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Vaginismus in Primary Health Care: Challenges in Diagnosis and Management - A Narrative Review

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Abstract

Vaginismus is a female sexual dysfunction characterized by involuntary spasms of the pelvic floor muscles that impede vaginal penetration, affecting 5–7% of women worldwide, with a higher prevalence reported in Eastern countries. This condition not only causes physical pain but also impacts mental health and interpersonal relationships. This research aims to explore the diagnostic challenges of vaginismus in primary health care settings and present evidence-based management strategies to support clinicians in delivering effective, patient-centered care. A narrative review was conducted by analyzing national and international literature published between 2019 and 2025 through PubMed, Google Scholar, and ScienceDirect databases using the keywords vaginismus, primary care, diagnosis, and management. The main challenges in diagnosing vaginismus in primary care include overlapping symptoms with other conditions, limited consultation time, stigma surrounding sexual health, and insufficient competence among healthcare providers. The DSM-5 has merged vaginismus and dyspareunia into Genito-Pelvic Pain/Penetration Disorder (GPPPD) to facilitate classification. Management is multimodal, involving education, pelvic floor muscle physiotherapy, psychological counseling, and simple pharmacotherapy. Primary health care plays an important role as the main gateway for vaginismus management. An integrated approach—including proactive screening, empathetic gradual examination, initial therapy, and timely referrals—can improve patient quality of life and the success of subsequent therapy.

Keywords: vaginismus, primary health care, sexual dysfunction, diagnosis, management, gpppd, pelvic floor physiotherapy, reproductive health

INTRODUCTION

Sexual function constitutes a vital aspect of human life. Disruptions in this domain, commonly referred to as sexual dysfunction, can significantly impact quality of life, mental health, and interpersonal relationships. Sexual dysfunction is reported to be more prevalent in women than in men. Globally, approximately 40–45% of women of reproductive age are estimated to experience some form of sexual dysfunction, with prevalence rates varying according to racial, cultural, socioeconomic, psychological, and health-related factors (Bulbuli & Kokate, 2024).

One specific form of sexual dysfunction in women is vaginismus, which is estimated to affect 5–7% of women worldwide, with a higher prevalence reported in Eastern countries (Nasim & Nashwan, 2025). Vaginismus is characterized by involuntary spasms of the pelvic floor muscles in the outer third of the vagina, which impede vaginal penetration. This condition not only results in pain but is also associated with an increased risk of psychological disorders such as anxiety, depression, and difficulties in interpersonal relationships (Alshahrani et al., 2023).

Diagnosing vaginismus can be challenging due to symptom overlap with other conditions such as dyspareunia, vestibulodynia, and other

psychosexual disorders. To streamline classification, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), has merged vaginismus and dyspareunia into a single diagnostic category: Genito-Pelvic Pain/Penetration Disorder (GPPPD), based on the similarities in symptoms and underlying mechanisms (Raveendran & Rajini, 2024). This reclassification reflects the clinical complexity of the condition and underscores the need for clinicians to carefully identify the dominant symptoms in each individual case. In the context of primary care, diagnostic accuracy is crucial, as it guides appropriate and effective management strategies (Sasotya, 2024).

In clinical practice, accurate diagnosis is essential for ensuring that patients receive appropriate treatment. However, in primary care settings, several barriers to accurate diagnosis may arise, including limited consultation time, stigma and embarrassment surrounding sexual health issues, and insufficient experience among physicians in addressing sexual complaints. As the first point of contact, primary care providers are responsible for conducting thorough anamnesis, targeted physical examinations, patient education, initial management, and making appropriate referrals to secondary or tertiary care when necessary.

Previous studies have provided valuable insights into the prevalence, etiology, and management of vaginismus, yet significant gaps remain in understanding its diagnosis and treatment in primary care settings. For instance, Reissing et al. (2004) conducted a cross-sectional study on 1,241 women in Canada and reported a prevalence of vaginismus of 6%, highlighting the psychosocial burden and the role of anxiety-related factors in symptom manifestation; however, this study focused primarily on secondary and tertiary care patients, limiting its generalizability to primary care populations. Similarly, Cuzzolaro et al. (2010) investigated psychosexual and sociodemographic correlates of vaginismus in a European sample, emphasizing the influence of cultural attitudes, sexual knowledge, and relationship dynamics on the disorder, yet they did not explore the practical barriers faced by primary care providers in diagnosing and managing the condition. These studies collectively underscore that while epidemiological and psychosocial aspects of vaginismus are relatively well-documented, there is a lack of research examining the real-world diagnostic challenges, including time constraints, clinician experience, patient embarrassment, and stigma in primary care, particularly in non-Western or resource-limited contexts.

