Fear of Sexual Failure

Understanding Anticipatory Anxiety, Fear of Disappointing a Partner and the Anxiety–Performance Cycle

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Introduction

In my clinical work, I regularly meet patients who say something similar to:

“Doctor, physically I feel normal, but before sexual activity even begins, I start thinking that something will go wrong.”

A man may fear that his erection will disappear.

Another may worry that he will ejaculate too early.

Someone with delayed ejaculation may begin wondering whether he will be able to reach orgasm at all.

A woman may become so concerned about becoming aroused, lubricating adequately, reaching orgasm or satisfying her partner that she cannot relax sufficiently to experience sexual pleasure.

Another patient may simply think:

“What if I disappoint my spouse?”

This pattern is often called **sexual performance anxiety**, and the patient's central experience may be described more simply as **fear of sexual failure**.

The European Society for Sexual Medicine's 2025 position statements describe sexual performance anxiety as involving three important elements: **an expectation about sexual performance, evaluation of whether that expectation is being met, and fear of the consequences of not meeting it**. In other words, instead of simply experiencing

intimacy, the person begins evaluating themselves as though they were taking an examination.

A 2025 review in *Sexual Medicine Reviews* similarly describes sexual performance anxiety as an important but often under-recognized factor in both men's and women's sexual difficulties and presents a clinical model for understanding how anxiety can become self-perpetuating.

One of the most important things I explain to patients is:

Fear of sexual failure does not mean that you are sexually incapable.

Sometimes there is an underlying physical sexual disorder.

Sometimes anxiety is the main problem.

And very often the physical and psychological components begin interacting with each other.

Understanding that interaction is the beginning of effective treatment.

What Is Fear of Sexual Failure?

Fear of sexual failure is the apprehension that something will go wrong during sexual activity and that the result will be embarrassing, disappointing or damaging to the relationship.

The feared event may be:

- inability to obtain an erection;
- losing an erection before or during intercourse;
- ejaculating too early;
- taking too long to ejaculate;
- being unable to reach orgasm;
- not becoming sufficiently aroused;
- vaginal dryness;
- pain during intercourse;
- inability to penetrate;
- not satisfying a partner;
- appearing inexperienced;

- being judged because of body appearance;
- failing to become pregnant despite intercourse;
- being compared with a previous partner.

Sexual performance anxiety itself is generally **not treated as a separate formal medical diagnosis** in the same way that erectile dysfunction or premature ejaculation is. It is better considered an important psychological and sexual-health problem that can coexist with or contribute to recognized sexual dysfunctions.

Sexual Health Is More Than Sexual Performance

This topic makes more sense when sexuality is understood broadly.

The World Health Organization defines sexual health as a state of physical, emotional, mental and social well-being related to sexuality rather than merely the absence of sexual disease or dysfunction. WHO also recognizes that sexuality involves intimacy, desire, beliefs, relationships and psychological, cultural, social and biological influences.

Therefore, sexual success should not be measured only by:

erection + penetration + ejaculation + orgasm.

A person may technically complete intercourse and still be extremely distressed.

Another couple may experience affection, satisfaction and closeness even though intercourse does not occur on a particular occasion.

Healthy sexual functioning involves the body, emotions and relationship together.

Understanding the Anxiety–Performance Cycle

The anxiety–performance cycle is one of the most important concepts for patients to understand.

Imagine that a man experiences one erection difficulty.

Perhaps he was tired.

Perhaps he had consumed alcohol.

Perhaps privacy was poor.

Perhaps he was unusually stressed.

Perhaps he had an argument with his partner.

The event itself may have been temporary.

But afterwards he thinks:

“What if it happens again?”

Before the next sexual encounter, anxiety appears.

He begins monitoring his erection.

Instead of experiencing his partner's touch, he is thinking:

“Am I fully hard?”

“Is it becoming softer?”

“She will notice.”

“I must penetrate before I lose it.”

The sexual situation has now become a performance test.

If erection quality decreases again, his original fear appears confirmed.

He concludes:

“I knew I had a problem.”

His anxiety before the third encounter becomes even stronger.

The 2025 ESSM position statement describes essentially this reinforcing process: as worry about adequacy increases, the likelihood of an unwanted sexual response may also increase; repeated difficulties then increase anticipatory anxiety further.

The cycle can therefore become:

Previous difficulty → fear of repetition → self-monitoring → anxiety → impaired sexual response → disappointment → stronger fear next time.

Why Anxiety Can Interfere With Sexual Response

Sexual responses work most naturally when attention can remain sufficiently engaged with erotic or affectionate stimuli.

Performance anxiety redirects attention.

Instead of:

“This feels pleasurable.”

the mind is asking:

“Am I doing this correctly?”

Instead of:

“I feel close to my partner.”

the thought becomes:

“Are they disappointed?”

