Unlearning Sexual Shame

Understanding and Healing Religious, Cultural or Familial Conditioning Around Sexuality

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Introduction

In my clinical practice, I frequently meet men and women who arrive with what initially appears to be a sexual-function problem. A man may say that he loses his erection despite feeling attracted to his wife. A woman may describe difficulty becoming sexually aroused even though she loves and trusts her husband. Another patient may experience severe anxiety before intimacy, feel unable to talk about sexual needs, or immediately feel guilty after experiencing sexual pleasure.

Sometimes laboratory investigations are normal. Hormones may be normal. There may be no significant genital disease. Yet the patient's distress is genuine.

In some of these cases, an important factor is **sexual shame**.

Sexual shame means experiencing one's sexual body, thoughts, feelings, desires or experiences through a powerful sense of being dirty, defective, immoral or fundamentally unacceptable. A major 2026 narrative review describes sexual shame as a form of negative self-evaluation connected with one's sexual self, thoughts, desires, experiences or behaviour. Research increasingly links it with several aspects of sexual well-being, although the field is still developing and not every study finds the same associations.

Sexual shame can arise from many sources. Sometimes it develops after sexual abuse or coercion. At other times it develops through repeated messages received during childhood and adolescence: that the body is shameful, that sexual feelings automatically indicate bad character, that asking questions about sexuality is indecent, or that respectable people should never acknowledge sexual desire.

Religion, culture and family values themselves should **not** be treated as diseases or psychological problems. For many people, faith, modesty, family values and religious practice are major sources of meaning, resilience and emotional support. The problem arises when a person internalizes messages in a way that creates persistent fear, self-hatred, misinformation, inability to communicate, marital distress or sexual dysfunction.

Therefore, **unlearning sexual shame does not mean abandoning religion, morality, modesty or culture**. It means learning to separate healthy personal values from destructive self-condemnation.

Is Sexual Shame a Disease?

Sexual shame is not a single formal medical disease in the same way that diabetes, hypertension or an infection is a disease.

It is better understood as a **psychological and psychosexual pattern** that can influence emotional health, relationships and sexual functioning.

It may occur by itself or alongside conditions such as anxiety, depression, trauma-related symptoms, relationship difficulties, erectile dysfunction, low desire, orgasm difficulties, vaginismus or genito-pelvic pain.

The World Health Organization emphasizes that sexual health is much broader than the absence of disease. It includes physical, emotional, mental and social well-being related to sexuality and requires a respectful approach to sexuality and relationships. WHO also recognizes that sexuality is shaped not only by biology but by psychological, social, cultural, religious and spiritual factors.

This broader understanding is particularly important when treating sexual shame.

Understanding the Difference Between Healthy Values and Sexual Shame

One of the most important things I explain to patients is that **having moral or religious boundaries about sexuality is not the same as having sexual shame**.

A person may sincerely choose to follow religious teachings about sexual behaviour and remain psychologically healthy.

There is an important conceptual difference between saying:

“According to my values, I do not want to do this.”

and believing:

“Because I have sexual feelings, there must be something dirty or defective about me.”

The first statement expresses a personal value or boundary.

The second attacks the person's entire identity.

In psychological language, guilt often focuses on a behaviour or perceived violation of one's values, whereas shame tends to involve a global negative judgment about the self. Contemporary sexual-health research therefore treats sexual shame as distinct from ordinary moral decision-making. The 2026 review found that shame can become particularly relevant when people believe that their sexual thoughts or behaviours violate strongly held sexual norms, but the authors also emphasize limitations in the existing evidence and the need for better research.

Our goal in treatment should therefore never be to tell a patient which religious belief to keep or discard. The purpose is to help the patient develop a healthier relationship with the body, sexuality, consent, intimacy and personal values.

How Sexual Shame Develops

Sexual attitudes begin developing long before adulthood.

Children and adolescents learn about their bodies not only from formal education but also from how adults respond to questions, puberty, menstruation, nocturnal emissions, attraction, relationships and physical development.

