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# Couple Sex Therapy Versus Group Therapy for Women with Genito-pelvic Pain

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## Abstract

**Purpose of Review** Cognitive-behavioral therapy (CBT) for genito-pelvic pain targets the reduction of pain and the improvement of sexual function/satisfaction. CBT has the additional advantage of being amenable to group and couple formats. However, guidelines for the choice of format have not been specified in the literature. The present review aimed to compare group and couple CBT and to formulate recommendations concerning when to choose one approach over the other.

**Recent Findings** Although group CBT has been studied more extensively via randomized clinical trials, both approaches are helpful in reducing women's pain and improving their sexual function/satisfaction. Advantages of group CBT include cost-effectiveness and social support, whereas advantages of couple CBT include incorporating the partner and focusing on couples' intimacy.

**Summary** Given its cost-effectiveness, group CBT should constitute a first-line treatment. Couple CBT should be recommended when both partners are motivated to improve their sexuality and relationship.

**Keywords** Genito-pelvic pain · Cognitive-behavioral · Couple therapy · Group therapy · Treatment · Relationship factors

## Introduction

The sexual pain disorders dyspareunia and vaginismus—now classified in the DSM-5 as a single entity termed genito-pelvic pain/penetration disorder (GPPPD)—affect 14 to 34% of younger women and 6.5 to 45% of older women [1, 2]. GPPPD involves persistent or recurrent difficulties with vaginal penetration during intercourse for at least 6 months, resulting in clinically significant distress and including but not limited to, pain during vaginal intercourse or penetration attempts, fear about pain during vaginal penetration, and tightening of the pelvic floor muscles during attempted vaginal penetration [2]. Despite the fact that this disorder results in significant sexual, psychological, and relationship impairments for afflicted women and their partners, only 60% of those seek help and 52% never receive a formal diagnosis, let alone appropriate treatment [3].

Although many treatment options have been proposed, including medical, physical therapy, surgical, and psychological, only a handful have been evaluated in a rigorous manner via randomized controlled designs. One such treatment is cognitive-behavioral therapy (CBT), which targets simultaneously the reduction of pain and the improvement of sexual function and satisfaction. CBT has the additional advantage of being amenable to group or couple formats. However, guidelines for choosing one format over the other have not been specified in the literature.

After outlining the repercussions of GPPPD and providing a brief overview of the role of relationship factors in its experience, the present review will compare group and couple CBT, highlighting empirical evidence in support of each approach. It will end with recommendations concerning when to choose couple versus group therapy, potential benefits and

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contraindications for each modality, and common issues encountered in the delivery of CBT.

## Consequences of Genito-pelvic Pain and Associated Difficulties

Women with genito-pelvic pain report significantly poorer quality of life than controls; almost half of affected women report a loss of agency in their lives and 60% report feeling no control over their body as a result of their pain [4]. Genito-pelvic pain is associated with several sexual, psychological, and relational difficulties for both affected women and their partners. Compared to controls, women with genito-pelvic pain report greater sexual distress, lower sexual frequency, and impairments in sexual desire, arousal, genital responsiveness, orgasm frequency, and sexual satisfaction [4–9, 10•, 11–13]. One proposed explanation for their lower sexual satisfaction is that women with genito-pelvic pain perceive fewer sexual rewards and more sexual costs in their sexual relationship compared to both their partners and to women without genital pain [14]. Moreover, affected women endorse less adaptive motives for sex (i.e., more avoidance and less approach sexual goals), and couples coping with genito-pelvic pain use poorer sexual communication than controls [15–17]. Sexual attitudes differ between women with and without genito-pelvic pain, with affected women reporting more erotophobia and holding poorer expectations about sex, and lower sexual self-efficacy, less adaptive cognitions about vaginal penetration, and a reduced sexual repertoire [6, 9, 12, 18–21]. The experience of pain also has implications for the psychological well-being of affected women.

Numerous studies indicate that women coping with genito-pelvic pain are more likely to report symptoms of anxiety and depression relative to women who do not experience this type of pain [21–29] (but see also [6, 11, 30] who found no links between genito-pelvic pain and symptoms of depression). Indeed, a case-control epidemiologic study demonstrated clinical depression and anxiety were both antecedents to and consequences of genito-pelvic pain, suggesting a bidirectional relationship between genito-pelvic pain and psychological distress [31]. Qualitative studies shed light on the nature of distress provoked by genito-pelvic pain: affected women interpret painful intercourse as a sign of failure and report feelings of guilt, shame, and inadequacy due to the pain and its interference to their relationships [32, 33]. Furthermore, women with genito-pelvic pain reported significantly poorer genital self-image and greater distress regarding their body image than women without pain in a sample of pre-menopausal women [28].

