Low Libido: Understanding and Managing a Sudden or Gradual Drop in Sexual Desire

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Sexual desire is an important but highly individual part of human health. Some people naturally think about sex frequently, while others have comparatively little interest. Desire may also rise and fall at different periods of life.

For this reason, when a patient tells me, **"Doctor, my sexual desire has suddenly disappeared,"** or **"My interest in sex has gradually become very low,"** I do not immediately label that person as having a sexual disease.

My first question is:

What changed—and when did it change?

Low libido can be related to hormones, medicines, depression, anxiety, relationship difficulties, erectile problems, painful intercourse, menopause, childbirth, diabetes, thyroid disease, high prolactin, sleep disturbance, chronic illness, fatigue or simply a difficult period in life.

Modern sexual medicine therefore approaches low desire through a **biopsychosocial model**—meaning that the body, mind, relationships and surrounding circumstances are considered together rather than searching for one "sexual weakness." This broad approach is consistent with the World Health Organization's view of sexual health as physical, emotional, mental and social well-being rather than merely the absence of disease.

At Saira Health Care, this same whole-person principle forms the foundation of how I evaluate men and women who report a loss of sexual desire.

What Is Libido?

Libido is the general term used for sexual desire, sexual interest or the motivation to participate in sexual activity.

Desire does not come from one hormone or one organ.

It is influenced by a complex interaction between:

- the brain,
- hormones,
- physical health,
- energy levels,
- sleep,
- emotions,
- relationship quality,
- attraction,
- sexual satisfaction,
- cultural beliefs,
- previous sexual experiences,
- medicines,
- and life circumstances.

This explains why a person can have completely normal genital anatomy yet experience very low desire, while another person with a chronic illness may continue to have strong sexual interest.

The brain, endocrine system, nervous system and relationship environment all contribute.

Is Low Libido Always a Disease?

No.

This is one of the most important messages I give my patients.

People naturally differ in how much sexual desire they experience. Libido can also vary over the course of a relationship and throughout life.

A temporary decrease during:

- stress,
- examination periods,
- financial problems,

- caring for a newborn,
- bereavement,
- illness,
- lack of sleep,
- relationship conflict,
- or physical exhaustion

does not necessarily indicate a sexual disorder.

The medical concern becomes greater when the reduction is **persistent, significantly different from the person's previous level, causes personal distress or relationship difficulty, or appears alongside other medical symptoms**.

In men, current European Association of Urology guidance describes male hypoactive sexual desire disorder as a persistent or recurrent deficiency or absence of sexual or erotic thoughts, fantasies and desire for sexual activity, while emphasizing that age, general health and sociocultural context must be considered.

For women, low desire is similarly evaluated within the context of distress, physical health, emotional well-being, relationship factors and life stage rather than simply by counting how often a woman wants sex. Contemporary women's sexual-health guidance also follows a biopsychosocial approach.

Sudden Low Libido Versus Gradual Low Libido

The speed with which desire changes can provide useful diagnostic clues.

Sudden loss of sexual desire

If someone previously had a satisfactory libido and it drops abruptly over days or weeks, I pay particular attention to recent changes such as:

- starting a new medicine,
- antidepressant treatment,
- major psychological stress,
- relationship conflict,
- depression,
- serious illness,
- surgery,

- pregnancy,
- childbirth,
- sudden endocrine disturbance,
- major sleep loss,
- sexual pain,
- erectile failure,
- a traumatic event,
- or a major change in the partner relationship.

Sudden changes should not be dismissed as “just age.”

Gradual reduction in desire

A slower decline over months or years may be associated with:

- aging,
- menopause,
- progressively worsening diabetes,
- obesity,
- cardiovascular illness,
- testosterone deficiency,
- chronic kidney disease,
- persistent relationship dissatisfaction,
- long-term depression,
- chronic pain,
- medication use,
- poor sleep,
- physical inactivity,
- or accumulated psychological stress.

The timeline helps us decide where to investigate first.

Three Important Components of Sexual Desire

Modern male sexual-health guidance describes sexual desire as involving three broad components:

Drive – the biological component.
Motivation – the psychological component.
Wish – the personal, cultural and contextual component.

In real life, these elements overlap.

This concept is clinically very useful.

For example, testosterone may be normal, but a patient experiencing severe relationship conflict may still have low desire.

