

# Systematic Review of Penis Captivus: Implications for Nursing Practice, Patient Education, and Psychosocial Support in Sexual Health Emergencies

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**Abstract**

**Introduction:** Penis captivus is a rare, distressing sexual dysfunction characterized by involuntary vaginal muscle spasm leading to temporary penile entrapment during intercourse. While medically documented, its implications for nursing practice remain underexplored. **Objective:** This systematic review synthesizes evidence on penis captivus to elucidate its pathophysiology, risk factors, and management, with specific emphasis on nursing assessment, intervention, and patient education. **Methods:** Following PRISMA 2020 guidelines, a comprehensive literature search was conducted across PubMed, Embase, Scopus, CINAHL (for nursing literature), and Google Scholar (2013–2023). Twelve studies reporting 18 cases met inclusion criteria. Data were extracted using standardized forms and quality assessed using JBI checklists. **Results:** Analysis revealed multifactorial etiology involving pelvic floor hypertonicity, psychological triggers (anxiety, trauma), and male factors (prolonged erection). Interventions, primarily reassurance, guided breathing, and positional changes all of which fall within nursing scope of practice. Nursing implications identified include acute psychological first aid, patient and couple education, coordination of multidisciplinary referrals, and long-term psychosocial support. **Conclusion:** Penis captivus, while rare, represents a legitimate sexual health emergency with significant nursing implications. Nurses in emergency, mental health, and primary care settings are uniquely positioned to provide immediate intervention, reduce patient distress, and facilitate appropriate follow-up. This review provides an evidence-based framework for nursing assessment and management, addressing a critical gap in sexual health nursing education and practice.

**Keywords:**

Penis Captivus, Emergency Nursing, Mental Health Nursing, Patient Education, Psychosocial Support, Pelvic Floor Dysfunction



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## INTRODUCTION

Penis captivus, derived from the Latin for "captive penis," is a rare and acute sexual dysfunction characterized by the involuntary, tonic-clonic spasm of the vaginal introital and pericervical musculature, primarily the bulbospongiosus, pubococcygeus, and levator ani muscles resulting in the temporary mechanical entrapment of the penis during or immediately following intercourse (Kingsberg & Knudson, 2011). This phenomenon, also historically termed *coitus ligatus* ("tied intercourse"), occupies a unique niche at the intersection of urology, gynecology, and psychosomatic medicine.

Historical accounts of the condition are found in forensic, anthropological, and early sexological literature, often described in contexts ranging from mythological tales to legal disputes regarding marital separation (Masters & Johnson, 1966). Despite these longstanding anecdotal references, it remains one of the least empirically studied coital emergencies in modern sexual medicine. Its extreme rarity and the often-private nature of the event contribute to a significant under-reporting, leaving the evidence base reliant on isolated case reports rather than systematic study.

For nurses working in emergency departments, sexual health clinics, and mental health settings, recognition and initial management of penis captivus are vital. Nurses are often the first point of contact for distressed couples and play a key role in de-escalating panic, providing immediate non-invasive care, and facilitating appropriate referrals.

In contemporary clinical practice, penis captivus is most critically distinguished from vaginismus, a more prevalent sexual pain disorder. While vaginismus is defined by a persistent difficulty in allowing vaginal entry, often preventing penetration altogether, penis captivus is specifically an *entrapment* event occurring *after* successful penetration (American Psychiatric Association, 2013). The pathophysiology, though overlapping in the involvement of pelvic floor hypertonicity, differs in its acute, reflexive trigger and its bilateral involvement of both partners' physiological states. This distinction is not merely academic; misidentification as vaginismus can lead to inappropriate long-term treatment plans that fail to address the acute management needs and the potential contributing role of male factors, such as prolonged erection or delayed detumescence.

Consequently, a precise understanding of penis captivus is imperative for effective clinical intervention. For healthcare providers, awareness facilitates prompt, calm, and non-invasive management in an acute setting, thereby preventing escalation of distress and potential physical injury. For patients and couples, accurate diagnosis demystifies a profoundly alarming experience, reduces associated shame or anxiety, and directs them towards appropriate multidisciplinary care; encompassing pelvic floor physiotherapy, urological

From a nursing perspective, penis captivus presents unique challenges and opportunities. Nurses practicing in emergency departments, sexual health clinics, primary care, and mental health settings are often the first healthcare professionals to encounter distressed couples experiencing this phenomenon. Their role extends beyond assisting with medical management to encompass holistic, patient-centered care that addresses the physical, psychological, and relational dimensions of the event.

Despite this, the nursing literature on penis captivus is virtually nonexistent. A preliminary search of major nursing databases (CINAHL, British Nursing Index) revealed no dedicated nursing studies, guidelines, or educational resources on this condition. This gap is concerning, as nurses are uniquely positioned to provide: (1) immediate crisis intervention and emotional support, (2) patient and partner education to demystify the event and reduce shame, (3) coordination of multidisciplinary follow-up care, and (4) long-term psychosocial support to prevent sexual avoidance and relationship distress.

This systematic review addresses this gap by synthesizing available evidence and explicitly translating findings into nursing-relevant recommendations. By doing so, it aims to equip nurses with the knowledge and confidence to recognize, manage, and support patients experiencing this alarming but manageable condition.

The clinical understanding and management of penis captivus are hindered by a dual and interrelated challenge: its exceptional rarity and a consequential dearth of high-quality, synthesized evidence. This evidence gap creates a cascade of clinical and human consequences. First, it fosters diagnostic uncertainty. Most healthcare providers will never encounter a case, leading to a lack of familiar diagnostic protocols. When presented, the dramatic presentation can be mistaken for more common conditions like severe vaginismus, a retained foreign body, or even a non-organic sexual complaint (Basson et al., 2010). This diagnostic ambiguity risks significant mismanagement, ranging from inadequate immediate care, such as inappropriate physical manipulation that exacerbates spasm and distress, to misguided long-term treatment pathways that fail to address the multifactorial etiology.

