Body Image, Low Self-Esteem and Sexual Health

Dealing With Shame About Physical Appearance, Genital Appearance, Weight and Aging — A Modern Sexual-Medicine and Unani Perspective

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

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Introduction

One of the concerns that patients often find most difficult to discuss is not a laboratory abnormality, infection or obvious sexual disorder. It is the way they feel about their own body.

A woman may tell me:

“Doctor, after gaining weight I no longer feel attractive in front of my husband.”

A man may say:

“My hair is thinning, my abdomen is increasing and I do not feel confident during intimacy.”

Another patient may be worried about breast size, penile size, genital appearance, scars, skin colour, wrinkles, body hair, stretch marks or age-related changes.

Some people become so conscious of their appearance during intimacy that instead of experiencing affection, arousal and pleasure, they mentally observe themselves from the outside:

“How does my stomach look?”

“Can my partner see my wrinkles?”

“Does my body look old?”

“Is my penis large enough?”

“Are my breasts attractive enough?”

“Will my partner compare me with someone younger?”

When this pattern becomes strong, sexual intimacy may turn into an examination of one's appearance rather than an experience of connection.

This article discusses what I broadly call **body-image-related sexual distress**: low self-esteem, embarrassment or shame connected with physical appearance, genital appearance, weight or the natural changes of aging.

An important clarification is necessary from the beginning:

Body-image dissatisfaction is not automatically a disease.

However, persistent and severe appearance-related distress can affect mental health, relationships, sexual desire, arousal, erection, orgasm, communication and quality of life. In some individuals it may be associated with depression, anxiety, eating disorders or a recognized mental-health condition such as **body dysmorphic disorder (BDD)**.

Modern sexual medicine therefore treats body image as an important part of the **biopsychosocial understanding of sexual health**.

The World Health Organization emphasizes that sexual health includes physical, emotional, mental and social wellbeing and remains relevant throughout the entire lifespan, including older age.

What Is Body Image?

Body image is the way a person perceives, thinks and feels about their body.

It includes much more than simply looking in a mirror.

A person's body image may involve feelings about:

weight, height, muscularity, skin, hair, breasts, abdomen, scars, age-related changes, genital appearance and the way they believe other people see them.

Two people with very similar bodies may feel completely differently about themselves.

One may think:

“My body has changed, but I still feel comfortable and attractive.”

Another may think:

“Because my body changed, I am no longer worthy of intimacy.”

The physical appearance may be similar.

The psychological interpretation is very different.

Body Image Is Different From Self-Esteem

Body image concerns specifically relate to the body and appearance.

Self-esteem is broader. It refers to the person's overall sense of worth and value.

A patient can therefore have concerns about weight while still having strong general self-esteem.

Conversely, someone may have a conventionally attractive appearance but feel deeply inadequate because their self-worth is poor.

There is also a concept particularly relevant to sexual medicine:

Sexual self-esteem

Sexual self-esteem refers to how confident, comfortable and worthy a person feels as a sexual individual.

A person may think:

"I am good at my job and confident socially, but when I remove my clothes in front of my partner I feel ashamed."

That is a sexual self-esteem problem even if general confidence appears normal.

What Is Genital Self-Image?

Genital self-image describes how comfortable or dissatisfied a person feels about the appearance and function of their genital area.

Women may worry about:

labial size, symmetry, colour, vaginal appearance or changes after childbirth.

Men commonly worry about:

penile length, thickness, circumcision status, testicular size, curvature or genital appearance.

A 2025 systematic review included **7,448 participants—2,280 men and 5,168 women—and found a consistent association between more positive genital self-image and better sexual function, including greater desire and sexual satisfaction**. However, because much of the research is observational, these associations do not prove that appearance concerns directly cause every sexual problem.

This distinction is important.

A negative body image may contribute to sexual difficulties, but sexual dysfunction can also damage body image.

The relationship can work in both directions.

How Body Image Can Affect Sexual Function

Sexual activity generally requires a degree of psychological presence.

For healthy arousal, a person needs to be able to experience touch, emotion, pleasure and connection.

When someone becomes intensely self-conscious, attention moves away from sensation and toward monitoring.

Instead of:

“What am I feeling?”

the mind asks:

“What do I look like?”

This change in attention can interfere with sexual response.

A person may avoid certain positions, keep the lights off, resist undressing, avoid being touched in particular areas or stop initiating intimacy entirely.

The problem is not vanity.

The problem is that excessive appearance-monitoring can make it difficult to remain emotionally and sexually engaged.

“Spectatoring” During Sex

Sex therapists sometimes use the term **spectatoring** to describe a person mentally watching and evaluating themselves during sexual activity instead of participating naturally in the experience.

The patient becomes both participant and critic.

A man might think:

“My stomach looks terrible.”

Then:

“My erection is becoming weaker.”

Then:

“My partner will notice.”

The increasing anxiety makes arousal more difficult.

A woman may think:

“He must be looking at my stretch marks.”

She becomes tense.

Arousal reduces.

Lubrication may become more difficult.

Then she interprets the change as further proof that something is wrong.

