Painful Intercourse (Dyspareunia)

Causes, Symptoms, Diagnosis, Modern Treatment and the Unani Approach to Pain During Sexual Activity

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Introduction

Pain during sexual intercourse is a health problem that many people hesitate to discuss. In my clinical practice, I have seen patients continue to tolerate pain for months or even years because they feel embarrassed, believe that discomfort is a normal part of married life, or are afraid that discussing sexual pain will be misunderstood.

I want to begin with a very clear message: **repeated or severe pain during sexual intercourse should not simply be accepted as normal.**

The medical term most commonly used for painful intercourse is **dyspareunia**. It generally refers to recurrent or persistent genital or pelvic pain occurring just before, during or after sexual intercourse. The pain may be located at the vaginal opening, deeper inside the pelvis, in the external genital area or sometimes after intercourse has finished. Mayo Clinic describes dyspareunia as recurrent or lasting genital pain occurring before, during or after sexual activity.

Painful intercourse is particularly well studied in women. ACOG notes that nearly **three out of four women experience pain during intercourse at some point in their lives**, although for many it is temporary and for some it becomes persistent.

Men can experience painful sexual activity as well. Pain may come from the penis, testicles, prostate, pelvis or pelvic-floor muscles, or may occur particularly during ejaculation. Conditions such as infection, prostatitis, Peyronie's disease, pelvic-floor dysfunction and certain neurological or surgical problems can contribute.

At **Saira Health Care**, I approach painful intercourse as a symptom that requires us to find the underlying cause rather than simply giving a painkiller, aphrodisiac or so-called sexual-power medicine.

Sometimes the cause is relatively simple, such as insufficient lubrication. In another patient it may be vaginal dryness after menopause, pelvic-floor muscle spasm, infection, endometriosis, childbirth-related injury, vulvodynia, a sexually transmitted infection, chronic pelvic disease, psychological stress or a combination of several factors.

The correct treatment therefore starts with one question:

Why is intercourse painful for this particular patient?

What Is Dyspareunia?

Dyspareunia means pain associated with sexual intercourse or penetration.

The experience differs greatly from one person to another. Some patients feel pain only at the moment penetration begins. Some are comfortable initially but develop deep pelvic pain during intercourse. Others experience burning, throbbing or aching for several hours afterward.

A clinically useful way to describe dyspareunia is according to where and when the pain occurs.

Superficial or entry dyspareunia occurs around the vulva or vaginal opening when penetration starts. **Deep dyspareunia** is felt further inside the vagina or pelvis, particularly during deeper penetration. Pain may also be described as **primary** when it has existed since a person's first attempts at intercourse, or **secondary** when it begins after a period of previously comfortable sexual activity.

Knowing where the pain is felt gives the physician important clues.

Pain directly at the vaginal opening may suggest dryness, infection, pelvic-floor spasm, vulvodynia or a skin condition.

Deep pelvic pain raises different possibilities, including endometriosis, pelvic inflammatory disease, ovarian or uterine disorders, pelvic-floor dysfunction, bladder problems or adhesions.

Dyspareunia, Vaginismus and Genito-Pelvic Pain/Penetration Disorder

Patients frequently use the words dyspareunia and vaginismus as though they mean exactly the same thing. They are closely related but not identical.

Dyspareunia primarily describes pain.

Vaginismus traditionally describes involuntary tightening of muscles around the vaginal opening when penetration is attempted.

Modern diagnostic terminology may combine persistent penetration difficulty, pelvic-floor tightening, pain and significant fear or anxiety about penetration under the term **Genito-Pelvic Pain/Penetration Disorder (GPPPD)**.

The MSD Manual describes this disorder as involving vaginal penetration difficulty, involuntary pelvic-floor contraction, pain during attempted penetration and fear or anxiety associated with penetration.

A woman may therefore experience pain without marked vaginismus, vaginismus with severe fear of penetration, or both problems together.

This distinction matters because treatment for pelvic-floor spasm may be very different from treatment for an infection or menopausal dryness.

What Does Painful Intercourse Feel Like?

Patients describe the discomfort in many different ways.

Some tell me it feels like burning at the entrance of the vagina. Others describe a cutting, stinging or tearing sensation. Some experience pressure or cramping deep in the lower abdomen. Others notice severe muscle tightening as soon as penetration is attempted.

Pain may occur during insertion of a tampon or during a pelvic examination as well as during sexual intercourse. Mayo Clinic notes that symptoms can include entry pain, pain with any vaginal penetration, deep pain during thrusting, burning or aching, and throbbing that continues after intercourse.