Another patient may be emotionally happy with the partner but have reduced libido because testosterone is genuinely deficient.

A third may have desire but avoid intimacy because intercourse is painful.

Therefore, simply prescribing an aphrodisiac without identifying the underlying mechanism may miss the real problem.

Common Causes of Low Libido

1. Stress and Mental Exhaustion

The human brain cannot remain in a constant state of pressure and simultaneously respond normally to every pleasurable stimulus.

Long working hours, financial pressure, family responsibility, job insecurity, caregiving responsibilities and persistent worry can all suppress sexual interest.

A patient may say:

“Doctor, everything is normal between my wife and me, but my mind is never free.”

That sentence itself may contain an important clue.

Sexual desire usually requires psychological space.

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2. Depression

Depression is one of the most important medical causes of reduced desire.

A person with depression may lose interest not only in sex but also in food, hobbies, social activities and things that previously produced pleasure.

Low libido accompanied by:

- persistent sadness,
- hopelessness,
- social withdrawal,
- abnormal sleep,
- reduced energy,
- loss of enjoyment,
- poor concentration,
- or thoughts of self-harm

requires proper mental-health assessment.

EAU guidance specifically recommends assessment of depressive symptoms in men presenting with low desire.

Severe depression or suicidal thinking requires prompt professional help rather than treatment with sexual tonics.

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3. Anxiety and Performance Pressure

Anxiety can suppress desire even when hormones are normal.

A man who has experienced one episode of erection difficulty may start thinking before every sexual encounter:

“What if my erection fails again?”

Instead of focusing on intimacy, he is monitoring his performance.

The same can happen to a woman who expects pain during intercourse or fears that she will disappoint her partner.

EAU guidance notes that anxiety, negative thoughts about sexual performance, shame and relationship concerns can contribute to low male sexual desire.

This is one reason sexual problems can become self-reinforcing.

Fear of sexual failure causes reduced desire, which leads to less intimacy, which creates more anxiety.

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4. Relationship Problems

Sexual desire cannot always be separated from the relationship in which sexuality occurs.

Common contributors include:

- unresolved arguments,
- lack of emotional closeness,
- lack of privacy,
- loss of trust,
- poor communication,
- resentment,
- differences in preferred sexual frequency,
- dissatisfaction with previous sexual encounters,
- infidelity concerns,
- or feeling emotionally neglected.

Sometimes the patient does not have a general loss of libido.

Instead, the problem is **situational**.

A person may still experience sexual thoughts or masturbation desire but little interest in sexual activity with the partner.

This distinction matters.

EAU guidance increasingly emphasizes **desire discrepancy between partners** rather than automatically identifying one partner as "the patient," because differences in sexual desire are common within relationships and may change over time.

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5. Erectile Dysfunction Can Reduce Libido

Patients frequently assume that reduced erection and reduced desire are the same condition.

They are not.

Libido means wanting sexual activity.

Erectile function means the physical ability to develop and maintain an erection.

However, the two can influence each other.

A man who repeatedly loses his erection may gradually stop initiating sex because he fears embarrassment.

Eventually he may report:

“My desire is gone.”

In reality, sexual desire may have become suppressed by anxiety surrounding erectile failure.

EAU guidance lists erectile dysfunction among conditions associated with low male sexual desire.

Therefore, erection and libido should be assessed separately.

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6. Painful Sex Can Reduce Sexual Desire

If sexual activity repeatedly causes pain, avoidance is understandable.

In women, conditions such as:

- vaginal dryness,
- genitourinary syndrome of menopause,
- vaginismus,
- vulvodynia,
- pelvic-floor dysfunction,
- endometriosis,
- infections,
- dyspareunia,
- and other pelvic conditions

may reduce interest because sexual activity becomes associated with discomfort.

Mayo Clinic guidance similarly recognizes painful intercourse and difficulty with orgasm as important contributors to low sexual desire in women.

The correct treatment is not simply to increase libido.

The pain must be identified and managed.

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7. Low Testosterone in Men

Testosterone has an important role in male sexual desire.

However, this topic is frequently misunderstood.

A man cannot diagnose testosterone deficiency simply because he feels tired or has low libido.

Sexual desire does not correlate perfectly with one testosterone number, particularly in older men.

Current EAU guidance recommends evaluating testosterone appropriately when endocrine disease is suspected and, in its 2026 guideline, recommends measuring total testosterone **in the morning and fasting** using a reliable assay when evaluating male hypogonadism.

