Pain During Intercourse in Women (Dyspareunia): Causes, Diagnosis, Treatment, Home Care and the Unani Perspective

Understanding Vaginal Pain, Painful Penetration, Vaginal Dryness, Pelvic-Floor Spasm, Infection, Endometriosis and Genito-Pelvic Pain/Penetration Disorder

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Introduction

One of the most important things I tell women who come to me with pain during sexual intercourse is:

"Pain is not something you are expected to tolerate simply because you are a woman or because you are married."

Some women experience burning at the vaginal opening. Others describe tightness that makes penetration difficult or impossible. Some feel dryness and friction, while others experience a deep pelvic pain only when penetration becomes deeper. A woman may have enjoyed intercourse comfortably for years and suddenly develop pain after childbirth, during menopause, following an infection or because of another pelvic condition.

All of these experiences are often grouped under the medical term **dyspareunia**, meaning recurrent or persistent pain associated with sexual intercourse or penetration.

The research material prepared for this article appropriately describes dyspareunia as a multifactorial sexual-pain problem that can substantially affect physical health, psychological wellbeing, intimacy and relationships.

Painful intercourse is common. ACOG notes that nearly **three out of four women experience pain during intercourse at some point in life**, although for many it is temporary and for others it becomes persistent. Frequent or severe pain should be assessed rather than simply accepted.

From my perspective as a physician focused on sexual disorders and infertility, the key principle is:

Dyspareunia is a symptom, not one single disease.

The correct treatment depends on finding out **where the pain occurs, when it occurs and why it occurs**.

What Is Dyspareunia?

Dyspareunia means pain related to sexual intercourse or attempted penetration.

The pain may occur:

before penetration, at the vaginal opening, inside the vagina, deep in the pelvis, during intercourse or for some time afterwards.

Modern sexual-medicine terminology also includes **Genito-Pelvic Pain/Penetration Disorder (GPPPD)**, a broader diagnostic concept combining persistent difficulty with vaginal penetration, pain, fear or anxiety about penetration and/or involuntary tightening of the pelvic-floor muscles. The supplied source correctly highlights this relationship between dyspareunia, vaginismus and GPPPD.

However, these terms should not be treated as completely interchangeable.

Dyspareunia can be a symptom caused by a specific medical condition such as endometriosis or vaginal dryness, while GPPPD describes a more persistent sexual-pain pattern involving pain, penetration difficulty, fear and/or pelvic-floor tightening.

Painful Intercourse Is Not "All in the Mind"

I want to emphasize this because many women have been dismissed with statements such as:

"Just relax."

"You are thinking too much."

"It happens to every woman."

That approach can be harmful.

Sexual pain can arise from genuine physical conditions involving the vulva, vaginal tissues, pelvic-floor muscles, bladder, uterus, ovaries or other pelvic structures.

At the same time, fear and anxiety can intensify an existing physical problem.

A modern approach therefore considers **both physical and psychological factors without assuming that one excludes the other**.

A major 2026 review reinforces this biopsychosocial approach, recommending that clinicians distinguish superficial from deep pain and assess vulvar, vestibular, pelvic-floor, inflammatory, urinary and psychological contributors rather than treating all dyspareunia identically.

The Two Main Patterns: Entry Pain and Deep Pain

The location of the pain gives me one of the first important clues.

Superficial or Entry Dyspareunia

This means the pain is felt mainly:

at the vulva, around the vaginal opening or during initial penetration.

Common causes include vaginal dryness, inadequate lubrication, vaginitis, vulvar skin disease, vulvodynia, childbirth scars and pelvic-floor muscle tightening.

The research material supplied for this article similarly distinguishes superficial pain from deep and positional forms.

Deep Dyspareunia

Deep dyspareunia is felt farther inside the pelvis, particularly during deeper penetration.

Women may describe it as:

“It feels as though something inside is being hit.”

Potential causes include endometriosis, adenomyosis, pelvic inflammatory disease, some ovarian cysts, fibroids, adhesions and other pelvic conditions.

The supplied research appropriately identifies several of these causes when discussing deep or “collision” pain.

A woman with deep pain therefore needs a different evaluation from someone whose main symptom is burning at the vaginal entrance.

Positional Pain

Some women are comfortable in one sexual position but experience significant pain in another.

That can occur because the depth and direction of penetration change.

Positional pain can be associated with:

pelvic-floor tenderness, endometriosis, pelvic adhesions or another deep pelvic condition.

Changing position may reduce symptoms, but persistent pain still deserves assessment because avoiding one position does not identify the underlying cause.

Primary and Secondary Dyspareunia

Another useful distinction is whether the pain has always been present.

Primary or lifelong dyspareunia begins from the first attempts at penetration.

Secondary or acquired dyspareunia develops after a period when intercourse was previously comfortable.

If a woman tells me:

"Intercourse was completely normal for five years, but pain started six months ago,"

I become particularly interested in recent changes such as:

childbirth, menopause, infection, surgery, medication, endometriosis symptoms or pelvic disease.

