Vaginismus: Causes, Symptoms, Diagnosis, Treatment and the Role of Unani Medicine

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Introduction: "Doctor, I Want to Have Intercourse, but My Body Automatically Tightens"

One of the most difficult and emotional problems a woman or newly married couple may discuss with me is:

"Doctor, whenever we try to have intercourse, my vaginal area becomes very tight. Penetration either becomes extremely painful or does not happen at all. I want to cooperate, but my body seems to stop me automatically."

Another woman may say:

"Even inserting a finger or tampon is difficult."

Some patients tell me:

"I am comfortable with my husband emotionally, but as soon as penetration is attempted, I become afraid and my muscles close involuntarily."

This condition is commonly known as **vaginismus**.

Vaginismus is not simply a woman "refusing sex," and it is not necessarily caused by lack of love, lack of desire or lack of cooperation.

The tightening is usually **involuntary**.

A woman may genuinely want penetration but find that the pelvic-floor muscles surrounding the vaginal opening tighten automatically when penetration is attempted or anticipated.

Modern medicine now commonly considers vaginismus within the broader diagnosis called **genito-pelvic pain/penetration disorder (GPPPD)**. This diagnosis recognizes that pain, fear of pain, difficulty with penetration and involuntary tightening of the pelvic-floor muscles often overlap rather than occurring as completely separate problems.

I want women experiencing this condition to understand something from the beginning:

Vaginismus is a genuine health condition. It is not a personal failure, and effective treatment is available.

The most successful management usually combines accurate diagnosis, pelvic-floor rehabilitation, gradual desensitization, sexual education, psychological or psychosexual support where needed, treatment of any physical cause of pain, and patient-centered care.

A major systematic review published in the *Journal of Sexual Medicine* in 2026 evaluated 18 studies involving 863 patients and found favorable outcomes with cognitive-behavioral therapy, pelvic-floor physiotherapy, vaginal dilator therapy and combined psychosexual approaches. The review concluded that multidisciplinary treatment addressing both the physical and psychological components appears particularly effective, although differences between studies mean that no fixed success percentage can be guaranteed to an individual patient.

This modern understanding also fits well with one of the strengths of the Unani approach: looking at the patient as a whole rather than treating one isolated symptom.

At **Saira Health Care**, therefore, my approach is not simply:

“The vagina is tight, so give a medicine to relax it.”

Instead, I try to understand:

Why does penetration hurt? Why is the pelvic floor contracting? Is fear occurring because of previous pain? Is there an underlying gynecological problem? Is there dryness? Is there a relationship or psychological factor? Is there previous trauma? Has intercourse never been possible, or was it previously normal?

The answers determine the treatment.

What Is Vaginismus?

Vaginismus refers to involuntary tightening or guarding of the pelvic-floor muscles associated with attempted or anticipated vaginal penetration.

The muscles involved are part of the pelvic floor, particularly muscles surrounding and supporting the vaginal opening and pelvic organs.

When these muscles contract excessively, penetration can become:

difficult, painful or completely impossible.

The response may occur during attempted:

sexual intercourse, insertion of a tampon, insertion of a finger, use of a vaginal dilator, or sometimes during a gynecological examination.

Modern descriptions emphasize that the patient may simultaneously experience pain, fear or anxiety about penetration and reflex tightening of the pelvic-floor muscles.

The important word is **involuntary**.

The woman is generally not deliberately closing the vagina.

Her muscles may tighten automatically, often before she consciously realizes what has happened.

Vaginismus Is Not Simply a "Small" or "Closed" Vagina

Many women come to me convinced:

"My vaginal opening must be too small."

Or:

"Maybe my vagina is naturally closed."

This is usually not the correct explanation.

In most cases of vaginismus, there is no anatomical blockage.

The vagina itself is a flexible muscular structure. The problem is commonly excessive guarding or contraction of the pelvic-floor muscles, often occurring together with fear, pain or anticipation of pain.

However, genuine structural conditions can occasionally interfere with penetration. This is why proper evaluation is important.

For example, a clinician may need to rule out:

an unusual hymenal abnormality, vaginal septum, scarring, vulvar skin disease, infection, severe vaginal dryness, endometriosis, vulvodynia, or other causes of painful penetration.

Therefore, I never assume that every woman who cannot tolerate intercourse has vaginismus without considering other possibilities.

The Modern Medical Term: Genito-Pelvic Pain/Penetration Disorder

Older classifications separated **vaginismus** and **dyspareunia**, meaning painful intercourse.

In current psychiatric diagnostic terminology, these overlapping symptoms are grouped under **genito-pelvic pain/penetration disorder**.

The condition may involve one or more persistent problems:

difficulty having vaginal penetration, significant vulvar or pelvic pain during attempted penetration, fear or anxiety about pain, and involuntary tightening of the pelvic-floor muscles during penetration attempts.

For a formal DSM-5-TR diagnosis, symptoms are generally expected to persist for approximately six months, cause significant distress and not be better explained by another condition or circumstance.

In everyday clinical practice, however, a woman does not need to suffer for six months before asking for help.

Early evaluation can prevent the pain–fear–muscle-tightening cycle from becoming more established.

How Does Vaginismus Develop?

I often explain vaginismus to patients using a simple cycle:

Pain or fear → anticipation of pain → involuntary muscle tightening → more difficult penetration → greater pain → greater fear.

Over time, the body can begin to anticipate danger before penetration is even attempted.

The woman may become anxious simply by thinking about intercourse.

The pelvic muscles then contract defensively.

Penetration becomes more painful.

The painful experience then confirms her fear:

“I knew it would hurt.”

At the next attempt, the muscles tighten even earlier.

This is why repeatedly forcing intercourse is one of the worst approaches.

The solution is usually to **break this pain–fear–guarding cycle gradually and safely**.

Primary or Lifelong Vaginismus

Some women have never been able to tolerate vaginal penetration.

A newly married woman may tell me:

“We have been married for several weeks or months but intercourse has never been completed.”

She may also report difficulty inserting:

a tampon, a finger, a vaginal medicine or a speculum during examination.

This is often described as **primary or lifelong vaginismus**.

Some women discover the problem only after marriage because they had never previously attempted vaginal penetration.