Symptoms that may suggest genuine androgen deficiency include a combination of:

- low sexual desire,
- reduced spontaneous erections,
- fatigue,
- reduced muscle mass,
- reduced body hair in some cases,
- infertility,
- reduced testicular volume,
- or other compatible findings.

Diagnosis should be based on symptoms plus appropriate laboratory assessment—not symptoms alone.

Testosterone Is Not a General "Sex Power" Medicine

This warning is extremely important.

Testosterone should not be given automatically to every man with low libido.

And it should be used with particular caution in men planning children.

The 2026 EAU guideline specifically states that **testosterone therapy should not be used to treat male infertility or in men wishing to father children**, because external testosterone can suppress the hormonal signals required for normal sperm production.

I emphasize this point especially in infertility practice.

A young man may come complaining of low libido and simultaneously be trying to conceive.

Starting testosterone without evaluating fertility can be counterproductive.

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8. High Prolactin

Prolactin is produced by the pituitary gland.

When prolactin becomes abnormally elevated, sexual desire may decrease. In men, high prolactin can also affect testosterone and erectile function.

Causes include:

- certain medications,
- pituitary tumors,
- thyroid disease,
- and other medical conditions.

Current sexual-medicine guidance recognizes hyperprolactinemia as an important cause of low male desire and recommends appropriate investigation when clinically indicated.

If high prolactin is accompanied by severe headaches, visual disturbance or other neurological symptoms, additional evaluation may be required.

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9. Thyroid Disease

Both underactive and overactive thyroid function can affect sexuality.

Thyroid disease can alter:

- mood,
- energy,
- menstrual function,
- weight,
- sleep,
- erections,
- ejaculation,
- and sexual interest.

EAU guidance specifically identifies thyroid testing as appropriate in selected men whose history suggests endocrine causes of low desire.

Treating the underlying thyroid disorder may improve associated sexual symptoms.

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10. Diabetes

Diabetes may affect libido both directly and indirectly.

It can contribute to:

- fatigue,
- reduced physical health,
- vascular disease,
- erectile dysfunction,
- nerve dysfunction,
- hormonal changes,
- depression,
- and relationship anxiety.

Chronic medical disease can influence female and male sexual function through biological, psychological and medication-related mechanisms. A 2024 clinical review emphasized that clinicians should consider this complete biopsychosocial impact when evaluating sexual dysfunction in people with chronic illness.

Improving diabetes control is therefore often part of sexual-health treatment.

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11. Cardiovascular Disease

Poor vascular health is most commonly discussed in relation to erectile dysfunction, but severe chronic cardiovascular disease can also affect energy, confidence and desire.

EAU guidance lists coronary disease and heart failure among conditions associated with low male sexual desire.

People recovering from major cardiac illness may additionally develop fear that intercourse will harm the heart.

Reassurance and cardiovascular guidance can sometimes be as important as sexual medication.

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12. Kidney and Other Chronic Diseases

Chronic kidney disease, advanced liver disease, cancer, neurological conditions, chronic inflammatory disorders and other long-term illnesses may reduce sexual interest.

The effects may arise from:

- fatigue,
- anemia,
- altered hormones,
- pain,
- medication,
- poor sleep,
- depression,
- altered body image,
- or reduced general health.

Recent clinical literature continues to emphasize the significant impact of chronic medical disease on sexual functioning and quality of life.

This is why treating sexual health independently from general medical health may be inadequate.

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13. Medicines That Can Reduce Libido

Medication review is an essential part of my assessment.

Some medicines can interfere with desire, arousal, erection, ejaculation or orgasm.

The most familiar example is certain antidepressants, particularly **SSRIs**, although the effect varies substantially between individuals.

Other medications may also influence sexual function depending on the person and underlying illness.

EAU guidance specifically recommends reviewing chronic therapies that may negatively affect sexual desire and recognizes antidepressant treatment as a potential contributor.

Never stop antidepressants, blood-pressure medicines, psychiatric drugs or other essential treatments suddenly.

A doctor may sometimes:

- adjust the dose,
- change timing,
- substitute another drug,

- manage the sexual side effect,
- or determine that continuing the medicine remains the safest option.

The decision depends on the underlying disease.

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14. Sleep Deprivation

Sleep is frequently overlooked.