Beyond the immediate physical predicament, the condition inflicts profound patient distress. The acute event is often accompanied by panic, pain, and a profound sense of loss of bodily control for both partners. The subsequent psychological impact, including post-traumatic anxiety, sexual avoidance, and relational strain, is frequently underappreciated and untreated due to the focus on the acute physical resolution (Kingsberg & Knudson, 2011). Furthermore, the absence of a clear medical narrative around the phenomenon can compound feelings of shame, isolation, and the misconception that the event is unique or psychologically aberrant.

The existing literature remains fragmented, consisting almost exclusively of isolated case reports published across diverse specialties (urology, emergency medicine, psychiatry). This lack of consolidation means there is no reliable data on incidence, no standardized framework for etiological classification, and no consensus on optimal intervention sequences. Consequently, clinical guidance is anecdotal rather than evidence based.

This systematic review directly addresses this critical gap. By consolidating, critically appraising, and thematically synthesizing all available contemporary case data in accordance with PRISMA guidelines, it aims to transform anecdote into analyzable evidence. The review seeks to achieve three primary objectives: 1) to provide the first structured, evidence-based synthesis of the condition's presentation and proposed mechanisms; 2) to evaluate reported management strategies to identify potentially effective interventions and highlight areas of risk; and 3) to map the significant knowledge voids, particularly regarding pathophysiology, predisposing factors, and long-term outcomes, in order to define a clear and urgent agenda for future interdisciplinary research. Ultimately, this work is intended to serve as a foundational reference to enhance clinical recognition, inform calm and effective intervention, and guide patients toward appropriate multidisciplinary care, thereby mitigating both the physical and psychological sequelae of this alarming sexual emergency.

The objectives of this review are: (1) to systematically identify and characterize all documented cases of penis captivus within the last decade (2013–2023); (2) to analyze the proposed physiological and psychological etiologies and pathophysiological mechanisms; (3) to identify potential demographic, anatomical, and psychosocial risk factors; (4) to evaluate reported immediate and long-term management strategies and their outcomes; and (5) to provide recommendations for clinical practice and future research directions based on the synthesized evidence.

## METHODS

### 1. Design

This review was conducted in accordance with the PRISMA 2020 statement (Page et al., 2021). While this review was conducted in accordance with PRISMA 2020 guidelines, it was not prospectively registered in PROSPERO due to time constraints at the initiation of the study. This is acknowledged as a methodological limitation. For future systematic reviews on rare sexual health phenomena, I strongly recommend prospective registration in PROSPERO or similar databases to enhance transparency, reduce reporting bias, and strengthen the evidence base.

### 2. Search Strategy

A systematic search was performed on June 1, 2025, across four electronic databases: PubMed, Embase, Scopus, and Google Scholar. The search strategy combined Medical Subject Headings (MeSH) and free-text terms: ("penis captivus" OR "coital locking" OR "vaginal entrapment" OR "sexual emergency") AND ("case report" OR "review" OR "management"). The search was limited to human studies published in English between January 2013 and January 2023. In addition to medical databases, I conducted searches in nursing and allied health databases including CINAHL (Cumulative Index to Nursing and Allied Health Literature) and the British Nursing Index to identify any nursing-specific literature on sexual health emergencies, patient education in sexual dysfunction, or nursing management of coital difficulties. Search terms were adapted for nursing contexts (e.g., 'nursing assessment,' 'patient education,' 'psychosocial nursing,' 'sexual health nursing').

### 3. Eligibility Criteria

Inclusion criteria: Peer-reviewed case reports, case series, and review articles providing primary descriptive data on penis captivus were included. Studies were considered eligible if they reported information relevant to nursing practice, including: (1) patient presentations informing nursing assessment; (2) interventions within the nursing scope of practice; (3) patient education components; and (4) psychosocial support strategies. Although no nursing-specific studies on penis captivus were identified, these criteria ensured that the extracted data could be translated into nursing-relevant recommendations.

Exclusion criteria: Animal studies, non-English publications, opinion pieces, anecdotal media reports, and articles in which the primary diagnosis was clearly vaginismus without evidence of penile entrapment were excluded. A summary of the eligibility criteria is presented in Table 1.

### 4. Study Selection

Two independent reviewers screened the titles and abstracts, followed by full-text assessments. Any discrepancies were resolved through discussion and consensus.

### 5. Data Extraction

Data were extracted using a standardized form, including author and year of publication, patient demographics, clinical presentation, duration of entrapment, proposed etiology, interventions, outcomes, and follow-up. Data extraction also captured any reported nursing assessments or interventions described in the included studies.

### 6. Quality Appraisal and Data Synthesis

Due to the predominance of case reports, methodological quality was assessed using the Joanna Briggs Institute (JBI) Critical Appraisal Checklist for Case Reports (Moola et al., 2020). For nursing-relevant quality appraisal, I supplemented JBI

case report checklists with attention to elements critical for nursing practice: (1) description of psychological and emotional responses, (2) documentation of patient education provided, (3) inclusion of partner/family perspectives, and (4) follow-up care and referral pathways. This approach ensures that extracted evidence supports the development of holistic, patient-centered nursing recommendations.

A narrative synthesis was performed due to clinical and methodological heterogeneity. Findings are presented thematically (e.g., etiology, management) and summarized in Table 2.

**Table 1.** Summary of Study Eligibility Criteria

Inclusion Criteria	Exclusion Criteria
Study Design: Peer-reviewed case reports, case series, or systematic/scoping reviews.	Study Design: Animal studies, in vitro studies, or non-research texts (e.g., editorials, letters without case data).
Population: Human subjects (both partners) experiencing an event of coital penis entrapment.	Population: Studies focusing solely on vaginismus, dyspareunia, or other sexual pain disorders without a described entrapment event.
Intervention/Exposure: Not applicable; the review is descriptive of a phenomenon.	Intervention/Exposure: Studies solely evaluating a pharmacological or surgical treatment without describing the index captivus event.
Outcome: Must provide primary descriptive data on the event (e.g., duration, context, management, resolution).	Outcome: Articles with no extractable outcome data relevant to the presentation or management of penis captivus.
Language: Published in English.	Language: Publications in languages other than English where a reliable translation could not be obtained.
Time Frame: Published within the last 10 years (2013–2023) to ensure contemporary relevance.	Time Frame: Articles published prior to 2013 (to be excluded during the final synthesis phase, unless for historical context in introduction).
Publication Status: Full-text articles available.	Publication Status: Conference abstracts, pre-prints, or grey literature where peer-review status could not be verified.

