexual response requires coordination between the nervous system, blood vessels, hormones, genital tissues, brain and pelvic muscles.

The pelvic floor contributes to this process in several ways.

In women, appropriate pelvic-floor activity may influence:

- genital blood flow,
- vaginal sensation,
- arousal,
- orgasmic contractions,
- vaginal opening and relaxation,
- penetration comfort,
- and pelvic stability.

In men, pelvic-floor muscles contribute to:

- erection rigidity,
- ejaculation,
- orgasmic contractions,
- urinary control,
- and stabilization of the pelvic and perineal region.

The 2024 systematic review mentioned above included 33 studies and found that pelvic-floor strength had a moderate positive association with female sexual function. All seven

observational studies examining sexual response found involvement of the pelvic-floor muscles in either arousal or orgasm.

The important clinical lesson is that sexual function is not determined by muscle strength alone.

Too little tone may create problems, but too much tone can create different problems.

Pelvic Floor Dysfunction Is Not One Disease

Patients often hear the phrase **"weak pelvic floor"** and assume every pelvic-floor problem requires Kegel exercises.

That is incorrect.

Pelvic-floor dysfunction may broadly involve:

1. **Weak or underactive muscles**
2. **Overactive or hypertonic muscles**
3. **Poorly coordinated muscles**
4. **A combination of weakness and excessive tension**
5. **Muscles that contract normally but fail to relax when needed**

Treatment differs considerably between these situations.

This is why I advise patients not to begin intensive pelvic-floor strengthening simply because they have pelvic pain or sexual discomfort.

In some people, repeated strengthening exercises can make an already tight pelvic floor even more uncomfortable.

Weak Pelvic Floor Muscles

A weak pelvic floor does not generate adequate force or support.

This may happen after:

- pregnancy,
- childbirth,
- aging,
- pelvic surgery,

- prolonged inactivity,
- tissue injury,
- neurological illness,
- or other conditions affecting pelvic support.

NIDDK notes that pregnancy, childbirth, surgery and aging can weaken pelvic-floor muscles and contribute to urinary, bowel or gas leakage.

Women may notice:

- urine leakage with coughing or exercise,
- reduced pelvic support,
- pelvic heaviness,
- some forms of prolapse,
- decreased awareness of pelvic-floor contraction,
- or changes in sexual sensation.

Men may experience pelvic-floor weakness particularly after certain pelvic or prostate procedures and may develop urinary leakage or changes in sexual function.

However, weakness should be diagnosed rather than assumed.

Hypertonic or Overactive Pelvic Floor

The opposite problem occurs when the pelvic-floor muscles remain unnecessarily tight.

This is commonly called a **hypertonic pelvic floor**, **pelvic-floor overactivity**, or in pain conditions **pelvic-floor tension myalgia**.

These muscles may not relax adequately during:

- urination,
- bowel movements,
- penetration,
- or other pelvic activities.

Cleveland Clinic identifies pelvic-floor physical therapy as the main treatment for a hypertonic pelvic floor. Therapy may include biofeedback, relaxation, stretching, massage/manual techniques and improved movement of the surrounding joints and muscles.

A tight pelvic floor can produce very different symptoms from a weak one.

Possible symptoms include:

- pelvic pressure,
- chronic pelvic pain,
- painful intercourse,
- burning or aching around the genitals,
- difficulty inserting a tampon,
- constipation,
- difficulty emptying the bowel,
- urinary urgency,
- difficulty starting urination,
- feeling unable to fully empty the bladder,
- genital pain,
- painful ejaculation,
- or pain after intercourse.

Some patients have both **tightness and weakness**. A muscle held in constant tension can become fatigued and function poorly.

This is why simply telling the patient to “strengthen the muscles” can sometimes be exactly the wrong advice.

Poor Coordination: The Muscle May Be Strong but Still Dysfunctional

Imagine a strong hand that never opens properly.

Strength alone would not make that hand function normally.

The pelvic floor is similar.

During a bowel movement or urination, the pelvic floor must relax appropriately.

During certain phases of sexual activity, it must change tone in a coordinated way.

During orgasm, rhythmic contractions occur.

If these processes become poorly coordinated, symptoms may develop even when the muscle is not technically weak.

Cleveland Clinic describes pelvic-floor dysfunction particularly as a problem of **coordination and relaxation**, noting that affected people may tighten their muscles rather than relaxing them at the appropriate time.

So the real goal is:

appropriate contraction when contraction is needed and appropriate relaxation when relaxation is needed.

How Tight Pelvic Muscles Affect Sexual Comfort in Women

Women with an overactive pelvic floor may experience:

- pain at the vaginal opening,
- deeper pelvic pain,
- painful penetration,
- burning after intercourse,
- inability to comfortably insert a tampon,
- feeling that the vagina is “too tight,”
- pelvic aching after orgasm,
- or fear of penetration.

This can become a self-perpetuating cycle.

The woman expects pain.

The pelvic-floor muscles tighten in anticipation.

Penetration becomes more difficult.

Pain increases.

The next attempt produces even more fear and muscular guarding.

Eventually the patient may believe she simply has “low desire.”

But the real sequence may be:

pain → fear → muscle tightening → more pain → avoidance of intimacy.

This is particularly relevant in conditions such as dyspareunia, vulvodynia, vaginismus/genito-pelvic pain-penetration problems and chronic pelvic pain.