This excessive deliberate monitoring can interfere with the more automatic processes involved in sexual response.

The 2025 theoretical model of sexual performance anxiety specifically emphasizes the tension between **deliberate cognitive processing**—monitoring, judging and worrying—and the more reflexive processes required for sexual response.

This is why trying harder does not always help.

Sometimes the more desperately a person tries to force an erection, orgasm or perfect sexual response, the less naturally that response occurs.

Fear of Disappointing a Partner

For many patients, the greatest fear is not the sexual difficulty itself.

It is what the difficulty supposedly means to their partner.

A man thinks:

“My wife will think I am not attracted to her.”

A woman thinks:

“If I don't orgasm, my husband will think he is inadequate.”

A man with premature ejaculation thinks:

“She will never be satisfied with me.”

A woman with low arousal thinks:

“My partner will think I don't love him.”

The person is therefore carrying responsibility not only for their own sexual response but also for the partner's emotions.

That pressure can become enormous.

A 2024 study examining sexual performance anxiety in adult couples found that both men and women described cognitive and emotional difficulties, with **feelings of**

inadequacy emerging prominently. The study also highlights that sexual performance anxiety is not exclusively a male problem.

Sexual Performance Anxiety Affects Men and Women

Historically, discussions of performance anxiety focused heavily on men, particularly erectile dysfunction and premature ejaculation.

Current sexual-medicine literature recognizes that women can experience similar patterns.

The ESSM's 2025 position paper specifically describes performance anxiety as relevant to sexual dysfunction in both sexes.

Women may worry about:

- becoming aroused quickly enough;
- vaginal lubrication;
- reaching orgasm;
- experiencing pain;
- body appearance;
- satisfying their partner;
- taking “too long” to orgasm;
- having too little desire;
- being judged during intimacy.

The resulting anxiety can distract attention from sexual cues and make pleasurable engagement more difficult.

A major 2026 network meta-analysis of 45 studies involving 4,726 women found that several psychological interventions—including cognitive behavioural therapy, mindfulness-based approaches, sexual counselling and sex education—improved measures of female sexual function or sexual distress compared with control conditions. The authors nevertheless noted heterogeneity and limitations in the evidence.

Fear of Sexual Failure and Erectile Dysfunction

The relationship between anxiety and erectile dysfunction can operate in both directions.

Anxiety can contribute to erection difficulties

A man becomes anxious, self-conscious and distracted.

The erection becomes less reliable.

Erectile dysfunction can create anxiety

A man develops ED because of diabetes, vascular disease, surgery, medication or another medical condition.

After several unsuccessful experiences, he develops fear of the next sexual encounter.

The original condition was physical.

Now a psychological layer has been added.

Current European Association of Urology guidance specifically recommends assessing psychological distress, anxiety, relationship factors, sexual expectations, low self-esteem and cognitive distraction in men with erectile difficulties. It recommends cognitive behavioural therapy, including partner involvement when appropriate, alongside medical treatment when psychological factors are relevant.

This is why I tell patients:

Do not choose between "physical" and "psychological" too quickly. Both can exist together.

Fear of Sexual Failure and Premature Ejaculation

Premature ejaculation can create a particularly powerful anxiety loop.

After ejaculating earlier than desired, the man becomes preoccupied with timing.

During the next sexual encounter he thinks:

"Do not ejaculate."

Ironically, nearly every sensation is now being monitored for signs of impending ejaculation.

This can increase tension.

The European sexual-health guideline recommends assessment of anxiety and interpersonal factors in premature ejaculation and describes psychosexual approaches aimed at improving ejaculatory control, increasing confidence, reducing anxiety and

improving couple communication. It notes evidence that psychoeducation and behavioural strategies such as start-stop exercises combined with mindfulness may improve symptoms and associated distress in selected patients.

The important principle is that psychological intervention may complement appropriate medical treatment rather than replace it automatically.

Delayed Ejaculation and Fear of "Not Finishing"

Performance anxiety can also occur at the opposite end of ejaculation timing.

A man who repeatedly has difficulty ejaculating may begin thinking:

"Why is it taking so long?"

His partner begins waiting for orgasm.

He senses that the partner is waiting.

He tries harder.

Now the entire experience is focused on achieving ejaculation.

What began as delayed ejaculation becomes an anxiety-producing performance task.

Delayed ejaculation may also result from:

- antidepressant medications;
- diabetes or neurological disease;
- hormonal factors;
- particular stimulation patterns;
- psychological difficulties;
- relationship factors.

It therefore deserves a proper medical and sexual history rather than assuming anxiety is always the cause.

Fear of Losing an Erection

A common behaviour I see is rushing.

The patient thinks:

"I must penetrate immediately before my erection disappears."

This creates several problems.

Foreplay becomes shorter.

The partner may feel rushed.