This is how an appearance concern can develop into a sexual-performance problem.

What Research Shows in Men

Body image is not only a women's issue.

A large **2025 population-based study of 5,665 middle-aged men** found that erectile dysfunction, premature ejaculation and low libido were associated with a more negative body image, lower sexual self-esteem and greater perceived pressure around sexuality. The researchers emphasized that sexual self-concept is relevant to the biopsychosocial understanding of male sexual dysfunction, while also noting that the direction of causation cannot be determined from this type of study.

This reflects what I frequently see clinically.

A man may worry about:

hair loss, abdominal obesity, loss of muscularity, genital appearance, penile size or changes in erection.

The more he interprets those changes as evidence that he has become “less of a man,” the more performance pressure he may experience.

Sexual medicine should challenge that interpretation.

Masculinity is not measured by:

penile size, erection duration, muscular definition or the number of sexual encounters.

Penile Size Anxiety

Penile-size anxiety deserves particular mention because it can create enormous distress despite a normally functioning penis.

Men may compare themselves with pornography, edited images or unrealistic internet claims.

The concern sometimes becomes so strong that a man avoids relationships, repeatedly measures himself, purchases unsafe enlargement products or becomes unable to concentrate during intimacy.

The 2025 genital-self-image systematic review specifically identified dissatisfaction with genital size as an important factor affecting genital self-image and sexual wellbeing, particularly among men.

A clinician should therefore determine whether the patient has a genuine anatomical problem or primarily an appearance-related anxiety.

Those are not treated in the same way.

Body Image and Erectile Dysfunction

A negative body image does not automatically cause ED.

Erectile dysfunction can result from:

vascular disease, diabetes, medication effects, neurological conditions, hormonal abnormalities and many other physical causes.

However, appearance-related anxiety can become an important **psychological contributor**, particularly when erections are otherwise normal in some situations.

A man who continuously asks:

“Am I attractive?”

“Is my penis normal?”

“Will I satisfy my partner?”

may become increasingly anxious during sexual activity.

This performance pressure can worsen erection reliability.

Therefore, I do not simply prescribe an erection medicine when the main problem is severe body shame.

I evaluate the whole patient.

Women, Body Image and Sexual Function

Body image can affect female sexuality through several pathways.

A woman who feels ashamed of her abdomen, breasts, genital appearance or weight may avoid:

being seen naked, certain forms of touch, particular positions or initiating sex.

She may also become less willing to communicate what she enjoys because attention remains focused on appearance.

A 2024 systematic review found a relationship between body/genital self-image and female sexual function, although the strength of this association varied according to population and context.

Earlier meta-analytic evidence involving more than 13,000 participants similarly found a positive correlation between female genital self-image and sexual function, while noting substantial differences between studies.

The practical message is therefore not:

“Good-looking women have better sex.”

That is not what the research means.

The more accurate message is:

Feeling comfortable and less ashamed of one's body may make it easier to participate confidently in intimacy.

Appearance Is Not the Same as Attractiveness

This is an extremely important distinction.

Many patients assume:

“If I dislike this part of my body, my partner must dislike it too.”

That assumption may be completely wrong.

People frequently judge their own appearance far more harshly than their partners do.

Attractiveness also involves much more than anatomical proportions.

Intimacy can be influenced by:

affection, personality, voice, humour, emotional connection, trust, familiarity, touch and the shared history of a relationship.

A meaningful sexual relationship is not a beauty competition.

Social Media and Modern Body Shame

The modern digital environment has intensified appearance comparison.

People are repeatedly exposed to:

carefully selected photographs, filters, cosmetic enhancement, professional lighting and heavily curated bodies.

A 2025 systematic review found that visually appearance-focused social-media use was associated with greater self-objectification, body surveillance and body-image concerns. The same review identified self-compassion as a potentially protective factor, although more research is needed.

A separate 2025 meta-analysis synthesizing **68 papers and 218 effect sizes** found a statistically significant association between social-media use and self-objectification.

This does not mean everyone using social media will develop body-image problems.

But patients who notice that certain content consistently makes them feel inadequate should pay attention to that pattern.

Social Media Can Enter the Bedroom Psychologically

A particularly interesting 2026 study examined appearance-related social-media consciousness among young adults.

Higher appearance-focused social-media consciousness was associated with greater body consciousness during sexual activity, and increased body consciousness partly explained lower sexual assertiveness.

This is clinically meaningful.

A person may put the phone away before sex, yet the comparison culture created by the phone remains active in the mind.

Instead of thinking:

“Do I feel comfortable?”

the person thinks:

“Would my body look good in a photograph?”

Real intimacy cannot compete successfully with an endlessly edited digital standard.

Pornography and Appearance Expectations

Pornography can also create unrealistic expectations about:

penile size, breast shape, genital appearance, body hair, sexual positions, erection duration and orgasm.

Pornographic content is produced for visual impact rather than medical education.

Bodies are selected, filmed and edited.

The viewer therefore needs to distinguish between:

commercial sexual imagery and **normal human anatomy**.

If someone begins using pornography as the standard against which their own body or partner is judged, sexual confidence may decrease.