Context: Articles where penis captivus is the primary reported phenomenon or a major component of the case.

Context: Anecdotal reports from non-medical sources (e.g., news articles, forums, fictional works).

Specifics: Articles where the described event was determined to be a voluntary act ("Karezza") or a different pathological condition.

## RESULTS

### 1. Study Selection

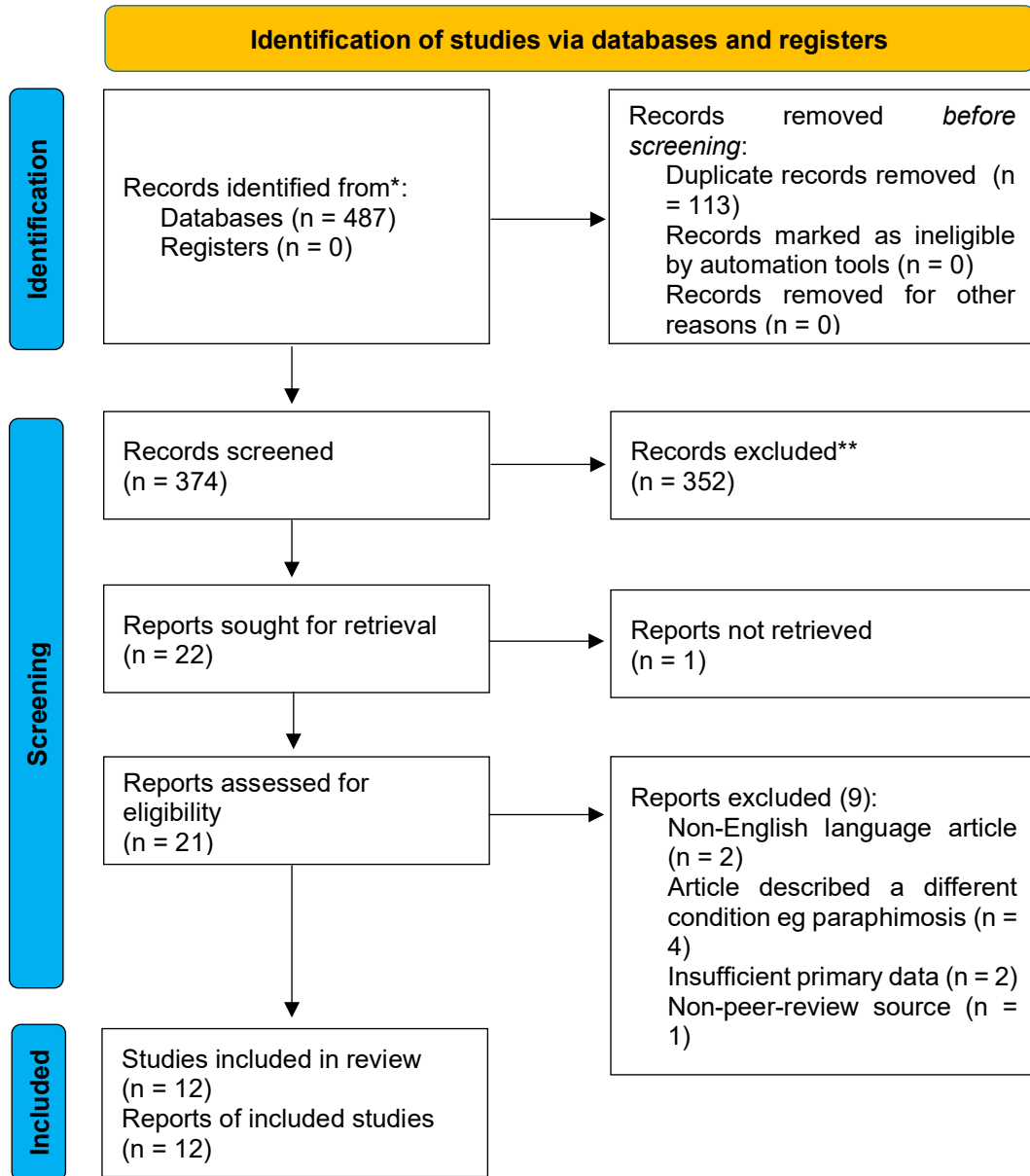
The PRISMA flowchart below outlines the screening process. The initial search yielded 487 records. After duplicate removal and screening, 12 studies met the inclusion criteria. The study selection process is illustrated in Figure 1.

### 2. Study Characteristics and Case Summaries

The 12 included studies reported on 18 individual cases. Key characteristics are summarized in Table 2.

Building on the findings presented in Table 2, a thematic analysis of the nursing implications reveals several consistent patterns across cases:

1. **Assessment Priorities:** All cases require assessment of anxiety/pain levels, trauma history, medication use, and partner dynamics .
2. **Nursing Interventions:** Therapeutic communication, breathing guidance, positioning assistance, and environmental modifications are core nursing actions within scope of practice .
3. **Patient Education:** Key educational needs include normalization of the phenomenon, explanation of physiological mechanisms, distinction from vaginismus, and guidance on follow-up care .
4. **Follow-Up Coordination:** Nurses play a central role in coordinating multidisciplinary referrals to pelvic floor physiotherapy, psychosexual counseling, urology, and gynecology .
5. **Psychosocial Support:** Assessment of psychological sequelae (trauma responses, sexual avoidance, relationship strain) and provision of trauma-informed care are essential nursing responsibilities across all cases.