If normal questions are repeatedly answered with disgust, threat or humiliation, a child may gradually associate sexuality with danger or disgrace.

Some people grow up hearing statements such as:

“Good people don't think about these things.”

“Never discuss anything sexual.”

“Your body is something to be ashamed of.”

“Sex is dirty.”

“Sexual pleasure is always sinful.”

“A respectable woman should never have sexual desire.”

“A real man should automatically know everything about sex.”

“Masturbation or sexual thoughts mean that you are permanently damaged.”

These messages vary greatly across families and communities. They should not be generalized to any particular religion or culture.

Research supports the importance of social and cultural context. WHO specifically recognizes that sexuality is influenced by religious, spiritual, cultural, psychological and social factors, while contemporary sex-therapy literature similarly emphasizes the need to understand the cultural meanings that patients attach to sexuality rather than treating culture itself as an obstacle.

Religion Is Not the Same as Sexual Shame

This distinction deserves special emphasis.

Religion can provide meaning, emotional support, behavioural structure, community and resilience. It would therefore be clinically inappropriate for a healthcare professional to assume that a religious patient needs to become less religious in order to become sexually healthy.

Psychological practice increasingly recognizes the importance of respecting a patient's religious and spiritual worldview. The American Psychological Association has emphasized that clinicians should approach religion and spirituality with knowledge and sensitivity, protect patient autonomy and recognize that faith can sometimes be a psychological resource while, in other situations, particular interpretations or experiences may contribute to distress.

Recent qualitative research involving Muslim psychotherapy users similarly found that some patients felt misunderstood or psychologically excluded when therapists minimized the importance of their Islamic beliefs. The authors emphasized culturally responsive treatment that allows the patient's religious worldview to be meaningfully included rather than forcing the patient to choose between faith and therapy.

I consider this principle extremely important.

If faith is important to my patient, treatment should respect that faith.

The clinical question is not:

“How can we remove religion from this person's sexuality?”

It is:

“How can this person live according to chosen values without fear, misinformation, humiliation or hatred of their own body?”

Family Conditioning and Silence Around Sexual Health

Families often intend to protect children by avoiding conversations about sexuality.

Unfortunately, complete silence can sometimes create another problem: young people may learn about sexuality from unreliable friends, pornography, social media or misinformation.

By adulthood, they may understand reproduction poorly, fear normal bodily responses or believe myths about fertility, erections, menstruation, masturbation, semen, virginity or sexual pleasure.

WHO's updated 2026 information on comprehensive sexuality education emphasizes that scientifically accurate and culturally relevant education can correct misconceptions and help young people understand bodies, relationships, consent, safety and reproductive health. WHO also notes that high-quality sexuality education does not cause earlier sexual activity; rather, evidence indicates that good education can improve knowledge and safer decision-making.

Education does not have to conflict with family values. Accurate anatomy, personal boundaries, consent, reproductive health and respect can be taught in ways that are age-appropriate and culturally sensitive.

Common Signs of Sexual Shame

Sexual shame does not look identical in every patient. Common patterns can include:

- feeling dirty, sinful or defective merely for experiencing sexual desire;
- severe embarrassment about normal genital anatomy or bodily functions;
- being unable to say words related to sexual health during medical consultation;
- avoiding appropriate medical examinations because of shame;
- anxiety before or after sexual activity;
- guilt immediately following orgasm or sexual pleasure;
- difficulty communicating sexual needs to a spouse;
- feeling that consensual marital intimacy is somehow wrong even when it agrees with the person's values;
- low sexual desire associated with fear or self-judgment;
- erection difficulties or performance anxiety associated with guilt;
- difficulty becoming aroused or reaching orgasm;
- involuntary pelvic-floor tightening or fear of penetration;

- excessive fear about masturbation, semen loss, nocturnal emissions or normal sexual thoughts;
- repeatedly seeking reassurance that normal bodily experiences have not caused permanent damage;
- avoiding relationships because sexuality feels frightening;
- believing that one's value as a human being depends entirely on sexual "purity";
- persistent anxiety about being judged by family, society or a religious community.