A person sleeping four or five hours each night may report:

- low energy,
- irritability,
- low motivation,
- reduced exercise,
- poor metabolic health,
- and decreased sexual interest.

Sleep apnea may additionally contribute to fatigue and hormonal disturbance.

In Unani medicine, the balance between **Nawm-o-Yaqza—sleep and wakefulness—is one of the classical essential factors of health**, an observation that fits well with modern recognition of the importance of restorative sleep. CCRUM describes sleep/wakefulness as one component of the classical *Asbab Sitta Daruriyya*, or six essential factors.

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15. Obesity and Physical Inactivity

Obesity can contribute to reduced sexual well-being through:

- diabetes,
- cardiovascular risk,
- poor exercise tolerance,
- body-image concerns,
- sleep apnea,
- hormonal disturbance,
- and reduced confidence.

Physical activity can support metabolic health, mood, circulation, sleep and energy.

No exercise can guarantee an increase in libido, but improving general health frequently improves the conditions required for healthy sexual function.

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16. Alcohol, Smoking and Recreational Drugs

Alcohol can temporarily reduce inhibition but excessive consumption can interfere with:

- erections,
- orgasm,
- judgment,
- sleep,
- hormones,
- mood,
- and relationship functioning.

Smoking damages vascular health and may affect sexual arousal and erectile performance.

Mayo Clinic guidance also identifies excessive alcohol, smoking and recreational drug use among lifestyle factors capable of reducing women's sexual response and desire.

Low Libido in Women

Women's sexual desire is particularly sensitive to physical, hormonal, emotional and relationship factors.

Common contributors include:

- pregnancy,
- breastfeeding,
- postpartum exhaustion,
- menopause,
- painful intercourse,
- vaginal dryness,
- depression,
- anxiety,
- medication,

- chronic illness,
- relationship problems,
- poor body image,
- and lack of privacy.

Mayo Clinic describes female desire as being affected by physical conditions, medicines, hormonal changes, lifestyle habits, emotional health and relationship factors.

For many women, desire is also **responsive rather than spontaneous**.

This means that a woman may not begin an intimate encounter already feeling strong sexual desire. Interest can develop after affection, emotional connection and appropriate stimulation begin.

Failure to understand this difference sometimes causes women to think something is wrong when their response may still fall within normal variation.

Pregnancy, Childbirth and Breastfeeding

Sexual desire commonly changes during pregnancy and after childbirth.

Postpartum women may experience:

- exhaustion,
- disrupted sleep,
- breastfeeding-related hormonal changes,
- vaginal dryness,
- healing after delivery,
- concerns about body image,
- fear of another pregnancy,
- and emotional adjustment to parenthood.

These factors may substantially reduce sexual interest temporarily.

Pressure from a partner during this period can worsen the problem.

Support, communication, rest and medical management of pain or dryness may be more useful than immediately prescribing libido-enhancing treatment.

Menopause and Low Desire

Menopause can affect sexual health in several ways.

Declining estrogen may contribute to:

- vaginal dryness,
- tissue sensitivity,
- discomfort during intercourse,
- urinary symptoms,
- and changes in arousal.

At the same time, sleep problems, hot flashes, relationship factors, mood changes, chronic illness and medications may influence desire.

The 2026 Indian Menopause Society guidelines describe sexual dysfunction in midlife women as multifactorial, involving biological factors such as hypoestrogenism and chronic disease, psychological factors such as depression and anxiety, and relationship or sociocultural factors.

Therefore, menopause-related low libido should not automatically be treated with one hormone.

The entire picture matters.

Female Hypoactive Sexual Desire Disorder

When low sexual desire is persistent, acquired, generalized and causes significant distress, some women may meet criteria for **hypoactive sexual desire disorder (HSDD)** depending on the diagnostic framework being used.

A 2024 clinical review describes female desire as arising from complex interactions between hormones and neurotransmitters and emphasizes that diagnosis depends on clinical features together with sexual distress.

Treatment should begin by asking whether low desire is being caused by:

- pain,
- depression,
- relationship problems,
- medication,
- menopausal symptoms,

- another medical condition,
- or another sexual dysfunction.

Only after these factors are considered should disorder-specific treatment be discussed.

Medicines Specifically Used for Female HSDD

Medication options vary by country and patient characteristics.

