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Title: Assessment and management of female Sexual pain-penetration disorder

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Title: Assessment and management of female Sexual pain-penetration disorder

Executive summary

Treatment of Sexual pain-penetration disorder (Vaginismus) often gets delayed due to lack of awareness and stigma. So all women should be asked as a part of routine clinical history if they experience pain during sex. A high index of suspicion should be kept in women presenting with infertility, marital discord or depression. A digital examination is not necessary for diagnosis. Vulval examination is sufficient to rule out organicity.

A comprehensive multi-disciplinary approach is recommended to improve success rates. Couples must be given psycho-sexual education, including why sex is usually painless and that the cause of pain in her case is an involuntary contraction. Relaxation exercises like diaphragmatic breathing, reverse Kegel's, asanas that relax pelvic floor muscles, Jacobson's progressive muscle relaxation, meditation must be taught. Then systematic desensitisation can be done with a set of graduated dilators or fingers. Using lubricant gel or coconut oil helps. Many women are not able to progress with dilators easily. Addressing underlying psycho-social factors makes it easier. If history of sexual abuse is there, therapy is essential. Later on, partner holding dilators helps with desensitisation. Sensate focus exercises take away the performance pressure and fear of pain, helping them to resume intimacy. During penetration, keeping a rolled towel below the lower back makes penetration easier. Some women find woman on top, straddle or doggy style position easier.

Benzodiazepines, Baclofen, antidepressants may help to decrease anxiety and relax. Trigger-point release by physiotherapist can help. Botox may be tried in refractory cases. Hymenectomy has no role.

Key Words: Vaginismus , Female Sexual pain-penetration disorder, Genito-pelvic pain/penetration disorder, painful sex, Clinical Practice Guideline, Pelvic floor dysfunction

Introduction

Treatment of Sexual pain-penetration disorder, also referred to as Vaginismus, often gets delayed because of lack of awareness about this condition, shame and fear of judgement.^[1,2] In culturally sex restrictive societies like India many patients visit gynecologists, often for infertility rather than for inability to have sex, before they come to a psychiatrist. Consequently few psychiatrists have sufficient experience of helping patients with Sexual pain-penetration disorder. Many couples receive inadequate treatment.^[1] The rate of treatment drop out and treatment failure can be high.^[2]

Consequently many couples continue to suffer for many years even after visiting many professionals. It is not uncommon to see couples with more than 5 years of unconsummated marriage due to this condition. This results in sexual frustration and emotional turmoil in both partners. The frustration of repeated failed attempts, ignorance about the condition, insecurity and other negative emotions experienced often lead to marital discord and at times divorce.

A curious aspect of this condition is that some clinical trials have reported very high success rates (71-86%)^[3,4] while others have reported very low success rates (15-35%).^[5,6] Part of the reason can be differences in inclusion and outcome criteria. For instance, a systematic review which included 43 observational studies and 3 RCTs observed that success rate was 73-89%; with relatively lower results (68%) in studies where unconsummated marriage was the inclusion criteria.^[7] This severity of this condition varies in different women and that can be another reason for different success rates. For instance, our Gynecologist colleagues have shared that while some cases are challenging, some cases heal with just reassurance after explaining them sexual anatomy and physiology. While many of our psychiatrist colleagues have reported that they have experienced very low success rates in their practice. It is possible that women with milder versions of this condition heal with basic psychoeducation and/or practising with dilators. But those with a severe disorder and having underlying traumas who end up reaching a psychiatrist, need prolonged therapy for many months to heal.

In this guideline we have discussed a comprehensive multidisciplinary approach to diagnosis and treatment of this challenging clinical condition. We hope that psychiatrists, psychologists, gynecologists & physiotherapists, all will find this guideline useful.

Terminologies:

In ICD 11 the term 'Sexual pain-penetration disorder' (HA20) was introduced to consolidate the two overlapping conditions of vaginismus (muscle spasm) and dyspareunia (pain). While ICD 11 includes only non-organic causes of dyspareunia under this diagnosis, in DSM 5 organic causes have also been included under the term 'Genito-pelvic pain/penetration Disorders' (GPPPD). This is because more than one physical and/ or psychological factor may be contributing towards the pain in a lady presenting to a doctor; and being mindful of all of them helps in providing comprehensive management. So while treating a lady suffering from pain during penetration, all possible physical and psychological factors must be screened for and accordingly treatment must be individualised.

Differentiating between superficial pain (felt on entry, near vaginal opening) and deep pain (felt on thrusting or referred to pelvis) can help in identifying possible contributing factors (Figure-1).