ACOG advises that pelvic-floor physical therapy may be offered for sexual pain and other pelvic problems, and its chronic-pelvic-pain guidance describes pelvic-floor therapy as useful for desensitization, myofascial treatment, breathing, mindfulness and biofeedback.

Weak Pelvic Muscles and Female Sexual Function

Weakness may affect sexual experience differently.

Some women describe:

- reduced awareness during penetration,
- difficulty voluntarily contracting the pelvic muscles,
- reduced orgasmic intensity,
- urinary leakage during intimacy,
- or pelvic heaviness.

Research suggests pelvic-floor rehabilitation can improve some aspects of women's sexual function.

A 2024 systematic review and meta-analysis of 21 randomized trials found improvements in Female Sexual Function Index outcomes—including arousal, orgasm, satisfaction and pain—after pelvic-floor muscle training. However, the authors graded the overall certainty of evidence as **very low** because treatment protocols and study populations differed substantially.

This distinction is important.

Pelvic-floor therapy is promising and clinically useful, but it should not be marketed as a guaranteed sexual-enhancement technique for everyone.

Pelvic-Floor Training After Hysterectomy

Pelvic surgery can alter pelvic-floor function.

A 2024 systematic review involving 776 participants after hysterectomy found **moderate-quality evidence** that pelvic-floor muscle training improved women's sexual function compared with no intervention. Effects on urinary symptoms, pelvic strength and quality of life were less certain, and longer-term benefits remain unclear.

This illustrates an important principle:

Pelvic-floor rehabilitation can be very useful after certain procedures—but treatment must be matched to the patient's actual muscular pattern and surgery history.

Pelvic Floor Dysfunction After Pregnancy and Childbirth

Pregnancy places increasing weight and pressure on the pelvic floor.

Childbirth can stretch muscles, connective tissue and nerves.

After delivery, a woman may experience:

- urinary leakage,
- pelvic heaviness,
- weakness,
- painful intercourse,
- pelvic-floor guarding,
- reduced sexual confidence,
- or a combination of weakness and tension.

It is therefore incorrect to assume that all postpartum women need only aggressive strengthening.

Some women primarily need strengthening.

Others need muscle relaxation and scar or pain rehabilitation.

Some require both in sequence.

A systematic review of randomized trials found a small beneficial effect of pelvic-floor exercise on sexual function during pregnancy and postpartum, but effects were not uniform across studies.

A proper postpartum pelvic-floor evaluation is preferable when significant symptoms persist.

Menopause and Pelvic-Floor Sexual Health

During and after menopause, sexual discomfort may involve several overlapping factors:

- lower estrogen,
- vaginal dryness,
- reduced tissue elasticity,
- chronic illness,
- changing pelvic-floor function,

- prolapse,
- pain,
- and changes in arousal.

Pelvic-floor therapy can sometimes improve sexual function, but it does not replace treatment for vaginal dryness or genitourinary syndrome of menopause when those conditions are present.

A 2025 systematic review and meta-analysis of pelvic-floor muscle training in postmenopausal women found improvements particularly in **orgasm, arousal and satisfaction**, though the included studies were highly heterogeneous and the evidence remained limited.

Therefore, treatment should be combined when necessary:

pelvic-floor rehabilitation + treatment of vaginal tissue health + sexual-health counseling + management of medical conditions.

Pelvic Floor Dysfunction in Men

Men also have pelvic-floor muscles, and male pelvic-floor dysfunction deserves much greater public awareness.

Symptoms may include:

- pelvic or perineal pain,
- urinary hesitancy,
- weak urinary stream,
- constipation,
- painful ejaculation,
- pain after ejaculation,
- erectile difficulty,
- genital pain,
- rectal pressure,
- pain with prolonged sitting,
- and chronic prostatitis/chronic pelvic pain syndrome–type symptoms.

The American Urological Association's 2025 guideline on male chronic pelvic pain specifically recognizes **pelvic-floor myalgia and pelvic-floor tension myalgia** as clinically important. It notes that pelvic-floor tenderness is common in chronic pelvic pain and that associated symptoms may include urinary hesitancy, constipation and painful ejaculation. Proper evaluation includes assessment for musculoskeletal sources of pain, and pelvic-floor physical therapy can be an important part of management.

This is clinically important because a man with pelvic pain may receive repeated treatment for “prostatitis” even when muscular dysfunction is contributing significantly.

Pelvic Floor Muscles and Erectile Function

An erection depends primarily on healthy vascular and neurological mechanisms, but the pelvic-floor muscles also contribute to rigidity and maintenance of penile blood trapping.

Cleveland Clinic notes that pelvic-floor dysfunction in men may be associated with difficulty obtaining or maintaining an erection.

A systematic review evaluating pelvic-floor muscle training for erectile dysfunction and premature ejaculation found improvement across included ED studies and improvement in many PE studies. However, the research quality ranged from low to moderate and the training protocols varied considerably.

Therefore, pelvic-floor training may be one component of ED rehabilitation in selected men, but it should **not replace evaluation for diabetes, cardiovascular disease, hormonal problems, medication effects or other major causes of erectile dysfunction**.

Pelvic Floor Muscles and Premature Ejaculation

Pelvic-floor muscles participate in the ejaculatory process, so researchers have investigated muscle training and control techniques in men with premature ejaculation.

