Sexual Avoidance

Why Some Men Begin Avoiding Intimacy Because of Anxiety, Previous Sexual Difficulties or Relationship Stress

By Dr. Nizamuddin Qasmi
Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

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

Prepared for patient education with reference to current sexual-medicine literature and guidance available through September 2026.

Introduction

In my clinical work with sexual disorders and infertility, I regularly meet men who initially tell me:

“Doctor, I don't feel interested in intimacy anymore.”

But after a detailed conversation, I sometimes discover that sexual desire has not truly disappeared.

Instead, the man is **avoiding situations in which something embarrassing, disappointing or emotionally difficult might happen**.

One patient worries:

“What if I lose my erection again?”

Another thinks:

“What if I ejaculate too quickly?”

Another man undergoing infertility treatment says:

“Every time my wife tells me it is the fertile day, I become tense, so now I avoid intimacy altogether.”

A patient recovering from prostate treatment may think:

“My body does not work the way it used to. I do not want my wife to see me fail.”

Another man may be emotionally hurt after criticism or repeated relationship conflict and begin avoiding physical closeness even though sexual desire is still present.

This pattern can broadly be described as **sexual avoidance**.

Sexual avoidance is not automatically a separate medical disease. It is a behavioural pattern in which a person reduces, postpones or avoids sexual or intimate situations because those situations have become associated with anxiety, shame, anticipated failure, pain, relationship conflict or another uncomfortable experience.

Research specifically examining men with sexual difficulties found that greater sexual avoidance was associated with poorer sexual well-being and with several aspects of sexual dysfunction. Negative sexual beliefs and attachment-related avoidance were also associated with more frequent sexual avoidance.

Current European Society for Sexual Medicine guidance goes further by recognizing that anxiety related to sexual dysfunction can involve performance anxiety, sexual phobia, sexual distress and attachment-related anxiety. Clinicians are advised to assess not only fear but also the **avoidance behaviour that follows the fear**.

My most important message to patients is this:

Avoiding intimacy does not automatically mean that love, attraction or masculinity has disappeared. Sometimes avoidance is the mind's attempt to prevent another distressing experience.

The treatment therefore begins by understanding what the patient believes will happen if intimacy occurs.

What Is Sexual Avoidance?

Sexual avoidance means deliberately or automatically creating distance from sexual situations because intimacy has become emotionally or physically uncomfortable.

A man may stop initiating sex.

He may go to sleep before his partner.

He may remain busy late into the evening.

He may avoid affectionate touch because he fears that it will progress toward intercourse.

He may become less physically affectionate.

He may repeatedly say that he is tired even when fatigue is not the main reason.

Sometimes the patient himself does not recognize that he is avoiding sex.

He simply tells me:

“I don't know why, but I keep finding reasons not to become intimate.”

The underlying thought may actually be:

“If I do not start, I cannot fail.”

That thought can temporarily reduce anxiety.

But it can also make the fear stronger over time.

Sexual Avoidance Is Not the Same as Low Sexual Desire

This distinction is very important.

A man with genuinely low desire may think:

“Sex does not interest me.”

A man with sexual avoidance may think:

“I want intimacy, but I am afraid of what will happen if I try.”

The outward behaviour can look identical because both men initiate less often.

But the internal experience is completely different.

Low sexual desire can result from hormonal problems, depression, medication, chronic illness, stress or relationship factors.

Sexual avoidance is often more directly connected with **anticipated negative consequences** such as erection failure, rapid ejaculation, embarrassment, rejection or conflict.

Some patients have both.

That is why a detailed sexual history is more useful than simply asking:

“How frequently do you have sex?”

Sexual Avoidance Is Also Different From a Personal Boundary

A person has the right to decline sexual activity.

Not wanting sex at a particular time is not a disorder.

Choosing abstinence for personal, cultural or religious reasons is not automatically a medical problem.

Needing privacy or personal space is not automatically avoidance.

WHO describes sexual health as involving physical, emotional, mental and social well-being and emphasizes that sexual relationships should be respectful, safe and free from coercion.

The concern becomes clinically relevant when a person **wants intimacy but repeatedly withdraws because of fear or distress**, and the pattern is affecting their sexual well-being or relationship.

The Sexual Avoidance Cycle

For many patients, the pattern begins with a single difficult sexual experience.

Imagine that a man loses his erection during intercourse.

Perhaps he was exhausted.

Perhaps he had consumed alcohol.

Perhaps he was anxious.

Perhaps privacy was poor.

Perhaps the couple had recently argued.

The event might originally have been temporary.

But afterwards he thinks:

“What if this happens again?”

Before the next encounter, anxiety appears.

He begins monitoring his erection.

Instead of paying attention to his partner or pleasurable sensations, he watches himself mentally:

“Is it hard enough?”

“Is it becoming soft?”

“She is going to notice.”

Another erection difficulty occurs.

Now the fear feels confirmed.

The man begins reducing initiation.

Eventually he avoids intimacy.

The cycle becomes:

Previous difficulty → fear of repetition → self-monitoring → increased anxiety → reduced sexual response → embarrassment → avoidance → temporary relief → even greater fear of the next attempt.

The 2025 theoretical model of sexual performance anxiety describes exactly this type of interaction between expectations, self-evaluation, feared consequences and excessive deliberate monitoring of sexual performance.

The 2025 ESSM position statements similarly describe sexual performance anxiety as involving expectations about performance, evaluation of whether those expectations are being met and fear of what will happen if they are not.

Why Avoidance Feels Helpful at First

Avoidance has an important psychological characteristic:

it works immediately.

If a man is afraid that his erection will fail tonight and decides not to have sex, his anxiety decreases.