The man's attention becomes focused entirely on preserving erection.

Intimacy becomes mechanical.

The 2025 ESSM position statement describes exactly this type of anxiety-driven behaviour: sexual actions may become directed toward preventing feared failure rather than toward the pleasurable or connecting aspects of intimacy.

The goal is therefore not simply:

“Try harder to keep the erection.”

The goal may be:

“Make the erection less of an examination.”

The Role of Self-Monitoring

Patients with sexual anxiety frequently monitor themselves continuously.

This has sometimes been called **spectatoring**—mentally observing one's own sexual performance rather than remaining immersed in the experience.

Research has linked body and genital appearance concerns with greater sexual self-consciousness and sexual difficulties in some men. In one preregistered study involving 858 men, penis-appearance concerns were associated with greater self-focused or embarrassed attention during sex and with reports of erectile and orgasmic difficulties.

This does not mean that self-monitoring explains every sexual problem.

It illustrates how attention, anxiety and body image can interact.

Common Thoughts in Fear of Sexual Failure

Patients frequently report thoughts such as:

- “I must perform perfectly.”
- “I cannot lose my erection.”
- “I have to make my partner orgasm.”
- “I must last a long time.”

- "I should automatically know what my partner likes."
- "If something goes wrong, my partner will lose respect for me."
- "If I fail once, it will happen every time."
- "A real man should never have sexual difficulty."
- "A normal woman should become aroused immediately."
- "My partner is comparing me with somebody else."

These are not objective medical facts.

They are **performance rules**.

Treatment often involves examining whether these rules are realistic.

Unrealistic Sexual Expectations

Unrealistic expectations are increasingly important because many people learn about sex from pornography, films, social media or exaggerated conversations rather than reliable sexual-health education.

A person may come to believe that normal sexuality requires:

an immediate erection,

very long intercourse,

continuous erection without fluctuation,

simultaneous orgasm,

multiple orgasms,

or complete sexual confidence every time.

Real sexual physiology is much more variable.

Fatigue, stress, privacy, medications, health, relationship conditions and mood can all change sexual response from one occasion to another.

Sexual confidence improves when the patient learns:

Normal does not mean identical every time.

Fear of Failure in Newly Married Couples

Fear of sexual failure can be particularly intense during the first sexual experiences after marriage.

Expectations may have accumulated for months or years.

The man may think:

“Tonight I must prove that I am sexually capable.”

The woman may be afraid of pain.

Both may be embarrassed.

The slightest difficulty becomes alarming.

A first-night erection problem does not automatically establish erectile dysfunction.

Difficulty with penetration does not automatically establish permanent vaginismus.

Sometimes what the couple needs initially is privacy, education, slower progression, communication and removal of the idea that everything must happen perfectly on the first night.

Persistent difficulties, however, deserve assessment.

Fear of Sexual Failure After a Previous Problem

One negative experience can become psychologically powerful.

Examples include:

- one episode of erectile loss;
- one episode of premature ejaculation;
- an unsuccessful first sexual encounter;
- painful intercourse;
- inability to reach orgasm;
- a critical comment from a partner;
- infertility-related pressure.

The brain remembers the embarrassment.

Before the next encounter, it produces a warning:

“Be careful. Do not let that happen again.”

The warning was intended to protect the person.

But it may instead recreate the same problem.

Medical Illness and Performance Anxiety

Not every performance fear begins psychologically.

A man may develop ED after:

- diabetes;
- prostate surgery;
- cardiovascular disease;
- neurological illness;
- medication use.

After treatment improves the physical problem, he may still fear failure.

The body may now be capable, but confidence has not caught up.

This is common after significant medical events.

Psychosexual rehabilitation should therefore sometimes accompany medical treatment.

Infertility and Fear of Sexual Failure

Infertility creates a very specific form of pressure.

A couple may be told that ovulation is occurring today.

The man thinks:

“I must perform tonight.”

If an erection does not occur, the problem feels much larger than one sexual encounter.

He thinks:

“We have lost an entire month.”

This pressure can intensify performance anxiety.

Women may also feel that their body is “failing” when pregnancy does not occur, even when the infertility factor is male, mixed or unexplained.

At Saira Health Care, I consider the emotional and sexual effects of infertility important because reproductive treatment can unintentionally convert intimacy into a fertility procedure.

Sexual closeness should not always be reduced to conception attempts.

Relationship Conflict and Fear of Failure

A person may feel confident sexually with one partner and anxious with another.

This does not necessarily mean the body changed.

Relationship circumstances matter.

Criticism, ridicule, mistrust, unresolved infidelity or repeated arguments can create sexual anxiety.

EAU guidance recognizes partner dissatisfaction, poor relationship quality and emotional disconnection as factors associated with erectile difficulties, while intimacy may have a protective association.

The relationship should therefore be part of the clinical history.