Vaginal Dryness: One of the Most Common Causes

Insufficient lubrication increases friction between tissues.

The result may be:

burning, soreness, tearing sensations or pain at penetration.

Dryness can occur because of inadequate arousal, but it can also have physical causes.

A woman should therefore never automatically be told:

"You are dry because you are not attracted to your partner."

Hormonal changes, breastfeeding, menopause and some medications can all contribute.

ACOG specifically recognizes hormonal changes, lack of arousal and other medical factors as causes of painful intercourse and recommends lubricants or vaginal moisturizers for appropriate patients.

Genitourinary Syndrome of Menopause

One of the most important causes of sexual pain after menopause is **Genitourinary Syndrome of Menopause (GSM)**.

As estrogen and androgen levels decline, vulvovaginal tissues may become:

thinner, drier, less elastic and more easily irritated.

Women may experience:

dryness, burning, itching, urinary symptoms and painful intercourse.

The 2025 AUA/SUFU/AUGS guideline—endorsed by ISSWSH and The Menopause Society—states that GSM is diagnosed from symptoms with or without examination findings after other causes are considered. Among available therapies, **local low-dose vaginal estrogen currently has the most robust evidence base**.

ACOG's November 2025 guidance likewise notes that topical vaginal estrogen can improve vaginal or vulvar dryness and pain with intercourse, often within several weeks.

This is important because postmenopausal dyspareunia is not simply “old age.”

It is often a treatable tissue-health problem.

Breastfeeding and Postpartum Dryness

A similar low-estrogen state can temporarily occur during breastfeeding.

A younger woman may therefore be surprised when she experiences:

dryness, reduced lubrication or discomfort after childbirth.

In addition, childbirth itself can cause:

perineal tears, episiotomy scars, pelvic-floor injury or tenderness.

ACOG specifically identifies childbirth-related scars and perineal injuries as causes of pain that can persist for several months in some women.

Recovery should not be rushed.

Inadequate Arousal Can Cause Pain

Natural lubrication and genital tissue expansion develop partly during sexual arousal.

If intercourse begins before the woman feels physically ready, friction may increase.

This can happen when sexual activity is:

rushed, associated with anxiety, occurring despite low interest or lacking sufficient stimulation.

The answer is not simply:

“Use more force until penetration becomes easier.”

That can worsen pain and fear.

Adequate time, communication and comfort matter.

Vaginitis and Vaginal Infection

Inflammation of the vaginal or vulvar tissues can make sexual activity painful.

Examples include:

bacterial vaginosis, vulvovaginal candidiasis and trichomoniasis.

Depending on the condition, associated symptoms may include:

abnormal discharge, odour, itching, burning or irritation.

The source supplied for this article also identifies infectious vulvovaginitis as an important cause of entry pain.

However, vaginal infections should **not** be treated by guessing from discharge colour alone.

Modern diagnosis may require:

clinical examination, vaginal pH assessment, microscopy or laboratory testing depending on the situation.

Sexually Transmitted Infections

Sexually transmitted infections can sometimes cause:

genital sores, vaginal or cervical inflammation, pelvic pain or painful intercourse.

An STI may also be present with few or no obvious symptoms.

If there is a new sexual exposure, unusual discharge, genital lesions, bleeding or pelvic pain, appropriate testing should be considered.

This is especially important because untreated cervical infections can sometimes progress upward into **pelvic inflammatory disease**.

Pelvic Inflammatory Disease

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

CDC guidance notes that PID may include:

endometritis, salpingitis, tubo-ovarian abscess or pelvic peritonitis.

Importantly, some patients have only mild or nonspecific symptoms such as:

abnormal bleeding, vaginal discharge or dyspareunia.

Even relatively mild PID can have reproductive consequences, including future infertility.

This is one condition where home remedies or herbal vaginal applications should **never delay appropriate antimicrobial treatment**.

Endometriosis

Endometriosis is an important cause of deep sexual pain.

Endometriosis involves endometrial-like tissue growing outside the uterus.

Depending on the location, a woman may experience:

painful periods, deep pain during intercourse, chronic pelvic pain and sometimes infertility.

Deep penetration may place pressure on tender tissues, ligaments or areas affected by endometriosis.

Sexual pain associated with endometriosis should be evaluated and treated as part of the underlying disease rather than dismissed as relationship anxiety.

Adenomyosis

In adenomyosis, endometrial-type tissue grows within the muscular wall of the uterus.

The uterus may become:

enlarged, tender and painful.

Some patients experience:

heavy menstrual bleeding, painful periods and deep dyspareunia.

Adenomyosis may require imaging and gynaecological assessment.

Fibroids and Ovarian Conditions

Fibroids do not cause painful intercourse in every woman.

But depending on their size and location, they can contribute to:

pelvic pressure, heavy menstruation or deep discomfort.

Similarly, some ovarian cysts or other adnexal conditions can produce pain during deep penetration.

This is one reason ultrasound may be useful in selected patients with deep pelvic pain.