This does not mean the condition suddenly developed on the wedding night. The underlying pattern may simply not have been recognized earlier.

Secondary or Acquired Vaginismus

Other women previously had comfortable intercourse but later develop difficulty.

This is known as **secondary or acquired vaginismus**.

When this happens, I particularly want to know:

“What changed before the problem started?”

Possible triggers can include:

painful intercourse, vaginal or vulvar infection, childbirth injury, pelvic surgery, vaginal dryness, menopause, endometriosis, relationship difficulties, sexual trauma, psychological stress or another painful pelvic condition.

The MSD Manual notes that genito-pelvic pain and pelvic-floor guarding can develop after a previous period of pain-free sexual activity.

In these patients, simply treating anxiety without identifying the new source of pain may be inadequate.

What Are the Symptoms of Vaginismus?

The presentation varies considerably.

One woman may tolerate partial penetration but experience severe pain.

Another may be completely unable to tolerate penetration.

Another may tolerate intercourse but experience intense burning afterward.

Another may be comfortable with a finger but not penile penetration.

Another cannot tolerate a gynecological examination.

The typical features are difficulty or inability with vaginal penetration, involuntary tightening of the pelvic-floor muscles, pain or burning at the vaginal entrance, fear before penetration, avoidance of intercourse because pain is expected, and emotional distress related to the problem. ACOG similarly describes tightening of the vaginal muscles, pain or burning with penetration, fear of pain and avoidance of sexual activity as important manifestations of sexual pain disorders.

Women sometimes describe the sensation as:

“It feels like there is a wall.”

This description is very common.

There is usually no literal wall.

The sensation may result from strong involuntary muscular guarding.

Vaginismus Can Exist Even When Sexual Desire Is Normal

This distinction is extremely important.

A woman with vaginismus may:

love her partner, feel sexually attracted to him, become sexually aroused, enjoy kissing and touching, have normal lubrication, experience orgasm through nonpenetrative stimulation, and still be unable to tolerate vaginal penetration.

Therefore:

Vaginismus does not automatically mean low libido.

Sexual desire, sexual arousal, orgasm and penetration are different aspects of sexual function.

This is one reason why a proper sexual-health history is essential.

Causes of Vaginismus: There Is Rarely One Single Cause

I do not like telling a patient:

“Your problem is psychological.”

Nor do I automatically tell her:

“Your muscles are weak.”

Both statements may oversimplify the condition.

Modern evidence supports a **biopsychosocial model**, meaning physical, psychological, sexual and relationship factors may interact.

Sometimes one factor dominates.

Sometimes several factors reinforce each other.

Fear of Pain

Fear is one of the most important maintaining factors.

The woman may anticipate:

“It will hurt.”

Her pelvic muscles tighten.

Penetration then does hurt.

The painful experience reinforces the fear.

This can happen even when the woman genuinely wants intercourse.

The response resembles other protective reflexes of the body.

If someone suddenly moves a finger toward your eye, you blink automatically.

You do not consciously decide:

“Now I shall contract my eyelid.”

Similarly, pelvic-floor guarding can become an involuntary defensive response.

A Painful First Attempt at Intercourse

Some women have their first sexual experience under considerable pressure.

There may be:

insufficient arousal, inadequate lubrication, fear of bleeding, pressure to consummate the marriage immediately, rough penetration, lack of privacy or misunderstanding about female sexual response.

If the first attempt becomes intensely painful, the woman's brain may begin associating penetration with danger.

Future attempts may then produce muscular guarding even before penetration occurs.

This is why I advise couples not to keep forcing intercourse repeatedly after an unsuccessful painful attempt.

Inadequate Arousal and Lubrication

Penetration attempted before adequate arousal may be uncomfortable.

When a woman is appropriately aroused, genital tissues become more prepared for sexual activity and lubrication usually increases.

When intercourse is rushed or the woman is anxious, lubrication may be inadequate.

Friction then causes pain.

Pain produces guarding.

Guarding creates more pain.

ACOG recognizes inadequate arousal and vaginal dryness among important contributors to painful intercourse.

Therefore, treatment sometimes requires improving the entire sexual experience rather than concentrating only on penetration.

Anxiety

A woman may experience general anxiety or anxiety specifically related to sexual intercourse.

Thoughts may include:

“Will it fit?”

“Will I bleed?”

“Will something tear?”

“Will intercourse damage my body?”

“Will my husband think I am abnormal?”

“What if penetration never happens?”

The more she anticipates failure, the more difficult it can become for the pelvic floor to relax.

Anxiety does not mean she is imagining the problem.

Anxiety produces genuine physical changes in muscle tone and pain perception.

Previous Sexual Trauma

Previous sexual abuse, coercion or traumatic sexual experiences can contribute to vaginismus in some women.

However, another misconception must be corrected:

Not every woman with vaginismus has a history of sexual trauma.

Some women with lifelong vaginismus have no such history at all.

Therefore, clinicians should ask sensitively rather than making assumptions.

When trauma is present, treatment should be **trauma-informed**, meaning the patient remains in control and is not pressured into examinations, penetration exercises or discussions before she is ready.

Cultural Fear and Misinformation About Sex

In some communities, a woman may grow up repeatedly hearing frightening messages about intercourse.

She may be told:

“The first night will be extremely painful.”

“There must be a lot of bleeding.”

“Penetration will tear you.”

“You should simply tolerate the pain.”

These ideas can create severe anticipatory fear.

Medically, first intercourse does not have to involve severe pain or significant bleeding.

The hymen is not an impenetrable wall that must be forcibly broken.

Education before or during treatment can therefore be extremely important.

Relationship Factors

Relationship difficulties can contribute in some patients.

Possible factors include lack of emotional security, unresolved conflict, sexual pressure, poor communication, fear of disappointing the partner or lack of respect for boundaries.

But again:

Vaginismus does not automatically mean the relationship is bad.

I see couples who have excellent emotional relationships and still face this condition.

The partner's role during treatment should be supportive rather than accusatory.

Vaginal and Vulvar Infections

A woman who develops:

burning, itching, abnormal discharge or inflammation

may experience painful penetration.

Repeated painful attempts can later produce defensive pelvic-floor tightening.

Therefore, vaginal infection should be treated when present.