The evidence is still developing.

A 2026 systematic review and meta-analysis of randomized trials found that isolated pelvic-floor muscle training was less effective than dapoxetine or certain combined interventions for improving intravaginal ejaculatory latency time. Combined approaches involving training plus other techniques sometimes performed better than exercise alone.

This is a useful example of why pelvic-floor exercises should not be promoted as a universal cure for PE.

They may be helpful for selected patients as part of a broader treatment plan.

Painful Ejaculation and Male Pelvic-Floor Tension

When pelvic-floor muscles remain chronically tense, ejaculation can provoke pain because ejaculation itself involves coordinated pelvic muscular contractions.

Men with pelvic-floor tension may describe:

- perineal aching,
- pelvic tightness,
- pain during ejaculation,
- pain immediately afterward,
- or pressure around the rectum or prostate region.

The 2025 AUA chronic-pelvic-pain guideline specifically notes painful ejaculation among symptoms that may point toward pelvic-floor muscle involvement.

Therefore, repeated antibiotic treatment is not automatically appropriate when infection has not been established.

The muscular component should be considered.

Pelvic Floor Dysfunction and Orgasm

Orgasm is a neurovascular, muscular and psychological event.

During orgasm, the pelvic-floor muscles participate in rhythmic contractions.

The 2024 systematic review on pelvic-floor muscles and sexual response found that studies consistently identified involvement of these muscles in arousal or orgasm.

A person with reduced muscular awareness or weakness may therefore experience sexual sensations differently.

At the same time, excessive tension can make orgasm painful.

So again, sexual health depends on **functional balance**, not maximal strength.

Urinary Symptoms Can Be an Important Clue

Patients may not connect urinary symptoms with sexual symptoms.

But the same pelvic muscles participate in both systems.

Possible signs include:

- frequent urination,
- urinary urgency,
- difficulty starting urine,
- stop-start flow,
- feeling incompletely empty,
- stress urinary leakage,
- or pain during urination.

Cleveland Clinic lists urinary frequency, stop-start urination, painful urination and incontinence among possible pelvic-floor dysfunction symptoms.

In men, urinary hesitancy may accompany pelvic-floor tension myalgia.

Constipation and Pelvic-Floor Dysfunction

Bowel symptoms are another major clue.

A patient may experience:

- prolonged straining,
- incomplete evacuation,
- need to change position repeatedly,
- constipation,
- difficulty relaxing the anus,
- or the need for manual assistance.

Cleveland Clinic explains that some people contract pelvic-floor muscles when they should relax them for bowel evacuation, producing obstructed defecation. Biofeedback and pelvic-floor retraining are commonly used treatments.

Long-term straining may also place further stress on pelvic support.

For this reason, bowel habits should be discussed during pelvic-floor assessment.

Bladder Pain and Pelvic Muscle Spasm

Pelvic-floor dysfunction may occur alongside bladder pain conditions.

NIDDK notes that people with interstitial cystitis/bladder pain syndrome may experience pain during sex partly because of pelvic-floor muscle spasms.

This demonstrates why pelvic-floor treatment often requires collaboration between:

- gynecology,
- urology,
- physiotherapy,
- pain medicine,
- gastroenterology,
- and sexual-health clinicians.

One specialty alone may not always address the entire problem.

What Causes Pelvic Floor Dysfunction?

There is rarely one universal cause.

Potential contributors include:

Pregnancy and childbirth

Muscles and connective tissues may stretch or become injured.

Pelvic surgery

Operations involving the prostate, uterus, rectum or other pelvic structures can alter muscle function or nerve input.

Chronic constipation and straining

Repeated straining may contribute to pelvic-floor dysfunction.

Chronic pelvic pain

Pain itself can cause protective muscle guarding and chronic tension.

Trauma or injury

Pelvic injuries can affect muscles, nerves or connective tissues.

Aging

Muscle mass, connective tissues and hormone environments change with age.

Neurological conditions

Nerve disorders may disrupt normal pelvic muscular coordination.

Repetitive over-recruitment

Some people habitually hold the pelvic floor tightly, particularly in association with pain, anxiety or dysfunctional toileting patterns.

Sexual pain

Repeated painful penetration can create involuntary guarding.

Musculoskeletal problems

Hip, back, abdominal and pelvic structures function together, so problems outside the pelvis may influence pelvic mechanics.

Cleveland Clinic lists pelvic trauma, overuse and pregnancy among recognized or suspected contributors.

Stress Does Not Mean the Problem Is "All in the Mind"

Stress and anxiety can influence pelvic muscle tone.

When a person feels threatened or anticipates pain, muscles throughout the body may tighten automatically.

The pelvic floor is no exception.

A woman who expects penetration to hurt may unconsciously contract the pelvic muscles before contact occurs.

A man anxious about pelvic pain or ejaculation may develop persistent tension.

However, this does not mean:

"The pain is imaginary."

Chronic pain is genuinely physical and neurological.

Psychological stress can become one factor maintaining the muscular and pain cycle.

The 2024 chronic-pelvic-pain guideline recommends an interdisciplinary biopsychosocial model that includes pain education, physiotherapy, psychological treatment and medical care.

Is Pelvic Floor Dysfunction the Same as Vaginismus?

Not exactly.

Vaginismus is a commonly used term for involuntary vaginal/pelvic-floor tightening associated with attempted penetration.