Pelvic-Floor Muscle Dysfunction

The pelvic floor deserves particular attention.

Many women hear about pelvic-floor exercise and assume:

“If I have sexual pain, I need Kegels.”

Sometimes exactly the opposite is true.

In women with dyspareunia, pelvic-floor muscles can become **hypertonic—too tight rather than too weak**.

The muscles may remain tense even at rest.

Attempted penetration then stretches already painful muscles and can produce:

burning, pressure, tightness or a feeling that penetration is physically blocked.

A 2026 review recommends pelvic-floor physiotherapy particularly when examination identifies tenderness, guarding or penetration-limiting hypertonicity.

Vaginismus and Penetration Difficulty

Vaginismus describes involuntary tightening around the vaginal opening with attempted penetration.

The woman is not choosing to “close the vagina.”

It is a reflexive muscular response.

Possible contributors include:

fear of pain, previous painful intercourse, anxiety, traumatic experiences and pelvic-floor dysfunction.

Treatment may involve pelvic-floor physiotherapy, education, relaxation techniques, gradual dilator therapy and psychosexual treatment where appropriate.

A woman with vaginismus should never be told:

“You just need to tolerate penetration until the muscles learn.”

Force usually makes the fear-pain cycle worse.

Pelvic-Floor Therapy: Strengthening Is Only One Part

A 2025 systematic review examining pelvic-floor muscle interventions for dyspareunia found considerable variation in treatment protocols. Interventions often combined contraction and relaxation with therapies such as biofeedback or manual techniques. The authors emphasized that available studies are heterogeneous and cannot support one universal exercise prescription.

This is why pelvic-floor treatment should be individualized.

For some women:

strengthening is appropriate.

For others:

relaxation, breathing, manual therapy or down-training is more important.

Vulvodynia and Vestibulodynia

Some women develop chronic vulvar pain without an obvious infection.

Pain may be:

burning, raw, stabbing or hypersensitive.

When pain is concentrated around the vaginal entrance or vestibule and provoked by touch, intercourse, tampon insertion or examination, vestibulodynia may be considered.

Treatment can be complex and may require:

vulvar care, medications, pelvic-floor physiotherapy, psychological support and specialist evaluation.

A modern 2026 review emphasizes that vulvovaginal pain conditions can take years to diagnose and can significantly impair relationships and quality of life.

Vulvar Skin Conditions

Diseases such as:

lichen sclerosus, lichen planus, eczema, psoriasis and contact dermatitis

can make the vulvar skin:

inflamed, fragile, itchy or painful.

Perfumed soaps, feminine sprays, douches and irritating products can worsen symptoms in sensitive women.

A careful examination is often necessary because the treatment depends on the actual dermatological condition.

Bladder and Bowel Conditions

Not every sexual pain originates in the reproductive organs.

Conditions such as:

painful bladder syndrome/interstitial cystitis, irritable bowel syndrome and other chronic pelvic disorders

can contribute to deep pelvic sensitivity.

The supplied research correctly notes that urological and gastrointestinal disorders may coexist with dyspareunia.

A whole-pelvis assessment may therefore be needed.

The Pain–Fear–Tension Cycle

This is one of the most important concepts I explain to patients.

Imagine that intercourse hurt badly once.

Before the next attempt, the woman thinks:

“It is going to hurt again.”

Her body prepares defensively.

Pelvic-floor muscles tighten.

Arousal may become more difficult.

Lubrication decreases.

Penetration now hurts even more.

This confirms the fear.

The source material appropriately discusses this physical and psychological feedback loop.

The cycle becomes:

pain → fear → muscle tightening → more pain → avoidance → greater fear.

Breaking that cycle may require treatment of both the original physical cause and the learned fear response.

Psychological Factors Do Not Mean the Pain Is Imaginary

Anxiety, depression and relationship distress can increase pain perception and muscular tension.

Previous sexual trauma may also influence the nervous system's response to penetration.

But saying that emotional factors contribute is very different from saying:

“The pain isn't real.”

Pain is real.

The purpose of psychological or psychosexual treatment is to reduce the nervous system's contribution to the pain cycle, not to accuse the patient of imagining symptoms.

Relationship Effects of Dyspareunia

Persistent painful intercourse affects both partners.

The woman may fear intimacy because she expects pain.

Her partner may feel:

rejected, guilty, confused or afraid of hurting her.

Eventually the couple may avoid all physical affection because they fear it will lead to an attempted intercourse.

A 2025 systematic review examining partners of women with GPPPD highlights the significant biopsychological effects sexual pain can have on couples.

Couple counselling can therefore be useful when relationship distress develops.

How I Evaluate Painful Intercourse

When a woman consults me, I do not simply ask:

“Does sex hurt?”

I need to understand the pattern.

I ask where the pain is located.

I ask whether it occurs at first penetration or deep inside.

I ask whether it is:

burning, sharp, aching, cramping or tight.

I ask whether the problem was always present or began recently.