Figure 1: Possible causes of superficial and deep pelvic pain.

A mental health professional is expected to manage Sexual pain-penetration disorder (Vaginismus) and we will focus on that in these guidelines. Sexual pain-penetration disorder is characterized by recurrent or persistent involuntary contraction of the pelvic floor muscles, leading to marked difficulty or inability in vaginal penetration. It often leads to marked pain during attempted or completed penetration and there is marked anxiety about experiencing pain in anticipation of penetration.^[8] As per ICD 11, If painless penetration was possible previously but now the woman faces difficulty, it is given the qualifier ‘acquired’ (also called secondary vaginismus). If painless penetration has never been possible the qualifier is ‘lifelong’ (also called primary vaginismus).

Epidemiology :

Sexual pain-penetration disorder is one of the 3 most common sexual problems for which women seek help. However enough studies are not there to confidently comment on its prevalence. Compared to women with un-consumated marriages, the number of women experiencing painful sex is much higher. A review including 22 studies conducted in 11 countries found that in representative community samples 6 - 31.6% women experience sexual pain.^[9] In a recent large sample of university students from Germany, 12-month prevalence of clinical GPPPD was 2.1 % while subclinical GPPPD was 12.9 %.^[10] A survey of 159 married women attending an outpatient clinic of a tertiary care hospital revealed that 64% were suffering from pain during intercourse.^[11] In that study, age above 40 yrs and lower education were associated with a higher prevalence of female sexual dysfunction in general. None of them had sought professional help for any sexual dysfunction. One Indian clinic reported that out of 900 women presenting for infertility 25 (2.8%) had Vaginismus.^[12] An internet based survey of 1201 women showed that Vaginismus was more common in bisexual women compared to heterosexual and lesbian women.^[13]

Clinical presentation of Primary Vaginismus

Sexual pain-penetration disorder can present in quite a range of ways. Being mindful of them can help us probe for it and diagnose it even if a couple has come to us for something else.

Painful penetration: This is the most common presentation. Women report a severe burning pain on any attempt to penetrate which makes penetration impossible. In milder cases, the lady may be able to allow penetration but with mild to severe pain.

Feels like a wall: This is another very common presentation. The contraction is so tight that penis does not go in the vagina at all. So there is no pain. They just report that penetration does not happen and it feels like a wall.

Lady refusing to allow a partner near the vagina: When the fear is extreme, the lady may reflexively cross her thighs or push the partner away.

Infertility: Many couples lose hope after attempting for a few years and start exploring other ways of getting pregnant. Many feel shy and may not proactively report about it, even while seeking help for infertility.

Marital discord: The couple may not be aware that the unsaid tension of an unconsummated marriage is the underlying cause of their frequent fights over trivial things.

Anxiety & Depression: The feeling of being sexually inadequate makes the lady worry a lot and some lose their confidence. Some patients are not fully aware that sexual dysfunction is the reason for their depression and may not report it on their own.

Situational Erectile Disturbance: In few cases, the husband may lose erection or get premature ejaculation secondary to her discomfort with the attempts at penetration. But the couple believes that the primary reason why penetration is not happening is erectile disturbance and may come with that as primary complaint.^[1]

Comorbid anxiety disorders: It is a type of phobic illness and often co-exists with other anxiety disorders like OCD.

Cycle of anticipated pain and muscle contraction

Sexual pain-penetration disorder is a psychosomatic condition in which subconscious fears of sex leads to involuntary contraction in pelvic floor muscles on attempted penetration. The contraction results in severe pain which feeds into the fear further as illustrated in figure-2.

Figure 2: Fear - spasm - pain cycle in Sexual pain-penetration disorder

Underlying psycho-socio factors

The number and severity of underlying psycho-socio factors decides the severity of this condition. Some common factors which contribute to this subconscious programming are shown in table-1.

Table 1: Psycho-social factors that can contribute to Sexual pain-penetration disorder

- Inadequate sexual knowledge. In particular, a belief that sex is painful
- Negative attitude towards sexuality
- Bad touch experiences
- Other types of childhood trauma: Punitive parenting, fights between parents, etc.
- Exposure to news or serials about sexual crimes
- Fear of pregnancy
- Own experiences of painful sex/ painful gynecological examinations reinforce the fear

Causes of Acquired Sexual pain-penetration disorder

Acquired Sexual pain-penetration disorder is usually due to marital discord. Other possible causes are mentioned in table-2. Organic causes need to be ruled out more carefully if painless penetration was possible in the past (Figure-1). Important things to be kept in mind during history and clinical examination to rule out organicity are mentioned in table-3.