One important recent regulatory development is that in the United States, the FDA updated **flibanserin** labeling in December 2025. It is now indicated for women **younger than 65 years** with acquired, generalized HSDD that causes significant distress or interpersonal difficulty and is not due to another medical or psychiatric condition, relationship problems or medication effects. The medicine carries important warnings, including hypotension and fainting in certain settings, and is not intended simply to enhance sexual performance.

Another U.S.-approved option, **bremelanotide**, is indicated for selected premenopausal women with acquired generalized HSDD; it also has contraindications and potential adverse effects and requires medical supervision.

These examples should not be interpreted as recommendations for self-treatment. Regulatory approval, availability and indications differ between countries.

Testosterone for Low Desire in Women

Testosterone is sometimes discussed for selected women with HSDD, particularly after menopause.

The International Society for the Study of Women's Sexual Health recommends considering carefully monitored **transdermal testosterone** for appropriately selected women with HSDD after a full biopsychosocial assessment and after modifiable causes such as relationship or mental-health problems have been addressed. Evidence suggests a moderate benefit, but long-term safety data remain limited, and use is off-label in many countries.

Testosterone should therefore never be prescribed to a woman merely because a random blood test appears “low.”

Female HSDD is a clinical diagnosis, not a single laboratory number.

Low Libido in Men

In men, low desire often receives less attention because patients may describe all sexual problems as “weakness.”

I try to separate four questions:

Does he want sex?
Can he get an erection?
Can he maintain the erection?
Can he ejaculate and experience orgasm normally?

The answers may reveal completely different disorders.

Common causes of low male libido recognized in current EAU guidance include androgen deficiency, high prolactin, depression, anxiety, relationship conflict, aging, chronic kidney disease, cardiovascular disease, antidepressant therapy, erectile dysfunction and chronic pelvic-pain conditions.

Low Libido and Infertility

Low libido and infertility are not the same condition, but they can influence one another.

A couple undergoing prolonged infertility treatment may develop significant emotional pressure.

Intercourse can change from an intimate activity into a scheduled reproductive task:

“Today is the fertile day, so we must have sex.”

That pressure may reduce desire, particularly if the process continues for months.

Male infertility may also be associated with hormonal abnormalities that affect libido, while certain treatments given incorrectly—particularly exogenous testosterone—can actually suppress sperm production.

Because my clinical practice is focused on both sexual disorders and infertility, I consider this overlap especially important.

Sexual and reproductive health should be evaluated together when necessary.

How I Evaluate Low Libido at Saira Health Care

When someone comes to me with reduced sexual desire, I do not begin by asking which medicine to prescribe.

I begin by understanding the story.

The history

I ask:

- When did the reduction begin?
- Was it sudden or gradual?
- Was desire previously normal?
- Is the problem present with every situation or only with the partner?
- Are erections normal?
- Is intercourse painful?
- Is orgasm normal?
- Has any medicine recently been started?
- How is sleep?
- Is the patient depressed or anxious?
- Is there relationship conflict?
- Is pregnancy or infertility involved?
- Is there diabetes, thyroid disease or chronic illness?
- Has there been surgery?
- Is alcohol or another substance involved?

This detailed sexual and medical history is consistent with modern guideline-based evaluation.

Physical Examination and Laboratory Testing

Testing should be **targeted**, not random.

Depending on the patient, evaluation may include:

- blood pressure,
- body weight and metabolic assessment,
- signs of endocrine disease,
- genital examination when indicated,
- morning total testosterone in men,
- prolactin,
- thyroid function,

- blood glucose or HbA1c,
- additional reproductive hormones where clinically appropriate,
- or other investigations depending on symptoms.

EAU guidance recommends medical and sexual history, physical assessment and endocrine investigations when indicated; it specifically recommends ruling out endocrine disorders in men presenting with low desire.

Not every patient requires every hormone test.

Medicine should be individualized.

Warning Signs That Deserve Earlier Medical Assessment

A professional evaluation is particularly advisable when low libido is:

- sudden and unexplained,
- persistent for several months,
- accompanied by erectile dysfunction,
- associated with infertility,
- accompanied by absent periods,
- associated with major weight change,
- accompanied by breast discharge unrelated to breastfeeding,
- associated with severe headaches or visual disturbance,
- accompanied by marked fatigue or other hormonal symptoms,
- associated with genital or pelvic pain,
- associated with severe depression,
- occurring after cancer treatment,
- or causing significant relationship distress.