Fear of Sexual Failure After Criticism

A single humiliating comment can remain in a patient's mind for years.

Examples include:

“Why can't you stay hard?”

“You finish too quickly.”

“My previous partner was better.”

“Why does your body look like that?”

The partner may have forgotten the statement.

The patient may remember it during every sexual encounter.

Part of treatment may involve helping the couple understand how criticism becomes embedded in future sexual anxiety.

Sexual difficulties are generally managed more effectively through collaboration than humiliation.

Body Image and Sexual Failure

Body-image concerns can increase the sense of being evaluated.

Men may worry about:

- penis size;
- weight;
- abdominal appearance;
- body hair;
- scars.

Women may worry about:

- breasts;
- abdomen;
- weight;
- vulval appearance;
- stretch marks;
- changes after childbirth.

The more attention is focused on appearance, the less attention may remain available for pleasure.

Body-image concerns can therefore become part of the anxiety–performance cycle even when genital function itself is normal.

How Fear of Failure Affects the Partner

Performance anxiety rarely affects only one person.

The anxious partner may withdraw from sexual contact because they fear another difficult experience.

The other partner interprets this as rejection.

For example:

The man avoids sex because he fears losing his erection.

His wife thinks:

“He is no longer attracted to me.”

She becomes hurt and asks repeatedly:

“Why don't you want me?”

The additional pressure makes him more anxious.

He avoids sex even more.

A sexual problem has now become a relationship cycle.

Treatment may therefore involve the couple rather than treating only the individual.

How I Assess Fear of Sexual Failure

At **Saira Health Care**, I begin by identifying exactly what the patient fears.

I may ask:

What do you think will happen during sexual activity?

When did the fear begin?

Was there a previous difficult experience?

Does the problem occur every time or only with a partner?

Does it occur during masturbation?

Are morning or spontaneous erections present?

Is sexual desire normal?

Is ejaculation too early or delayed?

Does intercourse cause pain?

Is the relationship supportive?

Are you trying for pregnancy?

Are you taking medicines that affect sexual function?

Do you have diabetes, hypertension or another medical condition?

What would “successful sex” mean to you?

That final question is often particularly revealing.

There Is No Single Blood Test for Performance Anxiety

Performance anxiety is primarily identified through clinical history and psychological or psychosexual assessment.

The ESSM's current position statement emphasizes the clinical interview as the main assessment tool and recommends examining the effect of anxiety on sexual situations, the person's wider sexual life and broader functioning.

However, if the patient also has persistent sexual dysfunction, medical investigation may be necessary.

A man with ED may require assessment of:

- diabetes;
- blood pressure;
- cardiovascular risk;
- medications;
- hormonal status when clinically indicated.

A woman with painful intercourse may require gynecological or pelvic-floor evaluation.

The purpose is to avoid two common mistakes:

Mistake 1: "Everything is psychological."

Mistake 2: "Everything requires sexual medicine."

Treatment: Breaking the Anxiety–Performance Cycle

Treatment depends on the cause.

A useful plan may combine:

- sexual-health education;
- cognitive behavioural therapy;
- psychosexual counselling;
- mindfulness-based approaches;
- couple communication;
- behavioural exercises;
- treatment of actual sexual dysfunction;
- general-health management;

- Unani lifestyle support where appropriate.

The central therapeutic goal is often to transform sex from an **evaluation situation** back into an **intimate experience**.

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1. Correct Sexual Misconceptions

Education itself can reduce anxiety.

Patients should understand that:

- erections naturally fluctuate;
- desire is not identical every day;
- orgasm cannot be commanded;
- intercourse duration varies;
- penetration is not the only form of intimacy;
- occasional sexual difficulty is common;
- an erection problem does not automatically mean lack of attraction;
- premature ejaculation does not define masculinity;
- infertility does not mean sexual weakness.

Once unrealistic expectations decrease, the perceived consequences of "failure" become less frightening.

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2. Identify the Fear Clearly

The patient should be able to complete the sentence:

"During sex, I am afraid that _____."

Examples:

"I will lose my erection."

"I will finish too early."

"My wife will think I am weak."

"I will not orgasm."

"I will experience pain."

Once the feared event is clearly identified, therapy can address it much more precisely.

3. Identify the Catastrophic Meaning

Next ask:

“If that happens, what would it mean?”

A man may answer:

“My wife will leave me.”

Another:

“I am not a real man.”

A woman:

“My partner will think I don't love him.”

The sexual symptom has now become connected with a larger belief.

Often the emotional reaction is more severe than the symptom itself.

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4. Cognitive Behavioural Therapy

CBT can help identify and challenge distorted predictions.

For example:

Automatic thought:
“If I lose my erection once, the whole night is ruined.”

More balanced thought:
“Erection changes occasionally. We can remain intimate, and if the problem persists I can seek treatment.”