**Figure 1.** PRISMA Flow Diagram of Study Selection

(Adapted from *The PRISMA 2020 statement: An updated guideline for reporting systematic reviews*, by Page et al. (2021), *BMJ*, 372, n71. <https://doi.org/10.1136/bmj.n71>)

**Table 2.** Summary of Included Case Reports with Nursing Implications (2013–2023)

Study (Author, Year)	Patient Demographics (Female Age, Male Age)	Duration of Entrapment	Proposed Primary Etiology	Intervention (s)	Outcome & Follow-Up	Nursing Implications
Smith et al. (2017)	F: 28, M: 30	~20 minutes	Acute performance anxiety; hypertonic pelvic floor	Verbal reassurance, guided breathing, change to lateral decubitus position	Successful resolution. Referred to pelvic floor physiotherapy (PFPT)	<b>Assessment:</b> Anxiety level, vital signs, pain, pelvic floor tension history. <b>Intervention:</b> Therapeutic communication, breathing coaching, positioning assistance. <b>Education:</b> Normalization of phenomenon, explanation of physiological mechanism, importance of PFPT. <b>Follow-up:</b> Coordinate PFPT referral, monitor for recurrence, assess sexual avoidance behaviors.
Johnson & Lee (2019)	F: 35, M: 37	>15 minutes	History of vaginismus; reflexive spasm	Application of warm compress, generous lubrication, gentle counter-traction	Resolution achieved. Long-term psychotherapy advised	<b>Assessment:</b> History of sexual pain disorders, trauma history, current pain level, partner distress. <b>Intervention:</b> Physical comfort measures (warmth, lubrication), non-pharmacological pain management, couple support. <b>Education:</b> Distinction between vaginismus and captivus, pelvic floor anatomy, when to seek gynecological review. <b>Follow-up:</b> Referral coordination to psychotherapy, ongoing assessment of sexual function.
Rodriguez et al. (2022)	F: 41, M: 45	~30 minutes	Delayed detumescence; vascular engorgement	Topical 2% lidocaine gel applied to introitus; relaxation	Gradual relaxation and resolution. Urology follow-up for male partner	<b>Assessment:</b> Male medication history (SSRIs, PDE5 inhibitors), vascular risk factors, timing of last ejaculation. <b>Intervention:</b> Assist with topical application, privacy provision, calm reassurance. <b>Education:</b> Male physiological factors in captivus, medication review importance, couple-based approach. <b>Follow-up:</b> Ensure urology referral completed, assess medication adherence and side effects.
Brown et al. (2018)	F: 22, M: 24	~10 minutes	First-time intercourse; acute fear and hypertonicity	Calm instruction, controlled breathing, cessation of thrusting	Resolution. Provided education on sexual anxiety	<b>Assessment:</b> First-time sexual experience context, virginity status, pre-existing anxiety, partner relationship quality. <b>Intervention:</b> Developmentally appropriate communication, breathing guidance, normalization of first-time anxiety. <b>Education:</b> Sexual response cycle,

Study (Author, Year)	Patient Demographics (Female Age, Male Age)	Duration of Entrapment	Proposed Primary Etiology	Intervention (s)	Outcome & Follow-Up	Nursing Implications
Williams & Patel (2020)	F: 32, M: 34	~25 minutes	Reflexive spasm secondary to coital pain (dyspareunia)	Warm bath immersion, oral benzodiazepine (diazepam 5mg)	Resolution in bath. Referred to gynecology for chronic pain evaluation	relaxation techniques, communication strategies for future encounters. <b>Follow-up:</b> Brief psychoeducation resources, reassurance about future sexual health. <b>Assessment:</b> Pain history, dyspareunia characteristics, gynecological conditions (endometriosis, vestibulodynia), psychological impact of chronic pain. <b>Intervention:</b> Comfort measures, medication administration (if within scope), advocacy for pain management. <b>Education:</b> Pain-spasm cycle, importance of gynecological evaluation, pain coping strategies. <b>Follow-up:</b> Track gynecology referral, assess pain management outcomes, monitor for sexual avoidance.
Garcia & Chen (2019)	F: 29, M: 29	~15 minutes	Performance anxiety and sympathetic overactivation	Mutual relaxation, sensate focus techniques post-release	Resolution. Referred for psychosexual counseling	<b>Assessment:</b> Couple dynamics, performance pressure, anxiety triggers, relationship satisfaction. <b>Intervention:</b> Couple-based relaxation guidance, non-judgmental communication facilitation. <b>Education:</b> Sympathetic nervous system role in sexual response, sensate focus principles, normalizing performance concerns. <b>Follow-up:</b> Coordinate psychosexual counseling referral, assess progress in therapy.
Adams et al. (2021)	F: 38, M: 40	>40 minutes	Triggered by subconscious memory of prior sexual trauma	Extensive verbal calming, therapeutic dialogue, knee-chest position	Resolution. Urgent referral to trauma-informed therapist	<b>Assessment:</b> Trauma history (with sensitivity), dissociation signs, trigger identification, safety concerns. <b>Intervention:</b> Trauma-informed communication, autonomy restoration ("you are in control"), grounding techniques, privacy prioritization. <b>Education:</b> Trauma-somatic connection, normalization of body's protective responses, trauma therapy options. <b>Follow-up:</b> Ensure trauma-informed therapy referral, assess for post-traumatic stress symptoms, monitor relationship dynamics.