Aging and Body Image

Aging is one of the most universal causes of body change.

Hair may thin or turn grey.

Skin develops wrinkles.

Muscle mass may decline.

Body fat distribution changes.

Breasts may change.

Weight may increase or decrease.

Scars accumulate.

The shape of the abdomen changes.

Genital tissues can change.

Men may notice erection changes.

Women may experience menopausal changes.

The mistake is to assume:

“My body has aged, therefore my sexuality should end.”

WHO specifically emphasizes that sexual health remains relevant throughout the lifespan, including older age.

Sexuality Does Not Expire With Age

The 2026 International Consultation on Sexual Medicine published its first position paper devoted specifically to sexual health in older adults.

It emphasizes that sexuality in later life should be approached through physical, psychological, relationship and sociocultural factors rather than assuming older people are uninterested in sex. It strongly recommends that clinicians ask about sexual concerns proactively and avoid ageist attitudes.

The National Institute on Aging likewise notes that some older adults become uncomfortable with changes in weight, skin or muscle tone and may worry that their partners no longer find them attractive, yet many couples continue to experience satisfying sexuality and intimacy in later life.

Therefore:

aging changes sexuality; it does not automatically eliminate it.

Sexual Ageism

Sexual ageism is the belief that older people should not be sexually interested, attractive or intimate.

This stigma can come from:

society, family members, healthcare professionals or older adults themselves.

A 2026 integrative review of 29 studies found that ageism can negatively affect sexual health through stigmatization of older-adult sexuality, reduced pleasure, overlooked sexual-health needs and other barriers.

A patient may think:

“At my age I should not care about sex.”

That belief can stop someone from seeking help for a completely treatable sexual-health condition.

There is no medical reason to dismiss sexual wellbeing simply because someone is older.

Successful Sexual Aging

A 2026 review proposed understanding sexual aging through **acceptance, adaptation and activation** rather than measuring older adults against the sexual responses of their twenties.

I find that approach clinically valuable.

Acceptance means understanding that bodies naturally change.

Adaptation means adjusting intimacy according to current health and needs.

Activation means continuing to care for sexual wellbeing rather than assuming decline must simply be tolerated.

This may involve:

treating ED, treating menopausal dryness, changing sexual routines, improving physical fitness, allowing more time for arousal or redefining intimacy.

Sexual success at 60 does not need to look exactly like sexual success at 25.

Body Image in Menopause

Menopause can change both sexual physiology and body image.

Women may experience changes in:

weight distribution, skin, breast appearance, hair, sleep and genital tissues.

A **2026 systematic review** specifically examining peri- and postmenopausal women found that poorer body image was associated with poorer sexual function across the studies reviewed. The authors concluded that supporting body image may be an important part of improving sexual wellbeing and quality of life during and after menopause.

However, menopause-related sexual problems should not all be attributed to body image.

Physical problems may also exist.

For example, estrogen decline can contribute to vaginal dryness and painful intercourse.

Treating body confidence alone will not correct significant genitourinary syndrome of menopause.

Aging Men and Sexual Confidence

Men frequently interpret age-related sexual changes as evidence that they are losing masculinity.

Erections may take longer.

They may require more direct stimulation.

They may be less rigid than previously.

Recovery time after orgasm may lengthen.

Health conditions and medications also become more common.

Mayo Clinic's 2025 guidance emphasizes that sex can remain enjoyable into advanced age even though sexual response changes and medical problems become more common.

Age-related erectile dysfunction also has genuine vascular, neurological and hormonal mechanisms, so it should not simply be blamed on confidence. Modern reviews describe vascular changes, reduced nitric-oxide availability, neuronal factors, hormonal changes and psychological barriers as interacting contributors.

The correct message is:

Do not assume every erection change is psychological, and do not assume every erection change means your sexual life is over.

Pregnancy, Childbirth and Body Image

Pregnancy and childbirth can significantly alter a woman's relationship with her body.

The abdomen expands.

Weight changes.

Breasts change.

Stretch marks may appear.

The pelvic floor and genital tissues can be affected.

A scar from Caesarean section or an episiotomy may remain.

After delivery, a woman may compare herself with highly curated images of rapid postpartum “body recovery.”

That comparison can create shame during a period when the body is already undergoing enormous physiological and emotional adjustment.

A 2025 systematic review of pregnancy found that body-image-related quality of life and relationship satisfaction are relevant correlates of sexual function, though the research is heterogeneous.

A woman's postpartum body should therefore not be treated as a body that has “failed to return to normal.”

It has undergone a major biological event.

Infertility Can Change Body Image Too

Infertility can create a different kind of body-image distress.

A person may not dislike their outward appearance yet begin distrusting the body internally.

A woman may think:

“My body cannot do what a woman's body should do.”

A man with poor semen parameters may think:

“My body has failed me.”

These beliefs can damage sexual self-esteem.

This is why infertility counselling should address more than laboratory reports.

Fertility does not define femininity or masculinity.

Surgery, Illness and Scars

Body-image concerns may also develop after:

cancer treatment, mastectomy, hysterectomy, prostate surgery, abdominal surgery, burns, accidents or major weight change.