I also ask about:

menstrual symptoms, pregnancy and childbirth history, menopause, vaginal discharge, urinary symptoms, bleeding, bowel symptoms, previous surgery, medications and fertility concerns.

This detailed history often narrows the diagnosis considerably.

Clinical Examination

A physical examination should be performed respectfully and only when clinically appropriate.

Depending on symptoms, it may include careful examination of the:

vulva, vestibule and vaginal tissues.

A clinician may look for:

dryness, inflammation, scars, skin disorders, discharge or other abnormalities.

Pelvic-floor muscles may be assessed for:

tenderness, excessive tension or difficulty relaxing.

For deep pain, a bimanual pelvic examination may provide additional information.

A 2026 review recommends a gradual examination moving from vulva and vestibule to vagina and pelvic floor, with selective imaging when deeper pelvic disease is suspected.

Ultrasound and Other Investigations

Not every woman with dyspareunia needs imaging.

Ultrasound becomes more useful when symptoms suggest:

ovarian pathology, fibroids, adenomyosis or another deep pelvic problem.

Further testing may sometimes include:

STI testing, vaginal infection testing or other targeted investigations.

Laparoscopy may occasionally be considered in selected patients where conditions such as endometriosis are strongly suspected.

Treatment Must Match the Cause

This is the central principle of the entire article.

There is **no single best medicine for painful intercourse**.

A lubricant will not cure endometriosis.

An antibiotic will not cure pelvic-floor hypertonicity.

Pelvic-floor exercise will not treat untreated gonorrhoea.

Hormonal vaginal therapy will not resolve severe relationship trauma.

Therefore:

diagnosis first, treatment second.

Lubricants

For pain caused mainly by friction or inadequate lubrication, an appropriate lubricant can make a major difference.

ACOG recommends water-soluble lubricants for women with irritation or sensitivity and notes that silicone-based lubricants generally remain slippery longer.

For patients using latex condoms, oil-based products require particular caution because certain oils and petroleum-based products can weaken latex.

This is why I generally prefer recommending a **commercially prepared water- or silicone-based lubricant compatible with the contraception being used** rather than advising patients to insert household oils into the vagina.

Vaginal Moisturizers

Lubricants are mainly used around sexual activity.

Vaginal moisturizers are designed for more regular use and may help women experiencing ongoing dryness.

When symptoms are associated with menopause, moisturizers can be part of treatment, though moderate or severe GSM may need prescription therapy.

Local Vaginal Estrogen

For appropriately selected women with GSM, low-dose vaginal estrogen is one of the best-supported treatments.

The 2025 AUA/SUFU/AUGS guideline states that local low-dose vaginal estrogen has the **most robust evidence base** among GSM therapies.

ACOG's 2025 patient guidance similarly reports improvement in vulvovaginal dryness and painful intercourse, often within weeks.

Women with complex medical histories, including some hormone-sensitive cancers, should discuss the decision with their treating clinicians.

Other Treatments for GSM

Selected patients may also be considered for options such as:

vaginal prasterone or oral ospemifene depending on clinical circumstances, local availability and contraindications.

The newest 2026 review of peri- and postmenopausal dyspareunia includes these as selected alternatives while continuing to identify low-dose vaginal estrogen as a common first-line prescription option for clinically significant GSM.

Pelvic-Floor Physiotherapy

For women with:

pelvic-floor tenderness, guarding, muscle spasm or difficulty tolerating penetration,

pelvic-floor physiotherapy can be extremely useful.

Treatment may involve:

education, relaxation training, breathing, manual techniques, biofeedback and gradual rehabilitation.

A 2025 review identifies dyspareunia and chronic pelvic pain among conditions that can benefit from pelvic-floor physical therapy.

Vaginal Dilators

Dilators can be useful for selected women with penetration difficulty.

They are graduated devices used slowly and progressively to help the pelvic floor learn that penetration can occur without threat or pain.

They should not be used aggressively.

ACOG includes dilators and pelvic-floor physical therapy among self-management and treatment options for some sexual-pain conditions.

Sex Therapy and Psychological Treatment

Sex therapy, CBT or trauma-informed psychological care can help when pain is associated with:

fear, performance anxiety, previous trauma, severe avoidance or relationship distress.

This does not replace treatment of an underlying physical disease.

Often the best results come from treating both components simultaneously.

Treatment of Infection

If testing confirms an infection, that infection should receive **specific evidence-based treatment**.

For PID, CDC recommends appropriate broad-spectrum antimicrobial therapy because untreated infection can damage the reproductive tract.

A herbal wash, vaginal douche or home remedy should not be used as a substitute for antibiotics when bacterial PID or another treatable STI is present.

Treatment of Endometriosis and Other Deep Pelvic Causes

Endometriosis, adenomyosis, significant fibroids or ovarian disease may require specialist gynaecological management.

Depending on the condition and reproductive plans, treatment may involve:

medication, hormonal therapy, pain management or surgery.

In women trying to conceive, fertility considerations become especially important.

Dyspareunia and Infertility

Painful intercourse does **not automatically mean infertility**.