Given this background, the present literature review aims to explore the challenges associated with diagnosing vaginismus in primary care settings and to present evidence-based management strategies. This review is intended to support clinicians in delivering effective, patient-centered care for individuals affected by this condition.

METHOD

This research employs a narrative review approach by examining both national and international literature published between 2019 and 2025. Literature searches were conducted through the PubMed, Google Scholar, and ScienceDirect databases using the following keywords: "vaginismus", "primary care" OR "general practice", "diagnosis", and "management" OR "treatment". The inclusion criteria comprised articles that specifically address the diagnosis and management of vaginismus, with a particular focus on its relevance within the context of primary health care.

RESULTS AND DISCUSSION

Implications for Primary Health Services

According to the American College of Obstetricians and Gynecologists (ACOG, 2019), delays in the diagnosis of vaginismus are commonly associated with several systemic barriers, including ineffective communication, limited consultation duration, and insufficient confidence among both patients and healthcare providers in recognizing and managing the condition. These challenges contribute to increased patient dissatisfaction, often manifesting as frustration and repeated consultations with different healthcare providers ("doctor shopping"), ultimately reflecting a decline in trust toward the healthcare system. Moreover, patients frequently report a lack of transparency and structure in the treatment process within primary care settings, which significantly undermines treatment adherence and continuity of care.

1. Challenges of Diagnosis in Primary Health Services

   Primary health care providers face several challenges, especially in the initial diagnosis of vaginismus. Clinical manifestations that arise and overlap with other similar conditions lead to wide differential diagnosis. In addition, the limited means of examination equipment and the condition of patients who are intolerant to basic examinations (patients with vaginismus are unable to undergo a full speculum examination), as well as the psychological factors involved further complicate the diagnosis of vaginismus in primary health services (Banaei et al., 2023; Reisy et al., 2020).
2. Integrated management in primary health services

   Primary health care as the first gateway in the initial therapy of vaginismus is multimodal and gradual until it includes specialist/advanced referrals. Practical recommendations for doctors in primary health services include the importance of proactively screening of symptoms felt by patients, conducting empathic gradual examinations, maximizing initial therapy and determining the need for timely referrals as indicated (Banaei et al., 2023; Mestre-Bach et al., 2022).

Challenges of Vaginismus Diagnosis in Primary Health Services

Vaginismus is a part of sexual disorders in women that is accompanied by involuntary contractions of the prevaginal muscles that inhibit penetration and cause significant discomfort or pain. This condition is often difficult to identify, especially in primary health care due to symptoms that overlap with other similar conditions. Therefore, a comprehensive examination in physical and psychosocial aspects is important to determine the next management (Pithavadian et al., 2024).

The DSM IV defines vaginismus as an involuntary muscle spasm in the outer third of the vagina that appears recurrent or persistent and gives rise to interpersonal disorders, usually triggered by sexual penetration. However, involuntary muscle spasms as the main feature are found only in some cases (American Psychiatric Association, 2000). In a study by Raveendran and Rajini (2024), it was found that only 28% of the vaginismus group experienced muscle spasms and only 24% experienced spasms during sexual intercourse experiments. Other symptoms, such as pain during penetration, are not included in the DSM-IV diagnostic criteria, making it difficult to distinguish vaginismus from other conditions such as dyspareunia, vulvodynia (PVD), or pseudovaginismus (American Psychiatric Association, 2013).

To overcome these limitations, the DSM-V combines vaginismus with dyspareunia and related conditions into the category of *Genito-Pelvic Pain/Penetration Disorder* (GPPPD). Its diagnosis criteria include persistent or recurrent difficulties in vaginal penetration, pelvic or vulvovaginal pain, a palpable fear or anxiety of pain, and tightening of the pelvic floor muscles during penetration attempts that last persistently for at least 6 months. Detailed differences in the diagnosis of vaginismus in DSM IV and DSM V, as outlined in Table 1. Vaginismus is now also considered to have the characteristics of phobia, because excessive fear of pain during penetration is the main factor that strengthens symptoms (American Psychiatric Association, 2013).