His brain learns:

“Avoiding sex kept me safe.”

Next time intimacy becomes possible, the nervous system produces the same warning.

The patient avoids again.

The short-term relief strengthens the behaviour.

This is one reason anxiety disorders in many areas of life can become self-perpetuating.

In sexual medicine, the situation is particularly difficult because the person then gets fewer opportunities to experience a calm, successful or simply non-catastrophic intimate interaction.

The 2025 ESSM position statements specifically emphasize behavioural avoidance when assessing sexual fear and phobic reactions.

Erectile Dysfunction Is One of the Most Important Triggers

Erectile dysfunction and sexual avoidance commonly interact.

A man may initially have genuine ED caused by diabetes, vascular disease, medication, hormonal disease or another medical problem.

After several unsuccessful attempts, he develops anxiety.

Then he begins avoiding intimacy.

At this point, the patient has two problems:

the original erection difficulty and the fear surrounding it.

Current EAU guidance recognizes that ED frequently coexists with psychological distress, anxiety and relationship difficulties. It recommends assessment of dysfunctional expectations, poor self-esteem, cognitive distraction and emotional disconnection in addition to physical causes.

European Society for Sexual Medicine guidance on psychosocial ED also specifically identifies **avoidance of sexual intimacy** as a treatment target and recommends combining medical treatment with psychological interventions when appropriate.

This means I do not tell a patient with genuine diabetes-related ED:

“It is only psychological.”

But I also do not assume that restoring blood flow alone will automatically remove months or years of fear.

Both dimensions may require treatment.

“If I Don't Start, I Cannot Fail”

This is a common thought in men with performance-related avoidance.

A patient may stop initiating affection because he believes every affectionate interaction creates the possibility that sex will be expected.

He thinks:

“Better not to start anything.”

His wife experiences:

“He never touches me anymore.”

She may interpret the withdrawal as loss of attraction.

She confronts him.

He becomes more embarrassed.

Now emotional pressure has been added to sexual pressure.

The original erection difficulty has become a relationship problem.

Premature Ejaculation Can Also Lead to Avoidance

A man with premature ejaculation may experience intimacy as a countdown.

He thinks:

“What if it happens immediately again?”

He may worry about disappointing his partner or being criticized.

The fear itself can increase tension.

Eventually avoiding sex appears easier than repeatedly confronting the problem.

Current EAU guidance recognizes performance anxiety, psychological factors and relationship problems among contributors to acquired premature ejaculation and recommends assessment of anxiety and interpersonal factors. Psychosexual treatment may include cognitive, behavioural and couple-based approaches in combination with appropriate medical treatment.

Therefore, a man who begins avoiding his partner because of PE does not necessarily have low desire.

He may be protecting himself from anticipated embarrassment.

Delayed Ejaculation and Orgasm Difficulties

The opposite problem can produce avoidance too.

A man who repeatedly takes a very long time to ejaculate or cannot reach orgasm may begin feeling:

“Everyone is waiting for me to finish.”

Sex becomes stressful.

His partner may interpret the problem as:

“Perhaps he is not attracted to me.”

Now the man feels pressure to prove attraction by reaching orgasm.

The more closely he monitors himself, the more difficult orgasm can become.

Current sexual-medicine guidance recognizes anxiety, control issues and psychological factors in delayed ejaculation and emphasizes detailed psychosexual as well as medical evaluation.

Sexual Performance Anxiety

Sometimes no major physical dysfunction exists initially.

The primary problem is fear of failure.

The patient enters intimacy already thinking:

“I must perform perfectly.”

He is not experiencing intimacy.

He is evaluating himself.

The 2025 ESSM position statement emphasizes that sexual performance anxiety can involve expectations, evaluation and feared consequences, with treatment directed at low confidence, negative thinking and other maintaining factors.

Sexual avoidance may then become the patient's preferred method of controlling anxiety:

“If I do not participate, I cannot be judged.”

This solves the immediate fear but creates a larger sexual problem.

Fear of Disappointing a Partner

Many men are not primarily afraid of sexual dysfunction.

They are afraid of what it supposedly means to their partner.

A man may think:

“If I cannot maintain an erection, she will think I do not love her.”

Another:

“If I ejaculate quickly, she will think I am sexually weak.”

Another:

“If I cannot conceive a child, she will think I am not a complete man.”

The anticipated reaction becomes more frightening than the sexual symptom itself.

This is one reason partner communication is often important.

Partner Criticism Can Strengthen Avoidance

One critical remark can remain in the patient's mind for years.

Examples include:

“Why can't you perform?”

“Why does this keep happening?”

“You finish too quickly.”

“You never satisfy me.”

The partner may have spoken during frustration.

But the patient remembers the sentence during future encounters.

Sexual intimacy now contains an imagined examiner.

When sexual difficulty is met repeatedly with humiliation, avoidance becomes understandable.

Treatment may therefore require changes from **both partners**, not simply medicine for the man.

Relationship Stress

Sex does not occur in isolation from the relationship.

A man may be perfectly capable physiologically but stop wanting intimate contact after months of:

arguments,

resentment,

betrayal,

criticism,

lack of emotional connection,

or unresolved conflict.

EAU guidance identifies poor relationship satisfaction, poor sexual relationships and emotional disconnection from a partner during sex among psychosocial factors associated with erectile difficulties, while intimacy can be protective.

In these cases, sexual avoidance may be communicating:

“I do not feel emotionally safe or connected.”

A sexual-strength medicine does not resolve this.

The Pursuit–Withdrawal Cycle

The partner may react to sexual avoidance by asking for more intimacy.

The man experiences this as pressure and withdraws further.

The partner becomes more distressed and pursues even more.