Table 2: Causes of Acquired Sexual pain-penetration disorder

- Marital discord
- Trauma in previous relationships
- Memory of painful experiences of UTI, episiotomy, etc.
- Stressful life situation increasing her anxiety

Status of research on its treatment

Clinical trials of treating this condition have been few and with small sample sizes. Systematic reviews state that no intervention modality has been established to be superior to other interventions for this condition.^[3]

Diagnosis and evaluation

A good history and clinical examination are sufficient to diagnose Sexual pain-penetration disorder. She may have never spoken about it to anyone. Expressing empathy and creating a non-judgemental space is important to help her open up and share all her concerns. Some salient things to keep in mind during evaluation are mentioned in table-3.

Table 3: Salient things to keep in mind during evaluation

History	● Most common symptoms reported are burning pain during and after penetration or that it felt like a wall ● Pain is felt near the vaginal opening. ● The lady can also feel the muscles around vagina contract or report a feeling of tightness. ● Having intense anxiety of penetrative sex or vaginal examination is strongly indicative. ● Enquire whether it has been lifelong or acquired. ● Ask about history of complications during previous delivery, if currently lactating, UTI, and other organic causes of superficial pelvic pain.
Clinical Examination	● To rule out hymenal abnormalities and other possible causes of genito-pelvic pain listed in figure-1, mainly infection, scarring or skin lesions. ● To see if there is a heightened fear response. ● To assess pelvic floor muscle tone ● A digital examination is not necessary for diagnosis. It is extremely important for the gynecologist to be very gentle while attempting PV examination. A forceful attempt to do PV results in pain, breaks the therapeutic bond and makes the patient avoid seeking professional help again. A general pelvic and vulval examination is sufficient^[1]
Investigations	Not required for diagnosis
Scales ^[14]	● Multidimensional Vaginal Penetration Disorder Questionnaire (MVPDQ).^[15] It is a validated comprehensive self report

	questionnaire with 72 items and 9 dimensions: Catastrophic cognitions and tightening, helplessness, marital adjustment, hypervigilance, avoidance, penetration motivation, sexual information, genital incompatibility, and optimism. Clinicians may use it to get a comprehensive clinical assessment and to plan treatment accordingly. ● Partner Version of Multidimensional Vaginal Penetration Disorder Questionnaire (MVPDQ)^[16] ● Vaginal Penetration Cognition Questionnaire (VPCQ).^[17] It evaluates cognitions about vaginal penetration under 5 domains: control cognitions, catastrophic and pain cognitions, self-image cognitions, positive cognitions and genital incompatibility cognitions. It can be helpful for planning cognitive interventions. ● Female Sexual Function Index (FSFI).^[18] It is a brief, 19-item self-report survey that gives a comprehensive idea of the 6 key dimensions of female sexual health: Desire, arousal, lubrication, orgasm, satisfaction and pain. ● Pain Visual Analog Scale (VAS)^[19] /Numeric Rating Scale (NRS).^[20] This 1 question can help know the severity of the condition and track treatment progress.
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Why must every woman be asked about it?

Compared to women who have an unconsummated marriage, more women experience a milder severity of pain and are able to allow penetration. Due to ignorance, many of them assume this is how sex is supposed to be and never approach for any help. They may never get diagnosed if clinicians proactively don't ask for it. Also, many women start finding sex to be painful later in life due to organic conditions. In our society, many women feel awkward talking about it and don't spontaneously report it. They continue to suffer in silence and just start avoiding intimacy. So ideally it must be asked as a part of the routine sexual history to any female patient being evaluated by a health professional. In particular, a high index of suspicion should be kept in women presenting with infertility, marital discord, anxiety or depression. Making the patient comfortable and asking a specific question Eg. "Do you face any difficulty or pain while having sex?" increases the probability of it being reported.

Treatment

Treatment of this psychosomatic disorder requires a combination of psychological and physical interventions. The broad principles of treating sexual dysfunctions have been published in previous IPS guidelines.^[21] For brevity, this article focuses on issues specific to Sexual pain-penetration disorder.

Psychosexual education of the couple

Educating both the partners about the reason for the pain and how the treatment process will break the fear - spasm - pain cycle, is essential to clear their doubts and to elicit commitment for the treatment process, which can get prolonged to a few months. Educating about sexual anatomy and physiology allays the fears and some women with mild fear can heal with just that much. Some common fears and possible responses are mentioned in table-4.

