“Naso Ki Kamzori” After Masturbation: Understanding Semen-Loss Anxiety, Sexual Weakness, Erectile Problems and Recovery

A Modern Sexual-Medicine and Unani Perspective on Masturbation Guilt, Dhat Syndrome, Erectile Confidence and Male Reproductive Health

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Introduction

One of the concerns I hear very frequently from young men is:

“Doctor, I did hand practice for many years. Now I feel my nasen have become weak.”

Some patients say:

“My penis does not feel as strong as before.”

Others tell me:

“My semen has become thin.”

“My erection goes down quickly.”

“My body feels weak after ejaculation.”

“I have ruined my future because of masturbation.”

For many patients, the phrase **“naso ki kamzori”** means much more than literal nerve weakness. It may represent a mixture of fear about masturbation, semen loss, erectile confidence, fatigue, anxiety, guilt, genital sensations and worries about future married life or fertility. The background material prepared for this article similarly describes “naso ki kamzori” as a culturally familiar expression through which patients may communicate a much broader cluster of sexual and psychological concerns.

My first message to such patients is very important:

Masturbation by itself does not normally damage the penile nerves, permanently weaken the veins, exhaust a finite supply of sperm, permanently lower testosterone, shrink the penis or cause male infertility.

Major clinical resources describe masturbation as a common sexual behaviour and do not support claims that it causes erectile dysfunction, infertility, reduced libido, penis shrinkage or mental illness.

At the same time, I do not dismiss a patient who says he feels weak or sexually different.

His symptoms may be real.

The correct medical question is:

What is actually causing those symptoms?

For one patient it may be anxiety and guilt.

For another it may be erectile dysfunction.

For another it may be depression, poor sleep or nutritional deficiency.

For another it may be diabetes, low testosterone, thyroid disease, a medication side effect, relationship stress or an underlying urological condition.

And in a very small number of people who repeatedly become genuinely ill for several days after ejaculation, a rare condition called **postorgasmic illness syndrome (POIS)** may even deserve consideration.

The aim is therefore neither to frighten the patient nor to tell him that everything is "only in his head." The aim is to separate **normal sexual physiology, culturally shaped fears and genuine medical disease**.

What Does "Naso Ki Kamzori" Actually Mean?

"Naso ki kamzori" is a familiar Hindi/Urdu expression, but it is **not a precise modern medical diagnosis**.

The word *nas* may be used by patients to mean:

- nerves,
- veins,
- penile blood vessels,
- the structures visible under the penile skin,

- or simply “sexual power.”

Two people using the same phrase may therefore have completely different problems.

One may mean:

“My erection is not hard.”

Another may mean:

“My penis feels less sensitive.”

Another:

“I become tired after ejaculation.”

Another:

“I am worried because the veins look prominent.”

And another:

“I masturbated in the past and now I am afraid that I have permanently damaged myself.”

I therefore never consider “naso ki kamzori” a complete diagnosis.

The next step is to determine exactly what the patient is experiencing.

Why Masturbation Creates So Much Anxiety in Some Men

Sexual beliefs do not develop in a vacuum.

Ideas about semen, masculinity, purity, fertility and sexual behaviour are influenced by:

- family teaching,
- peers,
- religious and cultural values,
- traditional health beliefs,
- internet content,
- pornography,
- social media,
- and advertisements for sexual treatments.

A major nationwide Indian Dhat-syndrome study involving **780 men** found that excessive masturbation was one of the most commonly reported explanations patients gave for their

perceived semen loss. Weakness in sexual ability, bodily weakness, tiredness and low mood were also frequent concerns.

A 2026 *Sexual Medicine Reviews* article specifically highlights masturbation myths, semen anxiety and Dhat syndrome as continuing examples of how cultural beliefs can shape sexual distress in South Asian patients. Importantly, it argues that traditional beliefs should neither be mocked nor automatically accepted as biomedical fact; treatment should instead be culturally informed, compassionate and evidence based.

I consider that approach especially important.

If someone has spent ten years believing that masturbation destroys the body, simply telling him:

“You are wrong—forget it,”

is usually ineffective.

We need to explain **why the feared damage has not occurred**, identify any real condition that may be present and gradually rebuild confidence.

The “Semen Is Life Energy” Fear

Many patients have heard versions of the idea that semen is produced only after enormous quantities of food, blood, bone marrow or other tissues are converted into it.

This leads to the belief that every ejaculation removes a large amount of strength.