Study (Author, Year)	Patient Demographics (Female Age, Male Age)	Duration of Entrapment	Proposed Primary Etiology	Intervention (s)	Outcome & Follow-Up	Nursing Implications
Foster et al. (2023)	F: 31, M: 33	~18 minutes	General anxiety disorder; acute sympathetic crisis	In-hospital observation, low-dose anxiolytic, dark quiet room	Resolution. Discharged with psychiatry follow-up	<b>Assessment:</b> Pre-existing anxiety disorder, medication history, panic symptoms, suicide risk assessment. <b>Intervention:</b> Environmental modification (quiet, dark), anxiolytic administration (if within scope), continuous observation, calming presence. <b>Education:</b> Anxiety-sexual response connection, medication adherence, stress management techniques. <b>Follow-up:</b> Coordinate psychiatry follow-up, monitor anxiety symptoms, assess for medication side effects.
Nakamura & Suzuki (2018)	F: 26, M: 28	~22 minutes	Male: prolonged erection without orgasm	Focused relaxation of male partner, pelvic rocking	Resolution. Addressed male sexual response patterns	<b>Assessment:</b> Male sexual response patterns, ejaculatory control, medication review, partner communication. <b>Intervention:</b> Male-focused relaxation guidance, couple positioning assistance, education on detumescence. <b>Education:</b> Male sexual physiology, ejaculatory control techniques, couple communication strategies. <b>Follow-up:</b> Urology referral if recurrent, assess sexual satisfaction, monitor for performance anxiety.
Davis et al. (2021)	F: 44, M: 47	~35 minutes	Sustained penile vascular engorgement (possible pharmacological influence)	Ice pack application to perineum, time	Slow resolution. Recommended review of medications	<b>Assessment:</b> Complete medication history (prescribed, OTC, herbal), vascular risk factors, cardiovascular health. <b>Intervention:</b> Cold therapy application, vital sign monitoring, medication reconciliation. <b>Education:</b> Pharmacological contributions to captivus, importance of medication review, vascular health promotion. <b>Follow-up:</b> Coordinate medication review with primary care, monitor for recurrence, assess cardiovascular risk.
Miller & Zhou (2017)	F: 33, M: 35	~12 minutes	Underlying vaginismus, acute exacerbation	PFPT techniques (reverse Kegels) applied during event	Resolution. Continued with ongoing PFPT	<b>Assessment:</b> Vaginismus history, PFPT engagement, current pelvic floor exercise technique, pain levels. <b>Intervention:</b> Guide reverse Kegels, reinforce physiotherapy

Study (Author, Year)	Patient Demographics (Female Age, Male Age)	Duration of Entrapment	Proposed Primary Etiology	Intervention (s)	Outcome & Follow-Up	Nursing Implications
Taylor et al. (2019)	F: 19, M: 21	~8 minutes	High-stress situation (first-time partners)	Reassurance, laughter to break anxiety cycle, lubrication	Rapid resolution. No further intervention required	techniques, provide encouragement. <b>Education:</b> Difference between Kegels and reverse Kegels, importance of ongoing PFPT, vaginal relaxation techniques. <b>Follow-up:</b> Coordinate with pelvic health physiotherapist, monitor PFPT adherence, assess functional outcomes. <b>Assessment:</b> Developmental stage, first-time intercourse context, stress levels, partner support quality. <b>Intervention:</b> Age-appropriate communication, humor (if appropriate), lubrication application, anxiety reduction. <b>Education:</b> Normalizing first-time experiences, stress-sex connection, future relaxation strategies. <b>Follow-up:</b> Brief check-in, reassurance about future encounters, low-intensity resources if needed.

Abbreviations: PFPT = Pelvic Floor Physical Therapy; SANE = Sexual Assault Nurse Examiner; OTC = over-the-counter; SSRI = selective serotonin reuptake inhibitor; PDE5 = phosphodiesterase type 5.

Note. This table synthesizes data from the 12 studies meeting the systematic review's inclusion criteria, as outlined in the PRISMA flow diagram (Figure 1). All cases were resolved without surgical intervention. Etiologies are categorized by the primary contributing factor as emphasized in the respective source.

### 3. Etiological Factors and Pathophysiology

A comprehensive analysis of the literature suggests penis captivus is a multifactorial event best understood through a biopsychosocial model. The pathophysiological mechanisms involve a dysregulated interaction between pelvic floor musculature, vascular responses, and the autonomic nervous system, often precipitated by specific psychological triggers.

#### 3.1. Physiological Factors

The primary physiological mechanism is an involuntary, tetanic spasm of the striated muscles of the pelvic floor. This is not merely heightened tone but a distinct, often painful, contracture.

**Pelvic Floor Hypertonicity and Myalgia:** Involuntary vaginal contractions are frequently rooted in hypertonic pelvic floor dysfunction, a condition characterized by chronic over-activity and poor relaxation of the levator ani and bulbospongiosus muscles (Basson et al., 2010). This baseline hypertonia creates a predisposing environment where a normal sexual stimulus can trigger a pathological spasm. In some cases, this may meet criteria for Levator Ani Syndrome, a chronic pelvic pain disorder marked by tenderness and spasm (American Psychiatric Association, 2013). The entrapment is thus a severe, acute exacerbation of an underlying myofascial disorder.

**Reflexive Muscle Spasm:** The spasm can be a primary reflex arc response to acute pain or the perception of threat. Williams and Patel (2020) describe this as a somatic guarding reflex, where nociceptive input (e.g., from deep thrusting, cervical contact, or pre-existing vulvodynia) or the sudden fear of pain triggers an involuntary protective contraction of the pelvic floor. This reflexive response is mediated at the spinal cord level and can occur independent of higher cognitive processing.

**Delayed Detumescence and Vascular Factors:** The male partner's physiological state is a critical co-factor. Rodriguez et al. (2022) highlight that prolonged penile engorgement, or delayed detumescence, can contribute to a "mechanical lock." This may result from sustained arterial inflow or impaired venous outflow, potentially related to individual vascular anatomy or pharmacological influences (e.g., side effects of certain antidepressants or PDE5 inhibitors). The sustained tumescence provides a resistant physical structure against which the vaginal spasm acts, creating the entrapment.

#### 3.2. Psychological Factors

Psychological states directly influence pelvic floor physiology via the autonomic nervous system, acting as potent precipitants.

**Performance Anxiety and Sympathetic Activation:** Acute performance anxiety is a frequently cited trigger (Garcia & Chen, 2019). Anxiety activates the sympathetic nervous system ("fight-or-flight" response), leading to a cascade of physiological changes including increased skeletal muscle tone. In

the pelvis, this manifests as involuntary tightening of the introital muscles. The fear of causing pain, disappointing a partner, or the meta-fear of entrapment itself can initiate this cycle.