A cycle develops:

Partner asks for closeness → man feels pressure → man withdraws → partner feels rejected → partner pursues more strongly → man feels even more pressure.

Neither partner may intend to create this pattern.

Both may actually want closeness.

But their strategies for managing distress are opposite.

Couple-focused treatment can help identify the pattern without deciding that one person is entirely responsible.

Infertility Can Turn Intimacy Into a Performance Test

This is especially important in my infertility practice.

A couple may begin trying for pregnancy with a normal sexual relationship.

Then ovulation is tracked.

Intercourse becomes timed.

A man hears:

“Today is the fertile day.”

Suddenly sexual activity feels mandatory.

He thinks:

“I have to get an erection now because we cannot waste this month.”

If an erection does not occur, the event feels much bigger than an ordinary sexual difficulty.

The patient may think:

“Because of me we have lost our chance this month.”

Current 2026 International Consultation on Sexual Medicine recommendations emphasize that infertility and sexual dysfunction can influence one another in both directions. Infertility treatment can turn intercourse from “love-making” toward “baby-making,” contributing to anxiety, low desire and erectile problems.

The same 2026 recommendations advise clinicians working with infertile couples to include a detailed sexual history as part of fertility assessment.

This is extremely important.

A semen report does not tell us whether the couple can comfortably achieve intercourse.

Male Infertility Can Produce Shame and Withdrawal

A diagnosis of low sperm count, poor motility, azoospermia or another male-factor condition may affect more than fertility.

Some men interpret the result as:

“I am less masculine.”

The medical conclusion does not justify that belief.

But psychologically, the patient may become ashamed.

A systematic review of men's experiences during infertility treatment found that men may use avoidant coping and experience problems with self-esteem, relationships and sexual function.

Current 2026 ICSM recommendations similarly describe guilt, shame, reduced self-confidence, anxiety and depression as possible experiences among men dealing with infertility.

The patient may then avoid both emotional and sexual intimacy.

Treatment should therefore address fertility **and** the effect the diagnosis has had on identity and relationships.

First-Time Sexual Anxiety

Sexual avoidance can also develop at the beginning of marriage.

A newly married man may experience erection difficulty on the first night.

He immediately thinks:

“I am impotent.”

The second night carries even greater pressure.

Another difficulty occurs.

Soon the man begins finding reasons not to attempt intercourse.

The couple may remain unconsummated even though no major permanent erectile disorder is present.

Modern infertility recommendations specifically recognize unconsummated marriage as a complex issue that may involve male and female sexual factors and recommend multidisciplinary care based on the couple's priorities.

Early professional help can prevent one stressful experience from becoming a long-term avoidance pattern.

Body Image and Penile Size Anxiety

A man may avoid intimacy because he does not want his partner to see his body.

He may worry about:

penile size,

weight,

abdominal appearance,

scars,

hair loss,

or aging.

His sexual function may be normal.

But undressing feels like exposure to judgment.

The patient may avoid situations where intimacy could develop.

In these cases, treatment should address body-image expectations rather than simply prescribing erection medication.

Low Sexual Self-Esteem

Some men develop a general belief:

“I am not sexually good enough.”

This may arise after ED, PE, infertility, rejection or criticism.

Once this identity-level belief develops, avoidance becomes a method of protecting self-esteem.

The person reasons:

“If nobody sees me perform, nobody can prove that I am inadequate.”

Treatment therefore needs to help the patient separate:

having a sexual problem

from

being a sexually defective person.

Those are completely different statements.

Sexual Shame and Cultural Expectations

Culture can influence the way men interpret sexual difficulties.

A patient may have learned:

“A real man should always be ready.”

“A man must always know exactly what to do.”

“A sexually capable man never loses an erection.”

“Male infertility means weakness.”

These are cultural expectations, not medical criteria.

WHO recognizes that sexuality is influenced by cultural, social, religious and psychological factors in addition to biology.

Good care should respect a patient's values while correcting medically inaccurate assumptions that create unnecessary shame.

Depression and Anxiety

Sexual avoidance may also be one part of a broader mental-health problem.

A man with depression may withdraw not only from sex but also from:

friends,

work,

hobbies,

and other pleasurable activities.

A man with generalized anxiety may constantly anticipate negative outcomes.

Someone with social anxiety may fear judgment in intimate situations.

In these circumstances, sexual avoidance should not be treated in isolation.

The wider psychological condition may require professional treatment.

Sexual Trauma

For some men, sexual avoidance reflects previous trauma rather than performance anxiety.

Sexual abuse and assault against men remain underrecognized.

A 2025 scoping review found substantial barriers to help-seeking among male sexual-assault survivors, including masculine norms and myths about male victimization.

A 2026 systematic review of disclosure among boys and men exposed to sexual trauma likewise found important barriers to disclosure and highlighted the need for more knowledgeable, supportive services.

Other research has documented persistent intimacy and sexual difficulties in some male survivors.

In this situation, the correct treatment is **not to push the man toward sexual activity**.

Trauma-informed care should prioritize safety, control, consent and restoration of personal choice.

Sexual Avoidance After Prostate Treatment

Men who have undergone prostate cancer treatment may face:

erection changes,

ejaculatory changes,

urinary leakage,

changes in orgasm,

loss of libido,

or body-image concerns.

The patient may therefore avoid intimacy because he does not want his partner to witness these changes.

A 2025 qualitative study after radical prostatectomy identified substantial changes in sexual behaviour, intimacy and relationship roles.

A 2026 scoping review of 53 studies found major physical, psychological, social and informational sexual-health needs among men and partners after prostatectomy and emphasized individualized rehabilitation and partner-inclusive care.