Vaginismus treatment cannot replace treatment of an actual infection.

ACOG lists vaginitis among causes of painful intercourse that should be medically assessed and treated.

Vulvodynia and Vestibulodynia

Some women experience significant pain around the vulva or vaginal entrance without a simple infection.

Provoked vestibulodynia can cause severe burning or stabbing pain when pressure is applied around the vaginal entrance.

Because penetration hurts, pelvic-floor muscles may begin tightening defensively.

Modern evaluation of genito-pelvic pain therefore includes assessment for vestibular pain and pelvic-floor hypertonicity rather than automatically assuming vaginismus is purely psychological.

Menopause and Vaginal Dryness

Around and after menopause, declining estrogen may produce **genitourinary syndrome of menopause**, involving thinning and dryness of vaginal and vulvar tissues.

Sex may become painful.

If painful intercourse continues, secondary pelvic-floor guarding may develop.

In this situation, treating muscular fear without treating vaginal dryness would be incomplete.

Depending on the patient, management may involve appropriate lubricants, vaginal moisturizers and medically indicated local hormonal treatment.

Childbirth and Postpartum Changes

After childbirth, women may experience:

perineal tears, episiotomy pain, scar tenderness, pelvic-floor dysfunction, fear of reinjury, hormonal dryness during breastfeeding and anxiety when sexual intercourse resumes.

Most women do not develop vaginismus after childbirth, but postpartum pain can trigger protective pelvic-floor tightening in susceptible patients.

The correct treatment depends on what is causing the pain.

Pelvic Surgery and Scarring

Previous surgery involving the vagina, vulva or pelvis may sometimes cause:

scar tenderness, narrowing or fear associated with pain.

Again, a physical cause should be identified before concluding that the problem is entirely psychological.

Endometriosis and Other Pelvic Conditions

Endometriosis typically causes deeper pelvic pain rather than classic superficial vaginismus, but chronic painful intercourse can lead to anticipatory muscle guarding.

Other pelvic conditions such as cysts, adhesions or inflammatory disease can also produce pain during sex.

The MSD Manual includes endometriosis and several other pelvic disorders in the differential diagnosis of genito-pelvic pain.

Vulvar Skin Disorders

Conditions such as lichen sclerosus and other inflammatory skin disorders can produce:

burning, tearing, irritation or painful penetration.

These conditions require proper gynecological or dermatological management.

They should not simply be treated with muscle-relaxing exercises.

Pelvic-Floor Muscle Dysfunction

The pelvic floor is central to vaginismus.

Some patients have excessive resting muscle tone or difficulty voluntarily relaxing the pelvic floor.

A specially trained pelvic-floor physiotherapist can assess:

muscle tension, coordination, tenderness, breathing patterns and the patient's ability to contract and relax appropriately.

This treatment is different from simply telling every woman to perform **Kegel exercises**.

In fact, if the muscles are already excessively tight, blindly doing repeated strengthening exercises may be unhelpful.

For vaginismus, the first goal is often **relaxation, coordination and control**, not simply greater strength.

Can Vaginismus Be Caused by Hormonal Imbalance?

Hormones are not the usual direct cause of primary vaginismus.

However, hormonal changes can indirectly contribute when they produce:

vaginal dryness, reduced tissue elasticity or painful intercourse.

This is particularly relevant after menopause and sometimes during breastfeeding.

Hormone testing is therefore not automatically required for every patient.

It should be ordered when the history suggests an endocrine or reproductive problem.

Diagnosis of Vaginismus

The diagnosis begins with one of the most powerful medical tools available:

listening to the patient.

Many women arrive frightened because they believe diagnosis means they will immediately undergo a painful internal examination.

That should not be the approach.

A woman with suspected vaginismus requires a respectful, consent-based evaluation.

My First Step: A Detailed Conversation

I generally want to understand:

When was penetration first attempted?

Has penetration ever been possible?

Can the patient insert a finger?

Can she tolerate a tampon?

Does pain begin before penetration or only after entry?

Does she feel burning, tearing, pressure or deep pelvic pain?

Is sexual arousal normal?

Is lubrication adequate?

Does she experience orgasm through nonpenetrative sexual activity?

Was intercourse previously comfortable?

Did symptoms start after childbirth, infection, surgery or a painful sexual experience?

Is there vaginal discharge, itching or bleeding?

Is she menopausal?

Is pregnancy currently desired?

Is there significant anxiety?

Does the patient have a history of sexual trauma?

How is communication between the couple?

These questions help distinguish different disorders that can look similar.

The Physical Examination Must Never Be Forced

This deserves special emphasis.

A woman with severe vaginismus may not initially tolerate an internal vaginal examination.

That does not mean the physician should hold her down or force the examination.

Forcing an examination can strengthen the brain's association between vaginal penetration and danger.

The MSD Manual specifically notes that pelvic examination can be difficult in patients with significant pelvic-floor guarding and recommends explaining each stage of examination carefully.

My principle is:

The examination should proceed only as far as the patient can comfortably consent to.

Sometimes the first visit consists mainly of:

discussion, education and external assessment.

Internal assessment can be considered later when necessary and when the patient feels safer.

What Does a Medical Examination Look For?

When examination is clinically indicated and tolerated, a clinician may assess the vulva and vaginal entrance for:

infection, inflammation, abnormal discharge, skin disorders, painful areas, scarring, anatomical abnormalities, dryness or atrophy.

A gentle cotton-swab examination may help identify localized vestibular pain.

The pelvic-floor muscles may be assessed carefully for excessive tension and tenderness.

A speculum examination is performed only when indicated and tolerated.

The aim is not to prove that penetration is possible.

The aim is to identify the cause of pain.

Are Blood Tests Necessary?

There is no blood test that directly diagnoses vaginismus.

Tests are selected according to the patient's symptoms.

For example, investigations may be appropriate if there is suspicion of:

diabetes, endocrine disease, infection, reproductive problems or another medical condition.

Many women with primary vaginismus require no extensive blood investigation.

Is Ultrasound Necessary?

Ultrasound does not diagnose pelvic-floor muscle guarding itself.

However, pelvic ultrasound may be appropriate if there are symptoms suggesting:

ovarian disease, uterine disease, endometriosis-related problems or another pelvic condition.