However, there are several important connections.

Severe dyspareunia can make intercourse infrequent or impossible.

Endometriosis can cause both pain and fertility difficulties.

Untreated PID can cause tubal damage and infertility.

Therefore, when a couple has both painful intercourse and delayed conception, I assess these problems together while remembering that they are not the same diagnosis.

At Saira Health Care, where my focused practice includes both sexual disorders and infertility, this distinction is particularly important.

The Unani Perspective on Painful Intercourse

The supplied traditional research describes terms such as **Waja-ul-Jama** or **Usr-e-Jima** for painful intercourse and relates sexual pain to other Unani concepts involving uterine or vaginal disorders.

As a physician trained in Unani medicine, I believe the strongest contribution of Unani care lies in its **whole-person approach**.

Unani medicine traditionally evaluates:

Mizaj – temperament,
Akhlat – the four classical humours,
diet and digestion,
physical activity and rest,
sleep,
psychological wellbeing,
and overall health.

The classical humours are:

Dam – blood
Balgham – phlegm

Safra – yellow bile
Sauda – black bile

These concepts belong to a traditional medical framework and should not be presented as direct laboratory equivalents of estrogen levels, vaginal pH, bacterial culture or inflammatory markers.

Asbab-e-Sitta Zarooriya

One of the most useful Unani concepts in modern integrative practice is **Asbab-e-Sitta Zarooriya**, the Six Essential Factors.

The Ministry of Ayush describes these as factors related to:

air, food and beverages, physical movement and rest, psychic movement and rest, sleep and wakefulness, and retention or evacuation.

These principles can help structure advice about:

nutrition, physical health, sleep, stress, bowel health and daily habits.

For a woman with dyspareunia, lifestyle care may support overall health—but it must be matched to the real diagnosis.

Ilaj bil Ghiza – Dietotherapy

A nutritious diet supports:

general health, tissue repair, energy and metabolic wellbeing.

But I do not recommend claiming that particular foods can directly cure:

vaginismus, PID, endometriosis or severe GSM.

Diet should instead be individualized.

For example:

a woman with diabetes should not be encouraged to take excessive honey or sweet preparations simply because they are traditionally considered strengthening.

A woman with anaemia may need evaluation and appropriate iron treatment.

A woman with significant gastrointestinal symptoms may need a different dietary approach.

Ilaj bit Tadbir – Regimenal and Lifestyle Care

Unani regimenal therapy traditionally includes methods intended to regulate lifestyle and support health.

In a modern responsible approach, the most relevant supportive areas for sexual pain include:

appropriate physical activity, relaxation, sleep, stress reduction and carefully selected external comfort measures.

However, traditional procedures should not be used simply because they are historical.

Their safety and evidence must be considered for the individual condition.

Psychological Balance in the Unani Framework

The Unani emphasis on **Harkat-o-Sukoon-e-Nafsani**, psychological activity and repose, is especially relevant to women caught in the pain–fear cycle.

Chronic anxiety can make pelvic muscles more tense.

Fear of pain can reduce arousal.

Relationship conflict can make intimacy more stressful.

This is one area where a traditional holistic perspective fits well with the modern biopsychosocial approach.

Unani Pharmacotherapy

Traditional Unani literature contains single herbs and compound preparations used for:

female reproductive complaints, abnormal discharge, general weakness and other gynaecological concerns.

The supplied material discusses several such formulations in detail.

But an important distinction must be made:

traditional use for a related symptom is not the same as clinical proof that a formulation treats dyspareunia itself.

Direct high-quality clinical trials of specific Unani formulations for diagnostically confirmed dyspareunia remain limited.

Therefore, I use a cautious integrative approach.

Unani Research on Leucorrhoea

CCRUM has published a clinical study of the Unani pharmacopoeial formulation **Maʿjūn Muqawwī-i-Raḥim** for *Sayalān al-Raḥim* or leucorrhoea.

In that study, 118 women were enrolled and 102 completed treatment, with varying levels of improvement and no significant reported deterioration in measured haematological or biochemical parameters.

This provides some clinical research for a **traditional leucorrhoea indication**.

However, it should not be interpreted as evidence that the formulation cures:

bacterial vaginosis, candidiasis, sexually transmitted infections, PID or dyspareunia.

Those conditions require their own diagnosis.

Vaginal Discharge Should Not Automatically Be Called "Uterine Weakness"

Normal vaginal discharge varies naturally across the menstrual cycle.

Pathological discharge can result from:

infection, inflammation or another genital-tract condition.

Modern testing is much more reliable than diagnosing disease solely from the colour or consistency of discharge.

The supplied research discusses historical Unani methods of classifying discharge according to humoral theory.

These are historically interesting traditional diagnostic concepts, but they should not be treated as substitutes for modern examination and microbiological testing when infection is suspected.

Important Correction: PID Should Not Be Managed With Cupping or Venesection

The supplied research describes historical Unani regimenal practices such as cupping and venesection in pelvic inflammation.

For a modern website, this needs a clear qualification.

