

Sexual Myths and Misconceptions in Men

Separating Sexual Health Facts From Fear, Shame, Misinformation and Performance Myths

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Introduction

In my clinical practice, I meet many men who come to me believing that they have a serious sexual disease.

But after a detailed consultation, I sometimes discover something very different.

The man is not necessarily suffering from a major disease.

He is suffering from a **myth**.

One young man tells me:

“Doctor, I had nightfall twice this month. I think my body is becoming weak.”

Another says:

“I masturbated when I was younger. Is that why my erection is not strong now?”

Another patient says:

“My semen looks thinner than before. Does that mean I am infertile?”

A newly married man tells me:

“I could not get a proper erection on my wedding night. Have I become impotent?”

Another asks:

“My penis is smaller than what I have seen in videos. Can I satisfy my wife?”

Some men believe:



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“If I ejaculate frequently, all my strength will disappear.”

Others believe:

“A real man should always be ready for sex.”

Still others are taking testosterone injections, sexual supplements or so-called “power medicines” without understanding whether they actually have a hormone deficiency or sexual disorder.

These beliefs can produce enormous anxiety.

Sometimes a man who originally had completely normal sexual functioning becomes so frightened about his body that anxiety itself begins interfering with erection, ejaculation, desire and intimacy.

This is why **sexual myths and misconceptions in men deserve serious clinical attention.**

They are not merely harmless misunderstandings.

They can contribute to:

- sexual performance anxiety;
- erection problems;
- premature-ejaculation concerns;
- semen-loss anxiety;
- low self-confidence;
- unnecessary medication;
- relationship conflict;
- avoidance of intimacy;
- infertility fears;
- depression or anxiety;
- repeated visits to unqualified practitioners;
- financial exploitation through misleading sexual-health products.

It is important to clarify at the beginning that **“sexual myths and misconceptions in men” is not itself a formal medical disease or diagnostic category.**

It is better understood as a sexual-health and counselling concern in which inaccurate beliefs influence how a man interprets his body, sexual function or reproductive health.



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The World Health Organization describes sexual health much more broadly than simply having an erection or being free from disease. Sexual health includes physical, emotional, mental and social well-being in relation to sexuality and requires respectful, safe and healthy sexual relationships.

Modern sexual medicine similarly recognizes that biological, psychological, interpersonal and cultural factors interact in sexual function. The Fifth International Consultation on Sexual Medicine recommends a biopsychosocial approach rather than treating every sexual complaint as a problem of the genital organs alone.

That is also the approach I follow in my clinical practice.

Why Are Sexual Myths So Common Among Men?

Sexuality remains difficult to discuss openly in many families and communities.

A boy may reach puberty without receiving accurate information about:

- erections;
- ejaculation;
- semen;
- masturbation;
- nightfall;
- penis size;
- sexual desire;
- fertility;
- sexual relationships.

Naturally, he looks for answers elsewhere.

Those answers may come from:

- friends;
- older boys;
- social media;
- pornography;
- anonymous internet forums;
- advertisements;



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- traditional beliefs;
- unqualified practitioners;
- exaggerated product marketing.

A qualitative study involving young Indian men found that participants wanted reliable sexual-health education but often obtained information from unreliable sources because sexuality remained socially difficult to discuss.

Studies from India have also demonstrated associations between sexual misconceptions—including fear about masturbation, nocturnal emission and semen loss—and sexual distress or dysfunction.

This does not mean Indian culture itself causes sexual dysfunction.

It means that when accurate medical information is unavailable, myths can become powerful.

Myth 1: “Semen Is My Vital Energy, and Every Ejaculation Makes Me Weak”

This is one of the most persistent sexual myths I hear.

A patient may tell me:

“Doctor, semen contains so much strength that losing it must weaken the whole body.”

This idea can produce intense fear.

A man ejaculates.

The next morning he feels tired.

He assumes:

“My semen loss caused weakness.”

But fatigue may actually be related to:

- poor sleep;
- stress;
- anxiety;
- insufficient nutrition;
- illness;
- depression;



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- overwork.

Semen is an important reproductive fluid.

But ejaculation is also a normal physiological function.

The body continuously produces components of semen and sperm through the normal reproductive system.

Normal ejaculation does not mean that a man's essential life force has permanently left his body.

When fear of semen loss becomes extreme and produces physical or psychological complaints, clinicians may encounter what has historically been called **Dhat syndrome or semen-loss anxiety**.

Systematic reviews describe this phenomenon particularly in South Asian populations, where patients may associate semen loss with fatigue, anxiety, weakness, depressed mood and sexual problems.

The correct approach is respectful education—not ridicule.

Myth 2: “Nightfall Is a Disease”

Nightfall, medically called a **nocturnal emission**, refers to involuntary ejaculation during sleep.

Many young men become frightened after experiencing it.

They may think:

“My semen is leaking.”

“My body cannot control itself.”

“I am becoming weak.”

These beliefs are medically inaccurate.

A major 2026 systematic review examining 157 sources concluded that nocturnal emissions are a common physiological phenomenon, particularly during adolescence. Reported prevalence was high, approximately 70–90% in many populations, although frequency varies substantially.

Another 2026 review similarly describes nocturnal emission as a normal biological function associated with sexual development and notes that medically unfounded myths remain widespread.

Therefore:



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Nightfall itself is not evidence of:

- infertility;
- permanent sexual weakness;
- testosterone loss;
- erectile dysfunction;
- loss of masculinity;
- sperm depletion.

However, medical evaluation may be appropriate when ejaculation during sleep is accompanied by unusual symptoms such as:

- significant pain;
- blood in semen;
- urinary symptoms;
- other genital complaints.

Myth 3: “Masturbation Permanently Weakens the Body”

Masturbation is surrounded by many myths.