In severe vaginismus, even transvaginal ultrasound may initially be intolerable, and alternative approaches can be considered when clinically appropriate.

Conditions That Can Be Mistaken for Vaginismus

I consider differential diagnosis very important.

Painful penetration may arise from:

vulvodynia or vestibulodynia, vaginal infection, genital herpes, vulvar skin disease, menopausal tissue changes, Bartholin gland problems, congenital abnormalities, endometriosis, pelvic masses, pelvic adhesions, childbirth injury or surgical scarring.

The MSD Manual lists many of these conditions as recognized physical causes of genito-pelvic pain/penetration disorder.

This is precisely why giving every patient the same “vaginismus medicine” is not good medical practice.

Treatment of Vaginismus

Treatment should be individualized.

Modern evidence increasingly supports **multidisciplinary treatment** rather than one isolated intervention.

A 2026 systematic review and meta-analysis evaluated cognitive-behavioral therapy, pelvic-floor physiotherapy, vaginal dilators, botulinum toxin and combined psychosexual programmes. Across 18 studies involving 863 patients, substantial improvement was reported with several approaches, and combined interventions appeared especially promising. However, the studies differed considerably in diagnosis, treatment protocol and

definition of "success," so the figures should not be presented to patients as guaranteed cure rates.

A separate 2026 review similarly concluded that patient-centered multimodal management currently has the strongest overall support while acknowledging limitations in the quality and consistency of the evidence.

Sexual Education Is Treatment

Education is one of the first things I provide.

The patient and partner may need to understand:

the anatomy of the vagina and vulva, the location of pelvic-floor muscles, the role of sexual arousal, the importance of lubrication, why involuntary tightening occurs, why forcing intercourse makes the problem worse, and why treatment progresses gradually.

When a woman understands:

"My body is not defective; these muscles are responding protectively, and they can learn a different response,"

much of the fear can begin to decrease.

Stop Repeated Forced Penetration

I consider this one of the most important early instructions.

If every attempt at intercourse produces severe pain, repeatedly forcing penetration may teach the nervous system:

penetration = danger.

That reinforces the condition.

Therefore, the couple may temporarily shift the goal away from vaginal intercourse while treatment progresses.

Affection, intimacy and nonpenetrative sexual activity can continue if both partners are comfortable.

The MSD Manual specifically recommends developing satisfying nonpenetrative sexual activity during treatment where appropriate.

Pelvic-Floor Physiotherapy

Pelvic-floor physiotherapy is one of the most important modern treatments for vaginismus.

The therapist may teach:

pelvic-floor awareness, relaxation rather than constant contraction, diaphragmatic breathing, voluntary control of muscle tightening and release, gentle manual techniques when appropriate, progressive exposure to vaginal entry and biofeedback.

The objective is:

not to force the vagina open.

The objective is to teach the nervous system and pelvic-floor muscles that penetration can occur without danger.

The MSD Manual recommends pelvic-floor physical therapy as an important part of managing genito-pelvic pain/penetration disorder.

Biofeedback

Some physiotherapy programmes use **biofeedback**.

Biofeedback allows a patient to gain greater awareness of pelvic-floor muscle activity.

Instead of being told:

“Relax your muscles,”

the woman may learn to recognize objectively when the pelvic floor is contracting and when it is releasing.

A randomized controlled trial published in 2025 involving women with primary vaginismus found improvement with vaginal dilator therapy and reported additional benefits in several sexual-function measures when biofeedback was added. The trial was small, involving 32 women, so it should be interpreted as supportive rather than definitive evidence.

Vaginal Dilator Therapy

Dilators are smooth medical devices available in gradually increasing sizes.

They are sometimes misunderstood.

A dilator is not supposed to be pushed forcibly into the vagina.

It is used gradually to help the woman become comfortable with:

touch around the vaginal opening, voluntary pelvic-floor relaxation, insertion of a very small device and eventually progressively larger sizes when the previous stage becomes completely manageable.

The objective is **desensitization and control**, not forced stretching.

Current clinical guidance includes progressive self-dilation as an important treatment option for pelvic-floor tightening associated with vaginismus.

Treatment should progress according to comfort—not according to an arbitrary deadline.

Progressive Desensitization

A woman may initially be uncomfortable even touching the vaginal entrance.

Treatment can therefore begin far earlier than actual penetration.

Gradual steps may involve becoming comfortable with the genital area, touching around the vaginal entrance, learning pelvic-floor relaxation, inserting a finger or the smallest appropriate dilator when ready, and gradually progressing.

Each new stage should begin only when the previous stage feels manageable.

That principle is also described in contemporary clinical guidance for vaginismus.

Cognitive Behavioral Therapy

Cognitive behavioral therapy, or CBT, can help when thoughts and fears are reinforcing the problem.

The patient may believe:

“Penetration will definitely tear me.”

“Something terrible will happen.”

“I must complete intercourse tonight.”

“My husband will leave me if I fail.”

“I am not a normal woman.”

CBT helps identify and gradually modify these fear-producing beliefs while behavioral exercises reduce avoidance.

The 2026 vaginismus systematic review found favorable outcomes with CBT and supported combining psychological treatment with physical interventions.

A broader 2025 meta-analysis of CBT for female sexual dysfunction also found improvements in sexual-function measures, although evidence quality varied across outcomes.

Psychosexual Therapy

A trained psychosexual therapist may help the woman or couple address:

fear of penetration, sexual misconceptions, communication, performance pressure, previous painful experiences, avoidance and relationship dynamics.

This does not mean:

“The disease is imaginary.”

The pelvic muscle contraction is real.

Psychosexual therapy helps change the nervous-system and behavioral patterns that may be reinforcing the physical response.

Sensate Focus and Pressure-Free Intimacy

In some couples, therapy deliberately removes penetration as the immediate goal.

Partners learn to focus instead on:

comfortable touch, closeness, pleasure, relaxation and communication.

Gradually, performance pressure reduces.

This is particularly useful when every sexual interaction has become:

“Will penetration happen today or not?”

Sexual intimacy should not feel like a pass-or-fail examination.

Lubrication

Appropriate lubrication may be helpful when dryness contributes to discomfort.