Table 4: Few common fears and possible responses	
Sex is painful for women	• While many women do experience some pain first few times, later on they also find it painless. Sex is painless and pleasurable for women also.
Vagina is so small for the penis to go in	• Vagina is highly elastic and can stretch to accommodate tampons, penis, etc. • When a woman is aroused, muscles around vagina relax and there is lubrication. This makes sexual intercourse easier.
There is something wrong with my Vagina, because of which I am getting pain	• There is enough room in your vagina. Pain is due to muscle contraction and friction occurring because of that. It is a treatable condition.

231
232 The male partner can feel rejected, may get resentful or may get doubts about himself. Hence
233 it's important to reassure him as well (Table-5).
234

Table 5: Things to reassure the male partner about	
• The contraction is involuntary. It does not indicate that she does not want to get intimate with him or that he is not able to make her feel comfortable. • There is friction due to the contraction. The pain is real and severe. She is not being too fainthearted. • A lady with Sexual pain-penetration disorder can not allow penetration no matter how hard the penis is. He should not unnecessarily doubt his erection.	

235
236
237 **Training her to relax the pelvic floor muscles (PFMs)**
238 Various Behaviour Therapy interventions can help in progressing towards this goal.
239 1) Diaphragmatic breathing exercise, wherein the lady practices to bring the belly out and
240 drop the pelvic floor down with each inhalation (Figure-3). When the pelvic floor goes
241 down, muscles of the pelvic floor relax.
242
243 Figure 3: Diaphragmatic breathing (AI generated) (Credit: Chat GPT)
244
245 2) Reverse Kegel's exercise, wherein after briefly contracting the muscles used to stop the
246 flow of urine, the lady practises to relax the muscles.
247
248 3) Asanas and exercises that relax the pelvic floor muscles.
249 Practising following asanas, as illustrated in figures 4-9, can help in relaxing the pelvic floor
250 muscles . Don't stretch excessively. The final position should be comfortable. Keep eyes
251 closed, breathe slowly, relax and maintain awareness of the body posture and breath.
252

1. Garland Pose (Malasana)

- Stand with feet a little wider than hip-width and toes turned out.
- Slowly squat only as far as comfortable, keeping your heels supported if possible.
- Bring your palms together and gently place your elbows inside your knees.

2. Reclined Bound Angle Pose (Supta Baddha Konasana)

- Lie on your back. Bring the soles of your feet together and let your knees fall open.
- Place your hands on your belly or by your sides.

3. Happy Baby Pose (Ananda Balasana)

- Lie on your back. Bring your knees toward your chest.
- Hold outside edges of feet with your hands. Gently guide your knees toward your armpits.

4. Child's Pose (Balasana)

- Kneel on the floor. Sit comfortably with your hips on your heels.
- Reach your arms forward and rest your forehead on the floor or a cushion.

5. Cow Pose (Bitilasana)

- Start on your hands and knees, with wrists under shoulders and knees under hips.
- Inhale, gently arch your back and lift your chest and tailbone.

6. Cat Pose (Marjaryasana)

- Start on your hands and knees.
- Exhale, round your back upward and gently tuck your chin and tailbone.

Figure 4: Garland Pose (Malasana) (AI generated) (Credit: Chat GPT)

Figure 5: Reclined Bound Angle Pose (Supta Baddha Konasana) (AI generated) (Credit: Chat GPT)

Figure 6: Happy Baby Pose (Ananda Balasana) (AI generated) (Credit: Chat GPT)

Figure 7: Child's Pose (Balasana) (AI generated) (Credit: Chat GPT)

Figure 8: Cow Pose (Bitilasana) (AI generated) (Credit: Chat GPT)

Figure 9: Cat Pose (Marjaryasana) (AI generated) (Credit: Chat GPT)

[or can be collectively labelled as Figure 4: Yogasanas that help relax pelvic floor muscles. (AI generated) (Credit: Chat GPT)]

- 4) Meditation, Jacobson's progressive muscle relaxation and various other relaxation exercises that can help to learn to relax the mind and body as a whole.
- 5) Trigger point release done by massaging the PFMs from within the vagina by a pelvic floor physiotherapist, can help in releasing the tightness in PFMs.^[22]

- 6) Graded exposure therapy with a set of graduated dilators or fingers: This is the most popular treatment strategy. After the lady has practised a bit to relax the PFMs, Systematic desensitisation is done by inserting dilators of increasing sizes. Once the biggest dilator goes in, she feels confident that she can also have painless intercourse. It is better to use the term ‘vaginal trainers’ instead of dilators as it clarifies that we are not dilating the vagina but just training the vaginal muscles to relax.^[1] It is also possible to practise with one’s fingers instead of dilators - little finger, index finger and then 2 fingers.