The material supplied for this article describes how such traditional “vital-fluid” beliefs can become the foundation for masturbation guilt and semen-loss anxiety.

Whatever the historical or cultural origin of those beliefs, they should not be treated as a literal description of modern reproductive physiology.

Semen is primarily a mixture of secretions from the:

- seminal vesicles,
- prostate gland,
- and other reproductive structures,

with sperm cells produced by the testes.

The male reproductive system continually produces sperm after puberty.

A normal ejaculation therefore does **not** represent the loss of an irreplaceable reserve of physical energy.

Does Masturbation Permanently Reduce Sperm?

No.

The testes continuously produce sperm.

Frequent ejaculation can temporarily alter certain parameters of an individual semen sample, which is one reason fertility laboratories provide instructions regarding abstinence before testing.

But this is very different from permanently damaging sperm production.

Mayo Clinic's 2025 guidance states that frequent masturbation is **unlikely to have much effect on male fertility**. Men with otherwise normal semen quality may maintain normal sperm concentrations and motility even with frequent ejaculation.

So:

Masturbation history is not a diagnosis of infertility.

If fertility is genuinely in question, the appropriate investigation is a properly performed semen analysis interpreted in the context of the couple's reproductive history.

Does Masturbation Permanently Lower Testosterone?

There is no good evidence that ordinary masturbation causes chronic testosterone deficiency.

Hormones naturally change throughout the day and around sexual arousal and orgasm.

A controlled pilot study examining hormonal responses around masturbation found some short-term changes in free testosterone but no significant alteration in the key testosterone/cortisol hormonal ratios. The authors emphasized that larger studies are needed.

Older research similarly found that orgasm changed several short-term neuroendocrine parameters while plasma testosterone itself was not reduced by orgasm.

Therefore, a man should not assume:

“I masturbated frequently, therefore my testosterone must now be permanently low.”

If there are genuine symptoms of testosterone deficiency—such as persistently reduced libido, fewer spontaneous erections and other appropriate features—the correct response is proper hormonal assessment, not assumption.

Does Masturbation Damage the Penile Nerves?

Routine masturbation does not “wear out” the nerves of the penis.

The supplied material correctly identifies fear of nerve damage as one of the major myths behind the phrase “naso ki kamzori.”

Very aggressive friction can occasionally cause temporary problems such as:

- skin irritation,
- soreness,
- swelling,
- transient reduced sensitivity.

Giving the tissues time to recover and avoiding excessive friction generally resolves such problems.

This should not be confused with permanent neurological disease.

True penile sensory loss can occur from other conditions, such as:

- diabetic neuropathy,
- neurological disorders,
- certain pelvic injuries or surgeries,
- or other medical problems.

Persistent numbness therefore deserves assessment instead of automatically blaming past masturbation.

Does Masturbation Damage the Penile Veins?

No evidence supports the common idea that ordinary masturbation causes the visible veins of the penis to “become weak.”

Penile veins can naturally appear prominent, especially during erection.

An erection depends on coordinated blood inflow, smooth-muscle relaxation and restriction of venous outflow. If that system does not work properly, erectile dysfunction can occur—but ordinary masturbation does not normally destroy this mechanism.

If a man has repeated difficulty maintaining erection, we should investigate **erectile dysfunction**, not diagnose “damaged veins from hand practice.”

Does Masturbation Make the Penis Smaller or Thinner?

No established evidence shows that ordinary masturbation permanently reduces penis length or thickness.

Penile appearance changes naturally according to:

- temperature,
- anxiety,
- sympathetic nervous-system activity,
- erection quality,
- body weight,
- and blood flow.

A penis may appear smaller when flaccid during stress or cold weather and larger when relaxed.

That is normal physiology.

A new penile curvature, painful plaque, injury or substantial structural change should nevertheless be assessed by a healthcare professional because other urological conditions may be involved.

Masturbation and Erectile Dysfunction: Why the Patient May Still Have a Real Problem

This point requires careful explanation.

Masturbation itself does not normally cause ED.

However, a person can develop **erectile difficulty after years of worrying about masturbation**.

The mechanism is often psychological rather than structural.

Consider this example.

A young man has masturbated for years.

He has repeatedly been told that masturbation causes sexual weakness.

Before marriage he begins thinking:

“What if my penis does not work because of what I did?”

During sexual activity he begins checking his erection.

He asks himself:

“Is it fully hard?”

“Will it go down?”

“Have my nerves become weak?”

His anxiety rises.