Men may have been told that masturbation causes:

- permanent weakness;
- memory loss;
- blindness;
- weight loss;
- erectile dysfunction;
- infertility;
- low testosterone;
- reduced masculinity;
- premature ejaculation;
- shrinkage of the penis.

These sweeping claims are not supported by modern medical evidence.

Masturbation is a sexual behaviour found in many populations.

A recent systematic review examining masturbation and sexual satisfaction emphasized that the relationship is complex. Frequency alone does not tell us whether masturbation is healthy, harmful or compensatory in a particular person's life.

The important clinical questions are:

- Is the behaviour under control?
- Is it causing injury?
- Is it interfering with work or sleep?
- Is it replacing desired partnered intimacy?
- Has the person developed a very specific stimulation pattern that creates difficulty with a partner?
- Is it part of a compulsive sexual-behaviour pattern?

That is very different from saying:

“Anyone who masturbates becomes weak.”

Myth 4: “Masturbation Permanently Lowers Testosterone”

This belief is particularly common among men interested in bodybuilding and fitness.

A young man may think:

“If I ejaculate, my testosterone will collapse.”

Current evidence does not support the idea that ordinary masturbation permanently lowers testosterone.

A randomized crossover pilot study examining hormonal responses after masturbation found some short-term changes in free testosterone but no significant alteration in hormonal ratios supporting the idea of long-term hormonal depletion.

Testosterone naturally varies according to factors including:

- time of day;
- age;
- obesity;
- chronic illness;
- sleep;



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- metabolic health;
- medications.

If genuine testosterone deficiency is suspected, it should be assessed medically with appropriate symptoms and laboratory testing.

It should not be diagnosed according to masturbation history.

Myth 5: “If My Semen Looks Thin, I Must Be Infertile”

This is another common misunderstanding.

Men often judge fertility by looking at semen.

They say:

“My semen is watery.”

“It is not white enough.”

“There is less semen than before.”

Therefore:

“My sperm must be weak.”

This conclusion cannot be made from appearance alone.

Semen and sperm are not the same thing.

Semen is the fluid.

Sperm cells are microscopic reproductive cells contained within it.

A man cannot accurately determine:

- sperm concentration;
- sperm motility;
- sperm morphology;

simply by looking at his ejaculate.

Male fertility assessment uses a properly performed **semen analysis** along with medical and reproductive history, examination and other tests where required.

The 2026 EAU male-infertility guideline specifically recommends semen analysis according to WHO laboratory standards and notes that semen analysis itself must be interpreted within the couple's wider reproductive context.



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Myth 6: “More Semen Means Greater Fertility”

Not necessarily.

Semen volume is only one component of a semen analysis.

A larger volume does not automatically mean:

- more healthy sperm;
- better motility;
- greater fertility.

Likewise, lower volume on one occasion does not automatically mean infertility.

Semen volume can change depending upon factors including:

- abstinence duration;
- collection circumstances;
- hydration;
- ejaculation frequency;
- medical conditions.

The fertility assessment therefore evaluates multiple parameters rather than semen quantity alone.

Myth 7: “Frequent Ejaculation Will Permanently Finish My Sperm”

The testes continuously produce sperm after puberty.

Frequent ejaculation may temporarily influence semen volume and certain semen-analysis parameters, but it does not mean the male body permanently “runs out” of sperm.

In fact, research examining abstinence periods shows a complex picture.

Longer abstinence generally increases semen volume and total sperm count, but shorter abstinence may improve some other parameters, including DNA fragmentation in particular circumstances.

This is another example of why simple statements such as:

“Never ejaculate or your sperm will disappear”

are medically misleading.

Myth 8: “Saving Semen for Months Will Make Me Extremely Fertile”

This is essentially the opposite myth.

Some men deliberately avoid ejaculation for very long periods because they believe stored semen becomes increasingly powerful.

Biology does not work in that simple way.

The male reproductive system continues producing sperm.

Older sperm are handled naturally by the body.

When a semen sample is required for fertility testing, the laboratory gives a specific abstinence instruction.

For fertility treatment, the ideal interval may depend on the clinical situation.

A 2024 systematic review and dose-response meta-analysis found that longer abstinence increased semen volume and total sperm count but could adversely affect some other semen-quality measures; shorter abstinence can sometimes be advantageous, especially in selected infertile men.

Therefore, extreme abstinence is not a universal fertility treatment.

Myth 9: “A Real Man Must Have a Large Penis”

Penis-size anxiety can become one of the strongest sexual misconceptions in men.

A patient tells me:

“Doctor, mine is not big enough.”

I ask:

“Compared with what?”

Often the comparison comes from pornography.

This is unreliable.

Pornography uses:

- selected performers;
- camera angles;



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- editing;
- perspective;
- visual exaggeration.

The European Association of Urology now specifically includes **penile-size abnormalities and dysmorphophobia** in its sexual-health guideline and recognizes that some men develop substantial distress despite having anatomically normal genital dimensions. It recommends appropriate psychological assessment when body dysmorphic disorder is suspected.

Sexual satisfaction depends on many factors:

- communication;
- arousal;
- affection;
- stimulation;
- emotional connection;
- comfort;
- sexual knowledge.

Penis size alone does not determine masculinity or relationship success.

Myth 10: “Penis Enlargement Oils, Powders and Tablets Can Permanently Increase Size”

Men should be extremely careful about commercial promises of permanent penile enlargement.

Many products advertised online or through informal markets claim to:

- lengthen the penis;
- increase girth;
- improve masculinity;
- produce permanent enlargement.

These claims should not automatically be accepted as medical fact.

Men who are distressed about penile size should first undergo proper clinical assessment.



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Often the penis is anatomically within the normal range and the main problem is perception or comparison.

The EAU guideline emphasizes assessing patient expectations and psychological concerns in men requesting augmentation and recognizes the role of psychotherapy in men with significant size anxiety or body dysmorphic concerns.

Myth 11: “One Failed Erection Means I Have Impotence”

No.