Having one of these experiences does not prove that sexual shame is the cause. Sexual symptoms require proper evaluation because hormonal disorders, medication effects, diabetes, thyroid disease, pelvic disorders, neurological conditions, relationship difficulties, depression, anxiety and many other problems can produce similar symptoms.

How Sexual Shame Can Affect Sexual Function

Sexual response requires a complicated interaction between the brain, nervous system, hormones, circulation, genital tissues, emotions and relationship context.

The brain is therefore deeply involved in sexual functioning.

If intimacy repeatedly activates thoughts such as:

"I should not enjoy this."

"My body is disgusting."

"I am doing something shameful."

"My partner will judge me."

or

"Something terrible will happen if I lose control,"

the resulting anxiety can interfere with arousal.

The Fifth International Consultation on Sexual Medicine recommendations published from the 2024 consultation emphasize a **biopsychosocial assessment** of sexual dysfunction. Psychological factors, chronic illness, mental health, relationship conflict and sociocultural context may all be relevant, and appropriate treatment can include psychoeducation, cognitive-behavioural approaches, mindfulness, couple interventions and specialist referral.

Sexual Shame and Erectile Dysfunction

Men commonly assume that every erection difficulty means that something is physically wrong with the penis.

That is not always true.

Anxiety, fear of failure, relationship tension and excessive self-monitoring can interfere with erection even when blood vessels and hormones are otherwise functioning normally.

For example, a man may begin marital life after years of being taught never to think about sexuality. Suddenly, immediately after marriage, he is expected to become confident, knowledgeable and sexually relaxed.

The psychological transition is not always instantaneous.

He may become hyper-alert:

“Will I get an erection?”

“Will I satisfy my wife?”

“Am I doing something wrong?”

This type of performance monitoring can itself interfere with sexual arousal.

European urological guidance recognizes the role of psychosocial treatment and recommends cognitive-behavioural approaches when psychological factors contribute to erectile dysfunction, often alongside medical treatment when appropriate.

Sexual Shame in Women

Women can experience a different set of pressures.

Some are raised to believe that expressing sexual desire is incompatible with modesty or respectable womanhood. After marriage, however, they may be expected to become immediately comfortable with intimacy.

The mind cannot always reverse years of conditioning overnight.

A woman may love her husband but still experience fear when touched. She may have difficulty becoming aroused, experience vaginal dryness or tense her pelvic-floor muscles involuntarily.

Others feel ashamed of communicating what feels comfortable or uncomfortable.

This does not mean that every sexual difficulty in women is psychological. Vaginal dryness, painful intercourse and low desire can have hormonal, gynecological,

medication-related and systemic medical causes, which must be appropriately evaluated.

Research nevertheless indicates that sexual shame may be clinically relevant in some women. For example, a study among women with histories of childhood sexual abuse found that sexual shame was strongly associated with sexual-function difficulties in that particular population.

Sexual Shame Can Affect Men Too

Sexual shame is sometimes wrongly discussed as though it affects only women.

Men may experience intense shame concerning erection quality, penis size, masturbation, nocturnal emissions, infertility, sperm count, ejaculation, sexual fantasies or previous sexual experiences.

A man may interpret a single episode of erection difficulty as proof that he is “not a real man.”

Another may feel that premature ejaculation makes him fundamentally inadequate.

Men with non-consensual sexual experiences can also experience significant sexual shame. Research has found associations between sexual shame and inhibitory sexual responses among men, although individual responses vary greatly.

Sexual health therefore deserves compassionate assessment irrespective of gender.

The Difference Between Privacy and Shame

Privacy is healthy.

Not everyone wants to discuss intimate matters openly, and there is no obligation to do so.

Modesty is also not automatically unhealthy.