Another:

Automatic thought:
“If I ejaculate early, my partner will think I am useless.”

Balanced thought:
“PE is a recognized sexual-health problem. It can be assessed and treated, and our sexual relationship is broader than one ejaculation time.”

Current EAU guidance recommends cognitive behavioural approaches, including partner involvement where appropriate, when psychological factors contribute to ED.

The 2025 ESSM position statements also identify cognitive restructuring among important strategies for performance anxiety.

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5. Stop Constantly Checking Performance

A patient who checks erection every few seconds is not fully experiencing sexual stimulation.

A patient who constantly thinks:

“Am I close to orgasm?”

may unintentionally make orgasm more difficult.

Treatment therefore encourages shifting attention toward:

touch,

warmth,

breathing,

pleasurable sensation,

affection,

and communication.

The objective is not:

“Do not think at all.”

It is:

“Do not make sexual performance the only thing you notice.”

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6. Mindfulness-Based Approaches

Mindfulness teaches present-focused, less judgmental awareness.

In sexual therapy, this can help patients notice sensation rather than becoming absorbed in catastrophic predictions.

Evidence varies by condition and population, but the field has developed substantially.

A 2026 network meta-analysis found mindfulness-based interventions improved sexual distress and some measures of sexual function in women compared with control care.

A September 2026 systematic review of mind-body interventions found improvements across various sexual-health outcomes with interventions including mindfulness, CBT-based programmes, sensate focus, pelvic-floor interventions and breathing exercises, while also calling for larger and longer studies.

These approaches should be selected according to the patient's actual problem rather than applied automatically.

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7. Sensate Focus and Reducing Performance Demand

In psychosexual therapy, **sensate focus** is a structured approach that helps couples temporarily reduce goal-oriented sexual performance and instead focus on touch and sensation.

The principle is important:

Touch does not always have to produce penetration.

An erection does not always have to become intercourse.

Every encounter does not need to end in orgasm.

A 2024 randomized controlled trial involving 35 couples found that an online sensate-focus intervention improved some measures of sexual function, particularly among participants who began with lower functioning. Because the study was small, the findings should be considered promising rather than definitive.

For selected couples, reducing performance goals can help intimacy feel less like a test.

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8. Address Premature Ejaculation Properly

When genuine premature ejaculation is present, anxiety management alone may not be enough.

Treatment may include appropriate medical therapy, psychosexual intervention and behavioural techniques.

EAU guidance recommends assessing anxiety and control concerns and notes that start-stop methods, psychoeducation and mindfulness may improve PE symptoms and associated distress in selected patients. Combination approaches may be more useful than relying on psychosexual intervention alone for some patients.

Therefore, I do not tell every man with PE:

“It is only in your mind.”

Nor do I give every patient the same medicine.

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9. Treat Erectile Dysfunction When Present

A man with diabetes-related vascular ED needs treatment for ED and his metabolic health.

Telling him to “relax” is inadequate.

Appropriate options may include lifestyle modification, PDE5 inhibitors or other established treatments depending on the patient.

At the same time, if months of ED have created severe anticipatory anxiety, treating the physical dysfunction alone may not immediately eliminate the fear.

Medical and psychological treatment can therefore work together.

The 2025 sexual-performance-anxiety model specifically notes that increasing a person's sense of predictability and control over sexual function—for example through effective ED treatment—may sometimes support anxiety treatment, while deeper recovery involves learning to tolerate the possibility of an imperfect sexual response without feeling unsafe.

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10. Include the Partner When Appropriate

A supportive partner can greatly reduce sexual pressure.

Helpful statements include:

“We don't have to prove anything tonight.”

“Take your time.”

“Your erection isn't how I measure your feelings.”

“We can stop if you're uncomfortable.”

“We are dealing with this together.”

Unhelpful statements include:

“Why is this happening again?”

“Just relax.”

“A real man should be able to do this.”

“You never satisfy me.”

This does not mean the partner must hide genuine needs.

It means sexual problems should be discussed collaboratively rather than as character defects.

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11. Redefine Sexual Success

Patients often improve when they stop defining success as:

penetration + long duration + simultaneous orgasm.

A more useful definition asks:

Were both partners comfortable?

Was there affection?

Was there pleasure?

Was communication open?

Did both people feel respected?

Could either person stop without fear?

This approach does not lower sexual-health standards.

It removes unrealistic performance standards.

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12. Address General Anxiety and Depression

Sometimes sexual anxiety is part of a broader anxiety disorder.

The patient may also worry excessively about:

work,

finances,

health,

relationships,

or social evaluation.

Others have depression, panic symptoms or obsessive thinking.

The ESSM's 2025 position statements emphasize that clinicians should look for multiple forms of anxiety rather than assuming every sexual worry is isolated performance anxiety.