A temporary erection difficulty can occur in a healthy man.

Possible temporary reasons include:

- tiredness;
- anxiety;
- relationship tension;
- alcohol;
- inadequate stimulation;
- distraction;
- unfamiliar surroundings;
- fear of pregnancy;
- wedding-night anxiety.

Erectile dysfunction refers to a persistent or recurrent inability to achieve or maintain an erection sufficient for satisfactory sexual activity.

Current EAU guidance recommends considering vascular, hormonal, neurological, psychological and medication-related factors when evaluating ED.

One unsuccessful sexual encounter is therefore not enough to diagnose chronic ED.

Myth 12: “Erectile Dysfunction Means I Am Not Masculine”

Erectile function is a biological process.

It is not a measure of a man's moral character, masculinity or personal worth.

An erection depends upon:



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- blood vessels;
- nerves;
- hormones;
- psychological state;
- sexual stimulation.

Medical causes include:

- diabetes;
- hypertension;
- cardiovascular disease;
- obesity;
- hormone disorders;
- neurological disease;
- medication effects.

Psychological contributors include:

- anxiety;
- depression;
- relationship distress;
- performance pressure.

A man with ED needs assessment—not humiliation.

Myth 13: “ED Is Always Psychological”

This myth can also be dangerous.

Because sexual performance is influenced by anxiety, some patients are told:

“It's all in your head.”

But ED may have important physical causes.

Current EAU guidance identifies associations with:

- diabetes;



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- hypertension;
- cardiovascular disease;
- obesity;
- metabolic syndrome;
- endocrine conditions;
- smoking;
- certain drugs.

Therefore, persistent ED should receive proper medical evaluation.

Myth 14: “ED Is Only a Problem of Old Men”

ED becomes more common with increasing age, but younger men can also experience it.

The EAU guideline cites studies in which substantial numbers of younger men presented for ED assessment.

In younger men, possible contributors include:

- performance anxiety;
- psychosexual problems;
- relationship difficulties;
- medication;
- metabolic disease;
- hormonal conditions;
- smoking;
- other medical problems.

Age should guide assessment but should never be used to dismiss a patient.

Myth 15: “If My Erection Is Not 100% Hard During Every Second of Sex, Something Is Wrong”

Human erections fluctuate.



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A man's sexual arousal can increase and decrease during intimacy.

Erection quality can change with:

- stimulation;
- position;
- distraction;
- anxiety;
- condom application;
- fatigue.

The real concern arises when difficulty is persistent or repeatedly interferes with desired sexual activity.

Constantly checking erection hardness may itself produce anxiety.

The EAU recommends assessment of dysfunctional thinking styles, expectations regarding sexuality and cognitive distraction in men with erection problems.

Myth 16: “Premature Ejaculation Simply Means Ejaculating Before a Certain Number of Minutes”

Premature ejaculation is more complex than a stopwatch.

Current diagnostic approaches consider:

- ejaculation latency;
- perceived control;
- distress;
- interpersonal difficulty.

The EAU guideline recognizes several forms of PE, including lifelong, acquired, variable and subjective presentations.

Importantly:

Variable PE

Occasional early ejaculation may simply represent normal variation.

Subjective PE



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Some men believe they ejaculate too quickly even when their actual ejaculation time is normal or even longer than normal.

EAU guidance explicitly notes that subjective PE should not be considered true medical pathology in the same way as established PE.

Myth 17: “Good Sex Must Last 30 Minutes, 45 Minutes or One Hour”

There is no scientific rule stating that intercourse must continue for a specific exaggerated period to be satisfying.

Pornography, advertisements and peer stories can create unrealistic standards.

Sexual satisfaction involves much more than penetration time.

It may include:

- affection;
- touching;
- foreplay;
- emotional connection;
- communication;
- comfort;
- orgasm;
- mutual enjoyment.

Turning intercourse into a stopwatch competition often increases anxiety.

Myth 18: “Longer Sex Is Always Better Sex”

No.

Longer is not automatically better.

Extremely prolonged intercourse may even become:

- uncomfortable;
- physically tiring;
- painful;
- emotionally disconnected.



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Quality matters more than achieving an artificial duration.

Myth 19: “A Man Must Always Want Sex”

Men are sometimes expected to have constant sexual desire.

That is unrealistic.

Male libido naturally varies.

It can change with:

- age;
- stress;
- sleep;
- illness;
- relationship circumstances;
- depression;
- medication;
- hormones.

The EAU describes male sexual desire as involving biological drive, psychological motivation and cultural influences. Negative sexual thoughts, erection concerns and restrictive attitudes can also contribute to reduced desire.

A man who does not want sex on a particular day has not stopped being masculine.

Myth 20: “Low Sexual Desire Always Means Low Testosterone”

Testosterone can influence sexual desire.

But low libido does **not** automatically mean testosterone deficiency.

Other causes include:

- depression;
- stress;
- relationship problems;
- medication;
- poor sleep;



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- chronic illness;
- performance anxiety.

Male hypogonadism should be diagnosed using clinical symptoms together with appropriate hormonal assessment—not from one complaint alone.

Current EAU patient information lists low libido, fatigue, mood changes, erectile difficulties and other symptoms among possible features of hypogonadism, but proper medical evaluation is necessary.

Myth 21: “Everyone Over 40 Needs Testosterone”

No.

Ageing does not automatically mean every man requires testosterone treatment.

Current EAU guidance specifically states:

Do not use testosterone therapy in men with normal testosterone levels.

Testosterone treatment should be considered only when appropriate clinical and laboratory criteria are met.

Taking hormones without proper diagnosis can create unnecessary health risks.

Myth 22: “Testosterone Injections Improve Male Fertility”

This is one of the most important myths to correct.

External testosterone can actually suppress the hormonal signals needed for sperm production.

The current EAU guideline states that testosterone therapy suppresses gonadotropins and spermatogenesis and should **not** be used to treat male infertility or in men actively trying to father a child.

