



Trauma and Female Sexual Dysfunction: An Integrative Review of Early Psychological Processes and the Role of Crisis Intervention

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Abstract: This study employs an integrative review design to examine the relationship between trauma and female sexual dysfunction (FSD), with a focus on early psychological processes. Literature published between 2000 and 2025 was analyzed, and studies were evaluated for methodological and conceptual relevance to identify patterns related to trauma exposure, psychological responses, sexual functioning, and intervention-related factors. Thematic synthesis of the select-ed studies resulted in five key themes: (1) peri-traumatic psychological responses, (2) disruption of safety, personal agency, and bodily autonomy, (3) early sexual health vulnerability, (4) behavioral and relational adaptations, and (5) intervention perspectives. The findings indicate that trauma influences sexual functioning through early disruptions in emotional regulation, perceived safety, and interpersonal processes, contributing to a stage of vulnerability prior to the development of clinically defined dysfunction. Based on these findings, a conceptual framework is proposed that reconceptualizes the trauma sexual dysfunction relationship as a dynamic trajectory rather than a direct out-come. Within this framework, crisis intervention is positioned as a moderating factor that may influence this pathway by stabilizing early psychological responses, restoring a sense of safety and control, and supporting adaptive coping. Overall, the study advances a prevention-oriented perspective by emphasizing early-stage processes and intervention. The findings high-light the need for future empirical research examining the impact of early psychological sup-port on long-term sexual health outcomes.

Keywords: Female sexual dysfunction, Trauma, Peritraumatic responses, Early psychological processes, Crisis intervention, Trauma-informed care.

1. Introduction

Female sexual dysfunction (FSD) is a complex and often underrecognized condition involving persistent difficulties in sexual desire, arousal, orgasm, or pain, which can lead to significant personal distress and strain within intimate relationships. It encompasses a wide range of concerns, including reduced sexual interest, impaired arousal, and pain-related conditions such as dyspareunia and vaginismus. Existing research suggests that a substantial proportion of women experience some form of sexual dysfunction during their lifetime, although prevalence rates vary across cultural and methodological contexts [1], [2]. Beyond its physical

manifestations, FSD has important implications for emotional well-being, relationship satisfaction, and overall quality of life [3]. Trauma has increasingly been recognized as a key factor influencing women's sexual health. Such experiences may include acute trauma resulting from a single distressing event, as well as chronic or complex trauma arising from repeated exposure, such as ongoing abuse or intimate partner violence. These experiences unfold across different phases, including the immediate peritraumatic period and the subsequent post-trauma phase. Both forms and phases have been associated with disruptions in sexual functioning [4], [5]. However, much of the existing literature has primarily focused on long-term psychological outcomes, particularly post-traumatic stress disorder (PTSD), emphasizing symptoms such as hyperarousal, avoidance, and emotional numbing [6]. While these frameworks have contributed significantly to understanding trauma-related difficulties, they tend to overlook the immediate psychological responses that occur during the early phase following trauma exposure. The relationship between trauma and sexual dysfunction is multifaceted and involves interacting psychological, behavioral, and physiological processes. Trauma can influence perceptions of safety, trust, and bodily autonomy, which are central to healthy sexual functioning. Early reactions such as fear, confusion, and loss of control may shape how individuals interpret and respond to intimate experiences, potentially contributing to later difficulties. Despite this, existing models often conceptualize trauma outcomes in a linear and long-term manner, with limited attention to how early-stage processes influence the trajectory of sexual health. A critical gap in the literature lies in the limited focus on the peritraumatic phase the period immediately following trauma, typically within the first few days to weeks. This phase may represent a crucial window during which initial psychological responses are formed and can be shaped by timely intervention. While therapeutic approaches for established sexual dysfunction are well documented, comparatively little attention has been given to preventive strategies that operate during this early stage. In addition, current frameworks rarely incorporate key recovery processes such as the restoration of safety, personal agency, and bodily