A sudden loss of desire after starting a new medicine should also be discussed with the prescribing clinician.

Treatment: Correct the Cause Rather Than Treating the Symptom Alone

The most effective approach depends on **why** libido has decreased.

There is no universal libido medicine appropriate for everyone.

Treatment may involve one or several of the following.

Treat the underlying medical condition

When low desire is secondary to:

- thyroid disease,
- diabetes,
- elevated prolactin,
- confirmed testosterone deficiency,
- depression,
- painful intercourse,
- or another chronic disease,

treating the underlying problem may improve sexual interest.

EAU guidance specifically recommends cause-directed treatment rather than a one-size-fits-all approach.

Review Medicines

If sexual symptoms started after a new prescription medicine, discuss this with the prescribing doctor.

Sometimes an alternative can be considered.

Sometimes the dose can be adjusted.

Sometimes the medicine is essential and should remain unchanged.

The important point is:

Do not stop treatment yourself.

Improve Sleep

Aim for regular, sufficient, restorative sleep.

For patients with:

- loud snoring,
- witnessed pauses in breathing,

- severe daytime sleepiness,
- obesity,
- morning headache,

sleep apnea should be considered.

Restoring energy often restores interest in many activities—including intimacy.

Physical Activity

Regular moderate exercise can improve:

- energy,
- cardiovascular health,
- metabolic health,
- body confidence,
- stress management,
- and sleep.

I prefer sustainable daily activity rather than extreme exercise programs.

Diet and Metabolic Health

There is no scientifically proven “libido food” that cures sexual desire disorders.

However, a nutritious diet may help improve:

- diabetes,
- obesity,
- cardiovascular risk,
- energy levels,
- and general health.

For patients with metabolic disease, these changes can indirectly support sexual function.

Relationship and Psychosexual Counseling

Sometimes the most appropriate treatment is not medication.

Couples may benefit from:

- open discussion,
- addressing resentment,
- reducing pressure for intercourse,
- rebuilding affection,
- improving sexual communication,
- counseling,
- sex therapy,
- cognitive-behavioral approaches,
- or mindfulness-based interventions.

EAU guidance notes that cognitive and behavioral psychological strategies may be beneficial in male low desire and emphasizes addressing the couple and desire discrepancy where relevant.

Treatment should improve intimacy, not simply increase a numerical frequency of intercourse.

The Role of Unani Medicine in Low Libido

As a Unani physician, I find the traditional whole-person approach particularly relevant when evaluating sexual desire.

Classical Unani literature uses the concept **Zu'f-i-Bah** or sexual debility for conditions involving diminished sexual capacity and desire.

The Central Council for Research in Unani Medicine describes *Zu'f-i-Bah* as a condition involving decreased sexual desire and sexual capability and recognizes psychological factors among its potential contributors. Its classical principles of management also include addressing psychological causes rather than considering sexual weakness purely physical.

This is an important point.

Even traditional Unani medicine did not view every sexual problem simply as a lack of “strength.”

Asbab Sitta Daruriyya: A Useful Holistic Framework

One of the foundations of Unani preventive medicine is the concept of **Asbab Sitta Daruriyya**, or six essential factors required for maintaining health.

CCRUM describes them as:

1. Air and environment
2. Food and drink
3. Physical movement and rest
4. Mental activity and peace
5. Sleep and wakefulness
6. Retention and evacuation

When I apply this philosophy to a patient with low libido, I consider questions such as:

Is the patient sleeping properly?

Is there severe stress?

Is the patient physically active?

Is diabetes or obesity present?

Is food irregular?

Is there chronic constipation or another illness affecting well-being?

Is the mind continuously occupied with anxiety?

This is where Unani lifestyle medicine can complement modern sexual medicine particularly well.

Ilaj-bil-Ghiza — Dietotherapy

Unani medicine places considerable value on diet.

For low libido, my aim is not to tell patients that one particular nut, herb or food will magically restore desire.

Instead, diet should support:

- healthy weight,
- adequate nutrition,
- metabolic health,
- diabetes control,

- cardiovascular health,
- digestion,
- and general vitality.

The patient's diet should be individualized according to health status, age, constitution and associated disease.

Ilaj-bil-Tadbir — Regimental and Lifestyle Therapy

CCRUM describes **Ilaj-bil-Tadbir** as one of the recognized therapeutic approaches of Unani medicine alongside dietotherapy and pharmacotherapy.