More broadly, the 2026 International Consultation on Sexual Medicine emphasizes that chronic illness and cancer can affect sexuality through interacting physical, psychological and relationship mechanisms.

Therefore, sexual avoidance after prostate treatment should not simply be interpreted as:

“He has lost interest in his wife.”

The patient may be grieving a change in sexual function.

Chronic Illness

Diabetes, cardiovascular disease, chronic pain, neurological disorders and other long-term illnesses can affect sexual function.

The man may become tired.

Erections may become unreliable.

Medication can produce side effects.

Body confidence may decrease.

The patient may worry about triggering symptoms.

Eventually he avoids intimacy.

Current 2026 ICSM guidance emphasizes that chronic disease can substantially affect both sexual function and intimate relationships and supports integrating sexual-health discussions into broader medical care.

A good treatment plan therefore addresses the illness as well as the sexual consequences.

Avoidance Can Be More Than Avoiding Intercourse

Sexual avoidance is not always obvious.

A patient may still sleep beside his spouse.

He may still talk normally.

But he gradually removes the behaviours that could create intimacy.

For example, he may stop kissing because kissing could lead to more.

He stops cuddling.

He avoids changing clothes in front of the partner.

He goes to bed only after the partner is asleep.

He stays on his phone late into the night.

The couple eventually says:

“We have become roommates.”

The difficulty may have started with one very specific sexual fear.

Solo Sexual Function Can Provide Useful Information

Sometimes a man tells me:

“I can become erect when I am alone, but I avoid sex with my wife.”

This does not automatically prove that the problem is entirely psychological.

But it provides useful clinical information.

It suggests that context, anxiety, partner interaction or performance expectations may be playing an important role.

A proper evaluation still needs to consider medical factors.

The clinician should avoid the two extremes:

“Normal alone means nothing physical can be wrong.”

and

“Any erection difficulty must be organic disease.”

Sexual medicine is usually more nuanced.

Why Repeated Avoidance Can Reduce Desire

Avoidance may eventually produce genuine low interest.

At first:

“I want sex but I am afraid.”

After months of avoiding sexual situations:

“I hardly think about sex anymore.”

The person has removed most sexual cues from the relationship.

Affection decreases.

Erotic attention decreases.

Conflict increases.

The relationship becomes associated with stress rather than intimacy.

The distinction between anxiety-driven avoidance and low desire can therefore become blurred over time.

That is why earlier intervention can be useful.

Sexual Avoidance Can Affect the Partner Too

The partner may experience withdrawal as:

rejection,

loss of attraction,

infidelity,

or emotional abandonment.

A wife may wonder:

“Why does my husband never touch me anymore?”

She may not know that he is lying awake thinking:

“What if my erection fails?”

Both people are suffering from completely different interpretations of the same behaviour.

Communication can reveal the hidden problem.

Avoidance Does Not Mean the Patient Is Uncaring

A man may actually withdraw because he cares deeply about his partner's opinion.

He is afraid of disappointing her.

He mistakenly believes avoiding intimacy will prevent disappointment.

Unfortunately, the avoidance itself may create the relationship pain he was trying to prevent.

This is an important point in counselling:

The protective strategy can become part of the problem.

What I Ask During Assessment

At Saira Health Care, I do not consider “sexual avoidance” a complete diagnosis.

I want to know:

“What are you afraid will happen if intimacy begins?”

That question is often the most important part of the consultation.

The answer may be:

“My erection will fail.”

“I will ejaculate too quickly.”

“She will criticize me.”

“I am ashamed of my infertility.”

“Sex has become stressful since fertility treatment.”

“I no longer feel emotionally connected.”

“My body changed after treatment.”

“I have a previous traumatic experience.”

Once we know the feared outcome, treatment becomes much more specific.

Medical Assessment Is Still Important

Sexual avoidance should never be used as an excuse to overlook physical disease.

A man with persistent erection difficulties may require evaluation of cardiovascular risk, diabetes, medication, hormones and other factors.

A man with ejaculation problems requires appropriate sexual and medical history.

A patient with pain requires evaluation.

A man with sudden loss of libido may require assessment for endocrine, psychological or medication-related causes.

The 2025 EAU sexual-health guidelines continue to emphasize integrated medical and psychosocial assessment in erectile dysfunction.

The correct approach is:

identify what the patient is avoiding and determine whether the feared sexual problem itself has a medical cause.

Treatment Begins With an Accurate Explanation

Many men improve when somebody finally explains what is happening.

Instead of believing:

“I have become sexually weak,”

the patient begins understanding:

“I experienced a problem, became frightened of repeating it, and now avoidance is maintaining the fear.”

This is a much more workable explanation.

Psychoeducation is an established component of psychosexual management for erectile difficulties and other sexual problems.

Understanding does not solve everything.

But it removes a great deal of shame.

Treat the Original Sexual Problem

If genuine ED exists, treat ED.

If PE exists, treat PE.

If delayed ejaculation exists, evaluate it.

If low desire is present, identify its cause.

If there is penile pain, curvature or another urological problem, investigate it.

If infertility has become the central stressor, address the reproductive problem.

Avoidance often improves when the patient no longer feels helpless in relation to the underlying symptom.

Cognitive Behavioural Therapy

CBT can be particularly useful when avoidance is maintained by catastrophic thinking.

For example:

Automatic thought:
"If I lose my erection once, my wife will think I am incapable."

A more balanced interpretation may be:

"Erection difficulties can occur for many reasons. One episode does not define my sexual future, and persistent ED can be assessed and treated."

Another patient thinks:

"If I ejaculate quickly, the whole encounter is a failure."

Treatment can help challenge all-or-nothing definitions of sexual success.