Table 1. Differences in the Diagnosis of Vaginismus in DSM IV and DSM V

COMPONENT	DSM IV	DSM V
Diagnosis	Vaginismus (distinguished from Dyspareunia)	Genito-Pelvic Pain/Penetration Disorder (GPPPD)
Status Diagnosis	Vaginismus is a Single Diagnosis	Combined diagnosis with dyspareunia
Characteristics	Specific focus on involuntary spasms or tightening of the outer walls of the third vagina	The focus is not only on involuntary spasms, but includes issues of pain, anxiety.
Clinical manifestation	Involuntary muscle spasms involving sexual intercourse	Criteria consist of 1 or more:• Difficulty in vaginal penetration• Vulvovaginal/pelvic pain during penetration attempts• Fear or anxiety about pain

COMPONENT	DSM IV	DSM V
		associated with vaginal penetration• Significant tension in the pelvic floor muscles during penetration attempts
Diagnosis Enforcement	Physical examination and anamnesis	Affirming that similar conditions are interrelated, Many patients have symptoms of both and are clinically difficult to distinguish and lack empirical support to make it easier
Clinical Rationale for Change	Diagnosis that overlaps between vaginismus and dyspareunia	More focus on the anamnesis of symptoms (recurrent/persistent symptom patterns that cause significant disruption) for at least 6 months

The DSM-5 changes brought several important impacts especially on primary health care practices. Diagnosis becomes more comprehensive because it includes both physical (muscle and pain) and psychological (anxiety/phobia) aspects, reducing the risk of underdiagnosis. A multidisciplinary approach is more needed, with possible referrals to a sexology specialist, pelvic physiotherapist, or psychologist/sexual therapist. In addition, this incorporation facilitates communication and research with uniform terminology, and emphasizes the importance of assessing psychological factors (American Psychiatric Association, 2013; Raveendran & Rajini, 2024).

However, this merger also has its drawbacks. The broader criteria can be less specific, so the hallmarks of classical vaginismus may not be obvious. Categorization also makes comparisons with older studies more difficult, limiting the consistency of long-term data regarding the prevalence or effectiveness of therapies. In addition, primary services with limited time and resources can face challenges in assessing physical and psychological aspects simultaneously (Raveendran & Rajini, 2024; Vakilian et al., 2022).

The difference between vaginismus and similar conditions remains important to identify in order to provide direction for future therapeutic steps. Vaginal or vulvar infections, such as candidiasis or bacterial vaginitis, can cause penetrating pain but are not accompanied by involuntary muscle contractions. Vulvar dermatosis, such as lichen sclerosis, usually causes skin changes and itching/pain that is different from the symptoms of vaginismus. Psychological problems or sexual phobias can also cause penetration discomfort without any real physical manifestations in the perivaginal muscles. Thus, differential diagnosis is an important step in primary care (Pithavadian et al., 2024; Zarski, 2025).

A systematic examination flow helps reduce the risk of misdiagnosis. A detailed anamnesis around sexual history, pain onset, anxiety, and traumatic experiences is a crucial first step. Physical examination includes evaluation of pelvic floor muscles, signs of inflammation, or skin lesions and observation of involuntary reflexes. When necessary, additional tests such as cultures, infection tests, or referrals to gynecologists or sexology specialists may be performed to establish an accurate diagnosis (Raveendran & Rajini, 2024).

Symptoms of vaginismus often overlap with other conditions, such as vulvodynia or chronic infections that also cause penetrating pain. Muscle tension or anxiety can also appear in patients with sexual trauma or phobias, so an objective examination is essential to distinguish the cause of pain (Pithavadian et al., 2024). The study concluded that in diagnosing vaginismus, there needs to be subjective criteria which include the symptoms presented by the patient, objective criteria obtained from the results of physical and supporting examinations, frequency and duration, and exclusion criteria which are fully explained in table 2. The results of these criteria can help the doctor to determine which diagnosis is in accordance with the patient's complaint (table 3) (Raveendran, 2024).