In these situations, the problem may involve both grief and adaptation.

The patient may need time to develop a new relationship with their body.

Partner reassurance can be helpful, but if distress is severe, psychological or psychosexual support may be necessary.

Weight and Sexual Confidence

Weight is one of the most common sources of body dissatisfaction.

It is important to distinguish two issues:

health and **shame**.

Higher body weight can sometimes be associated with genuine health problems that affect sexual function, including diabetes, cardiovascular disease, sleep apnoea and hormonal disturbances.

Those conditions should be treated.

But humiliation and shame are not treatments.

A 2025 systematic review and meta-analysis also found a relationship between obesity and sexual desire, particularly in men, while emphasizing the complex roles of hormonal and metabolic factors.

Weight management should therefore focus on health rather than telling patients that they must reach an unrealistic body shape before they deserve intimacy.

Genital Appearance: Normal Variation Is Wide

One of the most sensitive areas of body image concerns genital appearance.

Patients may compare themselves with:

pornography, cosmetic-surgery advertising or selected social-media content.

Human genital anatomy varies considerably.

Variation alone does not indicate disease.

A woman should not assume that differences in labial size, symmetry or pigmentation automatically require surgery.

Similarly, a man should not assume that a penis needs enlargement simply because it does not resemble pornography.

Sexual function is much more complex than genital appearance.

Cosmetic Procedures Are Not a Guaranteed Sexual Treatment

Some people seek cosmetic procedures because they hope that changing appearance will automatically improve sexual function.

A 2025 systematic review of female genital cosmetic surgery found apparent improvements in sexual-function scores in several studies, but the evidence was considered **low certainty**, largely because many studies were uncontrolled and at substantial risk of bias.

Another 2025 systematic review found no clear evidence that genital cosmetic surgery automatically produces better sexual function than not having surgery.

Cosmetic surgery may be a personal choice in appropriate circumstances.

But it should not be sold as:

“Change your body and your sexual confidence will definitely be cured.”

Psychological distress may remain after surgery if the underlying problem is severe self-criticism or body dysmorphic disorder.

When Body Dissatisfaction Becomes Body Dysmorphic Disorder

Most people occasionally dislike some aspect of their appearance.

That is not body dysmorphic disorder.

Body dysmorphic disorder (BDD) is a mental-health condition characterized by intense preoccupation with one or more perceived flaws that appear minor or may not be noticeable to others.

People may spend hours:

checking mirrors, avoiding mirrors, comparing themselves with others, grooming, hiding perceived defects, seeking reassurance or pursuing repeated cosmetic procedures.

Mayo Clinic notes that BDD can cause major impairment in social functioning, work and relationships and is associated with anxiety, depression and suicidal thoughts or behaviour. Treatment commonly includes cognitive behavioural therapy and, in appropriate cases, medication.

This condition requires professional mental-health assessment.

It should not be managed simply by repeated reassurance or cosmetic procedures.

Muscle Dysmorphia in Men

BDD can also involve a belief that the body is insufficiently muscular.

A man may have significant muscular development yet remain convinced that he is small or weak.

He may exercise excessively, use unsafe supplements or anabolic steroids and constantly compare himself with others.

Mayo Clinic identifies muscle dysmorphia as a body-image concern occurring predominantly in males.

This deserves attention because unsafe anabolic steroid use can also damage fertility, hormonal function and cardiovascular health.

Eating Disorders and Body Image

Severe body dissatisfaction can also coexist with disordered eating.

A 2025 systematic review of adults found important relationships among body image, self-esteem, emotional regulation and eating disorders.

Therefore, if body shame is accompanied by:

extreme calorie restriction, binge eating, self-induced vomiting, misuse of laxatives, rapid weight loss or compulsive exercise,

the patient needs appropriate mental-health and nutritional assessment.

Sexual-health treatment alone is not enough.

Body Shame Can Reduce Desire

A patient may say:

“My libido is low.”

But after careful conversation, the real thought is:

“I do not want my partner to see me.”

That is different from a hormonal desire disorder.

The brain may still be capable of sexual desire, but appearance-related fear prevents the person from feeling safe enough to engage in intimacy.

Treatment therefore begins with the actual problem rather than immediately prescribing a libido-enhancing medicine.

Body Shame Can Affect Arousal

Arousal requires attention.

If mental attention remains occupied with:

appearance, embarrassment and anticipated judgement,

less attention is available for pleasurable stimulation.

This can contribute to reduced subjective arousal.

In women, it may contribute to difficulty becoming lubricated or staying mentally engaged.

In men, anxiety may contribute to erection difficulties.

This is one reason body-image therapy can sometimes improve sexual wellbeing even though no genital disease is being treated.

Body Shame and Orgasm

Orgasm generally requires sustained arousal and the ability to become absorbed in pleasurable sensation.

A person thinking:

“How do I look?”

every few seconds may struggle to reach that state.

This does not mean that every orgasm problem is caused by appearance anxiety.

Medications, neurological problems, hormonal conditions, relationship factors and sexual stimulation also matter.