Therefore:

A man planning fertility should never begin testosterone therapy simply because somebody told him it will make him “more powerful.”

Hormonal fertility treatment is different from testosterone replacement and must be selected according to the cause.

Myth 23: “Over-the-Counter Testosterone Boosters Will Solve Sexual Weakness”



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Many products are marketed as “testosterone boosters.”

But claims should be treated cautiously.

A systematic review evaluating commercially promoted testosterone-boosting supplements found that evidence supporting meaningful increases in testosterone was generally limited or inconsistent across ingredients.

A man experiencing low desire or ED should receive proper evaluation rather than automatically taking supplements.

Myth 24: “Infertility Is Mainly a Woman's Problem”

This misconception can cause enormous emotional harm.

The EAU guideline reports that a male factor can be identified in approximately half of infertile couples, either alone or together with female factors.

Therefore, when a couple experiences infertility:

Both partners should be evaluated.

The wife should not automatically be blamed.

Likewise, a man should not be blamed simply because the semen analysis is abnormal.

Infertility is a medical problem requiring investigation.

Myth 25: “A Normal Semen Analysis Guarantees Fertility”

Not necessarily.

A semen analysis provides very useful information, but current EAU guidance specifically states that semen analysis alone cannot perfectly distinguish a fertile from an infertile man.

Pregnancy depends upon:

- male reproductive factors;
- female reproductive factors;
- age;
- ovulation;
- tubal health;
- intercourse timing;



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- sperm function.

Fertility is ultimately a couple-level reproductive outcome.

Myth 26: “One Abnormal Semen Test Means I Can Never Become a Father”

No.

Semen parameters naturally vary.

Illness, collection problems, abstinence duration and other factors can influence results.

EAU guidance recommends at least two semen analyses when a baseline analysis is abnormal.

An abnormal report requires interpretation—not panic.

Myth 27: “Pregnancy Should Happen Immediately After Marriage”

Many couples become anxious after only a few months.

Normal conception is probabilistic.

Pregnancy does not occur automatically after every episode of intercourse.

The EAU recommends infertility evaluation for couples who have not conceived after **12 consecutive months of regular unprotected intercourse**, although evaluation may be appropriate earlier in certain clinical situations.

Age and medical history also influence when assessment should begin.

Myth 28: “Pornography Always Causes Erectile Dysfunction”

The evidence is more complicated.

A 2026 systematic review evaluating pornography use and male sexual dysfunction found mixed results.

Some studies reported associations.

Others did not.

The review concluded that simple viewing frequency did not appear to be as important as factors such as:

- problematic pornography use;



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- body dissatisfaction;
- insecurity;
- psychological factors.

Therefore, it is inaccurate to say:

“Every man who watches pornography will develop ED.”

But it is equally inaccurate to say pornography can never be relevant.

Assessment should examine how pornography is being used and whether it is interfering with partnered sexuality.

Myth 29: “Pornography Shows What Normal Sex Should Look Like”

Pornography is produced sexual entertainment.

It is not a medical guide to ordinary sexual relationships.

It may create unrealistic expectations regarding:

- penis size;
- erection duration;
- intercourse duration;
- sexual positions;
- partner responses;
- orgasm;
- ejaculation;
- body appearance.

Real sexual relationships involve:

- communication;
- consent;
- affection;
- variable desire;
- variable arousal;



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- pauses;
- comfort;
- mutual preferences.

Comparing a private relationship with professionally produced sexual media can increase dissatisfaction.

Myth 30: “The First Night of Marriage Must Include Successful Intercourse”

This myth causes considerable anxiety.

A newly married man may think:

“Tonight I must prove my masculinity.”

The wife may also feel frightened or pressured.

The man becomes anxious.

His erection decreases.

Now he thinks:

“I am impotent.”

But wedding-night erection difficulty can be situational.

The first sexual encounter does not need to become an examination.

A healthy couple can develop intimacy gradually.

The first priorities should be:

- comfort;
- trust;
- consent;
- communication.

Myth 31: “If I Cannot Have Sex on My Wedding Night, My Marriage Is Sexually Failed”

No.

Many couples need time to become comfortable with one another.

Possible difficulties include:



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- male performance anxiety;
- female fear of penetration;
- insufficient arousal;
- vaginal dryness;
- misinformation;
- embarrassment.

Early difficulty does not automatically mean permanent incompatibility.

Myth 32: “If My Wife Doesn't Orgasm, I Am Sexually Weak”

Female orgasm is influenced by many factors.

It cannot be reduced to male erection duration or penis size.

Female sexual pleasure may depend on:

- adequate arousal;
- stimulation;
- communication;
- emotional comfort;
- appropriate touch;
- relationship context.

The expectation that penetration alone must automatically produce orgasm can create pressure for both partners.

Sexual satisfaction is cooperative—not a masculinity test.

Myth 33: “Both Partners Must Orgasm at Exactly the Same Time”

Simultaneous orgasm is not a medical requirement for healthy sexual functioning.

Trying to force simultaneous orgasm can actually create performance pressure.

The more useful objective is mutual satisfaction and communication.

Myth 34: “My Partner's Lower Desire Means She No Longer Loves Me”

Not necessarily.

Sexual desire and emotional love are related but not identical.

Desire may decrease because of:

- fatigue;
- stress;
- pregnancy;
- childbirth;
- hormonal changes;
- medication;
- pain;
- relationship conflict.

The appropriate response is communication and, when necessary, clinical assessment.

Myth 35: “More Sex Means a Better Marriage”

Sexual frequency varies enormously between couples.

There is no universal number of times per week that defines a healthy marriage.

One couple may be satisfied with a different frequency from another.

The key issue is whether both partners feel:

- respected;
 - emotionally connected;
 - reasonably satisfied;
 - free from coercion.
-

Myth 36: “Men Should Never Talk About Sexual Problems”

This belief delays treatment.