ESSM guidance on performance anxiety supports interventions directed toward negative thinking, self-efficacy and the factors that sustain anxiety.

Breaking the Avoidance Pattern

Psychological treatment for ED specifically includes strategies aimed at **disrupting sexual avoidance**, reducing anxiety, challenging dysfunctional beliefs and increasing intimacy and communication.

This does not mean:

"Force yourself to have intercourse tonight."

That can make anxiety worse.

Instead, the process should gradually make intimacy feel less like an examination.

The pace depends on the patient, the relationship and the cause of the fear.

Sensate-Focus and Non-Demand Intimacy

Traditional psychosexual therapy sometimes uses **sensate-focus principles**, in which couples temporarily reduce pressure to achieve erection, penetration or orgasm and focus instead on comfortable, consensual closeness and sensation.

ESSM psychosocial ED guidance includes this type of intervention among approaches used to reduce performance pressure and avoidance.

The important principle is not the name of the technique.

It is the change in expectation:

Intimacy does not have to prove anything tonight.

For a patient who believes every touch must end in successful intercourse, that change can be powerful.

Exposure Therapy Is Not the Same as Forcing Sex

In severe sexual fear or true sexual phobia, specialist psychological treatment may involve carefully planned exposure to feared aspects of intimacy.

The 2025 ESSM position statements describe exposure-based and cognitive approaches for sexual phobia.

However, this should be properly understood.

Therapeutic exposure is:

planned,

consensual,

gradual,

clinically supervised when necessary,

and designed to reduce fear.

It is **not** a justification for a partner to pressure someone into sexual activity.

Coercion is not therapy.

Partner Involvement Can Be Extremely Helpful

Sexual avoidance exists within a relationship.

Therefore, treatment often becomes easier when the partner understands what is happening.

A man may tell his wife for the first time:

“I have not been avoiding you because I do not love you. I have been afraid that my erection will fail.”

That sentence can completely change the meaning of months of withdrawal.

ESSM and EAU sexual-health guidance both support partner involvement and communication-focused intervention when relationship factors contribute to sexual dysfunction.

What a Supportive Partner Can Do

A supportive response reduces the feeling that sex is an examination.

The partner can communicate that intimacy does not require perfect erection, perfect timing or a particular outcome every time.

The partner can also express genuine needs without ridicule.

Support does not mean pretending that relationship problems do not exist.

It means discussing them in a way that makes treatment possible.

Remove the Pass–Fail Definition of Sex

Many men with avoidance define successful sex too narrowly.

Success means:

penetration happened,

erection remained completely rigid,

ejaculation occurred at exactly the desired time,

and the partner had a particular response.

Anything less is failure.

This is an unrealistic standard.

Modern psychosexual approaches emphasize quality, pleasure, satisfaction, realistic expectations and communication rather than judging sexual health only by mechanical performance.

The goal is not lower standards.

It is healthier standards.

Relationship Counselling

When avoidance is being maintained by anger, betrayal, criticism or emotional distance, sexual techniques alone may not help.

The couple may need to address:

trust,

conflict,

communication,

expectations,

and emotional safety.

A patient who feels chronically humiliated within a relationship is unlikely to become sexually relaxed simply because an erection medicine works.

The relational environment matters.

Trauma-Informed Treatment

If previous assault, abuse or coercion is involved, treatment should be trauma-informed.

The patient should retain control over:

what is discussed,

the pace of treatment,

physical contact,

and sexual boundaries.

Recent reviews of male sexual trauma emphasize both the long-term sexual or intimacy consequences and the barriers many men face when seeking help.

A man's trauma should never be treated as evidence of weakness.

And sexual activity should never be used as a test of whether he has “recovered.”

Infertility Treatment Should Protect Sexual Intimacy

When pregnancy is the goal, intercourse naturally has a reproductive purpose.

But I try to prevent the couple from allowing every intimate moment to become a fertility procedure.

The latest 2026 international recommendations specifically warn that highly specific intercourse timing can generate unnecessary stress and performance pressure in infertile couples.

When appropriate, couples can be counselled about fertility timing without turning a particular evening into:

“You must perform now.”

Sexual health and reproductive health should support each other rather than becoming competitors.

The Unani Perspective on Sexual Avoidance

The Unani system of medicine traditionally approaches health through the relationship between the body, psychological state, lifestyle and environment.

This whole-person framework can be very relevant to sexual avoidance because a patient may be affected simultaneously by:

stress,

poor sleep,

fatigue,

low confidence,

sexual dysfunction,

and relationship tension.

Official Ministry of AYUSH material describes Unani medicine as emphasizing the psychosomatic relationship between mind and body.

CCRUM material also identifies psychological and lifestyle dimensions within classical Unani health principles and formally recognizes approaches such as **Ilaj bil Ghiza**, **Ilaj bil Tadbir**, **Ilaj bil Dawa** and **Ilaj Nafsani**.

This provides a useful traditional framework for integrative care.

Asbab-e-Sitta Zarooriya — The Six Essential Factors

Unani medicine gives great importance to **Asbab-e-Sitta Zarooriya**, or six essential factors involved in maintaining health.

A recent CCRUM healthy-living publication describes these as air, food and drink, bodily movement and repose, **psychic movement and repose**, sleep and wakefulness, and evacuation and retention.

For sexual avoidance, several of these are particularly relevant.

A patient who is chronically exhausted may experience unreliable erections.

A man experiencing severe stress may become more anxious about sexual performance.

Someone who is sedentary, metabolically unhealthy and sleeping badly may have both poorer sexual function and lower confidence.

Addressing these areas can support recovery.

But they should be presented as components of comprehensive care—not as proof that every avoidance problem has one Unani explanation.