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autonomy in shaping post-trauma outcomes. Similarly, crisis intervention defined as immediate, short-term psychological support following traumatic events—has not been systematically integrated into models addressing female sexual dysfunction. In response to these gaps, the present study adopts an integrative review approach to examine the relationship between trauma and female sexual dysfunction, with a specific focus on early peritraumatic responses. It further explores the conceptual role of crisis intervention as a moderating factor within this pathway. By emphasizing a critical early window for intervention, this paper proposes a conceptual framework that shifts attention from long-term outcomes to early-stage processes. Within this framework, early psychological support is conceptualized not only as a means of stabilizing distress but also as facilitating the restoration of safety, control, and emotional regulation. These processes may enhance psychological resilience, promote adaptive coping, and reduce the impact of fear, shame, and social stigma. Importantly, they may also contribute to rebuilding sexual confidence and a positive sense of bodily autonomy, thereby influencing long-term sexual health outcomes. This perspective offers a novel and integrative direction for future research and clinical practice. By emphasizing early-stage processes, this study shifts the focus from long-term outcomes to the peritraumatic phase of trauma response. The proposed framework offers a novel integration of existing literature by conceptually positioning early psychological intervention as a moderating factor that may influence the trajectory from trauma exposure to sexual health outcomes. This perspective highlights an important gap in current research and provides a foundation for future empirical investigation.

2. Study Design

This study adopts an integrative review approach to examine the relationship between trauma and female sexual dysfunction, with a specific focus on early psychological responses occurring during the peritraumatic phase. In addition, it explores the conceptual role of crisis intervention and women's empowerment within this pathway. The integrative approach is well suited to this topic, as it allows for the inclusion and synthesis of diverse forms of evidence, including qualitative, quantitative, and theoretical studies, thereby supporting the analysis of complex and multidimensional phenomena. The review process was guided by the framework proposed by Whitemore and Knafl [1], which includes stages such as problem identification, literature search, data evaluation, analysis, and synthesis. This framework enables a structured yet flexible integration of findings across studies, facilitating the identification of patterns, gaps, and conceptual relationships within the literature. A comprehensive literature search was conducted using electronic databases including PubMed, Scopus, and Google Scholar. Keywords related to trauma, female sexual dysfunction, peritraumatic responses, crisis intervention, and psychological outcomes were used in various combinations to identify relevant studies. The search included publications from 2000 to 2025, with particular emphasis on recent studies to reflect current developments in the field.

Studies were selected based on predefined inclusion criteria, including relevance to trauma and female sexual dysfunction, focus on early psychological or emotional responses, and publication in peer-reviewed journals. Both empirical and theoretical studies were included to ensure a comprehensive understanding of the topic, particularly in areas where empirical evidence remains limited. Data from the selected studies were analyzed using a thematic synthesis approach. Themes were identified by examining patterns related to trauma exposure, peritraumatic responses, disruption of safety and control, and early sexual health vulnerability. These themes were subsequently integrated to develop a conceptual framework highlighting the role of early intervention and empowerment in shaping sexual health outcomes.

3. Problem Identification

This review examines the relationship between trauma and female sexual dysfunction, with a particular focus on early psychological processes that may shape this association. While existing research consistently demonstrates a link between traumatic experiences and adverse sexual health outcomes, the mechanisms underlying this relationship are often examined in isolation and primarily within long-term frameworks. Current literature has largely emphasized post-traumatic outcomes, particularly post-traumatic stress disorder (PTSD), in explaining disruptions in emotional regulation, cognition, and interpersonal functioning. Although these factors are closely associated with difficulties in sexual desire, arousal, and overall satisfaction, such approaches tend to overlook the immediate psychological responses that occur during the peritraumatic phase. Consequently, there remains limited understanding of how early responses to trauma influence subsequent sexual health trajectories. In addition, existing research is predominantly treatment-oriented, focusing on interventions after sexual dysfunction has already developed. Comparatively little attention has been given to preventive approaches operating in the immediate period following trauma exposure. Crisis intervention, defined as immediate and short-term psychological support, has not been systematically integrated into frameworks addressing female sexual dysfunction. Furthermore, current models rarely incorporate key recovery processes such as the restoration of safety, personal agency, and bodily autonomy in shaping post-trauma outcomes. These factors are central to rebuilding trust, reducing fear and shame, and supporting healthy relational and sexual functioning. In response to these gaps, the present review is guided by the following research question:

How does trauma influence the development of female sexual dysfunction during the peritraumatic phase, and how can early psychological intervention processes, including crisis support and the restoration of safety and agency, be conceptualized as moderating factors within this relationship?