However, lubrication alone does not cure true vaginismus.

If pelvic-floor muscles contract strongly because of fear and pain, lubricant may reduce friction but cannot by itself resolve the involuntary guarding response.

This is why treatment must match the cause.

Treating Infection, Skin Disease or Other Physical Pain

If a woman has:

vaginitis, vulvar skin disease, menopausal atrophy, endometriosis, painful scar tissue, vestibulodynia or another physical condition,

that condition must be treated.

One of the most important principles in my practice is:

Do not treat the muscle while ignoring the source of pain.

ACOG recommends medical evaluation for frequent or severe painful intercourse because gynecological causes should be identified and treated.

Is Medication Usually Necessary?

There is no single tablet that cures vaginismus in every woman.

Treatment is primarily directed at:

pelvic-floor control, pain, anxiety and the underlying cause.

Medication may sometimes be used for a specific associated condition, such as:

infection, menopausal vaginal changes, significant psychiatric illness or another diagnosed medical problem.

But a sedative or so-called sexual tonic alone rarely addresses the complete disorder.

Botulinum Toxin: Is Botox a Treatment for Vaginismus?

Botulinum toxin injections have been studied for difficult or treatment-resistant cases.

The 2026 systematic review reported favorable outcomes in some botulinum-toxin studies, but the available research remains heterogeneous and does not establish Botox as a universal first-line treatment.

A 2026 expert consensus on pelvic-floor botulinum toxin described it as a **third-line treatment for high-tone pelvic-floor dysfunction and myofascial pelvic pain**, with possible consideration for involuntary vaginismus in selected cases.

Therefore, I would not advise patients to jump directly to injections without first considering appropriate conservative treatment.

Does Vaginismus Require Surgery?

Usually, **no**.

Vaginismus is generally not a condition that requires an operation.

Surgery becomes relevant only if a genuine anatomical problem contributing to penetration difficulty is diagnosed.

A normal hymen should not automatically be surgically cut merely because penetration is difficult.

Unnecessary procedures can create additional pain or scarring.

The diagnosis must come first.

Does Vaginismus Affect Fertility?

This is a particularly important question in my practice because many couples come to Saira Health Care with both sexual and fertility concerns.

Vaginismus does not directly damage the ovaries, eggs or uterus.

A woman can have normal:

ovulation, menstrual cycles, ovarian reserve, fallopian tubes and reproductive hormones

and still have vaginismus.

However, if vaginal intercourse cannot occur, semen may not be deposited in the vagina through intercourse.

Therefore, a couple may present with what appears to be infertility when the main obstacle is actually **inability to consummate the marriage or have penetrative intercourse**.

The MSD Manual notes that inability to have intercourse can create significant distress particularly in women who wish to become pregnant.

This distinction is extremely important.

I often tell couples:

Sexual dysfunction and infertility are not the same condition, but one can interfere with the other.

Before starting expensive fertility treatment, the couple's sexual history should therefore be understood.

Vaginismus and Unconsummated Marriage

In South Asian clinical practice, some couples seek help because marriage has remained unconsummated for months or even years.

The couple may previously have consulted:

gynecologists, fertility clinics, general physicians or traditional practitioners

without openly explaining that penetration has never occurred.

Sometimes the husband is tested repeatedly.

Sometimes the woman's ultrasound and hormone reports are normal.

But nobody has asked:

“Has complete vaginal intercourse actually occurred?”

I consider that question extremely important in sexual and infertility medicine.

There is published evidence that psychosexual treatment can be successfully adapted even within culturally conservative populations, emphasizing that treatment should respect cultural context while remaining medically appropriate.

Should the Husband Be Evaluated Too?

Sometimes yes.

A couple may assume the woman has vaginismus when another problem is contributing.

For example, the male partner may have:

erectile dysfunction, premature loss of erection, severe performance anxiety, penile pain or misinformation about penetration.

Sometimes both partners become anxious after repeated unsuccessful attempts.

Because my focused practice includes both sexual disorders and infertility, I consider the **couple**, when appropriate, rather than automatically blaming one partner.

The Role of the Partner in Recovery

A supportive partner can make treatment much easier.

The partner should understand:

This is not deliberate rejection.

Anger, threats, pressure or repeated forced attempts generally make the problem worse.

Instead, the couple should work toward:

trust, patience, communication, adequate arousal, comfort and gradual progress.

The goal is not:

“Complete intercourse tonight.”

The goal is:

“Help the body learn that intimacy and penetration can be safe and comfortable.”

That change in mindset is extremely important.

Understanding Vaginismus Through the Unani System of Medicine

As a physician trained in Unani medicine, I view sexual health as closely connected with the patient's overall physical, psychological and reproductive state.

The Unani system traditionally evaluates health using concepts including:

Mizaj, or temperament; physical and psychological condition; lifestyle; sleep; diet; activity and rest; and traditional humoral theory.

The Ministry of AYUSH describes the classical Unani system as based historically on humoral theory involving **Dam, Balgham, Safra and Sauda**, while also emphasizing preservation of health through lifestyle and individualized treatment.

It is important for patients to understand that humoral terminology represents a **traditional Unani explanatory framework**.

It should not be presented as though modern research has shown that vaginismus occurs because a laboratory-measurable amount of “blood” or “phlegm” is out of balance.

Modern neuroscience describes vaginismus principally through mechanisms involving pelvic-floor muscle guarding, pain processing, fear and psychological and physical contributors.

Both frameworks can be used responsibly only when we are clear about what each represents.

Asbab-e-Sitta Zarooriya: Six Essential Factors

One of the strengths of Unani medicine is its emphasis on lifestyle as an essential component of health.

Classical Unani medicine describes six essential factors known as **Asbab-e-Sitta Zarooriya**, involving air and environment, food and drink, physical activity and rest, psychological activity and rest, sleep and wakefulness, and appropriate retention and elimination.

The Ministry of AYUSH continues to identify these six factors as fundamental principles of Unani health promotion.

For a condition such as vaginismus, several of these principles can be clinically relevant because:

poor sleep can increase anxiety and pain sensitivity; chronic psychological stress can make muscular relaxation more difficult; poor general health can reduce sexual well-being; and relationship or mental stress can influence the body's response to intimacy.