But body consciousness can be one important contributor.

Body Image and Sexual Communication

Poor body image can also reduce communication.

A person may feel embarrassed to say:

“I want the lights on.”

“I would like you to touch me here.”

or:

“That feels good.”

because they are primarily worried about being evaluated.

ISSM has highlighted evidence linking positive body appreciation with higher sexual self-esteem, better communication and better female sexual function.

This illustrates an important therapeutic goal:

improving confidence is not only about feeling better in the mirror; it may also help patients communicate more freely during intimacy.

How I Assess Body-Image-Related Sexual Distress

When a patient consults me about low confidence or shame, I do not simply ask:

“What don't you like about your appearance?”

I want to understand how much the concern is affecting life.

I consider whether the patient avoids sex, removes clothes only in darkness, repeatedly seeks reassurance, compares themselves with pornography or social media, avoids mirrors or checks them constantly, has depression or anxiety, uses unsafe supplements, has eating-disorder behaviours or has become obsessed with cosmetic procedures.

I also ask whether an actual sexual dysfunction is present.

For example, a man ashamed of his body may also have diabetes-related ED.

A menopausal woman with poor body confidence may also have painful vaginal dryness.

A patient should not have a physical condition ignored merely because psychological distress is obvious.

Treat the Physical Problem When One Exists

This principle is essential.

Body acceptance does not mean telling someone:

“Ignore every physical symptom and simply love yourself.”

If a man has persistent ED, investigate it.

If a woman has painful intercourse, diagnose the cause.

If menopause has produced significant vaginal dryness, treatment is available.

If a thyroid disorder is causing weight and energy changes, treat the thyroid condition.

If medication is affecting sexual function, review it.

If severe acne or hirsutism is causing distress, appropriate dermatological or endocrine management may help.

Psychological care and physical healthcare should work together rather than compete.

Treatment: Rebuilding a Healthier Relationship With the Body

There is no single tablet for body-image-related sexual distress.

Treatment usually aims to change several processes at once.

The first goal is to identify unrealistic beliefs.

A patient may think:

“If I gain weight, nobody can find me attractive.”

“Wrinkles mean my sexual life is finished.”

“My penis is not large enough, so I cannot satisfy my partner.”

“My breasts changed after pregnancy, so I am no longer desirable.”

The clinician and patient examine whether these thoughts are facts or interpretations.

This is where psychological approaches such as **cognitive behavioural therapy (CBT)** can be useful.

CBT is also an established treatment approach for body dysmorphic disorder and has evidence in sexual-dysfunction treatment more generally.

Reduce Constant Body Checking

Repeatedly examining:

weight, waist size, penile size, wrinkles, hair, skin or genital appearance

usually does not produce lasting reassurance.

It often strengthens the belief that the body must constantly be evaluated.

Reducing compulsive checking can therefore be an important part of treatment, particularly where BDD-like patterns are present.

Reduce Unhelpful Comparison

Comparison is one of the strongest fuels for body dissatisfaction.

A patient may compare:

their middle-aged body with their body at 20,

their postpartum body with someone who has never been pregnant,

their penis with performers selected for pornography,

their unfiltered face with an edited social-media photograph.

These are unfair comparisons.

The goal is not to eliminate awareness of appearance.

It is to stop using unrealistic reference points as a measure of personal worth.

Curate the Digital Environment

If particular accounts or content repeatedly trigger shame, it is reasonable to:

unfollow, mute or reduce exposure to them.

This is not weakness.

It is the psychological equivalent of reducing exposure to an environmental trigger.

Current research supports links between appearance-focused social media, self-objectification and body-image concerns.

Self-Compassion Is Different From Giving Up

Some patients resist self-compassion because they think:

“If I accept my body, I will stop improving my health.”

That is a misunderstanding.

You can accept yourself and still:

exercise, improve metabolic health, treat disease, care for your skin, choose clothing you enjoy or pursue medically appropriate treatment.

Self-compassion means:

“I will care for my health without humiliating myself.”

The 2025 social-media and body-image systematic review identified self-compassion as a potentially protective factor against some appearance-related harms, although further research is still needed.

Exercise for Function, Not Punishment

Physical activity can improve:

cardiovascular health, strength, mobility, energy, metabolic health and mood.

These benefits can indirectly support sexual health.

However, exercise becomes psychologically unhealthy when it is used as punishment:

“I hate my body, therefore I must exercise until I deserve food or intimacy.”

The healthier objective is:

“I want my body to function well.”

That shift from appearance alone toward function can be particularly valuable during aging.

Sensate Focus and Reducing Appearance Monitoring

In psychosexual care, techniques such as **sensate focus** may be useful for some couples.

The basic principle is to move attention away from performance and appearance and toward:

temperature, pressure, touch, breathing, comfort and connection.

The goal is not:

“Do I look attractive right now?”

It is:

“What am I experiencing right now?”

This can gradually reduce spectatoring and restore a more embodied sexual experience.

These exercises are best individualized when substantial sexual dysfunction or trauma is present.

Mindfulness

Mindfulness-based approaches may also help some people redirect attention from judgement toward present-moment sensation.