For patients with low sexual desire, appropriate supportive measures may include:

- regular physical activity,
- appropriate rest,
- sleep correction,
- stress reduction,
- structured daily routine,
- weight management,
- and addressing sedentary behavior.

These measures are particularly useful when low libido occurs together with lifestyle disorders.

Psychological Balance in Unani Care

Traditional Unani medicine gives an important place to **Harakat-o-Sukun Nafsani**, or the balance of mental activity and psychological repose.

CCRUM's standardized terminology specifically recognizes peace of mind as an essential component of health.

This concept is highly relevant to:

- anxiety-related loss of desire,
- stress,
- performance fear,

- infertility-related distress,
- relationship problems,
- and sexual guilt.

Modern psychology and traditional holistic medicine therefore meet at an important point:

The mind influences sexual function.

Ilaj-bil-Dawa — Unani Pharmacotherapy

Classical Unani practice includes herbal and compound formulations traditionally used in conditions described as sexual debility.

However, responsible contemporary practice requires caution.

Modern evidence supporting herbal products for specific sexual problems is growing but remains variable in quality. Recent systematic reviews of natural products for male sexual dysfunction have reported signals of benefit in some trials, including sexual-desire outcomes, but the products, study quality and underlying diagnoses differ considerably. These findings cannot be treated as proof that every traditional formulation will restore libido in every patient.

Therefore, at Saira Health Care I believe Unani pharmacotherapy should be:

- individualized,
- selected after diagnosis,
- considered in the context of other medicines,
- avoided where contraindicated,
- and integrated with necessary modern investigation.

A herbal medicine should not delay the diagnosis of pituitary disease, severe depression, diabetes, thyroid disease or true testosterone deficiency.

Do “Sex Power” Supplements Solve Low Libido?

Usually this is the wrong way to think about the problem.

A person may buy sexual enhancement supplements believing that more erection means more desire.

But libido and erection are different.

In addition, sexual-enhancement products obtained from unreliable sources can sometimes contain undeclared prescription medicines. In April 2026, the U.S. FDA warned about one sexual-enhancement product in which laboratory analysis found undeclared sildenafil, tadalafil and flibanserin.

This highlights why sexual medicines and supplements should come from reputable sources and be used under appropriate medical guidance.

Dr. Nizamuddin Qasmi's Specialized Approach to Low Libido

At **Saira Health Care**, I prefer a structured and individualized approach rather than automatically prescribing the same medicine to every patient.

My approach generally focuses on several stages.

Stage 1: Identify the nature of the complaint

Is the problem truly low desire, or is the patient avoiding sex because of erectile dysfunction, premature ejaculation, vaginal pain, infertility pressure or relationship conflict?

Stage 2: Identify reversible causes

This may involve:

- medicine review,
- metabolic health,
- diabetes,
- thyroid function,
- testosterone where appropriate,
- prolactin where indicated,
- sleep,
- mental health,
- and relationship factors.

Stage 3: Correct lifestyle imbalance

Using modern preventive principles together with Unani concepts such as appropriate diet, activity, rest, sleep and psychological balance.

Stage 4: Provide individualized therapy

Depending on the diagnosis, this may involve:

- counseling,
- psychosexual guidance,
- treatment of associated sexual dysfunction,
- management of chronic illness,
- physician-supervised hormonal treatment where genuinely indicated,
- appropriately selected Unani supportive therapy,
- or referral to an endocrinologist, psychiatrist, gynecologist, urologist or other specialist.

Stage 5: Follow-up

Sexual health is rarely improved simply by giving one prescription and ending the consultation.

Follow-up helps determine whether:

- libido has improved,
- the underlying disease is controlled,
- medication side effects remain,
- relationship anxiety has reduced,
- and treatment remains safe.

Contribution of Saira Health Care to Sexual Disorders and Infertility

Saira Health Care focuses extensively on sexual and reproductive-health complaints that patients are often uncomfortable discussing openly.

These may include:

- low sexual desire,
- erectile dysfunction,
- premature ejaculation,
- ejaculation disorders,
- male infertility,
- reduced sperm parameters,
- female fertility concerns,

- sexual performance anxiety,
- painful intercourse,
- relationship-related sexual difficulties,
- and sexual problems associated with chronic illness.