However, many women are not able to progress with dilators very easily. Few things which make it easier are:

- Psychotherapy to heal the underlying psycho-social factors which are leading to the contraction.
- Regular practice of relaxation exercises mentioned above.
- Starting still slower with just touching the dilator to the introitus or initially just looking at the genitalia in the mirror and getting comfortable with it.^[23]
- Following certain techniques of dilator practice as mentioned in table-6.
- Therapist assisted in-person exposure sessions^[2]
- Doing 5 mins of deep breathing and positive visualisation before the practice.

Table 6: Useful techniques to follow during vaginal dilator/trainer practice

- Ensure privacy and can play relaxing music
- To break the fear - spasm - pain cycle, it is important that they practice without it hurting too much. They must stop as soon as they experience some pain and start relaxing the pelvic floor muscles.
- To scan the body for tension in any muscle and to relax the whole body.
- Corrective self-talk: there is enough space in vagina, sex is painless & pleasurable, etc.
- Being in an aroused state can make it easier.
- Like we make it a graded exposure by going 1 dilator at a time, it is ok to further subdivide exposure to dilators in steps. First 1/3rd, then half, and then full dilator.
- Keep in mind the principle that one must master the previous step and get fully comfortable with it before going to the next step.
- Continue the session long enough for the fear/ pain to decrease. It can be 15 mins to 45 mins.

- 7) Dilator practice with the partner: Ultimately anxiety is of intimacy with a partner. So after practising with dilators the next step of desensitisation is for the partner to hold the dilators. It is better to do this step before trying for penetration.

Addressing underlying psycho-social factors

While this seems to be the most obvious solution, few women with Sexual pain-penetration disorder receive adequate psychotherapy. Childhood traumas often remain ignored.^[1] This may be the reason for treatment failure in many cases.

Any trauma focused therapy technique may be used. Techniques which have good research evidence for healing past traumas are Eye Movement Desensitisation and Reprocessing (EMDR), Cognitive Processing Therapy and Prolonged Exposure Therapy.^[24] Besides helping release the emotional distress associated with the traumatic memories, EMDR is

effective in helping release the physical manifestations of that trauma like increased tightness of muscles. Many RCTs have now proven the effectiveness of EMDR in healing past emotional traumas and various symptoms of PTSD.^[24,25]

Healing past traumas is particularly important if there is history of sexual abuse or a negative attitude towards sexuality. Otherwise even if penetration becomes possible, without a change in her attitude towards sex, her sexual life may not normalise.

Sensate focus exercises

These are a set of suggestions which encourage a couple to resume intimacy in a gradual manner, with focus on enjoying the process and not bothering about performance. Most couples with Sexual pain-penetration disorder start avoiding intimacy after a few years to avoid the stress of failed expectations and pain. Following a clear rule that penetration will not be attempted no matter how excited they feel, takes away the performance pressure and fear of pain.

Step 1: Alternate non-genital touch focusing on own pleasure.

Step 2: Alternate touch, including genital region and breasts.

Step3: No rules other than not to penetrate.

Getting comfortable with masturbating each other makes it easier for the couple to then try for penetration. Use of a vibrator can also help women in experiencing orgasm and opening up to intimacy.

Guidance regarding trying out peno-vaginal intercourse

It is important to instruct the couple to not attempt penetration till she gets comfortable with the dilators. Intermittent painful attempts at penetration can maintain her fear. After the lady is comfortable with a dilator of size similar to partner's penis or with insertion of partner's 2 fingers, the couple can start trying to penetrate keeping in mind the following:

- 1) To engage in adequate foreplay so that there is good arousal, lubrication and relaxation of the pelvic floor.
- 2) Male partner can go in slowly, checking her comfort and reactions. If there is pain, he can pause and give her time to relax. Can subdivide exposure to penis in steps, completed over multiple days. First 1/3rd, then half, and then full.^[23] After the penis is fully in, the couple can practice once or twice containment without any thrusting, to help her feel more confident about proceeding further.
- 3) To focus on enjoying intimacy rather than just penetration. If penetration doesn't happen, they can still end that session with mutual masturbation.
- 4) In missionary position, keeping a firm pillow or rolled towel below the lower back makes penetration easier. Bending the knees and opening the legs wider than the torso helps with relaxing the pelvic floor. Women on top position and straddle position allows women to feel in control of the depth and speed of penetration. In doggy style position weight is taken off the pelvic floor. So some women find these positions easier.