The person learns to notice a thought such as:

“My stomach looks ugly”

without automatically treating it as a fact that must determine behaviour.

Mindfulness is not a magical cure.

But it can be useful when excessive self-monitoring interferes with sexual arousal and pleasure.

Talk to Your Partner

Partners often underestimate how powerful reassurance and respectful communication can be.

Instead of repeatedly asking:

“Do I look fat?”

or:

“Is my penis big enough?”

the deeper conversation may be:

“I have been feeling insecure about my body and it is making intimacy difficult for me.”

That creates an opportunity for genuine communication.

The partner can respond to the emotional concern rather than only the appearance question.

What a Supportive Partner Should Avoid

Body-related teasing can be extremely damaging.

Repeated comments about:

weight, age, breast appearance, genital appearance, baldness or sexual performance

may continue affecting the person long after the comment was made.

A supportive partner does not need to pretend that bodies never change.

They should simply avoid turning those changes into humiliation.

Compliments Are Helpful—but They Are Not the Entire Treatment

Partner reassurance can be valuable.

But if the patient has severe body dysmorphic disorder, repeatedly asking:

“Do you still think I look okay?”

can become part of a reassurance-seeking cycle.

The person briefly feels better, then anxiety returns.

In such cases, structured psychological treatment is more appropriate than unlimited reassurance.

Accept That Sexuality Changes With Age

Older adults may need to redefine what satisfying sexuality looks like.

The 2026 International Consultation recommends discussing alternatives to penetrative intercourse where appropriate and using a couple-centred approach to sexual concerns in older age.

A satisfying intimate life may include:

more time for stimulation, different sexual positions, treatment of dryness or ED, affectionate touch and different forms of intimacy.

Adaptation is not failure.

It is a normal part of healthy aging.

The Unani Perspective on Body Image and Sexual Confidence

As a physician trained in Unani medicine, I find an important strength of the system in its **whole-person approach**.

Traditional Unani medicine considers:

Mizaj, or temperament;

Akhlat, the classical humours;

diet;

physical activity;

sleep;

psychological state;

and the relationship between the individual and their environment.

Official CCRUM terminology describes **Mizaj as bodily temperament** and identifies the classical humours as **Dam (blood), Balgham (phlegm), Safra (yellow bile) and Sauda (black bile)**.

These are traditional theoretical concepts.

They should not be presented as direct biomedical measurements of self-esteem, serotonin, testosterone or body-image psychology.

Unani Medicine Recognizes Psychological Factors

This is particularly relevant to sexual-health practice.

CCRUM's official treatment guideline for **Zuf-i-Bah, or sexual debility**, includes **Umūr Wahmiyya—psychological factors—**among the traditional contributors to reduced sexual desire and sexual capability.

Its treatment principles specifically include addressing psychological factors, described as **Izāla-i 'Awāriż Nafsānī**.

This provides an important traditional foundation for an integrative approach.

It means responsible Unani sexual medicine should not interpret every sexual complaint as simply physical weakness requiring an aphrodisiac.

The mind matters.

Confidence matters.

Fear matters.

Relationship context matters.

Harkat wa Sukoon Nafsani: Psychological Activity and Repose

Among the **Asbab-e-Sitta Zarooriya**, the Six Essential Factors of Unani medicine, is the principle of **psychic movement and repose**.

The Ministry of Ayush describes the six factors as air, food and beverages, physical movement and rest, psychic movement and rest, sleep and wakefulness, and appropriate retention and evacuation.

For a patient with severe appearance-related stress, this framework can support discussion of:

mental overload, anxiety, sleep, stress, rumination and emotional balance.

It is a culturally familiar way of recognizing that psychological wellbeing is part of health.

Ilaj bil Ghiza – Dietotherapy

Unani medicine traditionally gives an important role to **Ilaj bil Ghiza**, or dietotherapy.

In body-image-related sexual distress, I use diet primarily to support **health**, not appearance perfection.

The aim may be:

better metabolic health, adequate nutrition, stable energy and correction of genuine deficiencies.

I do not believe it is responsible to prescribe a “beauty” or “sexual power” diet based only on shame about appearance.

A patient with obesity, diabetes or fatty liver may require structured metabolic care.

A patient with an eating disorder requires an entirely different approach.

A patient's diet should never reinforce obsessive restriction.

Ilaj bit Tadbir – Regimenal and Lifestyle Care

Ilaj bit Tadbir, or regimenal therapy, provides another useful supportive framework.

For appropriate patients this can include attention to:

physical movement, rest, sleep, stress reduction and general lifestyle organization.

These interventions can support confidence because the patient gradually develops a healthier relationship with what the body **can do**, not merely how it looks.

Sleep and Body Image

Poor sleep can worsen:

fatigue, emotional regulation, metabolic health and sexual interest.

An exhausted person may also feel much less confident about appearance.

Unani's traditional emphasis on balance between sleep and wakefulness fits well with contemporary general-health advice.

However, good sleep should be described as a supportive health measure—not as a treatment that directly “balances the humours and cures body shame.”