Acute PID is an infectious disease requiring prompt antimicrobial treatment.

It should not be managed by bloodletting, cupping or herbal treatment alone.

Delaying appropriate treatment may increase the risk of:

chronic pelvic pain, ectopic pregnancy and infertility.

Historical descriptions can be academically discussed, but patient safety must take priority.

Avoid Unsupervised Vaginal Herbal Pessaries

The source also describes several historical intravaginal preparations.

I would **not recommend patients prepare or insert such formulations at home**, particularly preparations containing irritating substances, narcotics, animal fats or non-sterile herbal material.

The vagina has a delicate microbiological and mucosal environment.

Unregulated intravaginal remedies can potentially cause:

irritation, allergy, infection or tissue injury.

Professional diagnosis should come first.

Home Care: What Is Reasonably Safe?

Patients often ask:

“Is there something simple I can do at home?”

For mild friction-related discomfort while arranging evaluation, the safest strategies are usually straightforward.

Use a well-formulated **water-based or silicone-based lubricant** compatible with your contraception.

Allow adequate time for arousal.

Avoid perfumed soaps, vaginal sprays and douching.

Do not continue penetration when it is painful.

Communicate clearly with your partner.

A warm bath may help some women relax pelvic-floor tension.

These measures are compatible with current ACOG advice for sexual pain.

Almond Oil, Olive Oil, Coconut Oil and Ghee: Important Caution

The supplied source strongly recommends several household oils and fats as vaginal lubricants.

I would not present these as universally proven or preferable to commercial lubricants.

There are several concerns.

Oil-based products may not be appropriate with latex condoms because they can weaken latex.

Intravaginal household oils are not standardized for vaginal use.

Some people may experience irritation.

Therefore, a **purpose-made water- or silicone-based lubricant** is generally the safer first recommendation, particularly where condoms are used. ACOG specifically recommends water-soluble or silicone-based options and cautions against certain oil or petroleum products with latex condoms.

Aloe Vera and Tea Tree Oil: Do Not Overstate the Evidence

The supplied material recommends fresh Aloe vera vaginally and even suggests adding tea tree oil.

I would not recommend this as routine patient advice.

Fresh plant material is not sterile.

Tea tree oil can irritate sensitive genital tissue.

Evidence is not strong enough to say fresh Aloe vera is equivalent to established vaginal estrogen treatment for GSM.

Women with persistent dryness should use appropriately formulated products and seek medical advice rather than inserting home mixtures into the vagina.

Fenugreek and "Natural Estrogen"

Likewise, fenugreek or phytoestrogen foods should not be described as if they work like prescription estrogen.

They may be part of a healthy diet.

But there is insufficient evidence to tell a woman with significant GSM:

"Drink fenugreek water and the vaginal tissues will recover."

The evidence supporting local low-dose vaginal estrogen is substantially stronger.

Vaginal Laser Therapy

Vaginal laser treatments are heavily marketed as:

“vaginal rejuvenation,”
“non-hormonal restoration,”
or a treatment for dryness and painful sex.

Current evidence is much less convincing than the marketing.

The 2025 AUA/SUFU/AUGS guideline states that evidence **does not support CO_2 laser, Er:YAG laser or radiofrequency** for GSM-related dryness, discomfort or dyspareunia and considers such approaches experimental outside appropriate settings.

ACOG's November 2025 guidance also states that the FDA has not approved vaginal laser or other energy-based therapy for menopausal symptoms or sexual problems and warns about possible complications including:

burns, scarring, dyspareunia and persistent pain.

This directly corrects the much more favourable description of vaginal lasers in the supplied research.

What About the “O-Shot” or Vaginal PRP?

Platelet-rich plasma injections are also marketed for sexual function and vaginal rejuvenation.

At present, evidence remains insufficient to treat these injections as an established standard therapy for dyspareunia.

I therefore would not present an “O-Shot” as a proven regenerative treatment on a professional medical website.

Women should first be evaluated for established treatable conditions such as:

GSM, pelvic-floor dysfunction, infection, vulvodynia or endometriosis.

Kegel Exercises: Another Common Misunderstanding

Kegels can strengthen weak pelvic-floor muscles.

But a patient with sexual pain may already have excessively tight muscles.

More squeezing can sometimes aggravate the problem.

For pain associated with hypertonicity, the goal may instead be:

relaxation, coordination and reduction of guarding.

Current 2025–2026 research supports individualized pelvic-floor rehabilitation rather than one universal strengthening programme.

Communication With the Partner

I tell couples:

Never treat intercourse as something that must be completed despite pain.

A useful statement from the woman may be:

“This position causes pain; can we stop and try something more comfortable?”

The partner's response matters greatly.

Supportive communication reduces fear.

Pressure increases it.

The objective should be to restore comfort and trust before focusing on sexual frequency.

Non-Penetrative Intimacy During Recovery

A couple does not need to eliminate all affection while dyspareunia is being treated.

When mutually desired, intimacy can include:

affection, kissing, cuddling or other activities that do not reproduce the pain.