Table 2. Diagnostic Criteria of Vaginismus

Criteria Type	Sub-category	Description
1. Subjective criteria	-	Persistent and recurrent difficulty or inability to allow vaginal entry of penis, fingers, or any object despite the expressed wish of the female partner due to emotional distress or fear of pain, on anticipation or attempted penetration that is excessive and unreasonable leading to variable avoidance of vaginal penetration.
2. Objective criteria	A. Clinical criteria	Muscle spasm during vaginal clinical examination – marked tensing and tightening of pelvic floor muscle during attempted vaginal intercourse/penetration.
	B. Laboratory criteria	Increased muscle tone in an EMG study during induction of vaginismus by a vaginal dilator or attempted penetration.
3. Frequency-duration criteria	-	Symptoms persist for 6 months or more, with the inability or difficulty to penetrate during the majority of attempts (> 50%).
4. Exclusion criteria	-	No secondary cause for pain/difficulty in penetration.

Source: Cited from Raveendran and Rajini, 2024

Tabel 3. Interpretation of Diagnostic Criteria of Vaginismus

Subjective criteria	Objective criteria	Frequency-duration criteria	Exclusion criteria	Interpretation
+	+	+	+	Vaginismus
–	+	–	+	Asymptomatic vaginismus

+	+	–	+	Transient vaginismus
+	+	+	With features of dyspareunia	Vaginismus dyspareunia overlap syndrome
+	+	–	With features of dyspareunia	Transient vaginismus dyspareunia overlap syndrome
+	–	+	+	Probable vaginismus
+	–	–	+	Probable transient vaginismus

Source: Cited from Raveendran and Rajini, 2024

Overall, the main challenges in the diagnosis of vaginismus in primary health services include symptoms that overlap with other conditions, limited competence of health professionals in primary health services, and complexity of diagnosis that requires a physical and psychological approach. Efforts to improve understanding, training, and appropriate referrals can help optimize the identification and management of these conditions, so that patients receive appropriate interventions and reduce negative impacts on their quality of life (Banaei et al., 2023).

Management of Vaginismus in Primary Health Services

The management of vaginismus in primary health services is multimodal involving educational interventions, physiotherapy, especially pelvic floor muscles, psychological counseling, and simple pharmacotherapy. General practitioners in primary health services play a major role in determining the direction of diagnosis and subsequent management. Education in the form of improving understanding, reducing anxiety, and building trust, especially involving patients' spouses, is expected to be carried out by general practitioners as the initial stage of vaginismus management in primary health services (Chalmers, 2024). This initial step will determine the patient's readiness and compliance in undergoing a series of therapies. In addition, at this stage it helps to outline the patient's perspective which is an important point in the therapy section as obstacles such as difficulty seeking help, stigma, and cultural problems can be identified through this communication. It is hoped that at this stage the patient can understand a clear therapy plan through the empathic attitude of primary health workers to greatly determine the success of therapy (American Academy of Family Physicians, 2021; Starzec-Proserpio et al., 2025).

Specific research related to vaginismus is still limited but on the basis that the similarity of the pathological mechanism of pelvic floor muscle hypertonus can make some of the study results relevant in the realm of clinical practice, especially in primary health services. The strongest modality today is pelvic floor muscle physiotherapy (PFPT). An RCT showed that PFPT can reduce pain and improve sexual function in women with these clinical symptoms (Starzec-Proserpio et al., 2025). The meta-analysis also explains

that pelvic floor muscle exercises accompanied by electrotherapy can reduce chronic pelvic pain and improve quality of life (Huang et al., 2024).

Pharmacological management plays a role but is not the main one. Routinely, lubricants may be recommended, while local estrogens may be beneficial for patients with genitourinary syndrome of menopause (Starzec-Proserpio et al., 2025). Intervention in the form of botulinum toxin A injection can be given in refractory cases that do not improve with conservative therapy, binding the results of increased penetration ability, but the availability in primary health services is still very limited and there is no standard regarding the dosage (Desai et al., 2024).

In primary health services, education related to the consistent use of dilators can be carried out because it has been proven to be effective in increasing penetration tolerance. Combination with *gradual cognitive-behavioral therapy* (CBT) shows more optimal results (Starzec-Proserpio et al., 2025). For this reason, consideration of referring to psychosocial therapy can be an option when available. This confirms that the management of vaginismus is not only based on medical intervention, but also demands a humanist and contextual approach. Some of the more complex and refractory conditions require precise and clear reference as shown in table 4.