Couple therapy for marital discord

Many couples with Sexual pain-penetration disorder do develop significant discord. Such couples must be referred for couple therapy. Else the patient will feel unmotivated to work on

healing this condition. Also, till they are upset with each other they may not feel like getting intimate.

The lady can be explained that due to the insecurity and guilt that women with Sexual pain-penetration disorder experience, many of them end up misinterpreting things and develop exaggerated negative beliefs about their partners. This makes it more difficult for them to feel safe in the relationship and to relax during intimacy. Hence it is important to reconsider with an open mind the negative beliefs both partners may have developed about each other.

Medications and procedures

The role of medicines in the treatment of Sexual pain-penetration disorder has not been well studied. But they may play a good supportive role.

- 1) Baclofen: It may help with relaxation of pelvic floor muscles.^[22] In some countries intra-vaginal Baclofen suppositories have been tried
- 2) Benzodiazepines: When the lady is feeling relaxed, progressing with dilators indeed is faster. So taking a Benzodiazepine before dilator practice or during the first few attempts at penetration may help. Intravaginal diazepam has been tried and is well tolerated by many women.^[22] However, 2 small RCTS of Intravaginal Diazepam failed to show any significant difference in EMG recordings or pain scale.^[26]
- 3) Antidepressants: Some women experience clinical depression and/or anxiety due to the stress of unconsummated marriage. Feeling hopeless is common. If symptoms are significant or if she is unable to feel motivated to engage in the treatment process, an anti-depressant can help.^[2] The risk of antidepressant induced sexual dysfunction must be kept in mind.
- 4) Botulinum toxin: Some gynecologists give Botulinum injections into the pelvic floor nerves if the lady is not able to progress with dilators. This relaxes vaginal muscles by temporarily paralyzing them and may help some patients to progress with the dilators. There are few published case series that report high success rates of 80% to 95%.^[27,28] However it is important to note that it is not the gold standard and there are many patients who don't benefit from Botulinum injections as well.
- 5) Lubricant gel: Many women with Sexual pain-penetration disorder don't get adequate lubrication due to anxiety and low arousal. It is very helpful to recommend the use of a lubricant gel or coconut oil. Use of Saliva is not recommended as it may alter vaginal pH and increase risk of vaginal infection. Also saliva can decrease sperm motility.
- 6) Lignocaine gel: Some patients find it useful to use it initially while practising with dilators. However it is important to caution them to not push in the dilator too hard if they feel tightness. This may result in severe burning pain once the effect of lignocaine wears off. Lignocaine may help patients who are unable to tolerate internal massage of the pelvic floor muscles during physiotherapy.^[22]
- 7) Hymenectomy has no role in the treatment of Sexual pain-penetration disorder. It has a role only if hymenal abnormalities are there. Many women with Sexual pain-penetration disorder undergo the procedure without getting any benefit.^[1]

Importance of a multi-disciplinary team:

As described above there are multiple components of intervention that may be required in a patient of Vaginismus. Experts recommend having multi-disciplinary teams and a co-ordinated approach to increase treatment success rates.^[1,2,3] (Table-7)

Table 7: Role of various professionals in treatment of Sexual pain-penetration disorder	
Component of Intervention	Professionals who can deliver
Taking history & diagnosis	Psychiatrist, Gynecologist
Physical examination to rule out organic causes	Gynecologist
Psychosexual education to allay the fear Systematic desensitisation: Explaining practising with dilators or fingers	Psychiatrist, Gynecologist, Psychologist, Pelvic floor Physiotherapist
Therapy for healing of past traumas and addressing underlying psycho-social factors Relaxation exercises (eg. JPMR) & Meditation. Couple therapy	Psychologist, Psychiatrist
Explaining pelvic floor relaxation exercises	Pelvic floor Physiotherapist, Yoga therapist, Psychologist, Psychiatrist
Trigger point release/ Internal massage	Pelvic floor Physiotherapist
Therapist aided in-person exposure therapy with fingers/ dilators	Pelvic floor Physiotherapist, Gynecologist, Psychologist
Prescribe SSRI, Benzodiazepine or muscle relaxants if required	Psychiatrist
Botulinum injections may be tried in resistant cases	Gynecologist

Some important clinical considerations

Many patients do require prolonged treatment extending upto 6-8 months^[2] or upto around 20 sessions of behaviour therapy.^[23] It is important to set expectations accordingly and to persevere with the treatment process.