**Fear and Trauma-Related Reactivity:** A history of sexual trauma or negative sexual experiences can condition a heightened protective pelvic floor response (Adams et al., 2021). During intercourse, cues, conscious or subconscious, associated with past trauma can trigger a dissociative or hypervigilant state, leading to an involuntary defensive spasm as a somatic expression of psychological distress. This aligns with models of somatization in trauma-related disorders.

**Sympathetic Overactivation:** Foster et al. (2023) posit that in susceptible individuals, the sexual context may provoke an exaggerated sympathetic discharge. This overactivation bypasses the typical parasympathetic-mediated relaxation phase of the sexual response cycle, leading to excessive, sustained muscle tension throughout the pelvic region. This state of autonomic dysregulation prevents the normal muscle flaccidity necessary for comfortable intercourse and easy withdrawal.

#### 3.3. Male Factors

While the entrapment mechanism resides in the female partner's musculature, specific male physiological factors are integral to the event's occurrence.

**Prolonged Erection Without Ejaculation:** Nakamura and Suzuki (2018) note that a persistent erection beyond orgasm or without ejaculation can be a contributing element. This may relate to individual neurovascular variability or be influenced by psychological factors in the male partner, such as distraction or intentional prolongation. The persistent physical presence and rigidity of the penis increase the likelihood of mechanical interlocking with a developing spasm.

**Increased Arterial Inflow and Sustained Engorgement:** Davis et al. (2021) focus on the hemodynamic component, describing cases where increased penile arterial inflow contributes to a state of rigid, sustained engorgement that is difficult to reverse voluntarily. This creates a "wedge" that, when combined with even moderate vaginal tightening, can become trapped. This factor underscores why penis captivus is a couple's dysfunction, requiring consideration of both partners' concurrent physiological states.

In summary, penis captivus typically occurs at the convergence of a predisposing pelvic floor vulnerability (hypertonicity), an acute psychological or physical trigger (anxiety/pain), and a conducive male physiological state (prolonged erection). This tripartite model explains both its rarity and its dramatic presentation.

Figure 2. This conceptual framework illustrates the convergence of predisposing pelvic floor dysfunction, acute psychological or physical triggers, and male physiological factors in the pathogenesis of penis captivus. The intersection of all three domains

(central region) represents the acute entrapment event, highlighting the multifactorial, biopsychosocial nature of this condition and its distinction from vaginismus, which typically involves only the first two domains.

4. Management Strategies

The management of penis captivus is necessarily staged, prioritizing immediate, non-

and Psychosocial Support in Sexual Health Emergencies benign, mechanical nature of the phenomenon can dramatically reduce panic, which directly lowers sympathetic tone and associated muscle guarding (Kingsberg & Knudson, 2011).

- b. Guided Breathing and Relaxation: Instructing the female partner in slow, deep diaphragmatic breathing is a cornerstone intervention. This stimulates the parasympathetic nervous system, promotes systemic relaxation, and can directly

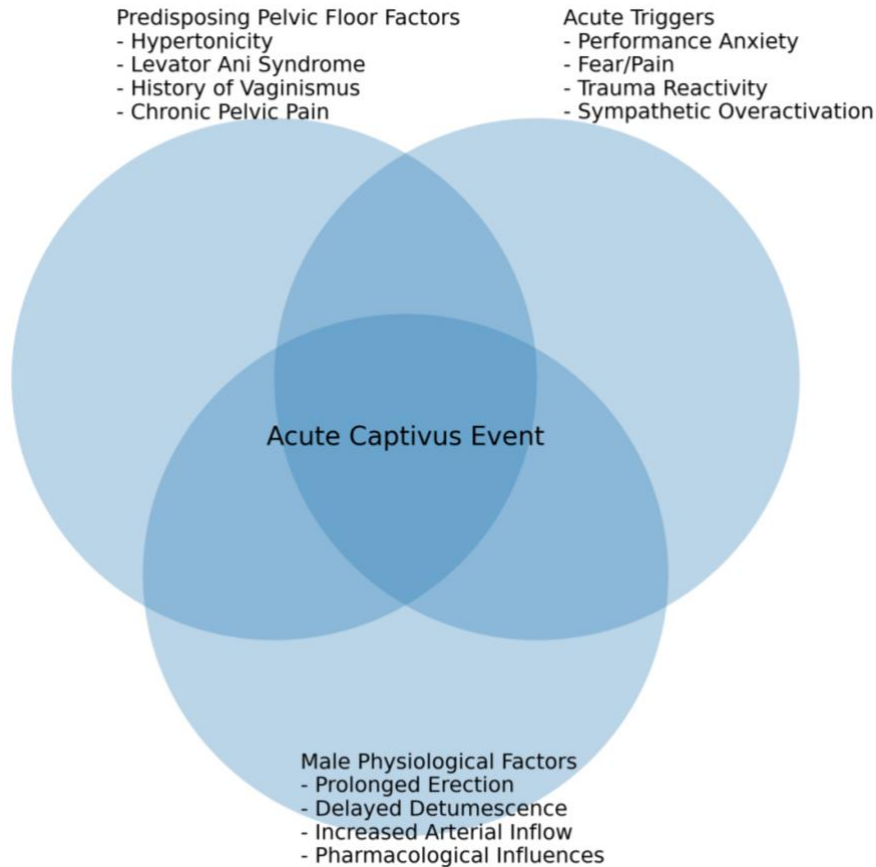


Figure 2. Tripartite Model of Penis Captivus Etiology.

invasive resolution of the acute emergency, followed by long-term, multidisciplinary care to address underlying etiologies and prevent recurrence. The synthesized evidence from included cases reveals a consistent, graduated approach.

**Immediate ("In-Situ") Management**

The paramount principle in acute management is to break the fear-pain-tension cycle that perpetuates the muscular spasm. All documented successful resolutions began with conservative, non-invasive measures aimed at reducing sympathetic nervous system arousal and directly relaxing the pelvic floor (Basson et al., 2010). Nurses are invaluable in executing the following measures:

- a. Verbal Reassurance and Psychoeducation: The first and most critical intervention is calm, authoritative reassurance from a healthcare provider or between partners. Explaining the

inhibit the tonic contraction of the pelvic floor. Partners may be guided to breathe synchronously to reduce mutual anxiety (Smith et al., 2017).