4. Data Sources and Search Strategy

A structured literature search was conducted to identify studies examining the relationship between trauma and female

sexual dysfunction, with particular attention to early psychological processes and intervention. Electronic databases including PubMed, Scopus, and Google Scholar were searched to ensure comprehensive and interdisciplinary coverage. The search strategy utilised combinations of keywords and Boolean operators, including "female sexual dysfunction" AND "trauma", "sexual abuse" AND "female sexual function", "intimate partner violence" AND "female sexual dysfunction", "peritraumatic responses" AND "psychological impact", and "crisis intervention" AND "trauma outcomes." Additional variations of these terms were applied, and reference lists of selected studies were manually screened to identify relevant articles.

Studies published between 2000 and 2025 were included to capture both foundational and recent research, with greater emphasis on literature from the past decade. Inclusion criteria comprised peer-reviewed studies published in English, focused on female populations, and examining trauma in relation to sexual dysfunction and early psychological processes. Both empirical (qualitative and quantitative) and theoretical studies were considered. Studies were excluded if they focused on male populations, did not address trauma-related sexual outcomes, were non-peer-reviewed, duplicated across databases, or lacked sufficient methodological or conceptual clarity.

5. Data Evaluation

Following the application of inclusion and exclusion criteria, the selected studies were systematically evaluated to ensure their relevance, quality, and contribution to the research question. Given the integrative nature of this review, which incorporates diverse methodological approaches, the evaluation process emphasized both methodological rigor and conceptual relevance rather than adherence to a single hierarchy of evidence.

Each study was assessed using the following criteria:

- Relevance to the research focus, particularly in relation to trauma, female sexual dysfunction, and early psychological responses following trauma.
- Clarity of study objectives and research design, including the appropriateness of the methods employed.
- Theoretical or empirical contribution, especially in explaining mechanisms linking trauma exposure to sexual health outcomes
- Consistency and credibility of findings, as reflected in the interpretation and discussion of results.

Both qualitative and quantitative studies were included and evaluated within their respective methodological contexts. The objective was not to rank studies hierarchically, but to ensure that each selected source contributed meaningfully to the overall synthesis.

In addition, particular attention was given to studies addressing early psychological processes, behavioral responses, and factors related to safety, control, and relational functioning, as these are central to understanding pathways between trauma and sexual health outcomes. Studies offering

insights into crisis intervention and early-stage support were also included, given the conceptual focus of this review. This evaluation process ensured that the final body of literature provided a coherent and comprehensive foundation for subsequent thematic analysis and the development of the proposed conceptual framework.

6. Data Analysis and Synthesis

The selected studies were analyzed using a thematic synthesis approach to identify, organize, and integrate key patterns across the literature. This approach aligns with integrative review methodology, allowing for the inclusion of diverse study designs while maintaining conceptual coherence. The analysis was conducted in a structured, stepwise manner. Initially, relevant data were extracted from each study and categorized according to their focus, including trauma exposure, early psychological responses, sexual functioning, and intervention-related concepts. These data were then systematically compared to identify recurring patterns, relationships, and conceptual linkages across studies. The analysis resulted in the identification of key themes reflecting the relationship between trauma and female sexual dysfunction within an early-stage framework. These themes move beyond a sole focus on long-term outcomes and instead emphasize immediate psychological responses, disruptions in safety and control, and their influence on sexual health.

The major themes identified include:

- Peritraumatic psychological responses, highlighting immediate reactions such as fear, shock, confusion, and loss of control following trauma [6].
- Disruption of safety, personal agency, and bodily autonomy, influencing perceptions of trust and intimacy [4], [5].
- Early sexual health vulnerability, reflected in avoidance, discomfort, and negative associations with intimacy [7], [8].
- Behavioral and relational adaptations, including withdrawal, avoidance patterns, and difficulties in interpersonal functioning [5], [8].
- Intervention perspectives, emphasizing the limited integration of early psychological support and the potential role of crisis intervention [9], [10].