Shame becomes clinically important when the person becomes unable to obtain medical help, communicate consensually with a spouse, accept the body, experience intimacy without severe distress or distinguish normal physiology from illness.

I often tell patients:

You can be private without being frightened of yourself.

A patient should be able to discuss symptoms confidentially with an appropriate healthcare professional without feeling degraded.

Sexual Shame and Fertility

Sexual shame can also enter infertility treatment.

Couples attempting pregnancy may suddenly feel that intimacy has become a medical task. Ovulation timing, semen collection, sexual frequency, erectile performance and laboratory testing may all generate anxiety.

Some men are extremely uncomfortable providing semen samples.

Some women feel ashamed discussing intercourse frequency, menstrual history or vaginal symptoms.

Others have been taught misinformation about conception.

WHO considers fertility and infertility care part of sexual and reproductive health, which includes physical, psychological and social well-being—not simply reproductive organs.

At Saira Health Care, I therefore consider sexual communication and psychological comfort an important part of infertility assessment rather than treating the reproductive system as separate from emotional health.

What Does "Unlearning" Sexual Shame Actually Mean?

Unlearning does not mean replacing one rigid belief system with another.

Instead, it involves examining beliefs carefully.

A person may ask:

Where did I learn this belief?

Is it medically accurate?

Is this genuinely my chosen religious or moral value, or am I acting from fear of humiliation?

Does this belief help me behave responsibly, or does it cause me to hate myself?

Can I respect my values while also accepting my body?

This process can take time.

Patients who were conditioned for years to associate sexuality with fear cannot always change simply because a doctor gives them one reassuring explanation.

Step One: Correcting Medical Misinformation

Psychoeducation is one of the most useful first steps.

Patients should understand normal sexual anatomy and physiology, including erection, ejaculation, sexual desire, arousal, lubrication, orgasm, menstruation, nocturnal emissions, fertility and age-related changes.

Correct knowledge often reduces unnecessary fear.

The objective is not to persuade someone to behave sexually in a way that contradicts their values.

The objective is to ensure that decisions are based on accurate information rather than myths.

WHO's approach similarly emphasizes scientifically accurate, culturally relevant sexual-health information alongside respect, responsibility, consent and informed decision-making.

Step Two: Identifying the Shame Message

Many patients carry an internal voice that they have heard for so long that it feels like their own.

Examples include:

“You are dirty.”

“You should be ashamed.”

“No respectable person enjoys sex.”

“If you have sexual thoughts, your character is bad.”

During therapy or counselling, the patient can gradually learn to recognize these statements as learned messages rather than unquestionable facts.

This does not require abandoning legitimate ethical boundaries.

A healthier replacement may be:

“I have values about sexual behaviour, and I can follow those values without hating my body.”

Step Three: Separating Thoughts From Actions

A thought is not automatically an action.

A physiological response is not automatically a moral decision.

A spontaneous sexual thought, erection, vaginal lubrication or dream is not the same as deliberately choosing behaviour.

Understanding this distinction can substantially reduce unnecessary self-blame.

This is particularly important for patients who become excessively anxious about involuntary bodily responses.

Step Four: Developing a More Respectful Relationship With the Body

Some patients have never learned to view their reproductive organs as normal parts of human anatomy.

Medical education can help.

A penis is part of normal male anatomy.

The vagina and vulva are normal female anatomy.

Menstruation, erections, ejaculation and vaginal lubrication are physiological processes.

Learning accurate anatomy can gradually replace disgust with understanding.

WHO's sexual-health framework explicitly treats sexuality as part of overall human well-being rather than something that can be separated completely from health.

Step Five: Values Clarification

This is especially important when religion or culture is involved.

The patient should be allowed to identify:

“What do I genuinely believe?”

“What values are important to me?”

“What was taught to me through fear rather than understanding?”

“Which beliefs support dignity and responsibility?”

“Which messages create unnecessary self-hatred?”

The therapist or physician should not impose personal beliefs.