Although select studies have found that experiencing genito-pelvic pain was linked to lower relationship satisfaction [6], a systematic review by Smith and Pukall found that, compared to controls, couples affected by genito-pelvic pain were equally satisfied with their relationship [34]. Yet, the intimate nature of the condition places a significant burden on the union of affected couples, with the fear of relationship dissolution due to genito-pelvic pain reported in several samples of women [32, 35, 36] and a negative relational impact of pain reported by affected women, regardless of sexual identity or relationship type (i.e., mixed-sex or same-sex) [37]. Indeed, women with genito-pelvic pain are more likely to endorse insecure attachment styles compared to women who do not experience pain during sex [38]. The relational impact of genito-pelvic pain extends beyond the romantic realm; a recent qualitative meta-analysis found affected women's experience of shame and isolation hinders their relationships with themselves, other women, and healthcare professionals [39].

The partners of women with genito-pelvic pain also experience negative consequences. For example, they report poorer sexual satisfaction, erectile function, and psychological adjustment relative to controls [17, 27]. Partners attribute a negative relational toll to women's genito-pelvic pain and report poorer affectional expression than partners of control women [17]. Together, these findings highlight the scope of influence that this condition may exert on the lives of affected women and their partners.

## Role of Relationship Factors

Although genito-pelvic pain frequently occurs within a relational context (i.e., during sexual activities), relationship factors have received relatively little empirical attention until recently. Nevertheless, studies published to date support the role of these factors in modulating women's pain and both partners' sexuality outcomes.

### Intimacy and Attachment

According to the Interpersonal Process Model of Intimacy, intimacy develops through a dynamic and reciprocal process [40]. It has two main components: disclosure and empathic response. In an observational study involving 50 couples coping with genito-pelvic pain, both partners' observed and reported greater empathic responses were associated with their higher sexual satisfaction and lower sexual distress, and both partners' greater perceived self-disclosure was associated with their better sexual satisfaction [41•]. In another study using the same sample, greater observed empathic response and perceived self-disclosure in women were associated with their higher quality of life, whereas women and male partners' greater empathic responses were associated with both partners' higher relationship satisfaction [42]. Intimacy may thus buffer the negative consequences of genito-pelvic pain.

More distal relationship factors are also thought to play a role in couples' adjustment to genito-pelvic pain. Attachment anxiety involves a negative representation of the self, fear of abandonment, and excessive proximity needs, whereas attachment avoidance involves a negative representation of others, discomfort with emotional intimacy, and excessive self-reliance [43, 44]. Two cross-sectional studies examined the role of romantic attachment in women with genito-pelvic pain. Granot, Zisman-Ilani, Ram, Goldstick, and Yovell [38] showed that higher levels of attachment avoidance were associated with women's greater pain intensity. In a sample of women with genito-pelvic pain and their partners, Leclerc et al. [45] found that women's higher attachment anxiety and avoidance were associated with their own lower sexual function and satisfaction, and partners' higher attachment anxiety and avoidance were associated with their own lower sexual function. By weakening the relational bond, attachment anxiety and avoidance could limit couples' dyadic coping strategies, contributing to worsen pain, sexual function, and sexual satisfaction [46].

## Partner-Related Cognitive-Affective Factors

Given that genito-pelvic pain commonly occurs in a dyadic context, cognitive and affective factors of the woman's partner may play a role in her pain experience. Cross-sectional studies showed that when a partner perceived the woman as confident in her ability to cope with pain (i.e., perceived her pain self-efficacy to be higher), this was associated with her lower pain intensity, whereas when a partner catastrophized about the woman's pain, this was associated with her greater pain intensity [47–49]. Similarly, the association between negative attributions and women's pain was mediated by partners' negative responses to pain; when partners had more negative attributions about the woman's pain (e.g., the pain would remain stable, it was partially the woman's fault), this predicted negative partner responses to pain, which then predicted greater pain for the woman [47].