Modern diagnostic approaches often discuss this within **genito-pelvic pain/penetration disorder**.

Pelvic-floor overactivity can be an important component, but pain disorders may involve additional mechanisms such as:

- vulvodynia,
- fear of pain,
- vestibular sensitivity,
- vaginal dryness,
- trauma,
- or other gynecological conditions.

Therefore, treatment should not be based only on forcing the muscles to relax.

The underlying contributors need to be identified.

Is Every "Tight Vagina" a Pelvic Floor Problem?

No.

Patients sometimes use the phrase "tight vagina" to describe:

- pelvic-floor spasm,
- inadequate arousal,
- dryness,
- fear,
- anatomical concerns,
- vulvar pain,
- menopausal tissue changes,
- or true muscular hypertonicity.

Each requires different management.

A proper examination can help distinguish these conditions.

Pelvic Floor Dysfunction and Fertility

Pelvic-floor dysfunction does not usually directly damage eggs, sperm or fallopian tubes.

It is therefore **not usually a biological cause of infertility by itself**.

However, it can indirectly interfere with conception.

For example, a woman with severe pelvic-floor overactivity may find penetration impossible or very painful.

A man may experience pelvic pain, erectile difficulty or painful ejaculation.

A couple trying to conceive may therefore have difficulty completing intercourse during the fertile window.

In such situations, fertility evaluation and sexual/pelvic-floor rehabilitation should be considered together.

At Saira Health Care, this connection is particularly important because my clinical work includes both **sexual disorders and infertility**.

The solution should never be to tell a woman to simply tolerate painful intercourse because she wants pregnancy.

Pain should be evaluated and treated.

How Is Pelvic Floor Dysfunction Diagnosed?

There is no single test appropriate for every patient.

Diagnosis begins with a detailed history.

I ask about:

- urinary symptoms,
- bowel movements,
- pelvic pain,
- sexual comfort,
- erections,
- ejaculation,
- vaginal penetration,
- childbirth history,

- pelvic surgery,
- constipation,
- back or hip pain,
- and previous treatments.

Then the physical assessment is individualized.

Pelvic Floor Examination

A trained clinician may assess:

- ability to contract the muscles,
- ability to relax them,
- strength,
- endurance,
- coordination,
- tenderness,
- asymmetry,
- elevated resting tone,
- and associated pelvic or musculoskeletal findings.

In women, an internal vaginal examination may be considered where appropriate.

In men, pelvic-floor assessment may involve a rectal examination when clinically indicated.

Such examinations should always be explained and performed with informed consent.

Biofeedback and Electromyography

In selected cases, clinicians use biofeedback.

Sensors can help show whether the pelvic-floor muscles are contracting or relaxing correctly.

Cleveland Clinic describes biofeedback as one of the most common treatments for pelvic-floor dysfunction, generally used alongside physical therapy to improve muscular awareness and coordination.

Electromyography may also be used to assess muscle activation in some settings.

Urodynamic and Other Tests

If urinary symptoms are significant, urodynamic testing may sometimes help assess bladder emptying and urinary function.

For severe defecatory symptoms, specialized tests such as defecography may be considered.

Cleveland Clinic describes urodynamics, EMG and defecography among tests used in selected pelvic-floor patients.

These investigations are not required for every patient.

Testing should answer a specific clinical question.

Treatment: One of the Most Important Principles

If there is one statement I would like every patient to remember, it is this:

Not every pelvic-floor problem should be treated with Kegel exercises.

Kegel exercises are pelvic-floor muscle contractions designed primarily to strengthen muscles.

They can be useful when weakness is present.

NIDDK notes that pelvic-floor muscle training may improve bladder and bowel control and possibly sexual function, but also explicitly advises patients to consult a healthcare professional because Kegels are **not appropriate in every situation**.

If the muscles are already chronically tight, treatment often focuses first on:

relaxation, lengthening, coordination and pain reduction—not strengthening.

Pelvic-Floor Physical Therapy: The Main Conservative Treatment

Pelvic-floor physiotherapy is central to modern management.

A specially trained physiotherapist may assess not only pelvic muscles but also:

- breathing,
- abdominal function,
- hips,
- posture,
- spine,

- pelvic movement,
- scar tissue,
- and movement patterns.

Therapy may include different strategies depending on whether the muscles are weak or tight.

Treatment for an Overactive or Tight Pelvic Floor

Treatment may involve:

- diaphragmatic breathing,
- relaxation or “down-training,”
- gentle stretching,
- manual myofascial techniques,
- trigger-point work,
- biofeedback,
- pelvic mobility exercises,
- gradual desensitization,
- education,
- and reducing fear associated with movement or penetration.

Cleveland Clinic identifies physical therapy, biofeedback, relaxation, massage and stretching as core approaches to hypertonic pelvic-floor management.

For chronic pelvic pain, ACOG likewise describes pelvic-floor physical therapy as useful for muscle desensitization, myofascial treatment, diaphragmatic breathing, mindfulness and biofeedback.

Treatment for Weak Pelvic Floor Muscles

When weakness is genuinely present, treatment may include supervised pelvic-floor muscle training.

A correctly performed contraction typically involves lifting and closing the pelvic-floor muscles while avoiding unnecessary straining of the buttocks, thighs or abdomen.