Harkat-o-Sukoon Nafsani — Psychological Activity and Repose

The traditional Unani concept of **Harkat-o-Sukoon Nafsani**, or psychic movement and repose, is particularly relevant when sexual avoidance is associated with fear and persistent mental tension.

The patient may repeatedly think:

“It will happen again.”

“She will judge me.”

“I am going to fail.”

This mental activity becomes part of the sexual problem.

CCRUM's official descriptions of Unani terminology include psychic movement and repose and recognize **Ilaj Nafsani** as a psychological treatment concept.

In contemporary practice, these traditional ideas can complement—not replace—modern psychosexual counselling, CBT or trauma-focused treatment where required.

Naum-o-Yaqza — Sleep and Wakefulness

The importance Unani medicine places on sleep is clinically sensible in many sexual-health problems.

A chronically sleep-deprived man may experience:

fatigue,

irritability,

poor mood,

lower sexual interest,

and inconsistent erections.

If one poor erection then triggers anxiety, a cycle of avoidance may begin.

Correcting sleep does not automatically cure sexual avoidance.

But it can remove one important physiological stressor.

Ilaj bil Ghiza — Dietotherapy

Dietotherapy can contribute to general sexual health where problems such as:

obesity,

diabetes,

poor metabolic health,

or fatigue

are present.

A patient with uncontrolled diabetes and ED may begin avoiding sex.

Improving general metabolic health can therefore form part of treating the actual condition that started the avoidance cycle.

But diet should not be described as a direct cure for fear.

No food can teach a patient to stop fearing rejection.

Ilaj bil Tadbir — Regimenal and Lifestyle Care

CCRUM officially identifies **Ilaj bil Tadbir**, or regimenal therapy, as one of the principal Unani therapeutic approaches.

In a modern integrative sexual-health setting, appropriate lifestyle care may include attention to:

physical activity,

rest,

sleep,

weight,

and general health.

Such measures may improve physiological sexual function in selected patients and help create a healthier background for psychological recovery.

Again, the role is supportive.

Ilaj Nafsani — Psychological Care

The traditional Unani literature also recognizes **Ilaj Nafsani**.

CCRUM describes it as addressing psychological or psychosomatic disease through attention to mind-related processes, sleep and verbal psychological methods.

This is particularly relevant because sexual avoidance is often maintained through:

fear,

beliefs,

shame,

and relationship meaning.

However, contemporary anxiety disorders, sexual phobias, trauma and severe depression require modern evidence-based psychological or psychiatric care when indicated.

Integrative medicine should integrate.

It should not prevent referral.

Can Unani Medicines Directly Cure Sexual Avoidance?

Patients deserve a clear answer.

There is no strong modern clinical evidence that one particular Unani herbal formulation directly cures sexual avoidance itself.

Sexual avoidance is primarily a behavioural and psychological pattern, although physical sexual dysfunction may trigger it.

Unani medicines may be considered individually when a separately diagnosed sexual or general-health condition is present and treatment is appropriate.

For example, the patient may simultaneously have fatigue or another health complaint addressed within Unani practice.

But if the central problem is:

"I am terrified that I will fail again,"

a medicine alone is unlikely to correct the entire fear–avoidance cycle.

Education, treatment of the original dysfunction, psychological strategies and partner communication may be more important.

Why Sexual Tonics Are Not Always the Answer

Imagine two patients.

The first has diabetes-related erectile dysfunction and avoids sex because his erections are unreliable.

The second has normal erections when relaxed but avoids his wife because one previous episode created overwhelming fear.

Giving both men the same sexual-strength medicine ignores the difference.

The first needs appropriate ED and metabolic evaluation.

The second may primarily need anxiety-focused sexual counselling.

Some patients need both.

Treatment should follow diagnosis.

My Clinical Approach at Saira Health Care

When a patient comes to **Saira Health Care** and says:

"I have stopped becoming intimate with my wife,"

my aim is not simply to increase sexual frequency.

I first want to understand:

what is being avoided and why.

Is he avoiding an erection test?

Is he afraid of premature ejaculation?

Is he ashamed about sperm results?

Is there relationship resentment?

Has sex become stressful because of infertility treatment?

Is desire genuinely low?

Is there a medical illness?

Has prostate treatment changed sexual function?

Is body-image anxiety present?

Is there previous trauma?

These are completely different clinical pathways.

The Special Treatment Approach of Dr. Nizamuddin Qasmi

My approach is individualized rather than relying on one medicine or one explanation.

When a physical sexual disorder is suspected, it is assessed.

When erectile dysfunction is present, the underlying medical and psychological contributors are considered.

When premature or delayed ejaculation is involved, the ejaculation disorder is evaluated specifically.

When infertility has created performance pressure, reproductive care and sexual counselling are considered together.

When the main problem is fear, sexual-health education, reduction of catastrophic thinking and appropriate psychosexual approaches may be necessary.

When relationship stress is central, couple-oriented guidance or specialist counselling may be appropriate.

When trauma is involved, trauma-informed mental-health care becomes important.

Where Unani dietary, lifestyle, regimenal or individualized supportive treatment is suitable, it can be incorporated without replacing necessary medical or psychological care.

This is the type of integrative approach I consider most responsible.

My Professional Focus in Sexual Disorders and Infertility

My clinical work is focused on **Sexual Disorders & Infertility**.

My professional education 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

Saira Health Care's current public professional profile lists the same focused practice and training background.

This combination of sexual-health, infertility, reproductive-health and Unani training supports an approach in which I consider **sexual function, reproductive goals, psychological stress, relationship context and general health together**.

Saira Health Care's Contribution to Sexual Disorders & Infertility

One of the greatest barriers in sexual-health care is silence.