An important part of my consultation is therefore what I sometimes describe to patients as making a **“pain map.”**

I want to know exactly where the pain begins, how it feels, what makes it worse and whether there are other symptoms.

That information is often more useful than simply knowing that “sex hurts.”

Common Causes of Painful Intercourse in Women

1. Inadequate Lubrication

Insufficient lubrication is one of the simplest and most common reasons for painful penetration.

Natural lubrication normally increases with sexual arousal. If penetration begins before adequate arousal has developed, friction can cause burning, irritation and pain.

This can happen because intimacy is rushed, there is inadequate stimulation, the woman feels anxious, or there is difficulty becoming aroused.

Hormonal changes can also reduce lubrication even when desire is present.

ACOG and Mayo Clinic both recognize reduced lubrication as an important cause of painful intercourse.

In these cases, more time for comfortable arousal and an appropriate lubricant can be surprisingly helpful.

However, persistent dryness should not automatically be attributed to inadequate foreplay. Hormonal and medical causes must also be considered.

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2. Vaginal Dryness After Menopause

This is one of the most important causes I see in middle-aged and older women.

As estrogen levels decrease during perimenopause and menopause, vaginal tissue may become thinner, less elastic and less naturally lubricated.

This group of changes is now commonly called **Genitourinary Syndrome of Menopause, or GSM**.

GSM may cause vaginal dryness, burning, itching, reduced lubrication, bleeding after intercourse, urinary symptoms and painful sex.

The 2026 Indian Menopause Society guideline also emphasizes that dyspareunia is an important sexual-health concern among midlife women and that sexual dysfunction in this period is often multifactorial, involving hormonal, psychological, medical and relationship factors.

Women should not be told that painful intercourse after menopause is simply part of getting older and must be tolerated.

Effective treatment is available.

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3. Breastfeeding and the Postpartum Period

A woman may experience pain during intercourse after childbirth for several reasons.

Breastfeeding can temporarily lower estrogen and reduce vaginal lubrication. Vaginal birth may also result in tears, an episiotomy, scar sensitivity or pelvic-floor injury.

ACOG notes that women who experience perineal tears or episiotomy during childbirth may continue to experience pain during intercourse for months, and treatment may include physical therapy, medicines or occasionally surgery depending upon the cause.

This is particularly important for new mothers because tiredness, hormonal changes, breastfeeding, fear of pain and the demands of caring for a baby may occur simultaneously.

A postpartum woman should not be pressured to resume painful intercourse simply because a certain number of weeks have passed since delivery.

Healing is individual.

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4. Vaginal and Vulval Infections

Inflammation caused by infection can make the genital tissues sensitive and painful.

Yeast infections, bacterial vaginosis and some sexually transmitted infections may cause pain together with itching, burning, discharge or genital irritation.

For example, trichomoniasis can produce abnormal vaginal discharge, vulval irritation and painful intercourse.

Sexually transmitted infections such as genital herpes can also cause painful sores or ulceration.

This is why pain accompanied by unusual discharge, foul odor, genital sores or urinary burning should not be treated simply with a sexual-health tonic.

The infection must be properly identified and treated.

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5. Pelvic Inflammatory Disease

Pelvic inflammatory disease, or **PID**, is an infection and inflammation involving the upper female reproductive tract.

Some cases are caused by sexually transmitted infections such as chlamydia or gonorrhoea.

Pain during intercourse, particularly deeper pelvic pain, may be one of its symptoms. Other possible signs include lower abdominal pain, abnormal discharge, fever and irregular bleeding.

PID deserves special attention in an infertility clinic because untreated disease can damage the fallopian tubes.

The CDC notes that even mild or unrecognized PID can be associated with future infertility.

This is why I take deep sexual pain accompanied by discharge, pelvic tenderness or fever seriously.

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6. Endometriosis

Endometriosis is an important cause of deep pain during intercourse.

In endometriosis, tissue similar to the lining of the uterus occurs outside the uterus and may lead to inflammation, adhesions and chronic pelvic pain.

ACOG lists pain during sexual intercourse as one of the recognized symptoms of endometriosis. The condition may also cause painful menstruation, chronic pelvic pain, bowel or bladder symptoms and infertility in some women.

An important 2026 development is that ACOG published updated clinical guidance aimed at improving and shortening the diagnosis of endometriosis, reflecting growing recognition that many patients wait too long for appropriate evaluation.

If a woman has deep intercourse pain together with progressively painful periods or fertility difficulty, endometriosis deserves consideration.

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7. Pelvic-Floor Muscle Dysfunction

The pelvic floor is a group of muscles supporting pelvic organs.

For comfortable penetration, these muscles need to relax appropriately.