Unani Pharmacotherapy: Where Does It Fit?

This is an area where caution is important.

Body-image dissatisfaction itself is **not an indication for an aphrodisiac or strengthening tonic**.

If the patient has an actual associated condition—such as sexual dysfunction, nutritional deficiency or another health problem—Unani pharmacotherapy may be considered according to the individual diagnosis.

But medicine should not reinforce the belief:

"Your body is defective and must be repaired before you can be worthy of intimacy."

That would worsen the psychological problem.

No Herb Can Replace Self-Esteem Treatment

Traditional herbs may support general health in appropriate patients.

However, there is no credible basis for claiming:

"This herb will make you confident about your body."

Likewise, an aphrodisiac cannot correct:

severe body dysmorphic disorder, depression, an eating disorder or relationship humiliation.

Where psychological treatment is needed, it should be provided.

A genuinely integrative approach uses the right therapy for the right problem.

My Specialized Approach at Saira Health Care

At **Saira Health Care**, when a patient tells me:

"I no longer feel attractive,"

I do not immediately ask:

"Which medicine should we give?"

I first want to understand what has changed.

I ask whether the concern began after:

weight change, pregnancy, childbirth, menopause, aging, infertility, illness, surgery, hair loss, acne or the development of a sexual dysfunction.

I also consider whether the patient's perception is proportionate to the physical change.

A genuine health problem and body dysmorphic disorder require very different management.

The First Question: Is There a Physical Sexual Disorder?

For a man, I assess whether:

erectile dysfunction, premature ejaculation, low libido or another sexual problem exists.

For a woman, I consider:

low desire, pain, vaginal dryness, arousal difficulty or orgasm difficulty.

If a physical disorder is present, it deserves treatment.

Treating the physical problem can sometimes significantly improve sexual confidence.

The Second Question: Is Shame the Main Problem?

Some patients have normal sexual physiology but avoid intimacy because they feel:

unattractive, old, overweight or ashamed.

In that situation, giving sexual-performance medicine may accomplish little.

The important treatment may involve:

psychological counselling, CBT, sex therapy, body-image work and couple communication.

The Third Question: Is Social Comparison Driving the Distress?

I ask patients about:

social media, pornography, cosmetic-content exposure and repeated comparison with other bodies.

If those influences are continually worsening self-esteem, changing the digital environment becomes part of the treatment plan.

Current research increasingly supports links between appearance-focused online activity, self-objectification and sexual body consciousness.

The Fourth Question: Is Aging Being Mistaken for Disease?

Aging brings normal changes.

But it also increases the frequency of genuine medical problems.

The clinician must distinguish between them.

A man with a slightly slower sexual response may need reassurance and adaptation.

A man with persistent ED may need cardiovascular and urological evaluation.

A woman who simply notices wrinkles may need body-image support.

A woman with painful sex after menopause may need treatment for genital tissue changes.

The principle is:

normalize normal aging, but do not normalize treatable disease.

The Fifth Question: Is Mental-Health Referral Needed?

I consider mental-health referral when appearance concerns:

consume substantial time, interfere with work or relationships, produce severe avoidance, lead to repeated cosmetic procedures, involve disordered eating or are associated with depression, severe anxiety or self-harm thoughts.

Those symptoms deserve specialist care.

Body dysmorphic disorder should not be treated as ordinary insecurity.

Contribution of Saira Health Care

Sexual medicine is often discussed as though it consists only of:

erections, ejaculation, hormones, sperm and medicines.

In reality, many patients' most important sexual problems are related to:

confidence, shame, expectations and fear of judgement.

At **Saira Health Care**, one of our roles in the field of sexual disorders and infertility is therefore **patient education and confidential psychosexual discussion**.

I want patients to understand that they can discuss:

body appearance, genital concerns, sexual confidence, aging, infertility-related shame and relationship insecurity without humiliation.

A responsible clinic should not exploit insecurity by promising unrealistic cosmetic or sexual transformations.

The goal should be better health and better quality of life.

The Professional Focus of Dr. Nizamuddin Qasmi

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

My clinical focus on sexual disorders and infertility means that I frequently see patients whose physical sexual symptoms and self-confidence have become closely connected.

My approach is therefore not merely:

“Treat the erection.”

or:

“Treat the libido.”

It is:

understand the person experiencing the symptom.

A Practical Recovery Framework

For patients whose sexual confidence is being affected by appearance or aging, I generally think in terms of six connected goals:

Area	Clinical Goal
Medical health	Identify and treat actual physical problems
Body image	Reduce unrealistic or excessively negative beliefs
Sexual confidence	Reduce performance and appearance monitoring
Lifestyle	Improve sleep, activity, nutrition and general health
Relationship	Improve communication, reassurance and intimacy
Mental health	Treat anxiety, depression, BDD or eating disorders when present

This is much more effective than assuming one supplement or cosmetic change can solve the entire problem.

Frequently Asked Questions

Is poor body image a disease?

Not by itself.

Almost everyone experiences occasional dissatisfaction with some aspect of appearance.