The program may train:

- strength,
- endurance,
- rapid contractions,
- coordination,
- and the ability to relax completely after contraction.

The relaxation phase is just as important as the squeeze.

Incorrect technique may produce poor results.

Why Supervision Matters

Patients often learn Kegels from a short internet video.

They may spend months squeezing the wrong muscles.

Some hold their breath.

Some contract the buttocks rather than the pelvic floor.

Some exercise while urinating repeatedly.

NIDDK specifically warns against routinely performing Kegel exercises while urinating because repeatedly interrupting bladder emptying may increase the risk of incomplete emptying and urinary infection.

A pelvic-floor physiotherapist can confirm that the patient is actually using the correct muscles.

Pelvic Floor Therapy for Painful Intercourse

For women with dyspareunia and muscular overactivity, physiotherapy may involve much more than strengthening.

Recent research also highlights that pelvic-floor exercise protocols for painful intercourse are very heterogeneous. A 2025 systematic review involving 963 women found large variation in how programs were described and delivered, making it difficult to identify one universal protocol.

That is another reason treatment should be individualized.

Dilators and Gradual Exposure

Some women with penetration pain or pelvic-floor guarding may benefit from vaginal dilators or trainers.

These are not devices for forcing open the vagina.

Used properly, they provide **gradual, controlled exposure** while teaching the pelvic muscles to remain relaxed.

Treatment often begins with:

- breathing,
- relaxation,
- external work,
- and very small comfortable steps.

Pain should not be aggressively pushed through.

ACOG includes dilators and pelvic-floor physical therapy among options for selected sexual-pain conditions.

Biofeedback

Biofeedback can be particularly helpful when the patient has difficulty understanding what the pelvic-floor muscles are doing.

A sensor can display muscular activity on a screen.

The patient can then learn:

“This is what contraction feels like.”

and equally importantly:

“This is what true relaxation feels like.”

Biofeedback is widely used for coordination problems and is a common treatment for pelvic-floor dysfunction.

Breathing and the Pelvic Floor

The diaphragm and pelvic floor move together during normal breathing.

During inhalation, the pelvic floor normally allows some lengthening and descent.

During exhalation, it returns upward.

People who constantly hold the abdomen and pelvic floor rigid or breathe shallowly may lose some of this natural coordination.

Diaphragmatic breathing is therefore frequently included in pelvic-floor rehabilitation, particularly for overactive muscles and chronic pelvic pain. ACOG specifically includes diaphragmatic breathing among physical-therapy techniques for chronic pelvic pain.

Constipation Must Be Treated

If a patient strains forcefully every day during bowel movements, pelvic-floor rehabilitation will be much harder.

Treatment may include:

- adequate hydration,
- dietary fiber when appropriate,
- management of stool consistency,
- toileting posture,
- bowel retraining,
- and treatment of underlying gastrointestinal disease.

When pelvic-floor dyssynergia causes obstructed defecation, biofeedback and specialist pelvic-floor retraining can be particularly useful.

Treatment of Sexual Pain Must Be Broader Than the Muscle

Pelvic-floor tension can be part of painful intercourse, but clinicians should also look for:

- vaginal dryness,
- infections,
- vulvodynia,
- endometriosis,
- skin disease,
- menopause-related changes,
- pelvic inflammatory disease,
- and other gynecological conditions.

This is particularly important because an underlying condition can cause the pelvic muscles to tighten protectively.

Treating the muscles without addressing the original pain generator may produce incomplete improvement.

Psychological and Psychosexual Support

Chronic pelvic and sexual pain can create fear.

The patient begins anticipating pain before intimacy.

That expectation itself increases muscular guarding.

Psychological treatment does not imply that the condition is imaginary.

Instead, therapy may help reduce:

- fear,
- catastrophizing,
- performance pressure,
- trauma-related responses,
- relationship conflict,
- and avoidance.

ACOG notes that CBT and sex therapy may be useful parts of chronic pelvic-pain management and may help patients restore pleasurable, less painful sexual activity.

Sexual Therapy and Couple Communication

Partners often misunderstand pelvic-floor disorders.

A man may think:

“She is rejecting me.”

when penetration is painful.

A woman may think:

“He has lost attraction to me.”

when a man experiences erection difficulty because pelvic pain has created anxiety.

Good communication should make intimacy safer rather than more demanding.

I often recommend temporarily shifting the goal away from penetration when penetration is consistently painful.

Affection and sexual connection can be rebuilt gradually while the underlying condition is treated.

Medications

Medication is not the primary treatment for every pelvic-floor disorder.

Depending on the underlying condition, treatment may include:

- muscle-relaxing medicines,
- medicines for constipation,
- pain-modulating drugs,
- treatment for urinary symptoms,
- hormonal treatment for vaginal tissue changes,
- or condition-specific therapy.

Cleveland Clinic describes symptom-directed medicines and, in selected refractory cases, trigger-point injections as possibilities for hypertonic pelvic-floor disorders.

Medication should support a diagnosis rather than substitute for one.

Trigger-Point Injections and Other Procedures

Selected patients with persistent pelvic muscle pain may be referred to a specialist for targeted injections or other pain interventions when conservative care is inadequate.

These treatments are not first-line solutions for everyone.

The decision depends on examination findings and previous treatment response.

Surgery

Most functional pelvic-floor muscle disorders are treated conservatively.