In some people, pelvic-floor muscles remain excessively tight or contract involuntarily. Penetration then becomes painful or sometimes impossible.

This may occur with vaginismus, after previous painful experiences, following childbirth or surgery, or alongside chronic pelvic pain.

Pelvic-floor physical therapy is an important evidence-based treatment. The MSD Manual notes that pelvic-floor physiotherapy is useful for many women with genito-pelvic pain/penetration disorder.

This point is important because patients sometimes repeatedly take medicines when the main problem is muscular.

In such cases, medication alone may never fully solve the problem.

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8. Vulvodynia and Vulval Pain Disorders

Some women experience chronic pain or burning around the vulva despite there being no obvious infection.

This condition may be called **vulvodynia**.

When pain is particularly triggered by touching the vaginal entrance, including during attempted intercourse, the condition may be described as provoked vestibulodynia.

The pain can be intense even with relatively light contact.

Vulvodynia often requires a multidisciplinary approach that may include pelvic-floor therapy, local treatment, pain management and psychological support depending upon the individual patient.

Repeated antifungal treatment without confirming infection is unlikely to help such a patient.

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9. Vulval Skin Disorders and Irritation

Pain may also come from the external genital skin.

Dermatitis, lichen sclerosus and other vulval skin conditions can cause cracking, burning, itching and pain during intercourse.

Even irritating products such as perfumed soaps, vaginal douches and fragranced personal-care products can contribute.

ACOG lists skin disorders and contact irritation among causes of pain during intercourse.

In these situations, correct dermatological or gynecological diagnosis can be much more useful than repeated sexual-health medicines.

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10. Ovarian, Uterine and Pelvic Conditions

Deep intercourse pain can sometimes be related to conditions affecting structures further inside the pelvis.

Possible causes include ovarian cysts, uterine fibroids, adenomyosis, pelvic adhesions, bladder disorders and certain bowel conditions.

ACOG specifically identifies endometriosis, pelvic inflammatory disease and adhesions among gynecological causes of painful intercourse.

The location of pain, menstrual symptoms, bowel and urinary symptoms, previous surgery and pelvic examination can help distinguish these conditions.

Emotional and Psychological Factors

Painful intercourse is not “all in the mind,” but the mind and body strongly influence one another.

Fear, anxiety, past trauma, stress, depression, shame, relationship conflict and performance pressure can all affect sexual response.

If someone expects penetration to hurt, the pelvic-floor muscles may tighten automatically. The tighter the muscles become, the more painful penetration becomes.

The next attempt is then approached with even greater fear.

This can create what I explain to patients as the **pain–fear–muscle tightening–more pain cycle**.

ACOG recognizes fear, shame, stress, fatigue, relationship problems and past traumatic experiences as factors that may contribute to painful sexual activity.

Appropriate counselling, cognitive behavioural approaches, trauma-informed therapy or sex therapy may therefore be important parts of treatment for selected patients.

This does not mean that physical causes should be ignored.

Very often, physical and psychological factors exist together.

Painful Intercourse in Men

Although the word dyspareunia is commonly discussed in women's health, men can also experience pain associated with sexual intercourse.

A man may feel pain in the head or shaft of the penis, foreskin, testicles, pelvis or during ejaculation.

Possible causes include penile skin inflammation, phimosis or foreskin problems, sexually transmitted infections, urinary infections, prostatitis, chronic pelvic pain syndrome, pelvic-floor dysfunction, nerve problems or previous surgery.

Peyronie's disease can cause painful erections and penile curvature, making intercourse uncomfortable or difficult.

Some men primarily experience pain at ejaculation rather than during penetration. Current medical terminology includes **painful ejaculation, odynorgasmia or dysorgasmia**. Causes may include prostatitis, ejaculatory-duct obstruction, STIs, pelvic-floor dysfunction, neurological conditions and occasionally side effects of medicines.

For this reason, a man who experiences repeated sexual pain should undergo appropriate urological or sexual-health assessment rather than simply taking erectile-dysfunction medicines.

Is Erectile Dysfunction a Cause of Painful Intercourse?

Not directly in every case, but the two conditions can interact.

A man who repeatedly loses his erection may become anxious and try to continue penetration despite inadequate firmness. This can create friction and discomfort for both partners.

Similarly, if the female partner has severe pain, the male partner may develop performance anxiety or erectile difficulty.

Therefore, in a couple presenting with painful intercourse, I sometimes need to assess the sexual health of **both partners**.

This is particularly relevant in my clinical work in sexual disorders and infertility.

How I Diagnose Painful Intercourse

Diagnosis should begin with conversation, not with a prescription.