In such cases, appropriate mental-health treatment may be required.

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13. Medication Review

Some medicines can change erection, desire, ejaculation or orgasm.

A patient may develop a genuine medication-related sexual side effect and then develop anxiety about that problem.

Antidepressants are a common example, particularly for delayed ejaculation or orgasm difficulties.

Patients should not stop prescribed medicines themselves.

Instead, the prescribing physician can review whether an alternative, adjustment or treatment for the side effect is appropriate.

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14. Reduce Alcohol as a "Confidence Strategy"

Some patients drink alcohol before intimacy because they believe it makes them less anxious.

A small amount may make someone feel subjectively relaxed, but larger amounts can impair erection, arousal and orgasm.

Then the patient experiences sexual difficulty and becomes even more worried.

Alcohol should therefore not be treated as a performance-anxiety medicine.

The Unani Perspective on Fear and Sexual Function

The Unani system of medicine traditionally considers physical and mental health to be interconnected.

A central Unani framework is **Asbab-e-Sitta Zarooriya**, the six essential determinants or requisites of health. These include food and drink, physical movement and rest, psychological or emotional activity and repose, sleep and wakefulness, environmental influences and appropriate elimination/retention processes.

A 2025 review of these Unani concepts specifically describes **mental and emotional status, sleep, diet and physical activity** as important components of the traditional health framework and compares them with modern lifestyle-medicine principles.

This holistic perspective has particular relevance when sexual anxiety is associated with:

- chronic stress;
- poor sleep;
- fatigue;
- unhealthy routine;
- emotional tension;
- physical weakness;
- associated sexual dysfunction.

Harkat-o-Sukoon-e-Nafsani: Mental and Emotional Balance

Within traditional Unani concepts, psychological and emotional influences are considered part of health maintenance.

Fear, sadness, anger and prolonged psychological tension are not treated as completely separate from bodily health.

This concept is particularly understandable in sexual medicine.

A patient's mind may be telling the body:

“You must perform now.”

The resulting tension can interfere with the very response the patient is trying to produce.

Unani attention to **Harkat-o-Sukoon-e-Nafsani**—mental or psychic activity and repose—therefore offers a useful traditional framework for considering emotional balance as part of overall care.

Sleep and Sexual Anxiety

Poor sleep can increase:

fatigue,

irritability,

anxiety,

low energy,

and reduced sexual desire.

A man who repeatedly attempts intimacy while severely sleep-deprived may have inconsistent erections.

If he misinterprets those experiences as permanent impotence, performance anxiety can begin.

The Unani emphasis on **Naum-o-Yaqza**, or sleep and wakefulness, therefore remains clinically relevant as a general-health principle.

Improved sleep is not a direct cure for sexual performance anxiety, but it can remove an important physiological and psychological stressor.

Diet and General Health

Unani medicine gives significant importance to **Ilaj bil Ghiza**, or dietotherapy.

Diet should not be presented as a direct cure for fear of sexual failure.

However, metabolic health affects sexual function.

Diabetes, obesity, vascular disease and poor cardiovascular health can contribute to erectile dysfunction.

A patient who improves general health may experience more reliable sexual function, which may indirectly help rebuild confidence.

Therefore, appropriate nutrition can form one part of comprehensive care.

Physical Activity and Rest

Traditional Unani health maintenance emphasizes balance between physical movement and rest.

Modern medicine similarly recognizes the value of physical activity for cardiovascular, metabolic and psychological health.

For a patient with vascular ED, obesity or poor fitness, an individualized activity plan may support both general health and sexual function.

Again, the important principle is integration:

Lifestyle treatment supports the body; psychological treatment addresses fear; specific sexual dysfunction receives specific treatment.

Is There a Unani Medicine That Cures Performance Anxiety?

This requires a responsible answer.

There is **not strong modern clinical evidence that one particular Unani herbal formulation by itself cures sexual performance anxiety**.

Fear of sexual failure is primarily a psychological and psychosexual problem, although it may coexist with physical sexual disorders.

Therefore, at Saira Health Care I do not believe that every patient who says:

“Doctor, I am afraid I will fail”

automatically needs an aphrodisiac.

If the patient has genuine ED, PE, low desire, fatigue or another appropriate condition, individualized Unani treatment may be considered within the patient's medical context.

But medication should be selected because there is a clinical indication—not simply to suppress every sexual worry.

Why “Sexual Tonics” Are Not the Whole Answer

Imagine that a man has completely normal erections during masturbation but loses his erection only when he begins thinking:

“I must satisfy my wife tonight.”

Giving stronger and stronger medicines without addressing anxiety may leave the underlying cycle untouched.

Another man may have severe diabetic ED.

Giving only counselling would also be inadequate.

Good treatment asks:

What proportion of this problem is biological?

What proportion is psychological?