Treatment received is often inadequate and it is natural for couples to lose hope after going to multiple professionals. So it's important to reassure them that Sexual pain-penetration disorder is a treatable condition. When practice with dilators is done consistently and is supported by healing of past traumas and practice of relaxation exercises, it does become possible.

It's common for some partners to develop Erectile disturbance and/ or Premature ejaculation. Either because they develop self-doubt or because they become anxious about causing her pain or because of the stress of the situation. Many respond to pharmacotherapy; some require a few sessions of psychotherapy as well.

It helps to differentiate between lifelong and acquired Sexual pain-penetration disorder as the underlying psycho-social causes are different (Table 1 & 2). Practice with dilators is useful in both but the focus of psychotherapy will be different.

Need to strengthen psychiatric training

Many psychiatry residents don't get an opportunity to actually treat cases of Sexual pain-penetration disorder in their training years. There is a need for better liaison between Gynaecology and Psychiatry departments and enhanced training of their residents in practical aspects of treating this important clinical condition.^[2] This will improve the quality of care that couples with Vaginismus receive in our society. Since many educated couples also remain undiagnosed for many years, increasing emphasis on this condition in undergraduate curriculum as well will increase awareness about this condition in the medical fraternity and through it in our broader society.

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Genito-pelvic pain/penetration Disorders

Superficial pain



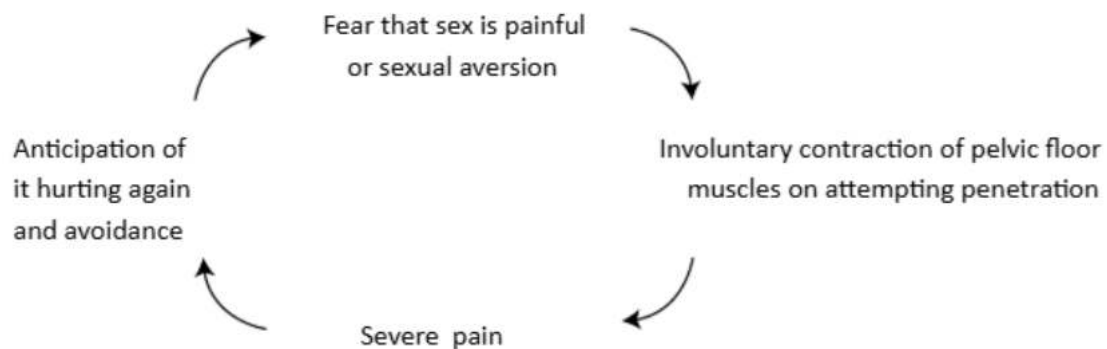
- **Vaginismus:** Involuntary contraction of pelvic floor muscles when penetration is attempted or anticipated.
- **Estrogen Deficiency:** Menopause, lactation-induced or medication-induced. Leads to thinning of the vaginal wall and inadequate lubrication.
- **Anatomical issues:** e.g. Micro-perforate or septate hymen, Septate vagina.
- **Scarring:** Due to episiotomy, vaginal tear or surgery.
- **Infections:** Vaginal candidiasis, Bacterial vaginosis, STDs (e.g. herpes, trichomoniasis).
- **Vulvar Skin Disorders:** Contact dermatitis, Lichen sclerosus, Lichen planus, Eczema.
- **Vestibulodynia:** Unexplained pain at the vaginal opening, typically triggered by pressure or friction from intercourse, tampon insertion, tight clothing, or prolonged sitting.
- **Glandular Conditions:** Eg. Bartholin's gland cysts or abscesses.