Many men wait months or years before seeking help because they feel:

- embarrassed;
- ashamed;



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- frightened of judgment.

But sexual medicine is a legitimate field of health care.

An erection problem deserves the same seriousness as any other health symptom.

A fertility problem deserves investigation.

Persistent genital pain deserves investigation.

Silence does not treat disease.

Myth 37: “Sexual Medicines Should Be Taken Before Marriage Just to Be Safe”

I strongly discourage unnecessary self-medication.

Some young men start using:

- erection medicines;
- herbal aphrodisiacs;
- testosterone;
- delay sprays;
- unknown supplements;

before they have even identified a sexual problem.

This may create:

- psychological dependence;
- side effects;
- anxiety;
- inappropriate treatment.

A medicine should have a reason.

Myth 38: “If a Medicine Produces an Erection, It Has Cured the Cause”

Not necessarily.

ED treatment should be individualized.

The underlying problem may involve:

- diabetes;



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- vascular disease;
- anxiety;
- relationship factors;
- medication;
- hormonal problems.

Current EAU guidance recommends comprehensive medical and sexual assessment rather than treating an erection symptom in isolation.

Myth 39: “Sexual Weakness Is One Single Disease”

The expression “sexual weakness” is medically too vague.

When a patient tells me:

“Doctor, I am weak,”

I ask:

“What exactly do you mean?”

Does he mean:

- low sexual desire?
- poor erection?
- early ejaculation?
- delayed ejaculation?
- infertility?
- fatigue?
- semen-loss anxiety?
- penis-size anxiety?

These require very different evaluations.

There is no universal “sexual weakness medicine.”

Myth 40: “Every Sexual Problem Needs an Aphrodisiac”

No.



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A man with diabetes-related ED needs medical assessment.

A man with subjective premature ejaculation may primarily need education.

A man with Dhat-type semen-loss anxiety may need counselling.

A man with infertility needs reproductive investigation.

A man with true hypogonadism needs hormonal assessment.

Giving everyone the same aphrodisiac is not individualized medicine.

How Sexual Myths Can Actually Create Sexual Dysfunction

A misconception can sometimes become self-fulfilling.

Consider this example.

A man believes:

“Masturbation has damaged my erection.”

He becomes sexually active after marriage.

He thinks:

“What if my erection fails?”

He begins checking his erection.

His anxiety increases.

The erection becomes weaker.

He concludes:

“I was right. Masturbation ruined me.”

But what may now be sustaining the erection problem is **performance anxiety**.

Current EAU ED guidelines specifically recommend assessment of dysfunctional sexual expectations, poor self-esteem and cognitive distraction from erotic stimulation because these factors can contribute to erection difficulties.

The Cycle of Sexual Misinformation

The cycle may look like this:

Myth

↓



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Fear



Self-monitoring



Sexual anxiety



Temporary sexual difficulty



Belief becomes stronger



More fear

This is why accurate sexual education can sometimes function as an important therapeutic intervention.

Semen-Loss Anxiety and Dhat-Type Concerns

This deserves special attention in South Asian sexual medicine.

A patient may become preoccupied with:

- semen in urine;
- nocturnal emission;
- masturbation;
- ejaculation.

He may then report:

- weakness;
- fatigue;
- anxiety;
- poor concentration;
- depressed mood;
- sexual dysfunction.



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Systematic reviews of Dhat syndrome emphasize that these complaints occur within a complex interaction between cultural beliefs, psychological distress and sexual-health concerns.

The Fifth International Consultation on Sexual Medicine also recognizes Dhat as a complex condition centred on pathological fear of semen loss and recommends sensitive, culturally appropriate care.

A patient should not be mocked for these beliefs.

He should be educated respectfully.

How I Evaluate Men With Sexual Myths and Misconceptions

When a patient comes to Saira Health Care and says:

“Doctor, I have sexual weakness,”

I do not immediately prescribe medicine.

I first investigate what the patient believes is wrong.

Step 1: Ask What the Patient Means

I ask:

What is your actual concern?

- erection?
- ejaculation?
- desire?
- penis size?
- semen?
- fertility?
- nightfall?
- masturbation?

This single question often changes the entire consultation.

Step 2: Ask Where the Belief Came From



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I may ask:

“Who told you masturbation causes impotence?”

“Why do you believe your penis is small?”

“Why do you think nightfall is dangerous?”

The source may be:

- social media;
- pornography;
- a friend;
- advertisement;
- an unqualified practitioner.

Identifying the source helps correct the misinformation.

Step 3: Take a Complete Sexual History

Depending on the problem, I ask about:

- sexual desire;
 - erection;
 - morning erections;
 - ejaculation;
 - orgasm;
 - masturbation;
 - pornography;
 - intercourse;
 - marital relationship;
 - infertility.
-

Step 4: Evaluate Physical Health

Sexual education should never be used to dismiss genuine disease.

If ED is present, assessment may consider:

- diabetes;
- blood pressure;
- cardiovascular risk;
- lipid profile;
- testosterone where appropriate;
- medication;
- smoking;
- obesity.

The current EAU guideline recommends comprehensive history, focused examination and appropriate metabolic and hormonal laboratory assessment in men with ED.

Step 5: Evaluate Fertility Properly

If the patient fears infertility, we do not diagnose fertility from:

- semen colour;
- semen thickness;
- sexual stamina;
- penis size.

Appropriate evaluation may include:

- reproductive history;
 - examination;
 - semen analysis;
 - hormonal testing where required;
 - genetic or imaging studies in selected patients.
-

Step 6: Assess Psychological Factors

I consider whether the patient has:

- performance anxiety;



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- depression;
- health anxiety;
- obsessive checking;
- body-image anxiety;
- shame;
- relationship distress.

Modern sexual medicine strongly recommends evaluating psychological and interpersonal contributors to sexual dysfunction.

Treatment: How Are Sexual Myths Corrected?