I ask when the pain began, whether intercourse was previously comfortable, exactly where pain occurs, whether it happens every time, whether the pain is burning, sharp or cramping, whether penetration itself is difficult, and whether symptoms continue afterward.

I also ask about vaginal dryness, menstrual symptoms, abnormal discharge, urinary problems, childbirth history, menopause, surgery, medications, contraception, fertility concerns, previous infections and emotional factors.

A respectful sexual history is important.

Depending upon the patient's symptoms, examination may include inspection of the vulva, gentle assessment of tender areas, pelvic examination and evaluation of pelvic-floor muscles.

Ultrasound can be useful when deeper pelvic pathology is suspected. Tests for vaginal infection or sexually transmitted infection may also be necessary.

Mayo Clinic and ACOG both emphasize detailed medical history, pelvic examination and selective investigations such as ultrasound in evaluating dyspareunia.

Most importantly, the examination should be performed respectfully and with the patient's consent.

A patient has the right to ask for an examination to stop if it becomes excessively painful.

Treatment of Painful Intercourse

There is **no single universal medicine for dyspareunia**.

Treatment must target the cause.

A woman whose pain is caused by vaginal dryness needs a different approach from someone with Candida infection.

A woman with pelvic-floor spasm requires different treatment from one with endometriosis.

A man with prostatitis requires different treatment from one with Peyronie's disease.

That is why diagnosis comes first.

Lubricants and Moisturizers

When insufficient lubrication contributes, an appropriate lubricant can reduce friction and discomfort.

WHO recommends making lubricants available for optional use during sexual activity and notes that they can be particularly helpful for people experiencing vaginal dryness or dyspareunia.

Water-based lubricants are widely used, while silicone-based lubricants generally last longer.

Oil-based products can interfere with latex condoms and therefore require caution.

For women with ongoing vaginal dryness rather than dryness only during intercourse, a vaginal moisturizer may also help. ACOG distinguishes moisturizers, which provide ongoing moisture, from lubricants used mainly to reduce friction during sexual activity.

Treatment of Menopausal Vaginal Dryness

If painful intercourse is caused by Genitourinary Syndrome of Menopause, treatment should address the underlying vaginal tissue changes.

For suitable patients, **local vaginal estrogen** can be very effective.

ACOG notes that vaginal estrogen may be given as a cream, ring or tablet and is used for symptoms such as dryness and painful sexual intercourse.

ACOG's November 2025 guidance also notes that topical estrogen for vulvovaginal dryness and painful intercourse often improves symptoms within several weeks and may be continued long term when medically appropriate.

Another prescription option in selected postmenopausal women is **ospemifene**, an oral selective estrogen receptor modulator approved in some jurisdictions for moderate-to-severe dyspareunia associated with menopausal vaginal changes.

Hormonal treatment is not appropriate for every woman, particularly without consideration of medical and cancer history.

It should therefore be individualized.

Treating Infections

If Candida, bacterial infection or an STI is responsible, the appropriate antimicrobial treatment is required.

No amount of lubrication or aphrodisiac medicine will eliminate a genuine infection.

In patients with suspected STI-related pelvic inflammatory disease, prompt treatment is particularly important because reproductive damage can occur even when symptoms are not dramatic.

Where an STI is identified, sexual partner testing or treatment may also be necessary.

Pelvic-Floor Physiotherapy

For pelvic-floor spasm, vaginismus and many forms of genito-pelvic pain, specialized pelvic-floor physical therapy can be extremely valuable.

Treatment may include learning how to recognize and relax pelvic-floor muscles, breathing techniques, gentle manual therapy, gradual desensitization and, when appropriate, carefully supervised vaginal dilators.

ACOG lists pelvic-floor physical therapy and dilator treatment among options for sexual pain and penetration difficulty.

This is quite different from simply advising a woman to “try harder” to tolerate penetration.

Painful penetration should never be forced.

Counselling and Sex Therapy

When fear, previous trauma, anxiety or relationship problems are contributing, counselling can help break the cycle of pain and fear.

Individual psychotherapy, cognitive behavioural therapy, couples counselling and sex therapy may all be appropriate in selected cases.

The aim is not to tell the patient that the pain is imaginary.

Rather, psychological treatment addresses the very real interaction between the nervous system, muscle tension, emotional memory and sexual response.

For some patients, the best results come from combining medical treatment, pelvic-floor therapy and psychological support.

Endometriosis and Other Pelvic Disease

When endometriosis is the cause, treatment may include medical therapy, pain treatment and, when appropriate, surgery.

The plan depends upon symptom severity and whether pregnancy is desired.