These themes were further synthesized to examine their interaction within a broader conceptual pathway. Rather than treating findings as isolated observations, the analysis emphasized the dynamic relationships between trauma exposure, early psychological responses, and sexual health outcomes [4], [5]. This integrative approach enabled the identification of a progression in which trauma influences perceptions of safety and control, contributing to early vulnerability in sexual functioning. Importantly, the synthesis highlights a critical gap in the literature regarding early-stage intervention. While long-term therapeutic approaches are well established, the role of immediate psychological support remains insufficiently explored [9], [10]. Within this context, crisis intervention is conceptually positioned as a moderating

factor that may influence the trajectory from trauma exposure to sexual health outcomes.

It is important to note that this study does not evaluate the effectiveness of crisis intervention. Rather, it introduces early psychological support as a theoretical construct derived from the integration of existing literature, illustrating its potential role in shaping recovery pathways.

The outcome of this analytical process is the development of a conceptual framework that integrates trauma exposure, early psychological processes, and female sexual dysfunction, while highlighting the influence of early intervention. This framework provides a structured basis for understanding the relationships identified in the literature and supports further discussion.

A. Peritraumatic Psychological Responses

Refer to the immediate cognitive and emotional reactions that occur during and shortly after exposure to a traumatic event. The literature consistently highlights that individuals may experience intense emotional states such as fear, shock, confusion, and helplessness during this phase [6], [7]. These responses often reflect a disruption in the individual's ability to process and regulate the traumatic experience in real time.

B. Disruption of Safety, Personal Agency, and Bodily Autonomy

A central theme emerging from the literature is the disruption of perceived safety, personal agency, and bodily autonomy following trauma exposure. Experiences such as sexual abuse, assault, and intimate partner violence can significantly alter an individual's sense of control over their body and environment, which are fundamental to healthy sexual functioning [4], [5]. These disruptions often extend beyond the immediate event, influencing how individuals perceive trust, vulnerability, and interpersonal boundaries.

In the early phase following trauma, individuals may experience a diminished sense of control and increased sensitivity to threat. This can result in difficulties in trusting others and engaging in intimate relationships, as interactions that were previously perceived as safe may now be associated with discomfort or fear. Such changes are particularly relevant in the context of sexual relationships, where a sense of safety and autonomy is essential for positive experiences.

The loss of bodily autonomy further contributes to altered self-perception and relational functioning. Individuals may feel disconnected from their bodies or perceive a lack of ownership over their physical experiences, which can interfere with sexual expression and responsiveness. These disruptions can create barriers to intimacy, reinforcing avoidance and emotional withdrawal over time.

Overall, the literature suggests that trauma impacts sexual functioning not only through psychological distress but also through fundamental changes in how safety, control, and bodily integrity are experienced. Addressing these early disruptions is therefore critical, as they represent key mechanisms through which trauma influences subsequent sexual health outcomes.

C. Early Sexual Health Vulnerability

The literature indicates that trauma can give rise to a state of early sexual health vulnerability, which may emerge before the development of clinically defined sexual dysfunction. In the immediate aftermath of trauma, disruptions in emotional processing, safety, and self-perception can influence how individuals experience intimacy and sexual interaction [7], [8]. These early changes often manifest as discomfort with physical closeness, reduced sexual interest, and negative associations with intimacy.

Such responses are not necessarily indicative of established dysfunction but reflect an initial stage in which sexual functioning becomes vulnerable to disruption. Individuals may begin to associate intimacy with fear, loss of control, or emotional distress, leading to avoidance or reduced engagement in sexual relationships. These patterns are shaped by underlying cognitive and emotional responses, including shame, self-blame, and heightened sensitivity to perceived threat [7].

Over time, if these early vulnerabilities are not addressed, they may contribute to the progression toward more persistent difficulties in sexual desire, arousal, and satisfaction. This highlights the importance of recognizing early-stage changes in sexual functioning as part of a dynamic process rather than as isolated clinical outcomes.