The treatment depends upon whether the patient has:

1. misinformation without disease;
 2. genuine sexual dysfunction;
 3. psychological distress;
 4. a combination of these.
-

1. Sexual Education

For many men, accurate information is one of the most important treatments.

I may explain:

Nightfall is physiological.

Normal masturbation does not automatically cause impotence.

Ejaculation does not permanently drain life energy.

Penis size does not define masculinity.

One failed erection is not necessarily ED.

Premature ejaculation is not diagnosed from one stopwatch number.

These explanations can remove years of fear.

2. Cognitive Restructuring



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A patient may think:

“My semen is thin, therefore I am infertile.”

We replace that with:

“Fertility cannot be determined by appearance; semen analysis is required.”

He thinks:

“My erection failed once, therefore I am impotent.”

We replace it with:

“Erection can fluctuate; persistent problems require assessment.”

This is not artificial positive thinking.

It is replacing inaccurate beliefs with more realistic interpretations.

3. Reduce Performance Anxiety

Sex should not become an examination.

I often advise patients to move attention away from:

- erection monitoring;
- stopwatch timing;
- penis comparison;
- orgasm counting.

Instead, attention should gradually return to:

- comfort;
 - touch;
 - communication;
 - pleasurable sensation.
-

4. Psychological or Psychosexual Therapy

When misconceptions have produced severe anxiety or compulsive thinking, psychosexual counselling or CBT may be useful.

Current EAU ED guidelines strongly recommend CBT when psychological factors are clinically relevant, ideally including the partner where appropriate.



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5. Couple Counselling

Some myths are shared by both partners.

The husband believes:

“I must perform for 30 minutes.”

The wife believes:

“A strong man never loses an erection.”

Both expectations increase pressure.

Education involving both partners can sometimes be more effective than treating one partner alone.

6. Treat Genuine Disease

Correcting myths does not mean telling every patient:

“You are completely normal.”

If genuine disease exists, it should be treated.

Examples include:

- diabetes-related ED;
- true premature ejaculation;
- hypogonadism;
- infertility;
- prostatitis;
- penile disease.

Proper medicine is based on diagnosis.

The Role of the Unani System of Medicine

The Unani system of medicine traditionally considers health through a broad framework rather than focusing on one isolated symptom.

Official Ministry of AYUSH material describes **Asbab-e-Sitta Zarooriya**, the six essential prerequisites for maintaining health:

1. air;
2. food and drink;
3. bodily movement and rest;
4. mental or psychic activity and rest;
5. sleep and wakefulness;
6. retention and evacuation.

CCRUM's healthy-living guidance similarly describes these factors as central to the traditional Unani approach to health maintenance.

This broad framework can be helpful when sexual concerns occur alongside:

- poor sleep;
- obesity;
- inactivity;
- stress;
- anxiety;
- metabolic illness;
- general poor health.

However, a scientific distinction is essential:

A sexual misconception cannot simply be “cured” with a herbal medicine.

If a man believes:

“Nightfall destroys the body,”

the primary treatment is accurate education.

If he believes:

“My normal penis is too small,”

an aphrodisiac will not correct that belief.

If his problem is severe performance anxiety, psychological intervention may be necessary.

Unani medicine can therefore be used responsibly as part of an **integrative approach** to overall health and appropriately diagnosed associated conditions.

Harakat-o-Sukoon Nafsani – Mental Activity and Peace

Traditional Unani terminology includes mental activity and peace among the essential factors that influence health.

This concept is particularly relevant in sexual medicine.

A man experiencing constant sexual fear may enter a cycle:

Anxiety →

poor sleep →

fatigue →

reduced sexual confidence →

more anxiety.

Addressing psychological stress therefore becomes part of comprehensive care.

Nawm-o-Yaqza – Sleep and Wakefulness

Adequate sleep is important for overall health.

Chronic sleep deprivation may worsen:

- fatigue;
- mood;
- metabolic health;
- sexual interest.

Therefore, at Saira Health Care I consider sleep history when a patient reports sexual weakness or unexplained fatigue.

Harakat-o-Sukoon Badani – Physical Activity and Rest

Physical activity supports:

- cardiovascular health;
- metabolic health;
- weight control;
- psychological well-being.



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These factors are particularly relevant because cardiovascular and metabolic health influence erection.

Current sexual-medicine guidelines also support addressing modifiable lifestyle factors in men with ED.

Ilaj bil Ghiza – Dietary Support

Dietary care can support:

- healthy body weight;
- metabolic health;
- cardiovascular health;
- general energy.

This may be particularly relevant in men with:

- obesity;
- diabetes;
- metabolic syndrome;
- infertility.

However, diet should not be presented as a magical cure for every sexual complaint.

What About Unani Herbal Medicines?

Unani pharmacotherapy may be considered when a properly diagnosed associated health condition falls within the practitioner's clinical scope.

But medicines should not replace:

- sexual education;
- semen analysis;
- diabetes evaluation;
- hormone testing;
- psychotherapy;
- fertility assessment;

when these are indicated.



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My clinical principle is:

First identify what the patient actually has. Then decide what treatment he actually needs.

My Approach at Saira Health Care

When a patient comes to Saira Health Care saying:

“Doctor, I have sexual weakness,”

I do not begin with:

“Which sexual medicine should I prescribe?”

I begin with:

“What exactly is troubling you?”

I want to understand whether the patient has:

- misinformation;
- fear;
- ED;
- PE;
- low desire;
- infertility;
- semen-loss anxiety;
- penis-size anxiety;
- hormonal illness;
- relationship difficulty.

Only after that can appropriate treatment begin.

Step One at Saira Health Care: Confidential Consultation

Men may find it difficult to discuss:

- masturbation;
- nightfall;



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- pornography;
- erection;
- ejaculation;
- infertility.

Therefore, confidentiality is essential.

Patients should be able to describe sexual concerns without humiliation.