Partner characteristics such as emotion regulation and self-worth are also thought to play a role in couples' experience of genito-pelvic pain. Awada et al. [50] found that when partners (and women) felt more comfortable with how they expressed their emotions, this was associated with couples' greater sexual and relationship well-being, as well as lower depression scores. In a sample of women with genito-pelvic pain and their partners, Glowacka, Bergeron, Dubé, and Rosen [51] found that when a partner's self-worth was more dependent on the perceived success or failure of their sexual relationship, not only did they experience poorer sexual and relationship satisfaction and more sexual distress, but women also reported lower relationship satisfaction and greater depressive symptoms. Partners of women with genito-pelvic pain tend to view the pain as negatively impacting their sexual interactions, beyond the difficulties with penetrative intercourse, and perceive failures in their sexual relationship as a result [52]. When partners perceive failures in the sexual relationship, basing their self-worth on this relationship was linked to poorer relational and psychosexual well-being for both members of the couple [51]. Catastrophizing, holding negative cognitions about women's pain, or basing one's own self-worth on the sexual relationship may lead partners to respond to the pain in unhelpful ways, contributing to worsen women's genito-pelvic pain.

## Sexual Motivation

Several studies have documented the important role of sexual motivation in women's genito-pelvic pain and couples' psychosocial adjustment [15, 32, 53–56, 57•, 58]. A population-based study indicated that as many as 90% of women who experience pain during sexual intercourse continue to engage in intercourse with their intimate partners [59]. Although they likely have the goal of avoiding this pain, affected women report many reasons for persisting with sex that include wanting to pursue positive outcomes (i.e., approach goals), such as feeling close to their partner, and to avoid negative outcomes (i.e., avoidance goals), such as losing or disappointing their partner [15, 32, 53]. In a recent study, women with PVD reported lower approach and higher avoidance sexual goals than control women, while partners of women with PVD did not differ from control partners in their sexual goals [15]. Such discrepancies highlight the salience of sexual motivation among women struggling with genito-pelvic pain.

In an 8-week daily diary study of women with PVD and their partners, on days when women reported higher approach goals compared to their average level across the study, they reported less pain. They also attended to more positive thoughts and feelings during sex and, in turn, reported greater sexual function and relationship satisfaction [56]. Their partners also appeared to benefit: when women engaged in sex for more approach goals, partners reported focusing on more positive cues during sex and, in turn, had higher sexual function and relationship satisfaction. In contrast, on days when women reported higher avoidance goals, both they and their partners attended more to negative sexual cues, and in turn, women reported greater pain, and both partners reported poorer sexual function.

One of the most common reasons reported by young women for persisting with painful sex is a desire to meet their partners' sexual needs [32, 53]. In another 8-week daily diary study, on days when women with PVD and their partners reported being more motivated to meet their partner's sexual needs—i.e., they reported higher sexual communal strength—both partners reporter greater sexual function, sexual satisfaction, and relationship satisfaction and women reported less anxiety and pain during intercourse [57•, 58]. However, when

affected women were overly focused on a partner's sexual needs and ignored their own needs—i.e., were higher in unmitigated sexual communion—they and their partners reported greater sexual distress and, in turn, experienced poorer outcomes. Thus, it is important to distinguish between being responsive to a partner's needs in an adaptive way and prioritizing a partner's needs to the detriment of one's own. Avoidance sexual goals and unmitigated sexual communion may promote the use of less adaptive emotion regulation strategies.

### Partner Responses to Pain

Women's sexual partners have a unique role to play given that they may be perceived as the "cause" of the pain during penetrative sexual activities. Partners typically witness women's reactions to the pain, in addition to experiencing their own reactions. Researchers have studied three types of (mainly male) partner responses to pain during or after sexual activity. Solicitous responses refer to expressions of attention, sympathy, and instrumental support (e.g., *Does this hurt? Should we stop?*); negative responses are demonstrations of anger, frustration, or ignoring the woman's pain (e.g., *It doesn't hurt—it's all in your head! Can't you just deal with it?*); and facilitative responses are those that show affection and encouragement of adaptive coping (e.g., *I love you. Do you want to try a less painful sexual position?*). In a series of cross-sectional and daily diary studies, greater negative and solicitous partner responses were associated with women's greater pain [60, 61•] and couples' greater anxiety and depression [61•, 62•], lower sexual function [63], and sexual and relationship satisfaction [64]. These types of partner responses may reinforce couples' avoidance of pain and sex and promote negative cognitive-affective appraisals of the pain (e.g., higher catastrophizing, reduced self-efficacy), thus interfering with couples' pain-related coping and emotion regulation. In contrast, greater facilitative partner responses were associated with women's lower intercourse pain [61•, 65] and better sexual function [63], as well as couples' greater relationship and sexual satisfaction [64, 65]. It may be that facilitative responses foster greater intimacy and promote couples' use of more effective emotion regulation and coping strategies in the face of pain.