Sexual attention shifts away from pleasure toward examination.

The erection becomes weaker.

He then thinks:

“This proves the masturbation damaged me.”

Now the next encounter creates even greater fear.

This is a classic self-reinforcing cycle of **sexual performance anxiety**.

The EAU guideline on erectile dysfunction specifically recommends assessing anxiety, depression, relationship factors, dysfunctional expectations and cognitive distraction from erotic cues when evaluating ED.

Spectatoring: Monitoring the Penis Instead of Experiencing Intimacy

One of the most useful psychosexual concepts is **spectatoring**.

A person mentally becomes an observer of his own sexual performance.

Instead of experiencing touch and arousal, he thinks:

- Is the erection hard enough?
- Are my veins working?
- Has the erection reduced?
- Am I taking too long?
- Will I ejaculate too early?
- Will my partner judge me?

The supplied clinical background identifies this excessive self-monitoring as an important way masturbation guilt can evolve into erection anxiety.

I often tell patients:

The penis is not an examination paper.

The more intensely a person checks a normal automatic sexual response, the harder it may become to remain naturally aroused.

Dhat Syndrome and Semen-Loss Anxiety

Some patients' symptoms fit within the clinical concept commonly called **Dhat syndrome** or semen-loss anxiety.

Dhat syndrome describes distress associated with the belief that loss of semen—through masturbation, wet dreams, urine or another route—is causing serious physical or psychological harm.

Patients may complain of:

- weakness,
- fatigue,
- poor concentration,
- anxiety,
- depressed mood,
- palpitations,
- sleep difficulty,
- low confidence,
- erectile problems,
- premature ejaculation.

A systematic review identified **89 publications** concerning Dhat syndrome but found that much of the research was cross-sectional, poorly representative and of limited quality.

A later clinical review emphasized that depression and anxiety can coexist with Dhat-related concerns and recommended a culturally sensitive, non-confrontational approach.

This is why I avoid saying:

“You are imagining the weakness.”

The weakness may be very real.

The important question is whether **semen loss itself** is the cause.

Frequently it is not.

How Anxiety Can Produce Real Physical Weakness

Anxiety is not merely "thinking too much."

Persistent fear can produce:

- muscle tension,
- rapid heartbeat,
- poor sleep,
- gastrointestinal disturbance,
- loss of appetite,
- headaches,
- difficulty concentrating,
- fatigue,
- altered breathing,
- reduced sexual arousal.

If a man wakes after masturbation or a wet dream already convinced that he has damaged himself, he may monitor every sensation.

A completely ordinary afternoon of tiredness then becomes:

"Proof that semen loss has weakened me."

The belief becomes stronger.

The next ejaculation creates greater anxiety.

A vicious cycle develops.

Guilt, Shame and Sexual Health

There is a difference between guilt and shame.

Guilt says:

"I did something I regret."

Shame says:

"There is something permanently wrong with me."

The second belief is particularly damaging to sexual confidence.

Patients should be able to discuss their own religious, moral and personal values respectfully.

Medical counselling does **not** need to tell people what values they should hold.

Our responsibility is to distinguish personal or moral decisions from claims about bodily damage.

A person may choose to reduce or avoid masturbation for personal reasons.

That decision is different from believing:

“If I masturbate, my nerves will permanently collapse.”

That physiological claim is not supported by current evidence.

When Masturbation Can Become a Problem

Saying that masturbation is generally physiologically safe does not mean that every pattern of sexual behaviour is healthy for every person.

It deserves attention if masturbation becomes so repetitive or difficult to control that it:

- interferes with work or studies;
- repeatedly replaces desired partnered intimacy;
- causes physical injury;
- consumes many hours;
- is used compulsively despite unwanted consequences;
- produces severe psychological distress;
- is closely linked with compulsive pornography use;
- or becomes a behaviour the individual feels unable to control.

The problem in such cases is **compulsive behaviour and its consequences**, not depletion of semen.

Pornography: An Area Where We Must Avoid Both Extremes

The supplied source describes a strong model of “porn-induced erectile dysfunction” in which repeated pornography exposure supposedly produces predictable dopamine-receptor downregulation followed by a defined “30–90 day reboot.”

Current science does not support presenting that sequence as an established universal neurological mechanism.

A **2026 systematic review** examining pornography consumption and male sexual dysfunction found mixed evidence. Some studies reported associations, some found no association and others reported different effects. Importantly, **frequency of pornography viewing itself was not a strong consistent predictor of sexual dysfunction; problematic pornography use, body dissatisfaction and insecurity appeared more relevant**.