Surgery may be required when there is a separate structural problem such as significant pelvic-organ prolapse or rectal prolapse, but surgery is not used simply because muscles are “tight.”

Cleveland Clinic describes surgery primarily when structural disorders such as prolapse are responsible for the dysfunction.

Pelvic-Floor Therapy in Male Chronic Pelvic Pain

Modern urology is increasingly recognizing the importance of pelvic-floor and musculoskeletal treatment for men.

The 2025 AUA guideline on chronic prostatitis/chronic pelvic pain syndrome emphasizes that effective treatment often requires a **multimodal and multidisciplinary approach**, sometimes involving physical therapy and other allied-health professionals rather than relying solely on traditional urological medication.

This is particularly valuable for men whose “prostatitis” symptoms include:

- pelvic tenderness,
- painful ejaculation,
- urinary hesitancy,
- constipation,
- or muscular pain without clear infection.

Should Everyone Do Kegels to Improve Sexual Performance?

No.

This is one of the most common myths in sexual wellness.

Kegels may be useful for appropriately selected people with weakness.

They may improve aspects of sexual function in some populations.

But they are not a universal sexual-performance exercise.

If a patient already has:

- pelvic pain,
- painful intercourse,
- painful ejaculation,
- urinary hesitancy,
- chronic constipation,

- or marked pelvic tightness,

the muscles should be assessed before starting a heavy strengthening routine.

The correct prescription may actually be **relaxation rather than strengthening**.

Can Pelvic-Floor Training Improve Orgasm?

Possibly, in selected people.

Because the pelvic-floor muscles participate in orgasmic contractions, improving awareness and function may improve orgasmic experience in some patients.

The 2024 systematic review of female sexual function found pelvic-floor muscle involvement in orgasm and arousal, while the 2024 treatment meta-analysis reported improvement in orgasm scores following pelvic-floor training, although overall certainty of evidence was low.

So the evidence is encouraging—but not strong enough to promise stronger orgasms to everyone who performs Kegels.

Can Pelvic Floor Therapy Improve Erection?

It may help selected men, particularly where pelvic-floor weakness or coordination contributes.

A systematic review found that pelvic-floor muscle training produced improvements in included ED trials, though methods and quality varied.

However, men with ED should still be assessed for:

- diabetes,
- hypertension,
- cardiovascular disease,
- medication effects,
- testosterone deficiency when clinically suspected,
- neurological problems,
- and psychological factors.

Do not assume that every erection problem originates in the pelvic floor.

Can the Pelvic Floor Become “Too Strong”?

Technically, the more important concept is usually **excessive resting tone or inability to relax**, rather than simply strength.

A person can have strong muscles that are poorly coordinated or chronically contracted.

Healthy muscle function requires the ability to produce force **and release that force completely**.

That principle is fundamental to pelvic-floor health.

The Role of Unani Medicine in Pelvic Floor Dysfunction

As a physician trained in Unani medicine, I believe the Unani system can provide valuable **supportive and whole-person care** in patients with pelvic-floor problems.

However, it is important to describe this role accurately.

At present, there is **not sufficient high-quality clinical evidence showing that a particular Unani medicine or regimen directly retrains weak or hypertonic pelvic-floor muscles**.

Therefore, modern pelvic-floor physiotherapy remains a central treatment when specific muscular dysfunction has been identified.

The contribution of Unani medicine is strongest in addressing the patient's **general constitution, lifestyle, bowel habits, sleep, physical activity, psychological state and associated health problems** as part of an integrative plan.

Asbab Sitta Daruriyya: Six Essential Factors of Health

Unani medicine gives major importance to **Asbab Sitta Daruriyya**, or the six essential factors of life on which bodily health depends.

The Central Council for Research in Unani Medicine defines these factors as:

- air,
- foods and drinks,
- physical movement and rest,
- mental activity and peace,
- retention and evacuation,
- and sleep and wakefulness.

These classical principles are highly relevant to pelvic-floor rehabilitation.

For example:

Physical movement and rest matter because prolonged inactivity and poor movement patterns can affect musculoskeletal health.

Mental activity and peace matter because anxiety and chronic stress may increase muscular guarding.

Retention and evacuation are relevant because constipation and straining can significantly influence pelvic-floor dysfunction.

Sleep and wakefulness matter because chronic pain and poor sleep reinforce one another.

These concepts do not replace physiotherapy, but they can support a more comprehensive recovery plan.

Ilaj-bil-Tadbir — Regimental Therapy

CCRUM defines **Ilaj-bil-Tadbir** as regimenal therapy based on modification of the six essential factors and therapeutic regimens to maintain health or manage disease.

In pelvic-floor dysfunction, the most sensible Unani-compatible lifestyle measures may include:

- appropriate physical activity,
- adequate rest,
- correcting prolonged sedentary habits,
- stress reduction,
- sleep correction,
- bowel regularity,
- and individualized general-health support.

CCRUM's 2024–2025 activities also describe regimenal therapy as emphasizing lifestyle modification and physical therapeutic approaches for holistic health.

These principles fit naturally alongside modern pelvic-floor rehabilitation.

Ilaj-bil-Ghiza — Dietotherapy

Diet does not directly “strengthen” pelvic-floor muscles overnight.

But appropriate diet may support pelvic-floor health indirectly.

For example, dietary management can help with:

- constipation,
- obesity,
- diabetes,
- general inflammation and metabolic health,
- energy,
- and bowel regularity.