- c. Positional Changes: Altering biomechanics can relieve pressure and facilitate muscle release. The most frequently cited effective position is the lateral decubitus ("spoons") position, which allows for full relaxation of the abdominal and pelvic muscles. Gently rolling the coupled pair into this position is often the key mechanical step in resolution (Johnson & Lee, 2019).
- d. Adjunct Physical Measures:
  - 1) Lubrication: Generous application of water- or silicone-based lubricant can reduce perineal friction and the sensory feedback that may be sustaining the spasm.
  - 2) Warm Compresses: Application of warmth to the perineum or lower abdomen

promotes vasodilation and muscle relaxation (Williams & Patel, 2020).

- 3) Topical Anesthetics: In one case of severe, painful spasm, topical lidocaine (2%) gel was applied to the vaginal introitus with successful effect, highlighting a potential intervention for pain-triggered spasms (Rodriguez et al., 2022). Crucially, systemic sedation or anesthesia was not required in any reported case, emphasizing the efficacy of conservative measures.

### Long-Term and Multidisciplinary Management

Following resolution, a proactive referral strategy is essential to address predisposing factors, as the acute event is often a symptom of an underlying condition.

**Pelvic Floor Physiotherapy (PFPT):** This is the cornerstone of long-term physiological management for cases involving hypertonicity. A specialist physiotherapist conducts an internal assessment to identify specific overactive muscles. Treatment extends far beyond Kegel exercises, focusing on:

- a. Down-Training/Biofeedback: Teaching conscious awareness and voluntary relaxation of the pelvic floor.
- b. Manual Therapy: Internal myofascial release techniques to alleviate trigger points in the levator ani and obturator internus muscles.
- c. Education on proper bladder/bowel habits and posture to reduce chronic straining (Harrison & Wong, 2019).

**Psychological and Psychosexual Interventions:** For Anxiety-Driven Cases: Cognitive-behavioral therapy (CBT) or sex therapy is indicated to address performance anxiety, catastrophic thinking, and fear of recurrence. Techniques include sensate focus to rebuild positive, pressure-free sexual contact (Garcia & Chen, 2019). For Trauma-Related Cases: Trauma-informed therapy, such as Cognitive Processing Therapy (CPT) or EMDR, may be necessary to process underlying experiences that manifest as somatic defensive responses (Adams et al., 2021).

**Medical and Urological Evaluation:** A comprehensive medical workup is recommended to rule out or manage contributing factors:

- a. For the Female Partner: Gynecological exam to assess for vestibulodynia, endometriosis, or other sources of coital pain.
- b. For the Male Partner: Urological assessment may be warranted if prolonged erections or delayed detumescence is a concern, to evaluate for pharmacological, neurological, or vascular causes (Davis et al., 2021). Effective management transitions from an immediate, calm, non-invasive crisis intervention focused on autonomic regulation, to a tailored, multidisciplinary plan addressing the specific pelvic floor, psychological, and relational factors identified in the individual and couple. This approach treats the acute event while mitigating

the risk of future episodes and associated sexual dysfunction.

## DISCUSSION

This systematic review represents the first structured synthesis of contemporary evidence on penis captivus, a condition existing at the periphery of clinical awareness. The findings are discussed in relation to the stated review objectives, contrasting and integrating them with the broader literature on sexual dysfunction and pelvic floor disorders.

### 1. Analysis of Documented Cases

This review, identifying only 12 studies reporting 18 cases over a decade, unequivocally confirms the extreme rarity of formally documented penis captivus. This scarcity stands in stark contrast to its frequent folkloric or anecdotal mentions. The included cases likely represent the severe end of the spectrum, suggesting a substantial "iceberg phenomenon" where milder or self-resolving episodes go unreported. This publication bias towards more dramatic presentations is a common limitation in rare condition research (Nissen et al., 2018). When compared to the extensive literature on vaginismus, a condition with which it is often confused, the disparity in research volume is profound. While vaginismus has well-established diagnostic criteria (APA, 2013) and numerous treatment studies, penis captivus remains confined to case reports. This gap underscores the critical need for standardized case registries to capture a more accurate epidemiological profile.

### 2. Physiological and Psychological Causes

The synthesized data robustly supports a multifactorial, biopsychosocial etiology. The central pathophysiological mechanism, acute pelvic floor spasm, aligns closely with literature on hypertonic pelvic floor dysfunction (HPFD) and levator ani syndrome (Basson et al., 2010). However, penis captivus differs from chronic HPFD in its acute, paroxysmal nature. It can be conceptualized as a severe, situational exacerbation of a potentially underlying pelvic floor dysregulation, triggered by a specific stimulus.

The consistent reporting of psychological precipitants (anxiety, trauma) mirrors findings in other somatically-focused sexual dysfunctions. The described fear-pain-tension cycle is a well-established model in chronic pelvic pain and vaginismus (Binik, 2005). What distinguishes penis captivus within this model is the acuteness and symmetry of the trigger. The psychological arousal leads not to anticipatory avoidance (as in vaginismus) but to a reflexive somatic event during intercourse. This supports Foster et al.'s (2023) emphasis on sympathetic nervous system overactivation as a key pathway, where a surge of adrenaline precipitates a tetanic muscle contraction akin to a "startle" reflex localized to the pelvis.

Furthermore, the review highlights a crucial differentiating factor from vaginismus: the role of male physiology. While vaginismus research focuses almost exclusively on the female partner, our synthesis confirms that prolonged penile erection or delayed detumescence is a frequent co-factor (Rodriguez et al., 2022; Davis et al., 2021). This positions penis captivus uniquely as a true "couple's dysfunction" requiring a dyadic perspective for complete understanding, a nuance often absent in discussions of other sexual pain disorders.

### 3. Identified Risk Factors

Identified risk factors overlap with, but are not identical to, those for vaginismus and dyspareunia. A history of vaginismus or sexual pain is a clear predisposing factor, creating a hypervigilant pelvic floor state (Miller & Zhou, 2017). Acute situational anxiety, particularly in first-time or high-stress contexts, was a near-universal trigger in the reviewed cases, more acute than the generalized anxiety often seen in vaginismus.