This is especially important in an infertility clinic because endometriosis can affect both sexual comfort and reproductive function.

Fibroids, ovarian pathology, pelvic adhesions and other disorders similarly require condition-specific treatment.

Painful Intercourse According to Unani Medicine

When discussing dyspareunia from a Unani perspective, I prefer to be medically and historically precise.

Classical Unani physicians did not necessarily describe the modern diagnosis **“dyspareunia”** as one single disease corresponding exactly to today's terminology.

However, Unani literature discusses disorders involving pelvic and uterine pain under concepts such as **Auja al-Rahim or Dard-e-Rahim**, disturbances of uterine temperament or **Su'-e-Mizaj al-Rahim**, inflammation, obstruction and other reproductive disorders.

Classical discussions of uterine and pelvic pain describe multiple possible causes rather than one universal mechanism. A review of Unani literature on uterine pain cites classical physicians such as Ibn Sina, Al-Majusi and others discussing altered uterine temperament, inflammation, ulceration, obstruction, postpartum conditions and other pelvic disorders as possible causes of uterine pain.

These historical concepts are useful for understanding the Unani framework, but they should **not be treated as exact scientific equivalents of modern diagnoses such as endometriosis, vaginismus, vulvodynia or pelvic inflammatory disease**.

The Four Humours in Unani Medicine

Classical Unani medicine recognizes four principal humours:

Dam — blood, Balgham — phlegm, Safra — yellow bile and Sauda — black bile.

Health is traditionally understood in relation to the qualitative and quantitative balance of these humours along with Mizaj, organ function and other natural factors.

Depending on the patient's constitution and symptoms, a Unani physician may consider whether dryness, excessive coldness, heat, inflammation, weakness, muscular tension or another pattern is dominant.

However, I do not tell patients that every case of painful intercourse is caused by a “humoral imbalance.”

A woman with laboratory-confirmed trichomoniasis has an infection.

A woman with endometriosis has a specific gynecological disorder.

A woman with pelvic-floor hypertonicity requires muscular and neurological assessment.

Traditional concepts can guide individualized supportive treatment, but they should not be used to obscure a clear modern diagnosis.

Asbab-e-Sitta Zarooriya: Why Lifestyle Still Matters

One of the most useful aspects of Unani medicine is the importance given to the **Asbab-e-Sitta Zarooriya**, or six essential factors of health.

These traditionally include air and environment, food and drink, physical movement and rest, mental activity and rest, sleep and wakefulness, and appropriate retention and elimination.

These concepts have considerable relevance to sexual health.

A patient who is continuously exhausted, sleeps poorly, experiences severe anxiety and has chronic digestive or metabolic problems may have more difficulty achieving comfortable sexual arousal.

Stress can increase pelvic-floor muscle tension.

Poor sleep can worsen pain perception and mood.

Sedentary behaviour and chronic illness can influence general well-being.

Unani medicine therefore encourages us to look beyond the genital organs alone.

Ilaj-bil-Ghiza — Dietary Management

Dietotherapy, or **Ilaj-bil-Ghiza**, is an established principle within Unani medicine.

The aim is not to claim that a particular food will “cure painful intercourse.”

Instead, food is selected according to general health, nutritional status, temperament and associated disease.

A patient with diabetes, obesity, anemia or chronic weakness may require a different dietary plan from a healthy young woman whose main problem is pelvic-floor spasm.

Research on Unani principles describes dietotherapy as modification of the type, quality or quantity of food according to the patient's condition.

I consider dietary management supportive rather than a substitute for diagnosing the actual source of genital or pelvic pain.

Ilaj-bil-Tadbir — Lifestyle and Regimental Care

Ilaj-bil-Tadbir, or regimental treatment, allows the physician to consider daily routine, physical activity, sleep, emotional strain and other factors that influence health.

For sexual pain, relaxation and reduction of excessive mental stress may be particularly useful when anxiety and pelvic-floor tension are involved.

However, a patient with severe vaginismus may still require specialist pelvic-floor physiotherapy.

A patient with vulvodynia may need pain-focused management.

A patient with infection requires antimicrobial treatment.

Therefore, Unani lifestyle therapy is most useful when incorporated into a rational overall plan.

Ilaj-bil-Dawa — Individualized Unani Medicines

Unani pharmacotherapy includes single and compound medicines selected according to the individual's Mizaj, symptoms and associated condition.

I do not recommend one fixed “dyspareunia medicine” for every patient.

I also advise patients not to insert homemade herbal oils, powders or preparations into the vagina without professional guidance.

Sensitive genital tissues can develop irritation, allergy or infection when inappropriate products are used.