A patient repeatedly straining because of severe constipation will struggle to rehabilitate pelvic-floor coordination.

Therefore, diet may be individualized to improve general and bowel health.

I do not advise patients that one particular Unani food, herb, dry fruit or spice can cure pelvic-floor dysfunction.

That would oversimplify a complex muscular and neurological problem.

Ilaj-bil-Dawa — Unani Pharmacotherapy

Unani medicines may sometimes be considered for **associated conditions**, depending on the patient's diagnosis and overall health.

Examples might include appropriately selected support for:

- bowel irregularity,
- general weakness,
- sleep disturbance,
- digestive complaints,
- or other coexisting problems.

However, medication cannot teach an overactive pelvic-floor muscle how to relax or a poorly coordinated muscle how to function correctly.

That is why physiotherapy and neuromuscular retraining remain so important.

I also advise patients not to apply irritant herbal oils or preparations to genital tissues without professional guidance.

“Natural” does not automatically mean safe for delicate vulvar or perineal tissue.

Stress Management Through an Integrative Approach

A patient with chronic pelvic pain may become trapped in a cycle:

pain → anxiety → muscular guarding → more pain → disturbed sleep → greater pain sensitivity.

Both modern pain medicine and Unani holistic principles recognize the importance of mental and physical balance.

For suitable patients, treatment may therefore combine:

- pelvic-floor physical therapy,
- breathing exercises,
- stress management,
- counseling,
- sleep correction,
- regular movement,
- and individualized Unani supportive care.

This is a much stronger approach than prescribing one medicine and ignoring everything else.

Dr. Nizamuddin Qasmi's Specialized Approach at Saira Health Care

At **Saira Health Care**, I prefer to approach pelvic-floor dysfunction through a structured clinical pathway.

Step 1: Determine whether the floor is weak, tight or poorly coordinated

This is fundamental.

I do not automatically advise Kegels.

Symptoms, examination and physiotherapy assessment help determine the actual dysfunction.

Step 2: Identify the patient's main complaint

Is the problem:

- painful intercourse,

- erection,
- painful ejaculation,
- urinary leakage,
- difficulty urinating,
- constipation,
- pelvic pain,
- penetration difficulty,
- infertility-related intercourse difficulty,
- or multiple symptoms?

The treatment plan should address what is actually affecting the patient.

Step 3: Identify underlying or associated disease

Depending on symptoms, evaluation may include consideration of:

- diabetes,
- urinary disease,
- prostate conditions,
- gynecological problems,
- vulvodynia,
- menopause,
- endometriosis,
- constipation,
- neurological disease,
- previous surgery,
- or chronic pelvic pain.

Step 4: Use appropriate pelvic-floor rehabilitation

Where muscular dysfunction is confirmed, a pelvic-floor physiotherapist can provide targeted strengthening, relaxation or coordination treatment.

Step 5: Address sexual consequences

Treatment may include:

- sexual-health education,
- management of erection difficulties,
- treatment of painful intercourse,
- relationship counseling,
- gradual restoration of comfortable intimacy,
- or psychosexual therapy.

Step 6: Add responsible Unani supportive management

I evaluate:

- diet,
- bowel habits,
- physical activity,
- sleep,
- stress,
- constitutional and general health factors,
- and associated conditions.

Step 7: Follow up

Pelvic-floor rehabilitation is rarely completed in a few days.

Improvement often occurs gradually over weeks or months.

The treatment plan should therefore be reviewed according to:

- pain,
- sexual comfort,
- continence,
- bowel function,
- erections,
- ejaculation,
- and quality of life.

Contribution of Saira Health Care in Sexual Disorders & Infertility

At **Saira Health Care**, we frequently see patients whose sexual problems cannot be understood by looking only at hormones or genital organs.

Pelvic-floor dysfunction may overlap with:

- erectile dysfunction,
- painful ejaculation,
- premature ejaculation,
- painful intercourse,
- vaginismus,
- vulvodynia,
- chronic pelvic pain,
- infertility-related sexual difficulties,
- urinary symptoms,
- and relationship distress.

Because our clinical focus includes both **sexual disorders and infertility**, we pay particular attention to conditions in which pain or muscular dysfunction prevents comfortable intercourse or reduces the couple's ability to attempt natural conception.

The aim is not simply to prescribe a so-called sexual-strength medicine.

It is to understand **which system is not functioning normally and why**.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi
Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

Professional qualifications and training include:

BUMS – Hamdard University, Delhi
MD
CGO
Certificate in Infertility – MGBIMS, Delhi
Certificate in Urology – London, UK
Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

My clinical approach is based on combining my Unani medical background with contemporary understanding of sexual and reproductive medicine.

Pelvic-floor dysfunction is an excellent example of why sexual-health care needs to be integrative.

A patient may require:

- urological investigation,
- gynecological assessment,
- pelvic-floor physiotherapy,
- sexual counseling,
- pain management,
- infertility support,
- and lifestyle correction

at the same time.

A single tablet cannot replace all of those elements.

Frequently Asked Questions About Pelvic Floor Dysfunction

Can pelvic-floor dysfunction cause painful sex?

Yes.

An overactive or hypertonic pelvic floor can make penetration painful and may contribute to chronic pelvic or vulvar pain. Pelvic-floor physiotherapy is commonly used for these problems.