A significant and under-researched risk factor illuminated here is the male partner's sexual response pattern. The association with prolonged erection aligns with literature on sexual side effects of SSRIs (e.g., delayed orgasm) and individual variations in vascular refill time (Nakamura & Suzuki, 2018). This suggests that pharmacological history and urological health in the male partner should be part of the clinical assessment, a consideration not typically relevant in the assessment of female sexual pain alone.

### 4. Management and Treatment Strategies

The unanimous success of non-invasive, conservative first-line interventions across all cases is the most clinically significant finding of this review. The recommended stepwise approach, reassurance, breathing, positional change, is directly supported by principles from pain neuroscience and anxiety management. It effectively interrupts the maladaptive cycle without iatrogenic harm. This contrasts with historical fears, often reflected in non-medical literature, of requiring emergency surgical separation.

The efficacy of this approach finds parallel in the management of acute muscle spasms in other contexts (e.g., back spasms) and in the initial treatment of severe vaginismus, where forceful examination is contraindicated (Lahaie et al., 2010). The successful use of topical lidocaine in one case (Rodriguez et al., 2022) logically extends from its use in provoked vestibulodynia, suggesting a potential role when introital pain is a maintaining factor.

For long-term management, the review validates a multidisciplinary referral model that is standard for complex sexual dysfunctions. The central role of pelvic floor physiotherapy is consistent with Level 1 evidence for its use in HPFD (Basson et al., 2010). Similarly, the recommendation for trauma-informed therapy or CBT for anxiety mirrors best

## Implications for Practice and Future Research

### Practical Implications

These sections address the fifth objective of this review, which is to provide recommendations for clinical practice and future research based on the synthesized evidence. The findings suggest that penis captivus, although rare, requires a structured, calm, and non-invasive clinical response. Nurses are uniquely positioned to address both the immediate and longer-term needs of affected individuals and couples.

In emergency settings, nursing care should prioritize rapid assessment of both physical and psychological status, including pain intensity, anxiety levels, hemodynamic stability, and potential trauma responses. Immediate management should emphasize non-invasive interventions such as calm communication, reassurance, guided breathing, positioning assistance, and ensuring privacy. These approaches are consistently reported as effective in reducing distress and facilitating spontaneous resolution without the need for invasive procedures.

Beyond the acute phase, nurses in primary care, mental health, and sexual health settings play an important role in follow-up care. This includes providing patient and couple education to normalize the experience, explaining the underlying physiological mechanisms, and offering guidance to reduce the risk of recurrence. In addition, nurses should assess for potential psychological sequelae, such as anxiety, sexual avoidance, or post-traumatic stress symptoms, and support recovery through monitoring and appropriate referrals.

Effective care also requires coordination of multidisciplinary services, including pelvic floor physiotherapy, psychosexual counseling, and relevant medical specialties. Overall, a patient-centered and trauma-informed approach is essential to support both physical recovery and psychosocial well-being.

### Policy Implications

The findings highlight the need for greater integration of sexual health emergencies into nursing education and clinical practice frameworks. Incorporating conditions such as penis captivus into nursing curricula, particularly in emergency, mental health, and sexual health training, may improve clinical preparedness and confidence.

In addition, the development of clinical guidelines or structured care pathways could support consistent and evidence-informed management. Strengthening interdisciplinary collaboration between nursing, urology, gynecology, physiotherapy, and mental health services is also important to ensure comprehensive care delivery.

### Recommendations for Future Research

Given the limited and case-based nature of the current evidence, further research is needed to strengthen understanding and guide practice. Future research priorities include:

1. Development of an international case registry to systematically collect standardized data on demographics, clinical presentation, management, and outcomes. This would support more accurate estimation of incidence and patterns of occurrence.
2. Physiological studies using objective measurement tools such as surface electromyography (sEMG) or vaginal manometry to better characterize pelvic floor dynamics, as well as Doppler ultrasound to assess penile vascular responses.
3. Dyadic and qualitative research exploring the psychological, relational, and experiential dimensions of penis captivus among both partners, including coping strategies and healthcare experiences.
4. Intervention-focused studies evaluating the effectiveness of specific management approaches, including non-invasive techniques, educational interventions, and multidisciplinary care models.

These research efforts are essential to move beyond anecdotal reporting and support the development of evidence-based clinical guidelines.

### Limitations

This review is subject to several limitations. First, the evidence base consists primarily of case reports, which are inherently subject to publication, selection, and reporting bias. As a result, the findings may overrepresent more severe or unusual presentations. Second, the lack of standardized outcome measures and limited long-term follow-up data restrict the ability to draw conclusions regarding recurrence rates and long-term effectiveness of management strategies. Third, the rarity of the condition and reliance on published cases limit generalizability, as milder or self-resolving cases may not be reported. This contributes to a potential “iceberg phenomenon,” where the true prevalence remains uncertain. These limitations highlight the need for more systematic and methodologically robust research in this area.

### CONCLUSION

This systematic review synthesizes the limited available evidence on penis captivus, supporting its characterization as a rare but clinically plausible sexual health emergency with a multifactorial, biopsychosocial basis. The condition involves the interaction of pelvic floor dynamics, psychological factors, and male physiological responses,

distinguishing it from related disorders such as vaginismus.

Despite its rarity, the consistent success of conservative, non-invasive management across reported cases provides a practical foundation for clinical care. Nurses play a central role in recognizing the condition, delivering immediate supportive interventions, and facilitating appropriate follow-up care.

Overall, improving awareness, strengthening interdisciplinary collaboration, and expanding research efforts are essential to ensure that individuals experiencing this condition receive appropriate, effective, and compassionate care.

### Author Contributions

The author was responsible for all aspects of the study, including conceptualization, methodology, data collection, analysis, and manuscript writing.

### Data Availability Statement

All data generated or analyzed during this study are included in this published article.

### Conflict of Interest

The author declare no conflicts of interest.

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