Understanding early sexual health vulnerability is critical for identifying opportunities for timely intervention. Addressing these responses during the initial phase following trauma may help prevent the consolidation of maladaptive patterns and support healthier long-term sexual and relational outcomes [8].

D. Behavioral and Relational Adaptations

Trauma-related experiences are often reflected in behavioral and relational patterns that influence sexual functioning. In the early stages following trauma, individuals may adopt coping strategies aimed at managing distress and maintaining a sense of safety. One of the most consistently reported patterns is avoidance, where individuals withdraw from intimate or sexual interactions as a protective response to perceived threat [5], [8].

These behavioral adaptations may also include emotional withdrawal, reduced communication, and difficulty forming or maintaining close relationships. While such responses may serve an adaptive function in the short term by minimizing distress, they can become maladaptive if they persist over time. Continued avoidance and disengagement can reinforce negative associations with intimacy, further limiting opportunities for positive relational and sexual experiences.

From a relational perspective, trauma can alter expectations of trust and safety within interpersonal contexts. Individuals may experience heightened sensitivity to rejection or vulnerability, leading to difficulties in establishing secure and supportive relationships. These changes can directly impact sexual functioning, as intimacy and emotional connection are closely linked to sexual satisfaction and responsiveness.

Overall, the literature suggests that behavioral and relational adaptations play a significant role in the development of trauma-related sexual difficulties. Addressing these patterns at an early stage is essential to prevent their consolidation and to

support healthier relational and sexual outcomes.

E. Intervention Perspectives and Gap

Existing literature outlines several therapeutic approaches for addressing trauma-related sexual difficulties, including cognitive-behavioral therapy, trauma-focused interventions, and psychosexual counseling [3]. These approaches have demonstrated effectiveness in improving psychological well-being and sexual functioning, particularly when applied after symptoms have become established.

However, a critical gap emerges in the limited attention given to early-stage psychological support following trauma exposure. Most existing models are treatment-oriented, focusing on recovery after the development of dysfunction rather than on prevention during the initial phase. As a result, the potential influence of immediate psychological responses on long-term sexual health outcomes remains insufficiently explored.

Within this gap, crisis intervention can be conceptually positioned as a form of early psychological support provided during the peritraumatic phase. Such interventions aim to stabilize emotional responses, enhance coping capacity, and facilitate the restoration of safety, personal agency, and control [9], [10]. By addressing distress at an early stage, crisis support may reduce the likelihood of maladaptive cognitive, emotional, and behavioral patterns becoming established.

Importantly, this review does not seek to evaluate the empirical effectiveness of crisis intervention in preventing female sexual dysfunction. Rather, it introduces early psychological support as a conceptual mechanism that may influence the trajectory from trauma exposure to sexual health outcomes. This perspective highlights the need to shift from a solely treatment-focused model toward one that integrates prevention and early intervention.

Overall, the findings underscore the importance of incorporating early-stage support into trauma-informed frameworks, offering a potential pathway for improving both psychological and sexual health outcomes in women following trauma.

7. Conceptual Framework

The present study proposes a conceptual framework that integrates findings from the reviewed literature to explain the relationship between trauma and female sexual dysfunction, with a specific focus on early-stage processes. Unlike traditional models that emphasize long-term psychological outcomes, this framework highlights the critical role of peritraumatic responses and early psychological mechanisms in shaping sexual health trajectories. At the foundation of the framework is trauma exposure, including experiences such as sexual abuse, assault, and intimate partner violence. These events act as initiating factors that disrupt psychological functioning and alter fundamental perceptions of safety, trust, and bodily autonomy [4], [5]. Rather than producing immediate clinical dysfunction, trauma initiates a series of early responses that influence subsequent emotional, cognitive, and relational processes. The first stage of the framework involves