Partner responses also play an important role in women's depressive symptoms, though this association depends on women's level of relationship satisfaction. In a daily diary study of couples coping with PVD, facilitative responses were linked to women's lower depressive symptoms only on days following women's higher relationship satisfaction [60], suggesting that the benefits of facilitative responding may be restricted to women who are more relationally satisfied. Similarly, higher relationship satisfaction had a buffering effect on the association between greater negative partner responses and women's depressive symptoms. Finally, in the case of solicitous responses, women's depressive symptoms were higher on days after men's relationship satisfaction was high, and lower on days after men's relationship satisfaction was low, suggesting that partner solicitousness was linked to women's greater depression only when their male partners were more satisfied with their relationship. Thus, daily relationship satisfaction may protect couples against male partner difficulties in self-regulation during or after painful sex and may potentiate more adaptive coping such as partner facilitative responses [60].

## Cognitive-Behavioral Therapy

### Group CBT: What Does It Look like?

Cognitive-behavioral therapy is the most commonly used and most studied psychological intervention to date. Contrary to some more traditional sex therapy methods focusing primarily on sexuality, this treatment has the two-fold aim of reducing pain and improving sexual function and satisfaction, by targeting the thoughts, emotions, behaviors, and couple interactions associated with the experience of genito-pelvic pain [10•]. It thus borrows some strategies from cognitive-behavioral therapy (CBT) pain management programs. Psycho-education about a multidimensional view of pain and its negative impact on sexuality, as well as on the role of psychological and relationship factors in the maintenance of pain and sexual difficulties, serves as a foundation for this approach. Self-exploration of the genitals and localization of the pain are generally introduced during this initial phase of therapy, as is the regular use of a pain diary to raise awareness about which factors influence pain [66]. The second phase involves targeting individual coping strategies that may lead to increased pain and sexual dysfunction, such as catastrophizing, hypervigilance to pain, avoidance, and excessive anxiety. Exercises associated with this phase may include breathing, discussing the impact of the pain on the romantic and sexual relationship, identifying distressing thoughts, emotions, and couple interactions, learning about what facilitates arousal and desire, how to communicate sexual preferences and needs, and using cognitive restructuring to facilitate more adaptive coping [67]. Although traditionally prescribed in sex therapy, Kegel and vaginal dilation exercises are best done with a physical therapist. During the last phase of treatment, the therapist will help in skill consolidation and maintenance of gains.

### Group CBT: Review of Empirical Work

Bergeron and colleagues investigated the efficacy of group CBT for genito-pelvic pain in two different randomized trials. In the first study, which compared vestibulectomy,

biofeedback, and group CBT in the treatment of women with provoked vestibulodynia (PVD)—the main subtype of GPPPD, participants who received CBT reported significant improvements in pain at a 6-month follow-up [68]. At a 2.5-year follow-up, their ratings of pain during intercourse were equivalent to those of women having undergone a vestibulectomy [69]. In another study, participants were randomly assigned either to a corticosteroid cream or to group CBT for a 13-week treatment period. Intent-to-treat multilevel analyses showed that participants of both groups reported statistically significant reductions on pain measures from baseline to post-treatment and 6-month follow-up, although the CBT group reported significantly more pain reduction at 6-month follow-up [70••]. At post-treatment, women in the CBT condition were significantly more satisfied with their treatment, displayed significantly less pain catastrophizing, and reported significantly better global improvements in sexual function than women assigned to the topical application. Findings suggest that CBT may yield a positive impact on more dimensions of genito-pelvic pain than does a topical treatment. Brotto and colleagues also prospectively evaluated a four-session mindfulness-based, group psychoeducational intervention in an uncontrolled study of 85 women with PVD [71]. Pain self-efficacy, catastrophizing, hypervigilance, and sexual distress and pain during gynecological examination all significantly improved from pre- to post-treatment. Group CBT thus constitutes an empirically validated, non-invasive, and safe psychological intervention for GPPPD.