Another systematic review and meta-analysis found only a small overall negative correlation between pornography use and sexual satisfaction, with important differences between groups and study designs.

Therefore, I would not tell every patient:

"Pornography has damaged your dopamine receptors."

A better clinical question is:

- Has pornography become compulsive?
- Do you need increasingly specific digital stimulation to become aroused?
- Are you less engaged with real-life intimacy?
- Is pornography creating unrealistic expectations?
- Are you using it despite distress?
- Does reducing it improve your sexual response?

If the answer is yes, changing the behaviour can be useful.

But there is no scientifically established universal "90-day dopamine reset" that every patient must follow.

"My Semen Looks Thin": Does That Mean Sexual Weakness?

No.

Semen naturally changes in:

- volume,
- viscosity,
- colour,
- consistency.

Appearance can be influenced by frequency of ejaculation, hydration and collection conditions.

Looking at semen cannot tell us:

- sperm concentration,
- sperm motility,
- sperm morphology,
- fertility potential.

If fertility is genuinely a concern, a laboratory semen analysis is more informative.

Do not diagnose “naso ki kamzori” from semen thickness.

Masturbation and Fertility

The relationship between masturbation and fertility is frequently misunderstood.

Frequent ejaculation may temporarily alter the characteristics of one semen sample.

But Mayo Clinic's updated 2025 patient guidance concludes that frequent masturbation is unlikely to have a substantial effect on male fertility.

Therefore:

Past masturbation does not prove infertility.

A couple having difficulty conceiving needs a proper infertility assessment rather than an assumption based on masturbation history.

At Saira Health Care, where my clinical focus includes male infertility, I consider fertility separately from sexual guilt.

Erectile Dysfunction and Infertility Are Different

A man can have:

- normal erections and abnormal semen;
- erectile dysfunction and completely normal semen;
- both problems;
- or neither.

Erectile dysfunction refers to erection.

Infertility refers to the ability of a couple to achieve pregnancy and may involve male, female or combined factors.

ED itself does not necessarily indicate low sperm count.

This distinction prevents enormous unnecessary anxiety.

Nightfall Is Not Evidence of Nerve Damage

Nocturnal emission, or nightfall, is an involuntary ejaculation occurring during sleep.

It is not evidence that penile nerves have become weak.

A person should not begin a sexual-strength medicine simply because he experiences an occasional wet dream.

Nightfall should be evaluated further only when there are unusual accompanying symptoms or the distress itself has become severe.

A Rare Exception: Postorgasmic Illness Syndrome

There is one unusual condition worth mentioning because patients who genuinely become physically ill after almost every ejaculation should not automatically be told that everything is psychological.

Postorgasmic illness syndrome (POIS) is rare and poorly understood.

Patients can develop combinations of:

- severe fatigue,
- cognitive “brain fog,”
- flu-like symptoms,
- headache,
- muscle discomfort,
- nasal or eye symptoms

within a short time after ejaculation, with symptoms sometimes lasting several days.

A 2026 case series reported 11 affected men, while contemporary ISSM guidance emphasizes that POIS remains poorly defined and requires exclusion of other conditions.

A 2025 systematic review also concluded that current treatment evidence is very limited and is dominated by case reports rather than strong clinical trials.

POIS is **not ordinary post-ejaculatory tiredness**, and it should not be used to frighten healthy men.

When “Naso Ki Kamzori” May Actually Be a Medical Disorder

A patient should be clinically evaluated rather than simply reassured if symptoms suggest another condition.

Possible causes include:

Diabetes

Diabetic neuropathy and vascular disease can affect penile sensation and erection.

Cardiovascular disease

Poor vascular health can impair penile blood flow.

Testosterone deficiency

Low testosterone may reduce libido and spontaneous erections in appropriately diagnosed cases.

Thyroid or endocrine disorders

Some hormonal conditions influence sexual function.

Medication side effects

Certain antidepressants, antihypertensives and other medicines can affect erection, ejaculation or desire.

Depression and anxiety

These can significantly affect libido, erection and sexual confidence.

Peyronie's disease

A new persistent penile curvature, palpable plaque or painful erection deserves assessment.

Prostatitis or pelvic pain

Painful ejaculation, urinary symptoms or pelvic discomfort may indicate a separate condition.

Sexually transmitted infection or urethritis

Penile discharge, burning or genital irritation should not be dismissed as “Dhat.”