Step Two: Separate Myth From Disease

This is often the most important part of the consultation.

A patient who needs education should receive education.

A patient who has medical disease should receive medical evaluation.

And sometimes the same patient needs both.

Step Three: Investigate When Necessary

Depending upon symptoms, assessment may include:

- blood pressure;
 - blood glucose;
 - lipid profile;
 - thyroid testing;
 - testosterone and other hormones where indicated;
 - semen analysis;
 - urological evaluation.
-

Step Four: Correct the Misconception

I explain the relevant physiology in simple language.

The goal is for the patient to understand his own body.

Education reduces fear.



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Step Five: Treat Associated Sexual Dysfunction

If ED is present, we assess ED.

If true PE is present, we assess PE.

If infertility is present, we investigate fertility.

If hypogonadism is suspected, we evaluate hormones.

One label should not be used for every man.

Step Six: Address Psychological Distress

When necessary, treatment may include:

- psychosexual counselling;
- CBT;
- couple therapy;
- psychological referral;
- psychiatric evaluation.

This is particularly important when anxiety or depression is severe.

Step Seven: Use Unani Care Responsibly

Unani support may be individualized around:

- diet;
- sleep;
- physical activity;
- rest;
- general health;
- associated sexual-health problems.

It should complement evidence-based evaluation rather than replace it.

Step Eight: Appropriate Referral

I may recommend specialist assessment when the patient requires:



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- urology;
- psychiatry;
- psychology;
- reproductive medicine;
- endocrinology;
- couple therapy.

Good clinical care includes knowing when another specialist is needed.

Dr. Nizamuddin Qasmi's Clinical Focus

My clinical work at Saira Health Care is focused on sexual disorders and infertility.

My qualifications and training include:

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

My work in sexual and reproductive health has reinforced an important lesson:

A sexual problem should never be evaluated from one symptom alone.

We must consider:

- physical health;
- sexual function;
- fertility;
- mental health;
- relationships;
- lifestyle;
- the patient's beliefs.

Saira Health Care's Contribution to Sexual Disorders & Infertility



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One of the important goals at Saira Health Care is to reduce misinformation surrounding sexual health.

Many patients reach us after years of worrying about things that were never properly explained to them.

Some have purchased multiple products.

Some have taken sexual medicines unnecessarily.

Some have been told that masturbation destroyed them.

Some believe nightfall is draining their body.

Some have been frightened about penis size.

Others have genuine ED or infertility but have never received proper assessment.

Our approach emphasizes:

- confidential consultation;
- accurate sexual-health education;
- evidence-aware medical assessment;
- individualized treatment;
- responsible Unani integration;
- fertility evaluation;
- psychosexual assessment;
- appropriate specialist referral.

The aim is not simply to sell a sexual medicine.

The aim is to understand and treat the patient correctly.

Frequently Asked Questions

Is masturbation a disease?

No.

Masturbation itself is not automatically a disease. It requires clinical attention when it becomes compulsive, causes injury, interferes significantly with life or contributes to sexual difficulties.



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Does masturbation cause erectile dysfunction?

There is no evidence that ordinary masturbation automatically causes permanent ED.

Persistent erection difficulty should be evaluated for medical, psychological and relationship causes.

Does masturbation reduce testosterone permanently?

No convincing evidence shows that normal masturbation permanently depletes testosterone. Testosterone deficiency requires proper clinical and laboratory assessment.

Is nightfall harmful?

Ordinary nocturnal emission is a normal physiological phenomenon, particularly in adolescence and young adulthood.

Does nightfall reduce fertility?

Normal nocturnal emission does not by itself diagnose infertility.

Male fertility should be evaluated through reproductive history and appropriate semen analysis when clinically indicated.

Does losing semen make a man weak?

Normal ejaculation is a physiological function. Persistent anxiety regarding semen loss may itself produce distress and is recognized in semen-loss/Dhat-type presentations.

How can I know whether my semen is healthy?

You cannot reliably determine sperm quality simply by looking at semen.

A laboratory semen analysis evaluates sperm concentration, motility and morphology, among other parameters.

Does watery semen mean infertility?

Not necessarily.



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Semen appearance alone cannot diagnose infertility.

Does penis size determine sexual ability?

No.

Penis size alone does not define masculinity or sexual satisfaction.

Men with severe size anxiety despite normal anatomy may benefit from appropriate counselling.

Can oils or capsules permanently increase penis size?

Claims of permanent enlargement from commercially marketed oils, tablets or supplements should be treated cautiously.

Proper medical assessment is preferable to self-treatment.

Is one failed erection ED?

Not necessarily.

Occasional erection difficulty can occur.

Persistent or recurrent problems should be evaluated.

Is erectile dysfunction only psychological?

No.

ED may involve vascular, metabolic, hormonal, neurological, medication-related and psychological factors.

Does early ejaculation always mean premature ejaculation?

No.

Occasional early ejaculation may be normal variation, and some men have subjective PE despite normal ejaculation latency.

How long should intercourse last?

There is no universal ideal duration that guarantees sexual satisfaction.

PE diagnosis involves time, control, distress and interpersonal impact rather than one arbitrary number.

Does a man have to want sex every day?

No.

Male sexual desire naturally varies and may be influenced by psychological, physical, hormonal and relationship factors.

Does low libido mean low testosterone?

Not automatically.

Testosterone deficiency is only one possible cause.

Should I take testosterone to become sexually stronger?

Not unless properly medically indicated.

Current EAU recommendations advise against testosterone therapy in men with normal testosterone levels.

Can testosterone treatment improve sperm count?

External testosterone can suppress sperm production and should not be used as male infertility treatment.

Is infertility mostly caused by women?

No.

Male factors contribute substantially to infertility and both partners should be evaluated.

Does a normal semen analysis guarantee pregnancy?

No.

Semen analysis is important, but fertility depends upon multiple male and female factors.