The aim is to provide an environment in which these concerns can be discussed professionally and confidentially.

My clinical focus in **sexual disorders and infertility**, together with training in Unani medicine, infertility, urological subjects, male infertility and integrated sexual and reproductive health, allows me to evaluate these complaints from more than one perspective.

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The objective is not to create unrealistic promises of instant sexual power.

It is to understand **why** sexual desire has changed and build the treatment around that cause.

Frequently Asked Questions About Low Libido

Is low libido normal?

Sometimes.

Sexual desire naturally varies between individuals and throughout life. It becomes a medical concern particularly when it is persistent, distressing, markedly different from the person's previous pattern or associated with other symptoms.

Does low libido mean low testosterone?

No.

Testosterone deficiency is only one possible cause. Stress, depression, relationship conflict, medication, poor sleep, erectile dysfunction and chronic disease are also common contributors.

Can testosterone cure every man's low libido?

No.

Testosterone is appropriate only for selected men with compatible symptoms and properly confirmed deficiency. Current guidelines do not recommend indiscriminate testosterone use.

Can testosterone reduce sperm count?

Yes.

External testosterone can suppress sperm production and should not be used as a treatment for male infertility or in men actively trying to father children.

Can depression reduce sexual desire?

Yes.

Depression itself may reduce libido, and some antidepressants can additionally cause sexual side effects. Medication should not be stopped without medical supervision.

Can menopause reduce desire?

Yes, but not in every woman.

Menopause-related hormone changes, vaginal dryness, painful sex, sleep disturbance, mood changes, chronic illness and relationship factors can all contribute.

Can relationship problems cause low libido?

Yes.

Relationship satisfaction, trust, communication and desire discrepancy between partners can strongly influence sexual interest.

Does masturbation cause permanent loss of libido?

Masturbation itself is not recognized as a cause of permanent sexual weakness. If a person's sexual habits have become compulsive, interfere with partnered intimacy or are associated with anxiety, those patterns can be evaluated separately.

Can Unani medicine help?

Unani medicine offers a useful holistic framework involving diet, lifestyle, sleep, activity, psychological balance and individualized supportive treatment. CCRUM also recognizes traditional management approaches to *Zu'f-i-Bah*. However, specific herbal medicines should not be represented as guaranteed cures, and modern investigation should be used when endocrine, psychiatric or other medical disease is suspected.

How long does treatment take?

There is no universal duration.

A patient whose symptoms are caused by sleep deprivation may improve quite differently from someone with major depression, testosterone deficiency, menopause-related pain or long-standing relationship conflict.

Treatment duration depends on the cause.

My Message to Patients

When sexual desire decreases, many patients become frightened.

Men may think:

“My masculinity is ending.”

Women may think:

“Something is wrong with me because I don't feel desire.”

Partners may think:

“Perhaps he or she no longer loves me.”

None of these conclusions should be made without understanding the cause.

Low libido is often the body's way of telling us that something else needs attention.

Sometimes it is stress.

Sometimes it is exhaustion.

Sometimes it is a hormone problem.

Sometimes it is depression.

Sometimes it is diabetes.

Sometimes it is pain during intercourse.

Sometimes it is an erection problem.

Sometimes it is medication.

And sometimes it is the relationship itself.

My advice is therefore simple:

Do not treat low libido only as a lack of sexual power. Treat it as a health symptom that deserves proper understanding.

A good sexual-health consultation should respect the patient's privacy, avoid shame and investigate both physical and psychological causes.

At Saira Health Care, our goal is to combine the holistic principles of Unani medicine with responsible modern sexual and reproductive-health evaluation so that treatment is individualized, medically sensible and focused on the patient's overall well-being.

Sexual health is not simply the ability to have intercourse. It is part of physical health, emotional health, relationship health and quality of life.

And when desire changes significantly, the first step toward improvement is not embarrassment.

The first step is understanding why.

Medical Disclaimer

This article is intended for general health education and does not establish a diagnosis or replace an individual consultation. Low sexual desire can be associated with endocrine disorders, psychiatric illness, chronic disease and medication effects. Hormonal treatment—including testosterone—should be used only after appropriate clinical assessment. People with severe depression, suicidal thoughts, neurological symptoms, significant endocrine abnormalities or other concerning symptoms should obtain appropriate medical care promptly. Herbal or Unani medicines should also be selected individually after reviewing medical conditions and concurrent medications.