

FEMALE SEXUAL DYSFUNCTION THROUGH A PSYCHOLOGICAL LENS: FROM CLINICAL IDENTIFICATION TO MULTIDISCIPLINARY INTERVENTION IN VIETNAM

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INTRODUCTION

Female Sexual Dysfunction (FSD) in Vietnam is a multifaceted clinical entity where somatic symptoms often mask deep-seated psychological conflicts and cultural barriers. Through a psychological lens, vaginismus is not merely a physiological contraction but a "body's narrative" of fear, disgust, or trauma. Clinical identification must therefore shift from purely anatomical screening to an in-depth exploration of psychological determinants. This report analyzes three distinct cases to demonstrate how divergent etiologies—ranging from simple phobias to complex childhood trauma—necessitate a multidisciplinary, biopsychosocial intervention model to restore sexual health and relational harmony.

TRIPLE-CASE CLINICAL NARRATIVES

Case 1: The Behavioral Success (Phobic-Avoidant Vaginismus). A 26-year-old female, married for two years, presented with primary vaginismus and a persistent fear of pain during intercourse. Despite a strong desire for consummation (FSFI: 23.7) and only mild anxiety (DASS-21), she was unable to achieve penetration. **Etiology:** The condition was identified as a conditioned fear response to perceived pain. **Intervention:** The strategy utilized systematic desensitization and gradual vaginal dilation. By addressing the behavioral avoidance and providing psychoeducation, the patient successfully achieved full intercourse within two months. This case represents the "straightforward" psychological pathway where targeted behavioral intervention leads to rapid clinical success.

Case 2: The Disgust Barrier and Reproductive Priority. A 36-year-old female, married for nine years, remained unconsummated despite maintaining non-penetrative intimacy. She exhibited a profound disgust-related phobia, characterized by a fear of seeing her own genitalia and a "contamination" anxiety regarding any insertion (FSFI: 16.8). **Etiology:** Her vaginismus was rooted in deep-seated disgust rather than mere pain-fear, making her unready for traditional dilation therapy. **Intervention:** Due to her advanced maternal age and low sexual motivation, the multidisciplinary team prioritized In Vitro Fertilization (IVF) to meet her reproductive goals first. The sexual therapy prognosis remains long-term, highlighting a strategic "goal-shift" in intervention where reproductive needs take precedence over sexual function in complex cases.

Case 3: The Layers of Trauma and Betrayal. A 33-year-old female with one child presented with severe secondary vaginismus (FSFI: 7.5) and significant psychological distress (moderate stress, mild anxiety/depression). **Etiology:** Her condition was a complex "somatic protest" triggered by her husband's infidelity during her pregnancy, layered upon a core childhood trauma. At age six, she witnessed a violent cinematic depiction of rape in the presence of her father, leading to a profound sense of "failed protection" and resentment toward male figures. Her current attempt to resume intercourse was driven by guilt rather than desire. **Intervention:** This case requires trauma-informed care and psychodynamic therapy to process the early-life betrayal and current relational trauma, illustrating that without addressing the "silent narrator" of trauma, physical interventions are likely to fail.

DISCUSSION

The divergence in these cases underscores that the pelvic floor is a "mirror" of the female psyche. Case 1 highlights the efficacy of Behavioral Desensitization for simple phobias. Case 2 introduces the challenge of Disgust-Based Avoidance, where cultural and personal hygiene schemas block sexual progress, necessitating a pragmatic multidisciplinary decision to prioritize fertility (IVF) over immediate sexual function. Case 3 is the most complex, demonstrating Traumatic Somatization, where the body "locks" as a defensive shield against both past childhood trauma and present relational betrayal. In the Vietnamese context, clinicians must look beyond the FSFI scores to understand the "Why" behind the "How." A multidisciplinary approach—integrating gynecological care, reproductive technology, and trauma-informed psychotherapy—is the only way to navigate these diverse psychological landscapes effectively.

CONCLUSION

Psychological difficulties often manifest earlier and serve as a foundation for physical symptoms in FSD. A successful treatment protocol requires close coordination between clinicians and psychotherapists to comprehensively address the patient's needs, particularly within the Vietnamese cultural context.

Keywords: Female Sexual Dysfunction, Vaginismus, Biopsychosocial Model, Psychosexual Therapy, Trauma-Informed Care, Vietnam.