Contemporary psychology increasingly supports ethically integrating religious and spiritual perspectives when they are meaningful to the patient.

Step Six: Psychosexual Therapy

Some patients benefit from consultation with a psychologist, psychotherapist, sex therapist or couples therapist.

Depending on the problem, treatment can include psychoeducation, cognitive-behavioural therapy, mindfulness-based interventions, communication work, anxiety management and couple-based treatment. Current international sexual-medicine recommendations support individualized psychological treatment based on the patient's biopsychosocial context.

A therapist working with religious patients should ideally be culturally competent and able to discuss values respectfully rather than treating faith as pathology.

Step Seven: Rebuilding Intimacy Gradually

When severe shame has affected a couple's sexual relationship, demanding immediate intercourse can worsen anxiety.

In appropriate cases, therapists may help couples gradually rebuild affection, trust, touch, communication and comfort without constantly measuring sexual "performance."

The aim becomes connection rather than examination.

Both partners should have the freedom to communicate boundaries.

Consent remains important within marriage and long-term relationships.

Healthy intimacy requires mutual respect rather than pressure.

What About Sexual Pleasure?

Some patients believe that seeking any pleasure from consensual marital intimacy is automatically unhealthy or selfish.

From a clinical sexual-health perspective, pleasurable and safe intimacy can be part of healthy sexual functioning.

WHO's definition of sexual health specifically recognizes the possibility of safe and pleasurable sexual experiences within a framework of respect and freedom from coercion.

This does not determine a person's religious rules. Religious questions should be interpreted within the individual's tradition, ideally with an appropriately knowledgeable religious scholar when clarification is needed.

Medicine and theology have different areas of expertise.

A physician can explain anatomy, physiology and health.

A trusted scholar can help interpret religious doctrine.

A psychologist or therapist can help address fear, shame and psychological distress.

These roles can complement rather than compete with one another.

The Unani Perspective on Sexual Shame and Emotional Health

The Unani system of medicine traditionally considers health in an integrated manner rather than separating the body entirely from mental and lifestyle factors.

An important Unani concept is **Asbab-e-Sitta Zarooriya**, the six essential factors considered important for maintaining health. Official Ministry of AYUSH material describes these factors as including air, food and drink, physical activity and rest, sleep and wakefulness, retention and elimination, and mental well-being. The same official overview also describes **Nafsiyati Tadbeer**, or psychological measures, within the Unani tradition.

This holistic framework can be particularly helpful when sexual complaints are influenced by stress, disturbed sleep, anxiety, poor lifestyle patterns and emotional distress.

However, it is important to practice responsibly.

There is currently **not strong clinical evidence showing that a particular Unani medicine by itself can "cure sexual shame."** Sexual shame is primarily a psychosexual and psychological issue. Herbal medicine should therefore not be used as a substitute for counselling or psychological treatment when those are required.

The valuable role of Unani care is supportive and integrative.

How I Use Unani Principles in an Integrative Approach

In appropriate patients, I may consider Unani principles alongside modern medical and psychological assessment.

Sleep is important because chronic anxiety and disturbed sleep can increase emotional reactivity.

Diet and digestion matter because general physical well-being influences energy and mood.

Physical activity can support cardiovascular, metabolic and psychological health.

Lifestyle organization can reduce chronic stress.

Relaxation and psychologically supportive measures fit naturally within the traditional Unani concept of maintaining equilibrium.

If a patient also has a specific sexual disorder—such as erectile dysfunction, premature ejaculation, low desire or infertility—it can be evaluated separately and treated according to its actual cause.

This approach avoids a common mistake: giving every sexually distressed person a "strength medicine" without first understanding what the patient is actually experiencing.

Herbal and Unani Medicines: When Are They Appropriate?

Medicines may be appropriate when a patient has a genuine medical indication identified during assessment.

But medication should not be used to silence emotional distress.

A patient who believes:

"I am disgusting because I experience sexual desire"

does not primarily need an aphrodisiac.