Similarly, simply giving Ashwagandha, Safed Musli or another vitality-promoting herb to every patient with painful intercourse is not rational treatment.

Pain is not always caused by weakness.

Sometimes the patient needs lubrication.

Sometimes she needs treatment for infection.

Sometimes she needs pelvic-floor therapy.

Sometimes she needs endometriosis evaluation.

Sometimes a male partner needs urological treatment.

The medicine must follow the diagnosis.

What Does Scientific Evidence Say About Unani Treatment for Dyspareunia?

This is an area where I believe honesty is particularly important.

There is a respectable body of traditional Unani literature concerning gynecological disorders, uterine pain, temperament and reproductive health, and the Central Council for Research in Unani Medicine continues to support research into gynecological and sexual disorders. In its current 2026–27 research priorities, CCRUM specifically includes **gynecological disorders and sexual disorders** among areas for scientific investigation.

However, **high-quality modern clinical trials specifically testing Unani medicines for dyspareunia itself remain limited**.

Therefore, I would not tell a patient that Unani medicine has a scientifically proven fixed cure rate for all painful intercourse.

What Unani medicine can provide particularly well is an individualized framework addressing Mizaj, diet, sleep, emotional state, physical activity, general vitality and associated reproductive problems.

When an appropriate traditional medicine is indicated, it can be incorporated responsibly.

When a modern treatment is clearly necessary, it should not be delayed.

This is the approach I prefer in contemporary Unani practice.

My Specialized Approach at Saira Health Care

When a patient consults me at **Saira Health Care** for painful intercourse, I do not begin by assuming that the problem is “sexual weakness.”

My approach is based on identifying the cause first.

I begin by determining whether the pain is at the vaginal entrance, deep inside the pelvis, around the vulva, during ejaculation in a man, or after intercourse.

I then assess lubrication, arousal, pelvic-floor tension, menstrual symptoms, menopause, childbirth history, infections, urinary symptoms, medications, psychological stress and relationship circumstances.

If necessary, appropriate gynecological, urological or laboratory investigations are advised.

Alongside this clinical assessment, as a Unani physician I consider the patient's **Mizaj, general physical strength, diet, digestion, sleep, stress, activity and reproductive health**.

Treatment is then individualized.

For one woman, the most important intervention may be management of menopausal vaginal dryness.

For another, it may be pelvic-floor physiotherapy.

For a third, it may be treatment of infection.

For another patient, endometriosis evaluation may be required.

In a man, we may need to evaluate prostatitis, penile curvature, infection, pelvic-floor dysfunction or painful ejaculation.

This individualized integration is what I consider the most responsible meaning of a **specialized Unani approach to sexual disorders**.

Why I Do Not Treat Every Patient With an Aphrodisiac

This is especially important in sexual medicine.

Patients often assume that if intercourse is painful, their body is “weak” or sexual power is reduced.

But an aphrodisiac does not treat a pelvic infection.

It does not correct severe vaginal dryness caused by low estrogen.

It does not relax a hypertonic pelvic floor.

It does not remove endometriosis.

It does not treat Peyronie's disease in a man.

A sexual-health physician should therefore resist the temptation to reduce every intimate problem to “strength.”

I believe the most effective treatment begins with **diagnostic clarity**.

Painful Intercourse and Infertility

Dyspareunia itself does not necessarily cause infertility.

However, some conditions that cause painful intercourse can also affect fertility.

Endometriosis is one example.

Pelvic inflammatory disease is another. Untreated PID can cause fallopian-tube scarring and infertility. The CDC reports that approximately **one in eight women with a history of PID experience difficulty becoming pregnant**.

Pain may also reduce the frequency of intercourse, especially around the fertile period, which can indirectly make conception more difficult.

In men, certain infections, prostatitis, ejaculatory problems or other reproductive disorders may sometimes affect sexual comfort and fertility simultaneously.

Because I work with both **sexual disorders and infertility**, I consider these connections particularly important.

If a couple is having difficulty conceiving, investigation should include the reproductive health of both partners rather than assuming that painful intercourse is the only problem.

Psychological Effects and Relationship Complications

Persistent sexual pain can affect much more than the body.

A person may begin avoiding intimacy because they expect pain.

Their partner may misinterpret this avoidance as emotional rejection or loss of attraction.

Fear can increase before each sexual encounter.

The person experiencing pain may develop frustration, guilt, low confidence, anxiety or depressive symptoms.

Cleveland Clinic recognizes loss of intimacy, relationship strain, anxiety and depression among possible consequences of persistent dyspareunia.

One of the most helpful changes couples can make is to stop treating intercourse as a test of performance.