peritraumatic psychological responses, including fear, shock, confusion, and a diminished sense of control [6]. These immediate reactions reflect an initial disruption in emotional regulation and cognitive processing. During this phase, individuals begin to interpret and internalize the traumatic experience, which plays a critical role in shaping future responses. These early reactions contribute to a disruption of safety, personal agency, and bodily autonomy. Individuals may experience a reduced sense of control over their bodies and environment, leading to difficulties in trust and increased sensitivity to perceived threat [4], [5]. This disruption represents a key mechanism through which trauma begins to influence intimate and sexual experiences. As these processes evolve, individuals may enter a stage of early sexual health vulnerability. This stage is characterized by discomfort with intimacy, reduced sexual desire, and negative associations with physical closeness [7], [8]. Importantly, these responses do not necessarily constitute established dysfunction but represent an intermediate phase in which sexual functioning becomes increasingly susceptible to disruption. Behavioral and relational adaptations further shape this trajectory. Individuals may adopt avoidance strategies, withdraw from intimate relationships, or experience difficulty forming secure interpersonal connections [5], [8]. While these responses may initially serve as protective mechanisms, their persistence can reinforce negative patterns and contribute to long-term sexual difficulties. Within this pathway, early psychological intervention is introduced as a conceptual moderating factor. Crisis intervention, defined as immediate and short-term psychological support following trauma, is positioned as a mechanism that can influence the trajectory between trauma exposure and sexual health outcomes [9], [10]. By stabilizing emotional responses, promoting adaptive coping, and facilitating the restoration of safety, control, and agency, early intervention may reduce the likelihood of maladaptive patterns becoming entrenched. Accordingly, the framework suggests that the progression from trauma to female sexual dysfunction is not inevitable but is shaped by early psychological processes and the presence or absence of timely support. In the absence of intervention, early disruptions may evolve into persistent difficulties in sexual desire, arousal, and relational functioning. Conversely, effective early support may interrupt this progression and promote more adaptive psychological and sexual outcomes. It is important to note that this framework is conceptual in nature and derived from the synthesis of existing literature. While it does not provide empirical validation, it offers a structured model for understanding the role of early-stage processes and highlights a critical direction for future research. Overall, the proposed framework shifts the focus from a predominantly treatment-oriented perspective to one that emphasizes prevention, early intervention, and the restoration of key psychological processes. This integrative approach provides a novel contribution to the literature and supports the development of more comprehensive, trauma-informed models of sexual health.

8. Discussion

The present integrative review synthesizes existing literature on the relationship between trauma and female sexual dysfunction, with a particular emphasis on early psychological processes and the potential role of timely intervention. The findings indicate that trauma is a significant factor influencing women's sexual health, operating through interconnected psychological, behavioral, and physiological pathways. However, rather than viewing these outcomes solely through long-term clinical conditions, the present analysis highlights the importance of early-stage responses in shaping subsequent trajectories. A central insight emerging from this review is that the impact of trauma on sexual functioning is not immediate or deterministic but develops through a series of early psychological and relational disruptions. During the peritraumatic phase, individuals often experience intense emotional reactions such as fear, confusion, and loss of control. These responses can disrupt perceptions of safety, personal agency, and bodily autonomy, which are foundational to healthy sexual functioning. As a result, individuals may begin to associate intimacy with discomfort or threat, leading to early patterns of avoidance and reduced engagement in sexual and relational contexts. The findings further suggest that these early disruptions contribute to a state of sexual health vulnerability. Rather than representing established dysfunction, this stage reflects an increased susceptibility to difficulties in desire, arousal, and satisfaction. Over time, if these responses remain unaddressed, they may evolve into more persistent patterns characterized by avoidance, relational difficulties, and negative associations with intimacy. This process-based understanding reinforces the need to conceptualize sexual dysfunction as a dynamic outcome rather than a fixed condition. Although previous research has frequently emphasized post-traumatic stress disorder (PTSD) in explaining trauma-related outcomes, the present review suggests that focusing exclusively on long-term clinical diagnoses may overlook critical early mechanisms. While symptoms such as hyperarousal and avoidance are relevant, they can be more effectively understood as part of a broader continuum of responses that originate in the immediate aftermath of trauma. This perspective supports a shift toward examining how early psychological processes influence longer-term sexual health trajectories. A key contribution of this study is the conceptual integration of early psychological intervention within this pathway. The findings highlight a notable gap in the literature regarding the limited attention given to immediate support following trauma exposure. Crisis intervention, understood as short-term psychological support during the early phase, is proposed as a potential moderating factor that may influence the trajectory from trauma to sexual dysfunction. Importantly, crisis