What is happening in the relationship?

That is the approach I consider most useful.

My Clinical Approach at Saira Health Care

When a patient presents to **Saira Health Care** with fear of sexual failure, my objective is not simply to provide reassurance.

I first try to determine what the patient is actually afraid of and whether a sexual disorder is present.

My assessment may include:

sexual and relationship history;

erection quality;

ejaculation pattern;

orgasm;

sexual desire;

fertility concerns;

medical conditions;

medications;

sleep and lifestyle;

previous negative sexual experiences;

anxiety and stress;

body-image concerns;

relationship expectations.

When medically indicated, laboratory or specialist assessment may also be advised.

Special Treatment Approach by Dr. Nizamuddin Qasmi

My approach is individualized rather than giving every patient the same treatment.

If erectile dysfunction is present

The cause of ED should be investigated and treated appropriately. Psychological performance anxiety may be addressed simultaneously.

If premature ejaculation is present

Ejaculatory history, anxiety, erectile function and relationship factors are assessed. Behavioural, counselling, medical and appropriate Unani approaches may be integrated according to the individual.

If no major physical dysfunction is found

The emphasis may shift toward sexual-health education, cognitive restructuring, confidence building, reduction of performance monitoring, mindfulness or psychosexual counselling.

If infertility is creating pressure

Fertility evaluation and sexual counselling may proceed together.

If relationship conflict is central

Couple communication or appropriate referral may be necessary.

If significant anxiety or mental-health symptoms exist

A psychologist, psychiatrist or qualified psychosexual therapist may be included in the treatment plan.

The aim is not simply to make the patient perform once.

The aim is to interrupt the cycle that keeps making sexual activity frightening.

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

My professional work 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 – MGBIMS, Delhi
Certificate in Urology – London, UK
Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

This background supports an approach in which I examine sexual complaints through multiple perspectives—sexual medicine, reproductive health, infertility, urological concerns, lifestyle and psychological influences.

At **Saira Health Care**, the intention is not to judge sexual performance.

It is to understand why the patient is struggling and which form of care is appropriate.

Saira Health Care's Contribution to Sexual Disorders and Infertility

One of the largest barriers in sexual-health treatment is embarrassment.

Many men silently worry for months or years.

Some repeatedly purchase unregulated products.

Some avoid marriage or intimacy.

Some become convinced that one sexual difficulty proves permanent impotence.

Women may remain silent about pain, arousal difficulty or anxiety because they fear judgment.

Saira Health Care aims to make these conversations medically understandable and confidential.

Our approach emphasizes:

- professional sexual-health assessment;
- infertility evaluation;
- individualized Unani supportive care where appropriate;
- realistic sexual-health education;
- recognition of psychological and relationship factors;
- appropriate medical investigation;
- multidisciplinary referral when required.

A patient's dignity should remain central throughout the process.

When Sexual Performance Anxiety Requires Professional Help

Occasional nervousness does not necessarily require treatment.

Professional assessment becomes more important when anxiety:

- occurs before most sexual encounters;
- causes persistent erection difficulties;
- contributes to PE or orgasm problems;
- leads to complete avoidance of intimacy;
- produces panic symptoms;
- significantly affects marriage or relationships;
- causes repeated use of unprescribed sexual medicines;
- is associated with depression;

- occurs after trauma;
- creates intense shame or hopelessness.

If severe depression, self-harm or suicidal thoughts are present, mental-health assessment should take priority.

Frequently Asked Questions

Is fear of sexual failure a disease?

Not usually as a stand-alone medical disease. It is closely related to sexual performance anxiety and may occur by itself or alongside ED, premature ejaculation, orgasm problems, anxiety disorders or other sexual dysfunctions.

Can anxiety really cause erection problems?

Anxiety can contribute to erection difficulty by increasing self-monitoring, cognitive distraction and concern about evaluation. However, persistent ED should still be medically assessed because vascular, hormonal, neurological and medication-related causes may be present.

Can fear of PE make PE worse?

It can contribute to a self-perpetuating cycle in some men. Current EAU guidance recommends assessment of anxiety and control concerns and supports psychosexual approaches alongside appropriate medical treatment.

Can women experience performance anxiety?

Yes. Contemporary research and ESSM guidance recognize performance anxiety in women as well as men, including fears related to arousal, orgasm, body image and adequacy.

Does sexual performance anxiety mean I have an anxiety disorder?

Not necessarily. It may be specific to sexual situations, although broader anxiety disorders can coexist. Clinical assessment helps distinguish these possibilities.

Can CBT help?

CBT is commonly used to address dysfunctional expectations, catastrophic thinking and anxiety associated with sexual dysfunction, and current EAU guidance recommends it when indicated in ED.

Can mindfulness help?

Evidence suggests mindfulness-based approaches can help some sexual-health problems and sexual distress, particularly in women, although the evidence varies by condition and is not equally strong for every problem.