He or she needs correct understanding, counselling and possibly psychological treatment.

Similarly, a man experiencing erectile dysfunction requires assessment for diabetes, vascular health, hormones, medications, anxiety and other possible causes rather than immediately assuming that the problem is "weakness."

An individualized approach is essential.

My Clinical Approach at Saira Health Care

At **Saira Health Care**, my approach to sexual shame is based on confidentiality, dignity and understanding the complete patient.

When a patient comes to me with a sexual complaint, I do not begin by assuming either that everything is psychological or that everything is physical.

I first try to understand the complaint carefully.

The assessment may include sexual history, medical conditions, medications, relationship circumstances, reproductive history, sleep, stress and relevant laboratory investigations where medically indicated.

If misinformation is contributing to the problem, we correct the misinformation.

If an identifiable sexual disorder is present, we address the disorder.

If infertility is present, the couple receives appropriate fertility evaluation.

If anxiety, depression, trauma or severe sexual shame is a major factor, psychological counselling or referral to an appropriately qualified mental-health professional may be recommended.

Where appropriate, Unani dietary, lifestyle and supportive treatment can be incorporated as part of an individualized plan.

In my view, this integration is particularly valuable because sexual problems rarely belong exclusively to one organ.

The patient has a body, mind, relationship, family environment and cultural background—all of which may influence sexual health.

Dr. Nizamuddin Qasmi's Focus in Sexual Disorders and Infertility

My professional work at Saira Health Care has a focused clinical emphasis on sexual disorders, reproductive health and infertility.

My educational and professional profile includes:

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

These areas of study support an approach in which sexual dysfunction is evaluated not only as a reproductive problem but through urological, fertility, psychological, relationship and lifestyle perspectives.

At Saira Health Care, our goal is not to judge the patient.

Our role is to understand why the patient is suffering and what form of care is appropriate.

What Saira Health Care Contributes to Sexual-Health Care

One of the continuing challenges in sexual medicine is that many patients delay consultation because they are embarrassed.

Some suffer silently for years.

Others purchase medicines without diagnosis.

Some search online and become more frightened after reading misinformation.

Through clinical consultation, patient education and public-health information, Saira Health Care aims to make discussion of sexual disorders and infertility more medically understandable and less humiliating.

We encourage patients to recognize that discussing an erection problem, ejaculation difficulty, infertility, vaginal pain, loss of desire or other sexual-health concern with an appropriate healthcare professional is no more shameful than discussing blood pressure or diabetes.

Privacy should be protected.

Dignity should be protected.

But silence should not prevent healthcare.

What Scientific Research Tells Us About Sexual Shame

Research into sexual shame is still relatively young.

The 2026 narrative review of the field found meaningful associations between sexual shame and several aspects of sexual well-being, including sexual violence outcomes and some forms of sexual dysfunction. At the same time, the authors specifically noted methodological limitations, variation in how shame is measured and mixed findings across studies. Therefore, sexual shame should not be treated as a universal explanation for every sexual difficulty.

A 2023 study examining sexual desire, emotion regulation and sexual shame illustrates this complexity: the researchers did not find sexual shame itself to significantly predict sexual desire in their particular sample, while cognitive reappraisal was associated with desire.

This is an important scientific lesson.

We should neither ignore sexual shame nor exaggerate its role.

Good medicine examines the individual patient.

Cultural and Religious Conditioning Can Have Different Effects

Research also shows that the relationship between religion and shame is not simple.

A study of religious Jewish men found that sexual guilt and shame were associated with psychological well-being in complex ways, and religiousness did not merely make outcomes worse; at higher levels of religiousness, some expected negative associations were not observed. The authors suggested that adaptive aspects of religion might sometimes help people cope.

At the same time, more recent research has shown that when people experience strong conflict between particular sexual behaviours and their moral beliefs, sexual shame may increase.

Therefore, the scientifically responsible position is not:

“Religion causes sexual shame.”

Nor is it:

“Religion can never contribute to sexual distress.”