## CBT Couple Therapy: What Does It Look like?

The first stage of CBT couple therapy for genito-pelvic pain focuses on establishing the therapeutic alliance and setting realistic and specific treatment goals regarding the pain and couples' sexual relationship. This stage involves psychoeducation about a multidimensional view of pain including the role of psychological factors—from both partners' perspective—in the maintenance and exacerbation of the pain and sexual difficulties. The couple explores the woman's genitals (at home) in order to localize the pain and begins journaling about the pain and their sexual interactions.

The second stage focuses on reducing less adaptive pain coping strategies, which couples often collude to maintain (intentionally or not), such as avoidance, catastrophizing, hypervigilance to pain, and excessive anxiety. Simultaneously, this stage aims to increase adaptive strategies, such as approach behaviors and assertiveness, and to promote pain self-efficacy. Drawing from cognitive-behavioral and acceptance-based approaches, interventions include breathing and relaxation exercises (e.g., tantric breathing) that target couple intimacy and relaxation together, as well as cognitive defusion. Promoting more effective communication is one of the most important tools for helping couples navigate the pain and is therefore introduced early and revisited regularly. The couple is taught concrete communication skills that prioritize both the disclosure of thoughts and feelings as well as how to respond to disclosures with empathy, acceptance, and validation. Couples also identify and work toward reducing solicitous and negative partner responses to the pain and promoting facilitative responses. Additional interventions focus on reconnecting with the partner through non-sexual physical and emotional intimacy, expanding the sexual repertoire beyond intercourse, and facilitating experiences of desire and arousal for both partners. For example, sensate focus exercises target couple avoidance of all physical affection and anticipatory anxiety and support the couple in identifying pain-free sexual activities that they find mutually satisfying.

The final phase of therapy involves reviewing and consolidating the learned strategies in relation to the couples' initial therapeutic goals. The couple is encouraged to take responsibility for changes they have made and identify elements that may require continued efforts following the end of therapy.

## CBT Couple Therapy: Review of Empirical Work

The involvement of both members of a couple in sex therapy is not a new concept (e.g., [72]). However, it is only recently that couple-based interventions for specific sexual problems have been developed and tested empirically. While there is some initial evidence that couple treatments for a variety of sexual problems (e.g., erectile dysfunction, premature ejaculation, orgasm difficulties, low desire) are effective, most studies have employed small sample sizes without adequate measurement of outcomes and have not included a control group (e.g., [72–76]).

Corsini-Munt, Bergeron, Rosen, Mayrand et al. [77] recently examined the efficacy of a cognitive-behavioral couple therapy (CBCT) for couples coping with genito-pelvic pain. After a 12-week manualized CBCT intervention (adapted from an empirically supported CBT group therapy for genito-pelvic pain [68, 69]), women experienced a significant decrease in their pain from pre to post-treatment. Women also reported greater sexual function and both women and their partners reported greater sexual satisfaction. In addition, both members of the couples reported declines in their pain catastrophizing and increases in their perceptions of the women's pain self-efficacy, suggesting that they acquired tools to improve their coping. Further, couples reported improvements in their psychological well-being, including decreased anxiety and depressive symptoms. In addition to objective outcome measures, the majority of couples reported that they experienced moderate improvement to complete resolution of the woman's pain, 100% reported improvement in their sexual life, and both men and women reported high levels of treatment satisfaction. While this was only a small

pilot study ($N = 8$ couples), it provides initial evidence for a CBCT approach for couples with genito-pelvic pain.

## Conclusions

### When Might Couple Therapy Be More Beneficial?

Given the accumulating evidence pointing to the important role of relationship factors in the experience of genito-pelvic pain, the sexual and relationship difficulties reported by partners, and the promising pilot findings concerning couple therapy, this treatment should be one of the top options offered to women and their partners. There are also specific instances in which it should be recommended as a first-line intervention. The first scenario in which it should take precedence over group therapy is when there are significant relationship difficulties. Such difficulties may interfere with ongoing group treatment, for example, if a partner sabotages the woman's efforts at improving her condition or exhibits angry and critical remarks on a regular basis [3]. Couple therapy can target these difficulties directly and reduce the negative impact of a more conflictual dynamic on the experience of pain and associated sexual problems. However, in a context where relationship conflict manifests itself in the form of psychological, physical, and/or sexual violence, couple therapy is contraindicated, as it tends to intensify relationship conflict in its early stages and may put both partners at increased risk for violent behavior and potential harm. In such a case, group CBT for the woman with GPPPD may be the best first step, while simultaneously recommending treatment for the violent behavior in one or both partners, as well as treatment for potential comorbidities such as alcohol and drug abuse.