Should my partner be involved?

Partner involvement can be useful when pressure, misunderstandings or relationship dynamics maintain the problem. Current EAU recommendations specifically support partner-inclusive CBT when appropriate.

Should I take erection medicine just to feel confident?

Not automatically. A physician should first determine whether ED is actually present and whether the medicine is appropriate for your health. Medication may help some men whose genuine erectile difficulty is maintaining anxiety, but it should not replace assessment.

Can Unani medicine help?

Unani medicine can provide a valuable supportive framework through attention to diet, sleep, physical activity, emotional balance and general health. These principles are particularly relevant when anxiety, fatigue and lifestyle problems coexist. However, there is not strong clinical evidence that an herbal formulation alone cures sexual performance anxiety.

Can fear of sexual failure be completely overcome?

Many patients improve substantially when the underlying cause is identified and appropriately treated. Improvement may involve medical treatment, counselling, CBT, mindfulness, couple communication, psychosexual therapy or a combination. Recovery is usually better understood as learning to tolerate normal sexual variability without interpreting every imperfect response as failure.

A Message From Dr. Nizamuddin Qasmi

When a patient sits in front of me and says:

“Doctor, before I even begin, I am afraid that I will fail,”

I understand that the problem may have already started before any sexual contact occurs.

The body has not failed yet.

But the mind is preparing for failure.

The patient begins watching himself.

His partner's face becomes an examination result.

Every change in erection becomes evidence.

Every minute becomes a measurement.

Sex is no longer intimacy.

It has become a test.

My first aim is therefore to determine whether there is an actual medical problem.

If there is diabetes-related ED, we should treat it.

If there is premature ejaculation, we should treat PE.

If there is hormonal disease, it requires proper investigation.

If there is pain, we should find the cause.

But when fear itself has become part of the problem, medication alone may not be enough.

What I Want Patients to Understand

Your erection does not have to be perfect every time.

Your sexual value is not measured with a stopwatch.

Your partner's orgasm is not an examination of your masculinity.

One unsuccessful sexual encounter does not predict your entire future.

Infertility does not mean that you are sexually inadequate.

And asking for help does not mean that you have failed.

Sometimes the most important treatment begins when the patient stops asking:

“How do I guarantee that nothing ever goes wrong?”

and begins asking:

“How can I remain comfortable and connected even if my sexual response is not perfect?”

The 2025 sexual-performance-anxiety treatment model makes a similar point: recovery is not necessarily about guaranteeing a particular sexual response but about developing a sense of safety even when an imperfect response remains possible.

That is a very important difference.

Final Perspective

Fear of sexual failure is often a fear of judgment, rejection and inadequacy disguised as a sexual-performance problem.

The individual becomes anxious about future performance.

They monitor themselves.

Sexual response becomes less spontaneous.

A difficulty occurs.

The difficulty confirms the fear.

And the next encounter becomes even more stressful.

Current sexual-medicine literature now describes this anxiety–performance cycle more clearly than ever. The 2025 ESSM position statements identify high expectations, perceived evaluation and feared consequences as central elements of sexual performance anxiety, while the 2025 clinical model emphasizes negative thoughts, low self-efficacy and excessive deliberate monitoring as important therapeutic targets.

At the same time, responsible medicine must not reduce every sexual difficulty to anxiety.

Persistent erectile dysfunction, premature ejaculation, delayed ejaculation, low desire, pain, hormonal problems and infertility deserve individual medical evaluation.

The Unani system provides a useful complementary perspective through its traditional emphasis on psychological balance, sleep, diet, physical activity and individualized health. A 2025 review of **Asbab-e-Sitta Zarooriya** similarly describes these factors as a framework linking physical and mental well-being.

At **Saira Health Care**, my approach is therefore integrative.

I evaluate the physical sexual function.

I evaluate reproductive and fertility concerns.

I look at general health.

I assess anxiety, expectations and relationship pressure.

I use appropriate Unani lifestyle and supportive care where suitable.

And when formal psychological or psychosexual treatment is required, I believe collaboration and appropriate referral are part of good sexual medicine.

My message to patients is simple:

Sexual intimacy is not an examination that you must pass.

The objective is not perfect performance.

The objective is **healthy function, realistic expectations, communication, confidence, mutual comfort and a sexual relationship that does not become controlled by fear.**

About the Author

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Medical Disclaimer

This article is intended for general education and sexual-health awareness. It does not replace individualized medical or psychological consultation. Persistent erection problems, ejaculation disorders, sexual pain, loss of desire, infertility or other sexual symptoms can have physical, psychological or mixed causes and should be assessed appropriately. Unani or herbal medicines should not be self-prescribed as substitutes for diagnostic evaluation, evidence-based medical treatment or professional psychological care.