A patient may spend five years avoiding his partner before ever telling a doctor:

“I am afraid my erection will fail.”

Another man may be undergoing infertility investigations but never mention that he can no longer comfortably perform during the fertile period.

Another may keep buying unregulated medicines because he is too embarrassed to explain the problem.

At **Saira Health Care**, one of our important contributions is providing a setting where such concerns can be discussed professionally and confidentially.

The clinic's published material describes a focused practice involving sexual disorders, sexual-performance anxiety, erectile dysfunction, premature ejaculation, low sexual

desire and male infertility, with individualized assessment, modern investigation where required and responsible Unani supportive care.

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

It is to identify why the patient is withdrawing and address that cause.

What I Want Men With Sexual Avoidance to Understand

A difficult erection does not define your masculinity.

Premature ejaculation does not make you inadequate.

Infertility does not mean you are sexually weak.

A difficult first experience does not predict every future sexual experience.

Needing psychological support does not mean that a sexual symptom is imaginary.

And avoiding your partner indefinitely usually does not solve the underlying problem.

These are the messages I repeatedly explain in clinical practice.

What I Want Partners to Understand

If your husband has begun withdrawing sexually, do not immediately assume:

“He no longer loves me.”

Ask what he is experiencing.

At the same time, avoidance should not become permanent silence.

The patient also has a responsibility to communicate and seek help rather than expecting the partner to guess indefinitely.

A healthier conversation is:

“I have noticed that we have become distant. I do not want to pressure you, but I would like to understand what has changed.”

That opens the possibility of treatment.

When Should a Man Seek Professional Help?

Occasionally avoiding intimacy because someone is exhausted, ill or emotionally overwhelmed is not necessarily a medical concern.

Professional assessment becomes more useful when the avoidance persists, repeatedly interferes with the relationship, or is associated with sexual symptoms such as ED, ejaculation problems, low desire, pain or fertility difficulties.

Help should also be considered when fear begins spreading from intercourse to all physical affection, when the patient becomes significantly depressed or isolated, or when reassurance no longer reduces anxiety.

Where previous sexual trauma is involved, trauma-informed psychological support may be particularly important.

When the Problem May Need Prompt Medical Assessment

Sexual avoidance itself is rarely an emergency.

But the underlying cause sometimes deserves prompt attention.

For example, a significant new erection problem in a man with cardiovascular risk factors deserves proper medical evaluation rather than years of secrecy.

Severe depression or thoughts of self-harm require urgent mental-health assessment.

Persistent genital pain, significant penile curvature or other new physical symptoms should be medically investigated.

Avoidance should not hide disease.

Can Sexual Avoidance Be Overcome?

Yes, many patients can improve substantially when the underlying cause is identified.

But the goal is not simply:

“Have sex more often.”

A meaningful recovery might look like this:

The patient understands why he withdrew.

The underlying ED or ejaculation problem is treated.

Anxiety decreases.

The partner understands the fear.

Affection no longer automatically feels like a performance demand.

The couple can communicate about intimacy.

The patient stops defining one difficult sexual response as evidence of permanent failure.

That is much more meaningful than counting sexual encounters.

Frequently Asked Questions

Is sexual avoidance a disease?

Not usually as a stand-alone medical diagnosis. It is better understood as a behavioural pattern that can occur with sexual dysfunction, performance anxiety, relationship difficulties, trauma, body-image problems or other psychological concerns. Research in men with sexual difficulties has found sexual avoidance associated with poorer sexual well-being.

Why would a man avoid sex if he still has desire?

Because desire and fear can exist simultaneously. He may want intimacy but fear erection loss, rapid ejaculation, criticism, rejection or another unwanted outcome.

Can erectile dysfunction make a man avoid his partner?

Yes. Psychological and relationship factors frequently develop around ED. Modern sexual-health guidance specifically identifies sexual avoidance as an important treatment target.

Can premature ejaculation cause avoidance?

Yes. Repeated anxiety and embarrassment can lead some men to reduce sexual initiation. Current EAU guidance recognizes performance anxiety and relationship factors in PE and recommends appropriate psychosexual assessment.

Can infertility make men avoid intimacy?

Yes. The latest 2026 International Consultation on Sexual Medicine emphasizes that infertility and male sexual dysfunction frequently coexist and can cause one another. Timed intercourse, shame, performance pressure and fertility treatment can all affect sexual intimacy.

Can sexual trauma cause avoidance?

Yes. Some male survivors experience long-term sexual and intimacy difficulties, and many face barriers to disclosure or help-seeking. Trauma-informed psychological care may be appropriate.

Does avoiding sex mean low libido?

Not necessarily. Some men still experience desire but avoid partnered intimacy because of anxiety. Others genuinely have low desire. The difference needs to be assessed clinically.

Can relationship conflict cause avoidance?

Yes. Emotional disconnection, criticism and relationship dissatisfaction can affect sexual function and willingness to become intimate.

Can counselling help?

Yes, particularly when anxiety, negative beliefs, relationship patterns or performance fears are maintaining the problem. Psychosexual approaches commonly include education, anxiety reduction, cognitive work, disruption of avoidance and couple communication.

Should I force myself to have intercourse to overcome the fear?

No. Forcing sexual activity can increase anxiety. When gradual exposure is clinically appropriate for severe sexual fear, it should be consensual and carefully structured.

Can erection medicine help?

It can help when actual erectile dysfunction is present and the medicine is medically appropriate. But erection medication does not automatically resolve relationship conflict, trauma, body-image anxiety or catastrophic beliefs.

Can Unani medicine help?