Deep pain

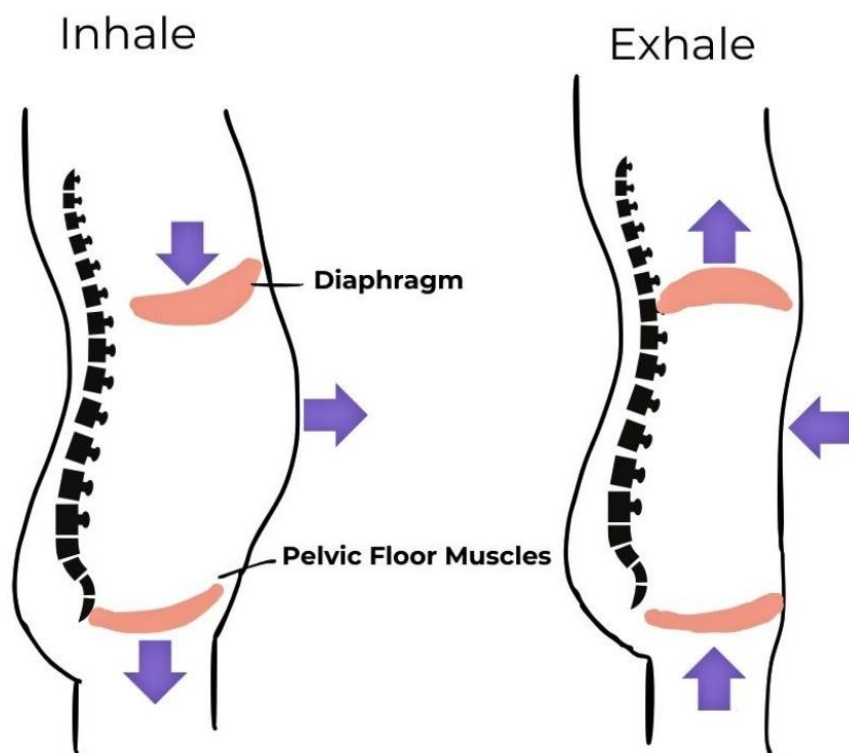


- **Endometriosis & Adenomyosis:** Inflammation and scarring caused by displaced endometrial tissue.
- **Pelvic Adhesions:** Scar tissue resulting from prior abdominal or pelvic surgeries.
- **Inflammation & Infection:** Pelvic inflammatory disease, chronic cervicitis.
- **Pelvic Masses:** Uterine fibroids, ovarian cysts, adnexal tumours.
- **Urinary or Bowel Conditions:** UTI, Interstitial cystitis, Irritable bowel syndrome, inflammatory bowel disease.
- **Retroverted uterus or uterine prolapse.**
- **Vascular Disorders:** Pelvic congestion syndrome (due to varicose veins in lower abdomen & pelvis).

Possible causes of superficial and deep pelvic pain.



Fear - spasm - pain cycle in Sexual pain-penetration disorder



Diaphragmatic breathing (AI generated) (Credit: Chat GPT)



Garland Pose (Malasana) (AI generated) (Credit: Chat GPT)

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Reclined Bound Angle Pose (Supta Baddha Konasana) (AI generated) (Credit: Chat GPT)



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Happy Baby Pose (Ananda Balasana) (AI generated) (Credit: Chat GPT)

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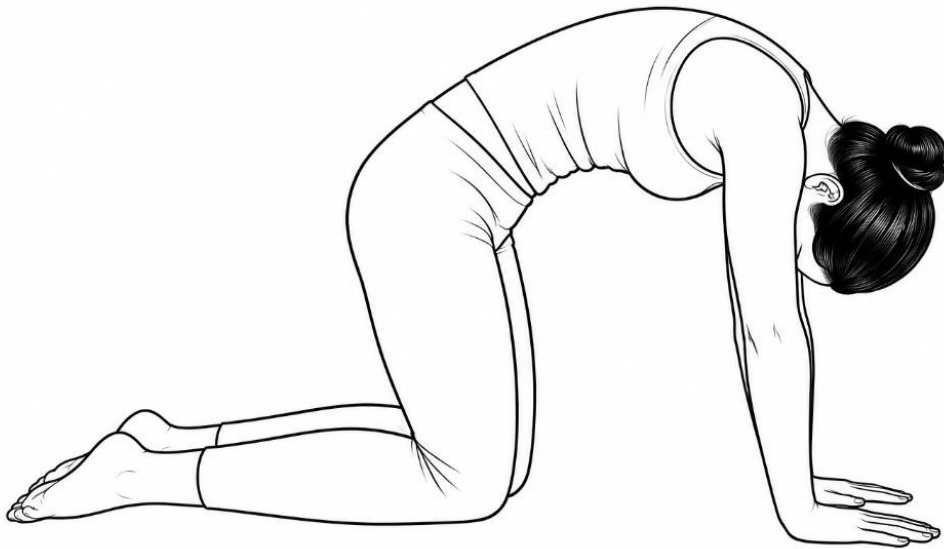


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Child's Pose (Balasana) (AI generated) (Credit: Chat GPT)



Cow Pose (Bitilasana) (AI generated) (Credit: Chat GPT)



Cat Pose (Marjaryasana) (AI generated) (Credit: Chat GPT)