Pain should be communicated, not hidden.

No partner should be expected to tolerate painful penetration to prove love, fertility or marital commitment.

Common Myths About Painful Intercourse

"Pain during the first intercourse is always normal." Mild temporary discomfort can occur, but severe pain, repeated inability to tolerate penetration or persistent bleeding should not automatically be considered normal.

"A woman who experiences pain simply needs to relax." Relaxation can help when anxiety contributes, but pain may arise from genuine gynecological, muscular, hormonal or infectious conditions.

"Pain means the vagina is too small." Usually this is not the correct explanation. Pelvic-floor tightening, insufficient lubrication, fear, infection and other causes are more common.

"Men cannot have dyspareunia." Men can experience pain during sexual activity, erections, penetration or ejaculation.

"A sexual-power medicine will solve the problem." Not when the underlying cause is infection, vaginal dryness, endometriosis, pelvic-floor dysfunction or another specific disorder.

"Pain after menopause is unavoidable." No. GSM is common, but lubricants, moisturizers and appropriate prescription treatments can substantially improve symptoms.

When Should You Consult a Doctor?

Please seek professional evaluation if you have **recurrent or severe pain during sexual activity; inability to tolerate penetration; unexplained bleeding during or after intercourse; unusual or foul-smelling vaginal or penile discharge; genital sores or significant itching; fever with pelvic pain; persistent lower abdominal pain; painful or swollen testicles; blood in urine or semen; severe pain during ejaculation; new pain after menopause; pain together with progressively worsening menstrual symptoms; or painful intercourse associated with infertility concerns**.

Women with lower abdominal pain, fever, abnormal discharge and pain during sex require particularly careful evaluation for infection or PID.

Sudden severe pelvic or testicular pain also warrants urgent assessment.

Frequently Asked Questions

Is painful intercourse common?

Yes. It is especially common among women. ACOG states that nearly three out of four women experience pain with intercourse at some time, although persistent pain requires evaluation.

Can vaginal dryness cause dyspareunia?

Yes. Insufficient lubrication is one of the common causes. It may result from inadequate arousal, menopause, breastfeeding, medications or other hormonal factors.

Can endometriosis cause painful sex?

Yes. Deep pain during intercourse is a recognized symptom of endometriosis, particularly when accompanied by painful menstruation or chronic pelvic pain.

Can infection cause pain during intercourse?

Yes. Vaginitis, some sexually transmitted infections and pelvic inflammatory disease can cause painful intercourse.

Can stress cause painful intercourse?

Stress and anxiety can increase pelvic-floor tension and interfere with arousal and lubrication. However, physical causes should still be assessed rather than automatically assuming the problem is psychological.

Is vaginismus treatable?

Yes. Management may include education, pelvic-floor physical therapy, relaxation techniques, gradual dilator therapy and psychological or sex therapy depending on the patient's condition.

Can pelvic-floor therapy help?

Yes. It is an important treatment when pelvic-floor muscle overactivity contributes to painful penetration.

Can men experience pain during sex?

Yes. Causes can include infection, prostatitis, pelvic-floor dysfunction, Peyronie's disease, penile conditions and painful ejaculation.

Can painful intercourse cause infertility?

Pain itself usually does not directly cause infertility. However, underlying conditions such as endometriosis or PID may affect fertility, and severe pain may reduce the frequency of intercourse.

Is Unani medicine useful for painful intercourse?

An individualized Unani approach can be valuable as part of comprehensive care by addressing Mizaj, nutrition, sleep, stress, lifestyle and associated reproductive or sexual-health concerns. However, direct high-quality clinical evidence for Unani treatment of dyspareunia remains limited, and specific conditions such as infections, endometriosis, severe GSM or pelvic-floor dysfunction require appropriate condition-specific management.

Can I use herbal oil inside the vagina for pain?

I do not advise inserting an unverified herbal oil or homemade preparation without professional assessment. Genital tissues are sensitive, and inappropriate substances may cause irritation or infection.

Can painful intercourse be successfully treated?

In many patients, yes. The chance of improvement depends largely on identifying the correct cause and choosing the appropriate combination of treatment.

The Contribution of Saira Health Care in Sexual Disorders and Infertility

At **Saira Health Care**, our continuing work in the field of **sexual disorders and infertility** is based on the principle that intimate-health problems deserve the same seriousness and clinical respect as any other medical condition.

Many patients come to us only after trying multiple medicines because they were too embarrassed to explain the actual problem.

Some women have repeatedly taken infection medicines despite having pelvic-floor dysfunction.

Some have been told that pain is simply part of marriage.