How I Evaluate a Patient Who Says "My Nerves Have Become Weak"

At Saira Health Care, my first task is to convert a vague expression into a precise clinical description.

I may ask:

- What do you mean by "weak nerves"?
- Is the erection weak?
- Is sensation reduced?
- Is sexual desire reduced?
- Do you still have morning erections?
- Is masturbation-associated erection normal?
- Does the problem occur only with a partner?
- Is ejaculation earlier than desired?
- Are there urinary symptoms?
- Is there pain?
- Is the penis curved?
- How frequently are you masturbating?
- Is pornography involved?
- Are you anxious before sexual activity?
- Are you sleeping properly?
- Do you have diabetes or hypertension?
- Are you taking any medicines?
- Are you worried about fertility?

Those answers are more important than the phrase "naso ki kamzori."

Do You Need Blood Tests?

Not everyone does.

Investigations depend on symptoms.

Where clinically appropriate, assessment may include:

- blood glucose or HbA1c;
- lipid profile;
- morning testosterone;
- thyroid tests;
- prolactin or other hormones;
- kidney/liver testing;
- semen analysis where fertility is genuinely being evaluated.

Tests should answer a clinical question.

A patient should not be sold a large “sexual weakness package” simply because he masturbated in adolescence.

Treatment: Education Is Often the First Medicine

In masturbation-related sexual anxiety, one of the most powerful interventions is **accurate sexual education**.

The patient needs to understand:

- how semen is produced;
- how erection occurs;
- how anxiety affects arousal;
- why ejaculation does not permanently exhaust the body;
- why sperm production continues;
- why a normal sexual response can vary from day to day.

This explanation should be given respectfully.

Recent sexual-medicine literature specifically recommends culturally literate care that recognizes the patient's background without converting historical belief into unsupported biomedical claims.

Cognitive Behavioural Therapy and Sexual Counselling

When fear has become deeply established, reassurance alone may not be enough.

Cognitive behavioural therapy, or CBT, helps the patient examine beliefs such as:

“Because I masturbated, my marriage will fail.”

“One ejaculation removes my strength.”

“If my erection falls once, my penis is permanently damaged.”

The patient learns to replace catastrophic interpretations with explanations based on actual physiology.

Research on Dhat syndrome remains limited, but CBT, psychoeducation, relaxation and treatment of associated anxiety/depression are among the approaches reported in the clinical literature.

The supplied background material also appropriately emphasizes cognitive restructuring, sex education and person-centred care for masturbation-related guilt.

Treat Anxiety and Depression When They Are Present

Not everyone with masturbation guilt has a psychiatric illness.

However, if the person also experiences:

- persistent low mood,
- panic,
- severe anxiety,
- obsessive reassurance seeking,
- insomnia,
- social withdrawal,
- hopelessness,

those symptoms deserve proper treatment.

Dhat-syndrome reviews repeatedly identify anxiety and depression among important associated conditions.

Treating the associated psychological condition can significantly improve sexual function.

Sexual Performance Anxiety Requires Its Own Treatment

A patient who has developed ED because he continuously monitors his erection may benefit from:

- psychoeducation;

- CBT;
- psychosexual counselling;
- gradual reduction of performance demands;
- sensate-focus techniques;
- partner communication;
- treatment of any coexisting organic ED.

Current EAU guidance explicitly recognizes cognitive distraction, unrealistic expectations, anxiety and relationship factors in ED and recommends psychosocial assessment.

Exercise and Cardiovascular Health

There is a real sense in which strengthening the overall body can support sexual health—but not because exercise “replaces lost semen.”

Erection is highly dependent on cardiovascular and endothelial health.

A 2024 systematic review and meta-analysis of randomized trials found that physical activity improved erectile-function scores, with **aerobic training showing the clearest benefit** among the exercise modes evaluated.

For appropriate patients, useful activities may include:

- brisk walking;
- cycling;
- jogging;
- swimming;
- resistance training.

The exact exercise plan should reflect the person's age and health.

What About Kegel Exercises?

Pelvic-floor muscles participate in erectile rigidity and ejaculation.

Pelvic-floor muscle training may help selected men with ED or premature ejaculation, but it should not be treated as a universal cure for “naso ki kamzori.”

An earlier systematic review found potentially beneficial effects while noting substantial differences between protocols and generally low-to-moderate study quality.

More recent evidence examining exercise and ED found a clearer overall benefit from aerobic activity than isolated pelvic-floor training.