Therefore, lifestyle treatment can be genuinely useful—but it must form part of a complete treatment plan rather than replacing pelvic-floor rehabilitation when that is needed.

The Four Main Modes of Unani Treatment

The Central Council for Research in Unani Medicine identifies four traditional therapeutic modes:

Ilaj-bil-Tadbir – Regimenal therapy

Ilaj-bil-Ghiza – Dietotherapy

Ilaj-bil-Dawa – Pharmacotherapy

and

Ilaj-bil-Yad – Surgery.

In vaginismus, I consider the first three potentially relevant depending on the individual patient, while surgery has no routine role unless a separate anatomical abnormality requires correction.

Ilaj-bil-Ghiza: Dietary Management

A special food cannot mechanically “open” the vagina.

I want to be very clear about that.

However, adequate nutrition remains important for:

general health, hormonal health, energy, recovery, metabolic health and emotional well-being.

My dietary assessment may therefore consider:

body weight, nutritional deficiencies, diabetes, digestion, hydration, constipation, reproductive status and overall diet quality.

The purpose of **Ilaj-bil-Ghiza** in this setting is to improve the patient's general physiological health rather than promise an immediate cure from a particular food.

Ilaj-bil-Tadbir: Regimenal and Lifestyle Management

Regimenal therapy has an important supportive role when it is individualized.

Depending on the patient, I may emphasize:

relaxation, healthy physical activity, appropriate rest, improved sleep, breathing techniques, reduction of chronic stress and measures to improve general well-being.

However, I distinguish traditional regimenal treatment from specialized **pelvic-floor physiotherapy**.

A trained pelvic-floor therapist has specific expertise in assessing and rehabilitating high-tone pelvic muscles.

Unani supportive care can complement this treatment but should not falsely claim to replace it.

Ilaj-bil-Dawa: Individualized Unani Pharmacotherapy

Unani medicine contains various traditional formulations used according to the patient's constitution and symptoms.

In my practice, I do not believe there should be one standard:

“Vaginismus medicine for every woman.”

If Unani pharmacotherapy is considered, I first assess the patient's complete condition.

The purpose may be supportive management of associated symptoms such as:

poor sleep, excessive stress, general weakness, digestive complaints or another individually assessed health problem.

I do **not** promise that an herbal medicine alone can mechanically relax every patient's pelvic floor and permanently cure vaginismus.

The strongest contemporary evidence for vaginismus continues to favor multimodal treatment involving psychosexual interventions, pelvic-floor therapy and gradual desensitization.

This evidence does not weaken responsible Unani practice.

It helps us use Unani medicine in the area where it is most appropriate.

Is There Scientific Proof That a Particular Unani Herb Cures Vaginismus?

At present, there is not enough high-quality clinical evidence to say:

“This particular Unani herb has been scientifically proven to cure vaginismus.”

That is an important distinction.

Traditional medicines may be used within individualized Unani clinical practice, but traditional use is not automatically equivalent to evidence from controlled clinical trials.

The Central Council for Research in Unani Medicine itself emphasizes the need for Unani drugs and therapies to undergo systematic scientific validation.

I consider this a positive principle.

Traditional medicine becomes more trustworthy when we are willing to investigate it scientifically.

My Special Individualized Approach at Saira Health Care

When a woman or couple consults me for vaginismus, I prefer to follow a structured, individualized pathway rather than immediately prescribing medicine.

First, I determine whether this is genuinely vaginismus or whether another painful condition is being mistaken for it.

Then I establish whether the problem is lifelong or acquired.

I assess whether intercourse has ever been completed.

I ask about pain, burning, dryness, infection, menstrual and reproductive health, childbirth, previous surgery, psychological stress, sexual fear and relevant trauma.

I also assess whether the patient has adequate sexual desire and arousal.

If the couple is trying to conceive, I consider whether vaginismus is preventing intercourse rather than assuming that an ovarian or sperm disorder must be present.

Where pelvic-floor overactivity is likely, I encourage appropriate pelvic-floor relaxation and specialist physiotherapy.

Where gradual desensitization is appropriate, dilator-based or progressive penetration work may be introduced carefully.

Where psychological fear is important, counselling, CBT or psychosexual therapy may be advised.

Where a physical gynecological cause is suspected, appropriate investigation or referral is arranged.

And where individualized Unani treatment can safely support sleep, lifestyle, general health, stress management or associated clinical concerns, I incorporate it as part of the overall care plan.

This is what I mean by **integrative treatment**.

It is not:

Unani versus modern medicine.

It is:

Use every appropriate and safe tool for the benefit of the patient.

Why I Do Not Force a Patient to Complete Penetration Quickly

Some patients arrive saying:

“Doctor, please cure me in one or two days because my family is asking why the marriage has not been consummated.”

I understand the social pressure these patients may be experiencing.

But the woman's body should not be treated according to somebody else's deadline.

Recovery can sometimes happen relatively quickly, while another woman requires a more gradual programme.

Treatment should never involve humiliating or frightening the patient.

The real objective is:

comfortable, voluntary, pain-free penetration—not penetration at any cost.

What Does Successful Treatment Mean?

Traditionally, success was often measured simply by whether penile-vaginal intercourse became possible.

That outcome is important for many couples.

However, I believe successful treatment should be broader.

Successful treatment can mean:

the woman no longer fears penetration, the pelvic floor can relax voluntarily, vaginal examination becomes tolerable, intercourse becomes comfortable, sexual activity becomes pleasurable instead of frightening, the couple communicates better, and a couple seeking pregnancy can have intercourse without pain.

Modern research increasingly evaluates sexual function and patient experience rather than penetration alone. For example, the 2025 randomized study of dilators with and without biofeedback assessed changes across desire, arousal, orgasm, satisfaction and pain rather than looking only at the mechanical ability to insert something into the vagina.

That is a more patient-centered definition of success.

Why I Avoid Invented "Success Stories"

Patients naturally want to know:

"Has anyone with my condition become completely better?"

Yes, many women respond successfully to appropriate vaginismus treatment, and the recent literature reports substantial improvement across several therapeutic approaches.

However, I do not believe a professional healthcare website should invent a story such as:

"Patient A took these herbs and was cured in 15 days."