Can pornography cause sexual dysfunction?

Research is mixed.

A 2026 systematic review found that simple pornography viewing frequency was not a consistent predictor of male sexual dysfunction, while problematic use, insecurity and body dissatisfaction may be more relevant in some men.

Does pornography represent normal sex?

No.

Pornography is produced sexual media and should not be treated as a standard of normal sexual anatomy, performance or relationship behaviour.

Can counselling really help sexual problems?

Yes.

Modern sexual-medicine recommendations support psychological and interpersonal assessment, and interventions such as CBT, psychosexual education and couple-based approaches can be clinically valuable when relevant.

Can Unani medicine help?

Unani medicine can contribute a supportive, holistic framework through attention to:

- diet;
- sleep;
- physical activity;
- mental well-being;
- general health;
- appropriately diagnosed associated conditions.

However, a sexual myth itself is primarily corrected through accurate education and counselling rather than by relying upon herbal medication alone.



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When Should a Man Seek Professional Help?

A professional sexual-health assessment is recommended when:

- erection problems persist;
- ejaculation difficulties repeatedly cause distress;
- sexual desire remains significantly reduced;
- there is genital pain;
- there is blood in semen;
- a couple is experiencing infertility;
- sexual anxiety is severe;
- penis-size anxiety becomes obsessive;
- fear of semen loss interferes with daily life;
- sexual concerns cause major relationship conflict;
- a man is self-medicating with testosterone or sexual medicines;
- depression or anxiety is significant.

A persistent sexual problem should not be hidden because of embarrassment.

A Message From Dr. Nizamuddin Qasmi

When a patient sits in front of me and says:

“Doctor, I think I destroyed my sexual health years ago,”

I do not immediately agree.

I ask:

Why do you believe that?

Sometimes he says:

“Because I masturbated.”

Sometimes:

“Because I have nightfall.”

Sometimes:



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“My semen looks thin.”

Sometimes:

“My penis is not big enough.”

Sometimes:

“I lost my erection once.”

These statements tell me that the patient's greatest problem may not initially be his sexual organ.

It may be what he has been taught to believe about that organ.

That does not mean I dismiss the patient.

Quite the opposite.

I take the concern seriously enough to separate myth from disease.

If he has erectile dysfunction, I want to identify the cause.

If he has infertility, I want proper reproductive evaluation.

If he has hormonal disease, I want appropriate laboratory testing.

If he has semen-loss anxiety, I want to correct that fear respectfully.

If he has performance anxiety, I want to help him understand the cycle.

And if he is physically healthy but has spent years believing that masturbation or nightfall destroyed his body, accurate education may itself be one of the most valuable treatments I can offer.

Final Perspective

Sexual myths are not trivial when they begin controlling a man's life.

A false belief can create:

fear.

Fear creates anxiety.

Anxiety affects sexual confidence.

Sexual difficulty then appears to confirm the false belief.

The cycle becomes stronger.



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Modern sexual medicine teaches us to evaluate men through a biopsychosocial approach.

Biology matters.

Psychology matters.

Relationships matter.

Culture matters.

Expectations matter.

Current international sexual-medicine guidance specifically recognizes psychological, interpersonal and cognitive factors as important components of sexual function and dysfunction.

The Unani system can contribute an additional supportive perspective through its traditional attention to:

- food and drink;
- bodily activity and rest;
- mental activity and peace;
- sleep and wakefulness;
- other lifestyle factors.

These concepts form part of the traditional **Asbab-e-Sitta Zarooriya** framework described by official AYUSH and CCRUM resources.

But responsible integrative medicine also means recognizing limits.

A myth should be corrected with knowledge.

An anxiety disorder may require psychological care.

Infertility requires reproductive assessment.

Persistent ED requires medical assessment.

Hormonal disease requires proper testing.

At Saira Health Care, my objective is therefore not merely to treat what the patient calls “sexual weakness.”

My objective is to discover what the patient actually has.

Sometimes the answer is a disease.

Sometimes it is misinformation.



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Sometimes it is both.

My message to men is simple:

Do not measure masculinity by semen quantity.

Do not measure masculinity by penis size.

Do not measure masculinity by the number of minutes you have intercourse.

Do not assume one failed erection defines your sexual future.

Do not believe every sexual claim you see online.

And do not take unnecessary sexual medicines because somebody has frightened you.

Accurate knowledge is one of the strongest foundations of healthy sexuality.

Selected Scientific References

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EAU Male Infertility Guideline. Male-factor infertility contributes substantially to couple infertility, and comprehensive evaluation includes history, examination, semen analysis and selective hormonal/genetic investigation.

Du C, et al. Abstinence Time, Semen Quality and Fertility Outcomes. Semen characteristics vary according to abstinence duration, demonstrating why simplistic ideas about “saving semen” are biologically misleading.

Ministry of AYUSH / CCRUM – Unani Medicine. Official materials describe the Asbab-e-Sitta Zarooriya framework, including food and drink, physical activity and rest, mental activity and peace, and sleep and wakefulness.

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Certificate in Urology – London, UK

Masters in Male Infertility – MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health – ISRH, UNFPA

Medical Disclaimer

This article is intended for patient education and general health information.

“Sexual myths and misconceptions in men” is not itself a formal medical diagnosis. Sexual symptoms may arise from physical, hormonal, psychological, relationship, reproductive or medication-related causes.

Persistent erectile dysfunction, ejaculation disorders, low sexual desire, infertility, genital pain, blood in semen or other sexual-health symptoms require individualized assessment.

Normal masturbation, ejaculation or nocturnal emissions should not automatically be labelled as disease or sexual weakness.



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The Unani system may contribute supportive lifestyle and individualized health care where clinically appropriate, but sexual myths themselves require accurate education, and significant medical or psychological conditions should receive appropriate evidence-based assessment and treatment.

This information does not replace a personal medical consultation or diagnosis.



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