Table 4. Referral Criteria for Vaginismus in Primary Services

Reference Criteria	Indication
Failure with conservative therapy	Does not improve after 8-12 weeks with basic therapy
Comorbid	Suspected endometriosis, anatomical abnormalities, vulvodynia Chronic infections or severe urogenital atrophy Psychiatric disorders (depression, PTSD, sexual trauma)
Barriers to basic medical examination	Barriers to the availability of examination tools Obstacles to the patient's condition in undergoing examination
Specialty/advanced Therapy Needs	CBT, advanced pharmacological therapy, specialized PFPT
Patient Preferences	Patient comfort and privacy

Recent evidence suggests that primary health services play an important first gate in the treatment of vaginismus. Early intervention in the form of education, pelvic floor relaxation exercises, dilators, psychological counseling, and simple pharmacotherapy can improve the patient's quality of life and facilitate the success of follow-up therapy. Proper referrals are required in complex or refractory cases. A multimodal approach that is tailored to the patient's biopsychosocial condition is the main strategy so that primary

services can provide effective and empathetic management. We have compiled a clearer flow related to the management of vaginismus in the primary service in Figure 1.

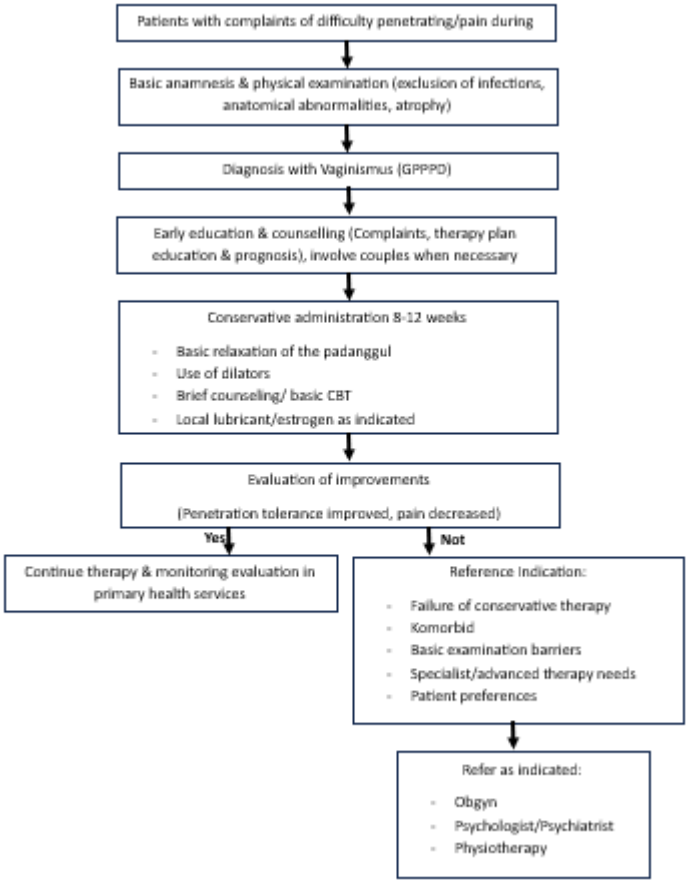

Figure 1. Vaginismus Management Flow in Primary Health Services

CONCLUSION

Vaginismus is a female sexual dysfunction characterized by involuntary pelvic floor muscle spasms that hinder vaginal penetration, affecting physical health, mental well-being, and relationships. Diagnosis in primary care is complicated by overlapping symptoms, limited consultation time, stigma, and inadequate provider training. The DSM-5 classification as Genito-Pelvic Pain/Penetration Disorder (GPPPD) aids diagnosis, while effective management involves a multimodal strategy combining education, pelvic floor physiotherapy, psychological counseling, and pharmacotherapy. Primary care is essential as the first point of contact, and an integrated approach with proactive screening, empathetic gradual examination, initial

treatment, and timely referrals improves outcomes. Future research should focus on developing standardized screening tools and training programs for primary care providers to enhance early diagnosis and tailored management of vaginismus.

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