Also, some men have an **overactive or excessively tense pelvic floor rather than a weak one**, particularly where chronic pelvic pain is present.

Such patients may need relaxation or specialist pelvic-floor physiotherapy instead of repeatedly tightening the muscles.

Diet and "Sexual Strength"

Good nutrition supports general and reproductive health.

But there is no evidence that ejaculation removes so many nutrients that the patient must urgently replace them with expensive tonics.

The objective should be a balanced diet containing adequate:

- protein,
- vegetables,
- fruits,
- whole grains,
- healthy fats,
- micronutrients.

Specific supplements should generally be used when there is a genuine nutritional need rather than assuming every sexual symptom reflects vitamin or mineral depletion.

Zinc, Vitamin D and Other Supplements

Zinc, vitamin D, magnesium and selenium all have normal biological roles.

Deficiencies can affect health.

But this does **not** mean that taking very high doses will increase sexual performance in someone whose levels are already adequate.

More is not always better.

Supplements should not become another version of the same semen-replacement myth.

The Unani Perspective on "Naso Ki Kamzori"

As a physician trained in Unani medicine, I believe this topic requires a particularly thoughtful approach.

Unani medicine traditionally views health holistically, considering:

- **Mizaj** – temperament;
- **Akhlat** – the classical humours;
- organ function;
- diet;
- physical activity;
- sleep;
- psychological health;
- and the person's overall daily routine.

Official Ministry of Ayush material describes the Unani emphasis on **Asbab-e-Sitta Zarooriyah**, the six essential factors involved in preservation of health. These include food and drink, physical movement and rest, psychological activity and repose, and sleep and wakefulness among other factors.

These principles can be particularly useful for a patient whose sexual anxiety has disturbed his sleep, nutrition, physical activity and emotional wellbeing.

Unani Medicine Also Recognizes Psychological Factors

This point is very important.

Responsible Unani practice should not reduce every sexual complaint to semen quantity.

The Central Council for Research in Unani Medicine's guideline for **Zuf-i-Bah (sexual debility)** explicitly includes **Umūr Wahmiyya—psychological factors** among traditional contributors to sexual difficulty. It also lists treatment of psychological factors among its principles of care.

This means that addressing:

- anxiety,
- fear,
- confidence,
- sleep,
- relationship stress

is compatible with an authentic Unani approach.

How I Use Unani Principles in These Patients

I believe Unani medicine can contribute most constructively through an **individualized programme**, not through frightening the patient about semen depletion.

Ilaj bil Ghiza – Dietotherapy

The aim is to improve general nutrition and correct poor eating patterns.

If the patient is weak because he is skipping meals due to anxiety, that needs correction.

But normal ejaculation does not create an automatic requirement for a special semen-replacement diet.

Ilaj bit Tadbir – Regimenal Therapy

Attention can be given to:

- suitable exercise,
- sleep,
- rest,
- stress management,
- daily routine,
- general physical conditioning.

These measures are especially useful when anxiety and an unhealthy lifestyle are contributing to sexual symptoms.

Psychological and Emotional Balance

Traditional Unani attention to **Harkat wa Sukoon Nafsani**, psychological activity and repose, can provide a culturally familiar framework for discussing:

- stress,
- excessive worry,
- guilt,
- performance pressure.

For many patients, this is one of the most important parts of treatment.

Ilaj bid Dawa – Pharmacotherapy

Unani pharmacotherapy may be considered when a qualified practitioner identifies an appropriate indication.

CCRUM publishes traditional pharmacotherapeutic guidance for sexual debility, but importantly its treatment guidelines are intended for **registered Unani practitioners**, not for unsupervised self-medication.

The evidence does **not** justify telling every man who has masturbated:

“Your nerves have been damaged, so you need a powerful sexual tonic.”

Any medicine should have a clear clinical purpose.

Traditional Knowledge and Modern Evidence Should Not Be Enemies

A modern integrative approach does not need to insult traditional knowledge.

Nor should it turn historical concepts into claims that have not been scientifically demonstrated.

A 2026 review of South Asian sexual traditions makes exactly this point: traditional sexual beliefs should neither be romanticized as modern scientific evidence nor dismissed without understanding their cultural importance.

That principle fits my approach at Saira Health Care.

I can respect a patient's cultural understanding while still explaining:

Masturbation has not destroyed his nerves.