Some couples experiencing infertility have continued painful intercourse for months without recognizing an underlying gynecological condition.

My aim through Saira Health Care is to create an environment where patients can discuss problems such as painful intercourse, vaginismus, vaginal dryness, reduced sexual desire, erectile dysfunction, ejaculation problems and infertility in a confidential and professional manner.

The focus is on **understanding the cause, individualizing treatment, using appropriate Unani principles, providing lifestyle and sexual-health guidance and recommending modern investigations or specialist care whenever required**.

That integrated approach is particularly important in sexual medicine because pain, hormones, emotions, pelvic-floor function, fertility and the relationship between partners frequently influence one another.

About Dr. Nizamuddin Qasmi

I am **Dr. Nizamuddin Qasmi, Founder and Chief Physician of Saira Health Care**, with a focused clinical practice in **Sexual Disorders & Infertility**.

My professional training includes **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 through ISRH, UNFPA**.

In sexual-health practice, I believe the most important qualities are clinical knowledge, confidentiality, patience and the ability to listen without making the patient feel uncomfortable.

Painful intercourse is a perfect example of why that matters.

A patient may take several minutes before she feels comfortable explaining exactly where intercourse hurts.

A man may hesitate to tell the doctor that ejaculation is painful.

A couple may be struggling with both intercourse pain and infertility.

Unless we listen carefully, we may treat the wrong problem.

A Personal Message From Dr. Nizamuddin Qasmi

If intercourse is painful for you, please do not assume that you have to tolerate it.

Pain is your body's way of telling you that something deserves attention.

Sometimes we discover a very manageable problem such as inadequate lubrication.

Sometimes the problem is hormonal vaginal dryness.

Sometimes it is pelvic-floor muscle tightening.

Sometimes an infection is responsible.

Sometimes we need to investigate endometriosis or another pelvic disorder.

And sometimes emotional stress and fear have become part of a cycle that keeps the pain going even after the original physical problem has improved.

In men, we may find prostatitis, pelvic-floor dysfunction, penile curvature, infection or painful ejaculation.

This is why I do not believe in prescribing the same medicine for every patient.

The Unani system of medicine gives us a valuable tradition of **individualized assessment through Mizaj, lifestyle, diet and whole-body health**. Modern sexual medicine gives us increasingly precise ways to diagnose hormonal, muscular, infectious and gynecological causes.

When these are used responsibly, the patient benefits from a more complete understanding of the problem.

My clinical principle is simple:

Do not treat painful intercourse as a test of sexual strength. Find the cause, reduce the pain, restore comfort and protect the patient's overall sexual and reproductive health.

Conclusion

Painful intercourse, medically known as **dyspareunia**, is not one single disease.

It is a symptom with many possible causes.

In women, important causes include vaginal dryness, Genitourinary Syndrome of Menopause, inadequate lubrication, infection, pelvic inflammatory disease, endometriosis, pelvic-floor dysfunction, vaginismus, vulvodynia, childbirth-related injury and emotional or relationship factors.

Men may experience sexual pain because of infection, prostatitis, Peyronie's disease, pelvic-floor dysfunction, neurological conditions or painful ejaculation.

Modern treatment is cause-specific and may involve lubricants, vaginal moisturizers, hormonal treatment in suitable menopausal women, infection treatment, pelvic-floor physiotherapy, counselling, treatment of endometriosis or other gynecological disease, and appropriate urological treatment in men.

From the Unani perspective, the patient can be understood through **Mizaj, Akhlat, organ function, Asbab-e-Sitta Zarooriya, Ilaj-bil-Ghiza, Ilaj-bil-Tadbir and individualized Ilaj-bil-Dawa**. These traditional principles can be particularly useful for comprehensive lifestyle and constitutional management, but they should be used alongside appropriate investigation rather than as a replacement for diagnosis.

At **Saira Health Care**, my approach is to combine careful sexual and reproductive-health assessment with individualized Unani care and appropriate modern evaluation.

Pain during intimacy should never be dismissed simply because it is difficult to talk about.

It deserves diagnosis.

It deserves compassionate treatment.

And in many patients, once the underlying causes are identified, **substantial improvement in comfort, confidence, intimacy and quality of life is possible.**

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

Visit Saira Health Care

Medical Disclaimer: This article is intended for general patient education and health awareness. It does not replace an individualized medical examination or diagnosis. Persistent or severe pelvic or genital pain, fever, unexplained bleeding, abnormal discharge, suspected sexually transmitted infection, pregnancy-related pain or acute testicular pain should receive prompt medical evaluation. Hormonal, antimicrobial, herbal and intravaginal medicines should not be started solely on the basis of online information.