This can prevent the relationship from developing a pattern in which every affectionate interaction becomes associated with fear of painful penetration.

ACOG specifically suggests considering activities that do not cause pain while treatment is underway.

My Approach at Saira Health Care

At **Saira Health Care**, when a woman consults me for painful intercourse, I do not begin by prescribing a general “female sexual medicine.”

I first determine:

Where is the pain?

Is it entry pain or deep pain?

Did it begin with the first attempted intercourse or later?

Is dryness present?

Is there abnormal discharge, itching or burning?

Is there bleeding?

Has she delivered a baby recently?

Is she breastfeeding?

Has menopause started?

Are the pelvic-floor muscles too tight?

Are endometriosis symptoms present?

Could infection be present?

Is the partner's sexual behaviour unintentionally contributing to pain?

Is fear now amplifying the original physical problem?

Is infertility also a concern?

Only after these questions are addressed does treatment become meaningful.

The Specialized Clinical Approach of Dr. Nizamuddin Qasmi

My professional profile includes:

Dr. Nizamuddin Qasmi

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

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

My approach is integrative, but integration does not mean mixing treatments indiscriminately.

It means:

using modern investigation where diagnosis requires it;

using appropriate evidence-based gynaecological treatment when indicated;

using pelvic-floor and psychological care where necessary;

and integrating responsible Unani lifestyle and therapeutic principles when they are suitable for the individual.

How Saira Health Care Contributes to Sexual and Reproductive Health

Many women continue living with painful intercourse for months or years because they believe:

“This is normal.”

“A wife has to tolerate it.”

“I am probably too sensitive.”

“There is nothing a doctor can do.”

That silence can create:

sexual avoidance, anxiety, loss of confidence and relationship distress.

At Saira Health Care, one of our most important contributions in the field of sexual disorders and infertility is **education without judgement**.

The patient should understand that sexual pain is a legitimate health concern.

The consultation should be confidential.

Her description of pain should be taken seriously.

And if another specialist, gynaecological investigation or pelvic-floor physiotherapist is required, that should become part of the treatment plan.

A Practical Treatment Pathway

When I summarize management for patients, I explain it in a simple sequence:

First, identify the location and cause of pain.

Second, stop activities that repeatedly reproduce significant pain.

Third, treat reversible physical conditions—dryness, infection, GSM, pelvic-floor dysfunction or pelvic disease.

Fourth, address fear, anxiety and relationship consequences.

Fifth, improve general health, sleep and stress management.

Sixth, integrate carefully selected Unani lifestyle or pharmacological support when appropriate.

Finally, review whether intercourse is actually becoming more comfortable rather than merely continuing medication indefinitely.

Frequently Asked Questions

Is pain during intercourse normal?

Occasional mild discomfort can occur, but recurrent or severe sexual pain should not be considered normal.

ACOG recommends medical evaluation when pain is frequent or severe.

Why does it hurt at the vaginal opening?

Possible causes include:

dryness, insufficient lubrication, vaginitis, vulvar skin disease, vestibulodynia, childbirth scars or pelvic-floor muscle tightening.

A clinical assessment helps distinguish them.

Why does intercourse hurt deep inside?

Deep pain can be associated with:

endometriosis, adenomyosis, PID, fibroids, ovarian disorders, pelvic adhesions or other pelvic conditions.

Persistent deep pain usually deserves gynaecological assessment.

Can vaginal dryness cause severe pain?

Yes.

Dry tissues experience greater friction and can become irritated or develop small tears.

This is particularly common around menopause, breastfeeding and other low-estrogen states.

Can menopause cause painful intercourse?

Yes.

GSM can cause vaginal dryness, tissue thinning and sexual pain.

The 2025 AUA/SUFU/AUGS guideline identifies local low-dose vaginal estrogen as the GSM treatment with the strongest current evidence base.

Is topical estrogen effective?

For appropriate women with menopause-related dryness or pain, yes.

ACOG reports that local estrogen commonly improves symptoms within weeks.

Individual medical history should still be considered.

Can infection make intercourse painful?

Yes.

Vaginitis, STIs and PID can cause sexual pain.

Persistent discharge, odour, burning, pelvic pain or fever should be medically evaluated rather than treated only with home remedies.

Can PID affect fertility?

Yes.

CDC notes that even mild or unrecognized PID can have reproductive consequences, including infertility.

Prompt treatment matters.

Can endometriosis cause painful sex?

Yes.

Deep dyspareunia is a common symptom in some women with endometriosis.

Associated painful periods, chronic pelvic pain or infertility increase the reason to consider appropriate evaluation.

Does painful sex mean vaginismus?

Not always.

Vaginismus/pelvic-floor tightening is only one cause.

Dyspareunia can also result from dryness, infection, endometriosis, menopause or other conditions.

Should I do Kegel exercises?

Not automatically.

If your pelvic-floor muscles are weak, strengthening may help.

If they are already tight and painful, relaxation-focused pelvic-floor physiotherapy may be more appropriate.