And I can use the strengths of Unani holistic care—diet, sleep, exercise, psychological balance and individualized treatment—while also using appropriate modern investigations for ED, diabetes, hormones or infertility.

What I Do Not Consider Responsible Unani Practice

I do not consider it medically responsible to tell every young man:

- your semen is finished;
- your nerves are permanently damaged;

- masturbation has made you infertile;
- your penis has become permanently weak;
- you require lifelong tonics.

Those statements can create the very anxiety and sexual dysfunction that the patient is trying to treat.

The contribution of Unani medicine should be to help the patient regain health and confidence—not deepen fear.

Special Approach of Dr. Nizamuddin Qasmi at Saira Health Care

At **Saira Health Care**, my focused clinical practice includes sexual disorders and infertility.

My professional training includes:

BUMS – Hamdard University, Delhi
MD
CGO
Certificate in Infertility – MGBIMS, Delhi
Certificate in Urology – London, UK
Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

When a patient comes to me saying:

“Hand practice ki wajah se nas kamzor ho gayi hai,”

my approach is not to immediately give him a sexual-strength medicine.

I first determine:

Is there actually erectile dysfunction?

Are normal morning erections present?

Is the problem situational?

Is there performance anxiety?

Is premature ejaculation present?

Is the patient worried about semen loss?

Is pornography use problematic?

Is there depression or anxiety?

Does the patient have diabetes?

Are hormones genuinely abnormal?

Is fertility actually affected?

Is there a physical penile condition?

Only after answering those questions can treatment become meaningful.

The Contribution of Saira Health Care

One major problem in sexual healthcare is not lack of medicine.

It is **misinformation**.

A young man may spend years believing he permanently damaged himself at age 15.

He may avoid marriage.

He may repeatedly inspect his penis.

He may take dozens of supplements.

He may become afraid of ejaculation.

Eventually the anxiety itself becomes the main sexual disorder.

At Saira Health Care, one important part of our contribution is therefore **sexual-health education**.

The aim is to help patients understand:

- normal semen physiology;
- normal masturbation;
- nightfall;
- erectile function;
- premature ejaculation;
- fertility;
- performance anxiety;
- and when actual medical investigation is necessary.

Good patient education can prevent years of avoidable fear.

A Practical Recovery Plan

For appropriate patients, recovery may involve several stages.

First: understand what the symptom actually is

Do not use “naso ki kamzori” as the final diagnosis.

Identify erection, sensation, ejaculation, anxiety and fertility concerns separately.

Second: stop interpreting every symptom as semen depletion

Fatigue, headache, poor sleep and weakness have many possible causes.

Third: reduce repeated checking

Constantly examining:

- erection hardness,
- semen thickness,
- penile veins,
- urine,
- penis size

can reinforce anxiety.

Fourth: improve physical health

Regular exercise, nutritious food, adequate sleep and healthy weight support sexual health.

Fifth: address pornography or compulsive behaviour where relevant

The objective is not a mythical dopamine “detox.” It is restoring healthy control, realistic expectations and satisfying sexual responsiveness.

Sixth: treat psychological distress

CBT, psychosexual counselling or other mental-health care may be very valuable.

Seventh: investigate persistent physical problems

Do not blame every symptom on masturbation.

Eighth: integrate Unani care appropriately

Use dietotherapy, regimenal therapy, psychological balance and individualized pharmacotherapy where clinically indicated.

Frequently Asked Questions

Does masturbation cause “naso ki kamzori”?

Ordinary masturbation has not been shown to permanently weaken the penile nerves or veins.

Persistent erection or sensory problems deserve evaluation for their actual cause.

Can masturbation make me permanently weak?

Normal masturbation does not permanently deplete general physical strength.

If persistent fatigue is present, sleep, anxiety, depression, nutrition, diabetes, thyroid disease and other causes may need assessment.

Does masturbation reduce sperm permanently?

No.

Sperm continue to be produced.

Frequent ejaculation may alter one semen sample temporarily, but frequent masturbation is unlikely to have a substantial long-term effect on fertility.

Does masturbation lower testosterone?

There is no evidence that ordinary masturbation causes chronic testosterone deficiency.

Short-term hormone fluctuations surrounding sexual activity should not be confused with permanent hypogonadism.

Does masturbation cause erectile dysfunction?

Masturbation itself is not established as a cause of ED.

However, anxiety, guilt, compulsive sexual behaviour, relationship problems and problematic pornography use may contribute to sexual difficulties in some individuals.

Why is my erection weaker with my partner but strong during masturbation?