Unani medicine can contribute valuable supportive care through attention to general health, sleep, diet, physical activity, rest and psychological well-being. CCRUM recognizes dietotherapy, regimenal therapy, pharmacotherapy and psychological treatment concepts within Unani medicine.

However, there is no strong modern evidence that a particular herbal medicine alone cures sexual avoidance. Treatment should address the reason the patient is avoiding intimacy.

A Message From Dr. Nizamuddin Qasmi

When a patient tells me:

“Doctor, I have stopped going near my wife,”

I do not immediately conclude:

“Your libido is low.”

I ask:

“What are you afraid will happen if you become intimate?”

Sometimes the answer is:

“My erection will disappear.”

Sometimes:

“I will ejaculate too quickly.”

Sometimes:

“My wife will judge me because of my infertility.”

Sometimes:

“We have been fighting for months.”

Sometimes:

“Ever since surgery, I do not feel like the same man.”

Sometimes:

“Something happened to me in the past that I have never told anyone.”

The same outward symptom—avoidance—can therefore represent completely different underlying problems.

The physician's job is to understand the difference.

Avoidance Is Often an Attempt at Self-Protection

I want patients and partners to remember this.

The man who is withdrawing is not necessarily trying to punish his spouse.

Sometimes he is trying to protect himself from:

embarrassment,

rejection,

pain,

shame,

or another frightening experience.

Unfortunately, the protection can become a prison.

The patient avoids intimacy to prevent anxiety.

Then he becomes more anxious about intimacy because he has been avoiding it.

Breaking that cycle is often an important part of recovery.

Do Not Make the Next Sexual Encounter Another Examination

One of the most common mistakes after a difficult experience is saying:

“Tonight we will see whether you are normal again.”

That creates a test.

The patient watches his erection.

The partner watches the patient.

Both wait for the result.

This is exactly the environment in which performance anxiety can intensify.

A healthier therapeutic objective is gradually restoring **comfort, connection and predictability** rather than demanding proof.

The Aim Is Not Perfect Sexual Performance

A patient sometimes asks me:

“How can I guarantee that this will never happen again?”

Sexual medicine cannot guarantee that a human body will respond identically every time.

Even healthy men occasionally experience erection changes.

Ejaculation timing varies.

Desire varies.

Fatigue matters.

Stress matters.

A better goal is:

“If an imperfect sexual response occurs, I will not immediately panic, withdraw or define myself by it.”

That is much more durable sexual confidence.

Final Perspective

Sexual avoidance in men is often not a loss of sexuality—it is a strategy for escaping anticipated distress.

A man may withdraw because of erectile dysfunction.

Another because of premature ejaculation.

Another because of fear of failure.

Another because infertility has turned intercourse into a duty.

Another because a partner's criticism has damaged confidence.

Another because prostate treatment or chronic illness has changed his sexual response.

Another because emotional intimacy feels unsafe.

And another because of previous trauma.

Research directly examining men with sexual difficulties has found sexual avoidance associated with impaired sexual function, negative sexual beliefs and poorer sexual well-being.

The latest 2025 ESSM guidance emphasizes that sexual anxiety can take several forms and that clinicians should assess not only the fear itself but its interference with sexual situations and broader functioning.

Current ED guidance supports combining appropriate medical treatment with psychological and relationship-focused approaches when anxiety and avoidance are involved.

The latest 2026 International Consultation on Sexual Medicine also emphasizes the importance of addressing sexual dysfunction, anxiety and relationship strain in men experiencing infertility rather than treating reproduction in isolation.

The **Unani system of medicine** can provide a valuable complementary framework through its traditional attention to diet, physical activity, rest, sleep and psychological balance. CCRUM and Ministry of AYUSH materials formally describe this whole-person orientation and concepts such as **Ilaj bil Ghiza, Ilaj bil Tadbir and Ilaj Nafsani**.

But responsible integrative practice must also recognize the limits of medication.

No sexual tonic can single-handedly repair a fear–avoidance cycle.

If ED exists, treat ED.

If PE exists, treat PE.

If infertility has created pressure, care for fertility and intimacy together.

If relationship conflict is central, address the relationship.

If performance anxiety is maintaining the problem, psychosexual treatment may be required.

If trauma is present, provide trauma-informed care.

And when sleep, stress, diet, general health or other lifestyle factors are contributing, appropriate Unani and lifestyle support can complement the plan.

At **Saira Health Care**, this is the approach I prefer:

understand why the patient is withdrawing, identify the physical and psychological factors involved, treat the underlying sexual or reproductive problem, reduce unnecessary fear, and help the patient and partner rebuild intimacy without humiliation or pressure.

My message to patients is simple:

Avoidance may protect you from anxiety tonight, but it should not be allowed to control your entire sexual relationship.

A difficult sexual experience is something that can be understood.

A sexual dysfunction can be evaluated.

Anxiety can be treated.

Communication can improve.

And intimacy can often be rebuilt gradually, respectfully and realistically.

About the Author

Dr. Nizamuddin Qasmi
Founder & Chief Physician
Saira Health Care
Focused Practice in Sexual Disorders & Infertility

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

Medical Disclaimer

This article is intended for general sexual-health education and does not replace individualized diagnosis or treatment. Sexual avoidance may occur with erectile dysfunction, ejaculation disorders, low desire, infertility, anxiety, depression, relationship difficulties, chronic illness, cancer treatment, body-image concerns or trauma. Persistent sexual symptoms should be professionally assessed. Unani and herbal medicines should be used under appropriate professional supervision and should not replace necessary urological, reproductive, endocrine, psychological, psychiatric or trauma-focused care. Sexual activity should always remain voluntary and consensual; pressure or forced sexual activity is not a treatment for avoidance.