intervention is conceptualized not as a single technique but as a set of supportive processes, including psychological first aid, psychoeducation, emotional stabilization, grounding strategies, and supportive communication. These approaches aim to reduce acute distress, restore a sense of safety and control, and promote adaptive coping. By addressing trauma responses at an early stage, such interventions may reduce the likelihood of maladaptive cognitive, emotional, and behavioral patterns becoming established, thereby influencing long-term sexual health outcomes. From a clinical perspective, these findings underscore the importance of adopting a more integrated and prevention-oriented approach to trauma care. Interventions should not be limited to treating established dysfunction but should also focus on early-stage support that addresses emotional regulation, safety, and relational functioning. Incorporating such approaches into trauma-informed care models may enhance recovery and reduce the risk of persistent sexual difficulties. However, several limitations must be acknowledged. The integrative nature of the review involves the inclusion of studies with diverse methodologies, which may limit direct comparability. Additionally, the relative scarcity of research specifically examining early psychological intervention in relation to female sexual dysfunction restricts the ability to draw definitive conclusions. The role of crisis intervention within this framework remains conceptual and requires empirical validation. Overall, the findings support the proposed conceptual framework and highlight that the relationship between trauma and female sexual dysfunction is dynamic and modifiable. By emphasizing early psychological processes and intervention, this study offers a novel perspective that extends beyond traditional treatment-focused models. This approach provides a foundation for future research aimed at examining the effectiveness of early interventions and contributes to the development of more comprehensive and responsive clinical practices.

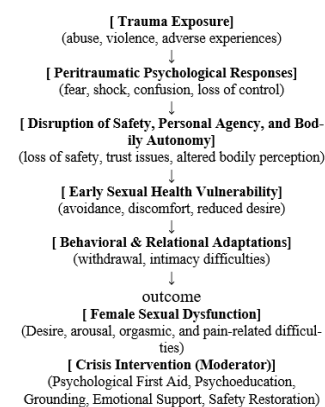


Fig. 1. Conceptual framework illustrating the relationship between trauma, peritraumatic psychological responses, and female sexual dysfunction, with crisis intervention as a moderating factor

Table 1
Themes and subthemes identified through thematic analysis

| Theme | Subthemes |
|---|---|
| Peritraumatic Psychological Responses | Fear, shock, confusion, loss of control |
| Disruption of Safety, Personal Agency & Bodily Autonomy | Loss of safety, trust difficulties, altered self-perception |
| Early Sexual Health Vulnerability | Reduced desire, avoidance of intimacy, negative associations |
| Behavioral & Relational Adaptations | Withdrawal, avoidance, relational difficulties |
| Intervention Perspectives | Crisis intervention, emotional stabilization, restoration of safety |

These themes collectively represent a sequential pathway contributing to the development of female sexual dysfunction.

Moderates:

- Intensity of early psychological responses
- Disruption of safety, agency, and control
- Progression toward maladaptive behavioral and relational patterns

9. Conclusion

This integrative review examined the relationship between trauma and female sexual dysfunction, emphasizing early psychological processes and the role of intervention timing. The findings suggest that trauma influences sexual health through disruptions in emotional regulation, safety, and relational functioning, which may gradually contribute to sexual difficulties.

A key contribution of this study is its focus on the peritraumatic phase, highlighting how early responses to trauma shape later outcomes. The review identifies a gap in existing literature regarding early-stage intervention and conceptually positions crisis intervention as a moderating factor within this pathway. Early support processes, including psychological first aid, psychoeducation, and emotional stabilization, may help reduce the likelihood of maladaptive patterns developing. Although conceptual in nature, this framework offers a novel, prevention-oriented perspective and underscores the need for future empirical research. Integrating

early psychological support into trauma-informed care may improve both psychological and sexual health outcomes.

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