The more accurate question is:

How does this particular person's understanding of religion, family, culture, sexuality and self-worth interact with his or her mental and sexual health?

Unlearning Shame Without Losing Your Identity

For many patients this is the central concern.

They ask me:

“If I stop feeling ashamed, does that mean I am abandoning my values?”

No.

A person can maintain modesty without hating the body.

A person can observe religious sexual boundaries without believing normal anatomy is disgusting.

A person can decide against particular sexual behaviours without believing that experiencing a thought makes them worthless.

A married couple can maintain religious values while learning accurate sexual anatomy and improving communication.

A patient can speak honestly to a doctor without becoming immodest.

Healthier sexuality does not require abandoning identity.

It requires replacing fear and misinformation with knowledge, responsibility, dignity and chosen values.

Sexual Shame in Marriage

Some couples enter marriage with almost no ability to discuss sexual matters.

Both may be anxious, but each assumes the other should automatically understand everything.

This can create misunderstanding.

A wife may believe that her husband's erection difficulty means he does not find her attractive.

A husband may interpret his wife's anxiety or vaginal dryness as rejection.

Both may remain silent.

The problem becomes larger.

Marriage counselling or psychosexual counselling can help couples replace assumptions with communication.

A simple conversation about comfort, fear, affection and expectations can sometimes reveal that neither partner is rejecting the other.

Sexual Shame and Performance Anxiety

Sexual shame frequently overlaps with performance anxiety.

The person stops experiencing intimacy and begins examining themselves.

“Is my erection hard enough?”

“Am I taking too long?”

“Am I finishing too quickly?”

“Am I attractive?”

“Am I behaving correctly?”

This internal monitoring creates anxiety.

The International Consultation on Sexual Medicine emphasizes that psychological and interpersonal factors should be assessed as part of sexual dysfunction and supports interventions including psychoeducation, cognitive-behavioural approaches, mindfulness and couple-based care according to clinical circumstances.

When Sexual Shame Is Related to Trauma

Not all sexual shame comes from family or religious conditioning.

Sexual assault, childhood sexual abuse, coercion, humiliation and traumatic sexual experiences can produce profound shame.

Research has found sexual shame to be particularly relevant among some survivors of non-consensual sexual experiences.

These patients require a trauma-informed approach.

They should not be pressured to disclose details before they feel safe.

If PTSD, severe anxiety, dissociation or depression is present, care from an appropriately trained psychologist or psychiatrist may be necessary.

When to Seek Professional Help

Sexual shame deserves professional attention when it repeatedly interferes with marriage or relationships, prevents someone from obtaining necessary medical care, causes major distress, contributes to persistent sexual dysfunction, produces panic or severe anxiety around intimacy, is associated with depression or trauma, creates compulsive reassurance-seeking, or causes a person to feel worthless or hopeless.

When suicidal thoughts, self-harm, severe depression or an immediate safety risk is present, ordinary sexual-health counselling is not sufficient and urgent mental-health support is appropriate.

In India, the Government of India's **Tele-MANAS** service provides 24-hour tele-mental-health support through **14416** or **1800-89-14416**, with links to counselling and specialist services.

Frequently Asked Questions

Is feeling embarrassed about sex always unhealthy?

No. Privacy, modesty and occasional embarrassment are common. It becomes clinically important when shame causes persistent distress, misinformation, avoidance, relationship problems or sexual dysfunction.

Does unlearning sexual shame mean becoming sexually permissive?

No. A person can maintain strong moral boundaries while developing a healthy understanding of anatomy, consent, intimacy and bodily function.

Does religion cause sexual dysfunction?

Religion itself should not be treated as a disease or universal cause of dysfunction. Religious beliefs can be protective and meaningful for many people. Problems may arise when particular interpretations become associated with severe shame, fear or misinformation. Research indicates that this relationship is complex and varies considerably between individuals and communities.

Can sexual shame cause erectile dysfunction?