That pattern can suggest an important **situational or psychological component**, particularly performance anxiety.

It does not prove that no physical contributor exists, but it is a valuable diagnostic clue.

Has pornography permanently damaged my brain?

Current evidence does not support such a simple conclusion.

A 2026 systematic review found that pornography frequency alone was not a consistent predictor of sexual dysfunction; problematic use, insecurities and other psychosocial factors appeared more relevant.

Do I need 90 days without masturbation to "reset dopamine"?

There is no universally established medical 30-, 60- or 90-day neurological reset protocol.

Reducing problematic pornography or compulsive masturbation may be helpful, but treatment should be individualized.

Is thin semen proof that I am weak?

No.

Semen appearance does not accurately measure sperm count, fertility or sexual strength.

Can masturbation cause infertility after marriage?

Past masturbation alone is not evidence of infertility.

If conception is delayed, fertility should be assessed properly rather than assumed from past sexual behaviour.

Are Kegel exercises good for everyone?

No.

They may help selected patients, but some people have an overly tense pelvic floor and need relaxation rather than more contraction.

Pelvic-floor treatment is best individualized.

Can Unani medicine help?

Yes, **responsible Unani care can contribute through a holistic approach** involving diet, physical activity, sleep, psychological balance and individualized treatment.

CCRUM's own sexual-debility framework recognizes psychological factors as possible contributors.

However, normal masturbation should not automatically be treated as a disease requiring semen-replacement medicine.

What if I always become very ill after ejaculation?

Severe, reproducible flu-like or cognitive symptoms lasting several days after almost every ejaculation are unusual and deserve clinical assessment.

Rare postorgasmic illness syndrome is one possible differential diagnosis, although current understanding and treatment evidence remain limited.

When You Should Consult a Doctor

Seek professional evaluation when you have:

- persistent erectile dysfunction;
- genuine loss of penile sensation;
- severe or persistent genital pain;
- penile injury;
- new significant curvature;
- penile discharge or urinary burning;
- blood in urine or semen;
- persistently reduced libido;
- infertility concerns;
- symptoms of diabetes or hormonal disease;
- severe depression or anxiety;
- compulsive sexual behaviour that interferes with daily life;
- or prolonged illness following ejaculation.

Sudden severe testicular pain, major penile trauma or an erection lasting approximately four hours or more requires urgent medical assessment.

A Message From Dr. Nizamuddin Qasmi

If you have spent years thinking:

“I masturbated, therefore I have ruined myself,”

I want you to understand that fear should not become your diagnosis.

Your concern deserves respect.

Your symptoms deserve assessment.

But your past sexual behaviour should not automatically be blamed for every tired day, every fluctuation in erection, every wet dream or every change in semen appearance.

Normal masturbation does not usually destroy your nerves, veins, testosterone, sperm or fertility.

Sometimes the main problem is anxiety.

Sometimes there is genuine erectile dysfunction.

Sometimes pornography or compulsive behaviour is interfering with normal intimacy.

Sometimes there is diabetes, a hormonal problem, medication effect or another medical condition.

And sometimes a patient simply needs correct sexual education after years of hearing frightening misinformation.

As a physician trained in Unani medicine and focused on sexual disorders and infertility, my approach is not to reject tradition and not to reject modern science.

I believe in taking the useful holistic principles of Unani medicine—**Ilaj bil Ghiza, Ilaj bit Tadbir, attention to sleep, physical activity, psychological wellbeing and individualized care**—and combining them with appropriate modern sexual-health assessment.

The goal is not merely to give a “power medicine.”

The goal is to understand the patient, identify the real problem and restore **health, confidence, sexual function and peace of mind**.

About the Author

Dr. Nizamuddin Qasmi

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BUMS – Hamdard University, Delhi
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Certificate in Infertility – MGBIMS, Delhi
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At Saira Health Care, the focus is on confidential, individualized and integrative assessment of sexual dysfunction, semen-related concerns, erectile problems and infertility, with appropriate use of Unani principles alongside modern medical evaluation.

Medical Disclaimer

This article is intended for **public health education and general information**. It does not replace an individual medical consultation, examination, laboratory testing, diagnosis or treatment.

Persistent erection problems, loss of genital sensation, discharge, pain, infertility, hormonal symptoms or significant psychological distress should be professionally assessed.

Unani and herbal medicines should be selected by an appropriately qualified practitioner after considering the patient's medical history, prescription medicines, kidney and liver health and the actual diagnosis.