Which lubricant is safest?

Water-based and silicone-based products designed for sexual use are generally reasonable options.

ACOG notes that silicone products tend to remain slippery longer and cautions about using oil-based products with latex condoms.

Can I use coconut or almond oil?

Oil may reduce friction, but it is not automatically the best or safest vaginal lubricant.

Some oil products can damage latex condoms, and household oils are not standardized vaginal products.

A purpose-made lubricant is usually easier to recommend safely.

Is vaginal laser a good treatment for painful sex?

It is not currently supported as routine evidence-based treatment for GSM-related dyspareunia.

The 2025 AUA guideline states that evidence does not support vaginal laser or radiofrequency for GSM-related dyspareunia, while ACOG notes FDA concerns regarding burns, scarring and persistent pain.

Can Unani medicine help?

Unani medicine can contribute as part of an **individualized integrative plan**, particularly through:

diet and general nutrition, healthy daily routine, sleep, stress management, psychological balance and appropriately supervised traditional treatment.

Official Ministry of Ayush descriptions of Unani medicine emphasize the Six Essential Factors and the roles of dietotherapy, pharmacotherapy and regimenal therapy.

However, conditions such as PID, severe endometriosis, significant GSM or vulvar disease should not be managed with Unani treatment alone.

Can Unani medicine cure vaginal infection naturally?

It is not responsible to make such a broad claim.

Some Unani research exists for conditions such as leucorrhoea, but a discharge syndrome is not the same as a confirmed bacterial, fungal or sexually transmitted infection.

Confirmed infections require condition-specific treatment.

Does dyspareunia cause infertility?

Not directly in every case.

But some causes of dyspareunia—particularly PID and endometriosis—can also affect fertility, and severe sexual pain can reduce the frequency of intercourse.

When Should a Woman Seek Medical Care?

A woman should arrange professional assessment when intercourse is repeatedly painful, penetration becomes difficult or impossible, there is persistent vaginal dryness, unusual discharge or odour, genital itching, pain with urination, bleeding during or after intercourse, significant pelvic pain, painful menstruation, persistent pain after childbirth, or fertility concerns.

Urgent assessment is particularly important for:

sudden severe pelvic pain, severe pain with fever, fainting, heavy bleeding, severe vomiting, pain associated with possible pregnancy or symptoms suggesting a serious pelvic infection.

Postmenopausal bleeding should also be evaluated rather than simply attributed to dryness.

A Message From Dr. Nizamuddin Qasmi

When a woman tells me:

"Doctor, संबंध बनाते समय दर्द होता है,"

my first message is:

Do not force yourself through the pain.

Pain is the body's signal that something needs to be understood.

Sometimes the cause is relatively simple—dryness or insufficient lubrication.

Sometimes the pelvic-floor muscles are excessively tight.

Sometimes menopause has changed the vaginal tissues.

Sometimes infection is present.

Sometimes endometriosis or another pelvic condition is responsible.

And sometimes an initially physical pain has developed into a powerful fear–tension cycle that needs both medical and psychological care.

As a physician trained in Unani medicine, I find its whole-person approach valuable.

A woman's diet matters.

Sleep matters.

Stress matters.

Physical activity matters.

Psychological wellbeing matters.

These are areas in which **Ilaj bil Ghiza, Ilaj bit Tadbir and the principles of Asbab-e-Sitta Zarooriya** can complement modern care.

But responsible Unani practice also means recognizing when another form of treatment is necessary.

An infection should be diagnosed and treated properly.

Severe menopause-related dryness deserves evidence-based options.

Endometriosis requires appropriate gynaecological care.

Pelvic-floor spasm may require physiotherapy.

Trauma-related fear deserves compassionate psychological care.

My goal at Saira Health Care is not simply to suppress pain for a few hours.

The goal is to identify the cause and help the woman restore **comfort, confidence, healthy intimacy, reproductive wellbeing and overall quality of life**.

About the Author

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

BUMS – Hamdard University, Delhi
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Integrated Sexual and Reproductive Health – ISRH, UNFPA

At **Saira Health Care**, the clinical focus includes confidential and individualized assessment of sexual and reproductive-health concerns, including painful intercourse, female sexual dysfunction, pelvic and intimacy-related problems and infertility, using an integrative approach that respects Unani principles while incorporating appropriate contemporary medical evaluation.

Medical Disclaimer

This article is intended for **patient education and general health information**. It does not replace an individual consultation, gynaecological examination, laboratory testing or treatment plan.

Dyspareunia may result from hormonal, infectious, dermatological, pelvic-floor, gynaecological, neurological or psychological conditions. Persistent pain therefore requires individualized assessment.

Herbal or Unani treatments should be used under appropriately qualified supervision. Home remedies should not delay treatment of suspected infection, PID, significant bleeding, severe pelvic pain or other potentially serious conditions.

Intravaginal herbal mixtures, essential oils, household products and unregulated preparations can irritate genital tissue and should not be assumed safe simply because they are natural.