Unless that is a genuine, documented patient case published with proper consent, it should not be presented as evidence.

Every woman's starting point is different.

A genuine success story should therefore include:

an accurate diagnosis, actual treatment received, meaningful outcome and informed patient consent.

That protects both patients and the credibility of Saira Health Care.

Common Myths About Vaginismus

One of the most useful things I can do for my patients is correct the myths surrounding this condition.

"Vaginismus means the vagina is physically closed." Usually false. The problem commonly involves involuntary pelvic-floor guarding rather than a blocked vagina.

"She is doing it deliberately." False. The muscle response is commonly involuntary.

"If the husband pushes harder, penetration will eventually happen." This can worsen pain, fear and muscle guarding and should not be considered treatment.

"Every woman with vaginismus was sexually abused." False. Trauma is one possible factor, not a requirement.

"If she loves her husband, vaginismus cannot happen." False. Loving relationships and vaginismus can coexist.

"The hymen must be cut." Usually false unless a genuine hymenal or structural abnormality has been diagnosed.

"She is infertile." Not necessarily. Vaginismus can interfere with intercourse, but it does not itself prove that the ovaries, eggs, uterus or reproductive hormones are abnormal.

"Kegel exercises always cure it." Not necessarily. In a high-tone pelvic floor, learning relaxation and coordination may be more important than repeated strengthening.

"One herbal capsule can cure every patient." There is no reliable evidence supporting such a universal claim.

What Couples Should Avoid

During treatment, I particularly advise against repeated forced penetration, blaming the woman, threatening divorce or remarriage, involving family members in intimate details without the couple's consent, treating bleeding as proof of successful intercourse, repeatedly performing painful self-testing, taking sedatives or hormones without medical supervision, and buying unverified "vaginal opening" medicines or products online.

These actions can increase fear rather than resolve the underlying problem.

Treatment should create **safety and control**.

Can Vaginismus Return After Successful Treatment?

It can occasionally recur.

For example, a woman who previously recovered may develop pain again after:

childbirth, pelvic surgery, severe vaginal dryness, infection, menopause or another painful experience.

However, previous recovery often gives the patient valuable knowledge about:

pelvic-floor relaxation, gradual exposure, communication and fear management.

If symptoms return, the cause should be assessed rather than assuming that all previous progress has been lost.

Vaginismus Before a Gynecological Examination

Some women avoid medical care for years because they cannot tolerate a speculum examination.

I want such women to know:

You can tell your doctor before the examination that you have vaginismus or severe penetration anxiety.

A good clinician can adapt the examination.

Sometimes an external examination provides enough initial information.

Sometimes treatment can begin before any internal examination is attempted.

When an internal examination becomes necessary, it can be approached gradually with consent.

Your medical care should not become another traumatic experience.

Vaginismus and the First Night of Marriage

I want newly married couples to understand this particularly clearly.

There is **no medical rule that intercourse must be completed on the wedding night.**

The female sexual response requires:

comfort, privacy, emotional security, adequate arousal and sufficient lubrication.

If penetration becomes painful, stop.

Do not repeatedly try harder because someone has said:

“Pain is normal, just continue.”

Temporary mild discomfort can occur in some women during first intercourse, but severe pain or complete inability to tolerate penetration deserves understanding rather than force.

Taking pressure away from the first few sexual encounters can prevent a minor difficulty from developing into a persistent fear–pain cycle.

When Should You Seek Medical Help?

Seek professional evaluation when penetration repeatedly remains impossible, intercourse causes significant or recurrent pain, there is severe burning at the vaginal entrance, fear of penetration is becoming overwhelming, tampon or examination insertion is impossible and distressing, symptoms appeared after previously comfortable intercourse, vaginal dryness is significant, or the condition is preventing a couple from consummating marriage or trying naturally for pregnancy.

A woman should seek prompt medical assessment rather than assuming vaginismus if pain is accompanied by abnormal bleeding, unusual or foul-smelling discharge, fever, genital sores, a new lump or swelling, severe pelvic pain or other concerning symptoms.

These may suggest another condition requiring treatment.

Latest Research: What Does the Evidence Say in 2026?

Modern research increasingly favors a combined approach.

The 2026 *Journal of Sexual Medicine* systematic review and meta-analysis included 18 studies and 863 patients. Reported pooled treatment-success estimates were approximately 86% for combined psychosexual interventions, 82% for CBT, 85% for pelvic-floor physiotherapy, 85% for botulinum toxin and 78% for dilator therapy. However, the authors stressed that diagnostic criteria, outcome definitions and treatment protocols differed among studies. Therefore, these numbers should be understood as research estimates—not promises to individual patients.

A separate 2026 review similarly reported that multimodal approaches incorporating pelvic-floor therapy, psychological interventions and other individualized treatment currently appear most effective, while calling for better-quality trials, standardized protocols and longer follow-up.

A 2025 randomized controlled trial found that both dilator therapy alone and dilators combined with pelvic-floor biofeedback improved sexual function in women with primary vaginismus, with additional improvements in several measures in the biofeedback group.

These findings support the treatment philosophy I emphasize to patients:

Do not search only for one medicine. Treat the complete condition.

Dr. Nizamuddin Qasmi and the Saira Health Care Approach

I am **Dr. Nizamuddin Qasmi**, Founder and Chief Physician of **Saira Health Care**, with focused clinical practice in **sexual disorders and infertility**.

My professional education and training listed for this clinical work 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

Saira Health Care's public physician profile lists BUMS, MD, CGO, Certificate in Infertility and Certificate in Urology – London, UK, and describes my clinical focus in sexual disorders and infertility.

MasterHealthPro publicly lists its six-month **Male Infertility Masters** programme, with its curriculum covering male infertility, sexual dysfunction and exposure to female sexual-dysfunction topics.

My focused work in sexual disorders and infertility is relevant to vaginismus because this condition sits at the intersection of:

female sexual health, pelvic-floor function, psychological well-being, couple intimacy, painful intercourse, consummation difficulties and sometimes fertility planning.

Saira Health Care's Contribution to Sexual Disorders and Infertility

One of the most important challenges in sexual medicine is not lack of treatment.

It is lack of conversation.