Another instance in which couple therapy may be more beneficial is when women present with a pre-existing mood or anxiety disorder and could be in need of more intensive psychotherapy to cope with the added burden of genito-pelvic pain [31]. Women who have tried multiple treatments with little to no success may also need a more personalized approach, which cannot be offered in group therapy. In both cases, a couple therapy format would facilitate the delivery of patient-centered care and tailoring of the therapy to suit both the woman and her partner's specific needs. Moreover, it would have the advantage of harnessing additional support from the partner and providing therapist support to this partner, who may be at a loss concerning how to manage the woman's distress, as well as present with mood issues of his/her own.

### When Might Group Therapy Be More Beneficial?

Group CBT tends to be more cost-effective, in that it can treat multiple patients in the time usually taken to treat one or two. With parsimony as a guiding principle, this cost-effective option should be the first line of treatment offered to women with GPPPD. It is also ideal for single women or women whose partner is not available every week to attend a couple therapy, or who for other reasons is not interested in a couple intervention. Women who may be isolated and feel inadequate and abnormal due to the pain may benefit from group members' continued support and normalizing of their experience. Group therapy being more structured, it can also be offered more readily by psychology interns or other health professionals with less in-depth psychotherapy training and/or knowledge of psychopathology, further emphasizing the cost-effectiveness of this option. Women who present with either high levels of psychological distress or personality traits that would render them disruptive to group processes may not be ideal candidates for this treatment. Finally, although not yet examined empirically, couple group therapy might be beneficial to many women and their partners. It could represent a logical middle ground between a women-only group therapy and a more costly, time-consuming couple therapy. It thus warrants further scientific study.

### Common Barriers and Issues

When psychological distress reaches clinical levels, this aspect of the woman's presentation should become the focus of the intervention and the first step in the treatment plan. Once mood is stabilized, pain and sexuality-focused CBT becomes more feasible. Reasons for elevated psychological distress can range from a history of childhood maltreatment to significant relationship conflict. Childhood maltreatment can become the focus of treatment if briefer CBT interventions, such as group CBT, are ineffective and the woman is ready to attend to this aspect of her past more directly. However, the mental health professional needs to have sufficient experience and training in trauma-informed psychotherapy and childhood maltreatment should not be presented as the sole cause of GPPPD—a complex, multifactorial phenomenon.

Another issue concerns the common resistance to a psychological intervention. Sometimes, women or couples' first reaction to a mental health professional may be a defensive one. When this occurs, it is important to validate the woman's experience of pain, including its very real physical dimensions, if possible in front of the partner, who may also have doubts about a psychological intervention and/or the cause of the pain. This validation process can be repeated as often as needed throughout therapy. Once the therapeutic alliance is stronger, then one can proceed to the psychoeducation regarding how psychosocial factors can impact the pain experience and how the pain itself, even if originally caused by a medical issue, can be maintained by and result in psychosocial disturbances [67]. Working on the credibility of psychological

treatments is an important part of the initial phase of CBT, whether in group or couple therapy format.

## Moving Forward: Dissemination of Cognitive-Behavioral Approaches

Despite solid scientific evidence supporting their efficacy, cognitive-behavioral approaches for GPPPD still have bad press. On the one hand, sex therapists often do not want to make pain reduction a therapeutic goal, in part because they are skeptical that this is an attainable one. On the other, physicians tend to view CBT as an adjuvant rather than a treatment in and of itself. More work is needed to demystify this treatment approach both to afflicted women and their partners and to health professionals. Beyond the scientific evidence, knowledge mobilization efforts, such as the #ItsNotInYourHead campaign (https://www.youtube.com/watch?v=4zT2NYvXgvs), are critical to promoting a biopsychosocial conceptualization of GPPPD, which will ultimately lift treatment barriers for women, improve the referral process from health professionals, and lead to pain relief and increased sexual wellbeing for afflicted couples.

## Compliance with Ethical Standards

**Conflict of Interest** The authors declare that they have no conflicts of interest.

**Human and Animal Rights and Informed Consent** This article does not contain any studies with human or animal subjects performed by any of the authors.

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