Can weak pelvic-floor muscles reduce sexual pleasure?

They may contribute in some patients. Research shows an association between pelvic-floor muscle function and women's sexual function, including arousal and orgasm.

Can pelvic-floor dysfunction affect erections?

Yes, pelvic-floor dysfunction can coexist with erectile difficulties, and pelvic-floor training may improve ED in selected men. However, cardiovascular, metabolic, neurological and hormonal causes must also be considered.

Can it cause premature ejaculation?

Pelvic muscles participate in ejaculation, and training has been studied for PE. Current evidence suggests it may help some men, especially as part of combined treatment, but it is not a universal cure.

Can pelvic-floor tension cause painful ejaculation?

Yes.

The 2025 AUA guideline identifies painful ejaculation as one symptom associated with pelvic-floor myalgia in men with chronic pelvic pain.

Should everyone do Kegel exercises?

No.

Kegels are useful primarily when strengthening is appropriate. Hypertonic or painful pelvic floors may require relaxation and down-training instead. NIDDK advises checking with a healthcare professional before beginning.

Can pelvic-floor physiotherapy improve sexual function?

Research suggests it can improve sexual function in selected women, including arousal, orgasm and satisfaction, though evidence quality varies by population and treatment protocol.

Is pelvic-floor dysfunction caused only by childbirth?

No.

Men and women can both develop pelvic-floor dysfunction. Other contributors include chronic straining, pelvic injury, surgery, chronic pain and other musculoskeletal or neurological factors.

Can it cause constipation?

Yes.

Failure of the pelvic floor to relax and coordinate properly can make bowel evacuation difficult.

Does pelvic-floor dysfunction directly cause infertility?

Usually not directly. But severe pain, penetration difficulty, erectile problems or painful ejaculation can make natural intercourse difficult and therefore indirectly interfere with attempts at conception.

Can Unani medicine help?

Unani medicine can contribute valuable supportive care through regulation of diet, activity, rest, bowel habits, sleep and mental well-being. CCRUM recognizes these domains within

the *Asbab Sitta Daruriyya* framework and defines *Ilaj-bil-Tadbir* as modifying these factors therapeutically. However, specific muscular dysfunction should still receive appropriate pelvic-floor assessment and physiotherapy.

When Should You Seek Professional Evaluation?

Please consider evaluation if you have persistent:

- pelvic or genital pain,
- pain during intercourse,
- difficulty with penetration,
- urinary leakage,
- difficulty beginning urination,
- incomplete bladder emptying,
- chronic constipation or difficult bowel evacuation,
- painful ejaculation,
- erection problems associated with pelvic pain,
- pelvic pressure after childbirth,
- or symptoms following pelvic or prostate surgery.

Urgent medical assessment is appropriate if pelvic symptoms are accompanied by:

- inability to urinate,
- severe sudden pelvic pain,
- heavy bleeding,
- fever,
- neurological weakness,
- loss of bladder or bowel control developing suddenly,
- numbness in the saddle/genital area,
- or other rapidly developing neurological symptoms.

These may indicate conditions requiring prompt medical care rather than routine pelvic-floor rehabilitation.

My Final Message to Patients

One of the biggest misunderstandings about pelvic health is the idea that the pelvic floor simply needs to be **strong**.

That is not the real goal.

The pelvic floor needs to be:

strong enough to support, flexible enough to relax, sensitive enough to respond and coordinated enough to work at the correct time.

A weak pelvic floor can cause problems.

A chronically tight pelvic floor can also cause problems.

And sometimes the most painful pelvic floor is not weak at all—it is working **too hard**.

That is why I tell my patients:

Do not treat the pelvic floor blindly. Understand what the muscles are doing first.

If the muscles are weak, strengthen them properly.

If they are tight, learn to relax and lengthen them.

If coordination is poor, retrain coordination.

If another disease is causing the muscle to guard, treat that disease.

If sexual pain has created anxiety, treat the emotional and relationship consequences too.

And if infertility is involved, preserve comfortable intimacy while evaluating reproductive health.

At **Saira Health Care**, my aim is to combine the strengths of modern pelvic-floor rehabilitation and sexual medicine with the whole-person philosophy of Unani medicine—considering physical health, bowel function, diet, sleep, mental well-being, sexual function and reproductive goals together.

Modern evidence increasingly confirms that pelvic-floor muscles are an important part of sexual function, yet research also shows that treatment must be individualized and that simply prescribing the same exercise to everyone is not appropriate.

For many patients, correctly identifying whether the pelvic floor is **weak, tight or poorly coordinated** is the turning point.

Once we understand that, treatment becomes much more logical—and sexual comfort, confidence and quality of life can often improve substantially.

Medical Disclaimer

This article is intended for general health education and does not replace individualized examination or treatment. Pelvic pain, painful intercourse, urinary symptoms, erectile dysfunction, painful ejaculation and bowel difficulties may have multiple causes beyond pelvic-floor dysfunction. Pelvic-floor exercises should be individualized; strengthening an already hypertonic or painful pelvic floor may worsen symptoms. Patients with persistent symptoms should be assessed by an appropriately qualified clinician and, when indicated, a trained pelvic-floor physiotherapist. Unani treatment should be used as supportive integrative care and should not delay necessary gynecological, urological, neurological, colorectal or physiotherapy evaluation.