Many patients live with sexual-health disorders for months or years because they feel too embarrassed to describe them.

A couple may spend money on fertility tests without mentioning that penetration has never occurred.

A woman may repeatedly tolerate painful intercourse because she believes pain is her duty.

A husband may believe his wife is deliberately refusing him.

A family may begin blaming either partner.

These misunderstandings can cause enormous emotional harm.

At **Saira Health Care**, our broader goal in sexual disorders and infertility is to provide a setting where patients can discuss intimate problems with:

privacy, dignity, respect and proper medical understanding.

Our approach emphasizes accurate diagnosis, individualized counselling, appropriate investigation, lifestyle assessment, responsible Unani treatment where suitable, evidence-based modern interventions where needed and specialist referral when a patient's condition requires expertise outside our scope.

Saira Health Care currently describes its clinical model as patient-centered and focused particularly on sexual disorders and infertility.

Why an Integrative Approach Is Particularly Suitable for Vaginismus

Vaginismus demonstrates why one-system-only thinking can sometimes be inadequate.

The pelvic floor is physical.

Pain is neurological and physical.

Fear is psychological.

Relationship pressure is social.

Sexual arousal is physiological and psychological.

Lifestyle can influence stress and general health.

Gynecological disease can initiate pain.

Previous painful experiences can condition the nervous system.

Therefore, effective treatment often requires more than one therapeutic perspective.

My philosophy is:

Use modern diagnosis to understand the problem accurately.

Use pelvic-floor rehabilitation when the muscles require retraining.

Use psychosexual or psychological treatment when fear, trauma or anxiety is important.

Treat gynecological disease when it is present.

Use appropriate Unani diet, lifestyle and individualized supportive treatment where it can contribute safely.

And never allow one system of treatment to delay necessary care from another.

That is responsible integrative medicine.

My Message to Women With Vaginismus

If you are experiencing vaginismus, I want you to remember:

Your vagina is probably not "broken."

Your body is not deliberately rejecting your partner.

You are not less feminine.

You are not automatically infertile.

You do not have to tolerate forced intercourse.

You do not have to prove anything by bleeding.

And you do not have to remain silent because the problem is sexual.

The pelvic-floor muscles can learn patterns of guarding.

They can also learn relaxation and control.

Fear can be conditioned.

It can also be reduced.

Pain can create avoidance.

When its cause is identified and treated properly, confidence can return.

For many women, vaginismus is a very treatable condition.

The most important first step is receiving the **correct diagnosis without judgement**.

Conclusion

Vaginismus is a genuine and often distressing sexual-health condition characterized by involuntary pelvic-floor tightening associated with attempted or anticipated vaginal penetration.

In current medicine, it is commonly understood within the broader category of **genito-pelvic pain/penetration disorder**.

The condition may be lifelong or acquired.

Its causes and maintaining factors can include:

painful sexual experiences, fear of pain, anxiety, insufficient arousal or lubrication, vaginal or vulvar disease, menopausal dryness, childbirth-related pain, pelvic surgery, endometriosis, pelvic-floor dysfunction, relationship difficulties, cultural fear and previous trauma.

Not every patient has every factor.

Therefore, treatment must be individualized.

Current evidence supports a multimodal approach involving:

sexual education, avoidance of forced penetration, pelvic-floor physiotherapy, progressive desensitization, vaginal dilators where appropriate, cognitive-behavioral therapy, psychosexual treatment, partner involvement and treatment of underlying gynecological or medical causes. Recent 2026 research particularly supports combining psychological and physical approaches rather than relying on a single intervention.

Unani medicine can contribute meaningfully within an integrative programme through its traditional emphasis on **Mizaj, Ilaj-bil-Ghiza, Ilaj-bil-Tadbir, individualized pharmacotherapy and the Asbab-e-Sitta Zarooriya**.

Its greatest value in vaginismus is as part of a whole-person approach addressing:

general health, nutrition, lifestyle, sleep, psychological well-being and associated health concerns.

However, responsible Unani treatment should not promise that a particular herb alone can cure involuntary pelvic-floor dysfunction, and it should not replace pelvic-floor physiotherapy, psychosexual care or gynecological treatment when these are medically required.

At **Saira Health Care**, my treatment philosophy for vaginismus can be summarized in a few words:

Understand before treating.

Find the cause of pain.

Remove fear rather than creating more fear.

Retrain the pelvic floor rather than forcing penetration.

Treat the woman and couple with dignity.

Use Unani medicine responsibly and individually.

Integrate modern diagnostic and therapeutic knowledge whenever necessary.

For me, the goal is not simply to make penetration mechanically possible.

The real goal is to help the woman achieve **comfortable, voluntary and confident sexual intimacy without fear or unnecessary pain**.

About the Author

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

Dr. Nizamuddin Qasmi's professional education and training listed for this clinical work include **BUMS from Hamdard University, Delhi; MD; CGO; Certificate in Infertility from MGBIMS, Delhi; Certificate in Urology – London, UK; Masters in Male Infertility from MasterHealthPro (HealthPro); and Integrated Sexual and Reproductive Health – ISRH, UNFPA.**

Saira Health Care's public profile describes Dr. Nizamuddin Qasmi's clinical work as focused on sexual disorders, infertility and reproductive-health concerns.

Medical Disclaimer

This article is intended for patient education and general health information. It is not a substitute for an individual medical consultation, examination, diagnosis or treatment plan.

Vaginismus and painful intercourse can have gynecological, muscular, neurological, psychological, hormonal, relationship-related and other causes. Treatment should therefore be individualized.

Do not force vaginal penetration as a treatment.

Do not use sedatives, hormonal medicines, anesthetic creams, herbal preparations or other medicines solely to overcome painful intercourse without appropriate professional advice.

Unani medicines should also be used under qualified supervision. Traditional or natural origin does not automatically mean that a medicine is suitable for every patient or free from adverse effects.

Patients with significant vaginal bleeding, abnormal discharge, genital sores, fever, severe pelvic pain, a new mass or swelling, persistent postmenopausal symptoms or another concerning medical problem should receive appropriate medical evaluation.

Where specialist pelvic-floor physiotherapy, gynecology, psychology, psychiatry, psychosexual therapy or another specialty is required, referral should form part of responsible treatment.