It may contribute in some men by increasing anxiety and sexual inhibition, but erectile dysfunction has many potential physical and psychological causes. Medical evaluation should therefore not be skipped.

Can sexual shame affect women's sexual function?

Yes, it may contribute to difficulties involving desire, arousal, orgasm, pain or avoidance in some women. However, these symptoms can also arise from hormonal, gynecological, medication-related, relationship and other causes.

Can a couple overcome years of sexual shame?

Many people can substantially improve their comfort, communication and sexual functioning through education, counselling, appropriate medical care and time. There is no universal timetable.

Should I discuss sexual questions with my religious scholar or my doctor?

It depends on the question. Medical questions about anatomy, fertility, disease and sexual function belong with qualified healthcare professionals. Questions of religious law or doctrine may appropriately be discussed with a trusted qualified religious scholar. Psychological distress may require a therapist. These sources of support do not need to oppose one another.

Is Unani medicine useful in this condition?

Unani medicine can offer a useful **supportive and holistic framework**, particularly regarding lifestyle, sleep, nutrition, physical activity and mental well-being. Official AYUSH descriptions of Unani medicine recognize both psychological measures and

mental well-being within its traditional health framework. However, no herbal preparation should be represented as a proven stand-alone cure for sexual shame. Counselling and psychosexual or mental-health treatment should be incorporated when required.

A Message From Dr. Nizamuddin Qasmi

In my experience, one of the biggest barriers in sexual medicine is not always disease.

Sometimes it is silence.

A person may spend ten years suffering from a problem that could have been discussed in ten minutes.

Patients often enter my consultation room believing that I will judge them.

My responsibility as a physician is not to judge them.

It is to understand them.

A patient's religious beliefs deserve respect.

Their cultural identity deserves respect.

Their personal boundaries deserve respect.

Their body also deserves respect.

Healthy sexual medicine should never force a patient to abandon values, nor should it allow misinformation and unnecessary shame to continue harming health.

When I treat sexual disorders and infertility at Saira Health Care, I therefore try to look beyond the symptom.

If a man tells me that he has erectile dysfunction, I want to know whether the cause is vascular, hormonal, metabolic, medication-related, psychological, relationship-related or a combination.

If a woman tells me that she fears intimacy, I want to know whether pain, hormonal factors, pelvic problems, previous trauma, anxiety or learned shame are contributing.

If a couple is unable to communicate about sexuality, simply prescribing medicine may not solve the real problem.

My approach combines appropriate medical investigation, sexual-health education, individualized Unani and lifestyle support when suitable, infertility assessment when required, and referral for psychological or psychosexual treatment when necessary.

The aim is not simply better sexual performance.

The aim is a healthier person and a healthier relationship.

Conclusion

Unlearning sexual shame is the process of learning that sexuality can be understood with knowledge, dignity, responsibility and respect rather than fear and self-hatred.

It does not require rejecting family.

It does not require rejecting culture.

It does not require rejecting religion.

It requires examining which messages are medically accurate, which values are genuinely chosen and which patterns are causing unnecessary psychological or sexual suffering.

Modern sexual medicine increasingly recognizes sexual health as biopsychosocial: physical function, psychological well-being, relationships, culture and personal values all matter.

The Unani system, with its traditional emphasis on balance between physical health, lifestyle and mental well-being, can contribute a valuable supportive perspective when used responsibly and integrated with appropriate modern medical and psychological care.

At **Saira Health Care**, my goal is to create a confidential and respectful environment where men and women can discuss sexual disorders and infertility without humiliation. Through accurate education, careful diagnosis, individualized treatment and appropriate multidisciplinary referral, patients can gradually replace fear with understanding and shame with dignity.

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Medical disclaimer: This article is intended for patient education and general health information. It does not provide an individual diagnosis and does not replace consultation with a physician, psychologist, psychiatrist or appropriately trained

psychosexual therapist. Sexual symptoms may have physical, psychological or combined causes and should be assessed individually.