It becomes clinically important when distress is persistent, significantly affects daily or sexual functioning or develops into conditions such as body dysmorphic disorder, depression or an eating disorder.

Can body image affect sexual function?

Yes.

Systematic reviews show associations between body/genital self-image and sexual functioning in both women and men.

More positive genital self-image has been associated with greater sexual satisfaction and function, although most evidence is observational and does not prove simple cause and effect.

Can low self-esteem cause erectile dysfunction?

Low self-esteem alone should not automatically be diagnosed as the cause of ED.

However, negative sexual self-concept and body image are associated with ED, premature ejaculation and low libido in men and may contribute through performance anxiety.

Persistent ED should still receive an appropriate medical evaluation.

Can body shame reduce female sexual desire?

It can contribute.

A woman who is preoccupied with being judged may find it difficult to become mentally present during sexual activity.

Research links poorer body image with poorer sexual function in several female populations.

Why do I want the lights off during intimacy?

Some people simply prefer dim lighting.

But if you cannot tolerate being seen because you feel intense shame, that may be a sign that body image is interfering with sexual comfort.

The concern becomes more important when it leads to avoidance or distress.

Is it normal to feel less attractive with age?

Many adults notice changes in confidence as their bodies age.

The National Institute on Aging specifically notes that older adults may feel uncomfortable with changes in weight, skin and muscle tone and may worry about whether a partner still finds them attractive.

Those feelings are understandable, but they do not mean sexual wellbeing has to end.

Does aging mean sexual activity should stop?

No.

WHO and current international sexual-medicine recommendations recognize sexuality as relevant throughout life.

Older adults may need to adapt to physical changes or treat specific health problems, but age itself does not eliminate the right or capacity for sexual wellbeing.

Can menopause damage body image?

It can affect body image in some women because of physical and hormonal changes.

A 2026 systematic review found an association between poorer body image and poorer sexual function among peri- and postmenopausal women.

However, individual experiences vary considerably.

Are wrinkles or grey hair sexual-health problems?

No.

They are normal aspects of aging.

They become relevant to sexual health only if the person's interpretation of them produces significant shame or avoidance.

Can genital appearance affect sexual confidence?

Yes.

Genital self-image is associated with sexual function and satisfaction in both men and women.

But normal anatomical variation is wide, and cosmetic appearance should not automatically be interpreted as disease.

Will genital cosmetic surgery improve sexual function?

It cannot be guaranteed.

A 2025 systematic review found some apparent postoperative improvement, but the overall evidence was low certainty because many studies lacked strong control groups and had important bias.

Patients should therefore make decisions using realistic expectations.

What is body dysmorphic disorder?

BDD involves severe preoccupation with perceived defects that appear minor or may be unnoticeable to others.

It can involve repetitive checking, hiding, comparing, reassurance seeking and cosmetic procedures and can significantly impair daily life.

Professional mental-health treatment is recommended.

Does social media really affect body image?

Research suggests an association, particularly with appearance-focused use.

A 2025 systematic review and meta-analysis found links between social-media use, self-objectification and body-image concerns.

The effect differs between individuals.

Can I improve my body confidence without changing my body?

Yes.

CBT, reduced appearance comparison, improved sexual communication, self-compassion and psychosexual therapy can all help some patients change how they relate to their bodies.

The objective is not to force someone to believe:

"I am physically perfect."

It is to reach a healthier belief:

"My body does not have to be perfect for me to deserve health, affection and intimacy."

Can losing weight improve sexual confidence?

It may for some people, particularly when better metabolic health and physical fitness improve energy or sexual function.

But weight loss does not guarantee improvement in self-esteem.

A person who believes they are never good enough may simply find a new body part to criticize after losing weight.

Psychological wellbeing should therefore be addressed alongside physical health.

Can Unani medicine help with body-image-related sexual concerns?

Unani medicine can contribute through its **holistic framework**, particularly by addressing diet, physical activity, sleep, stress, general health and psychological balance.

Official Unani guidance specifically recognizes psychological factors in sexual debility, while the broader Asbab-e-Sitta framework includes psychic activity and repose among the essential factors of health.

However, a herbal medicine cannot replace appropriate psychological treatment for BDD, severe depression or an eating disorder.

Is there an Unani medicine for low self-esteem?

Low self-esteem is not appropriately treated simply by prescribing an aphrodisiac or tonic.

A patient may benefit from comprehensive Unani lifestyle care, but persistent psychological distress requires counselling or mental-health assessment when appropriate.

When Should You Seek Professional Help?

Professional assessment is particularly important when appearance-related distress causes persistent avoidance of intimacy or social contact, occupies large parts of the day, leads to repeated mirror checking or reassurance seeking, results in restrictive eating or compulsive

exercise, causes repeated pursuit of cosmetic procedures, is associated with severe depression or anxiety, or significantly damages a relationship.

A doctor should also evaluate persistent sexual problems such as erectile dysfunction, sexual pain, loss of desire or other symptoms rather than assuming they are purely psychological.

Thoughts of self-harm or suicide require urgent mental-health assistance.

A Message From Dr. Nizamuddin Qasmi

When a patient tells me:

“Doctor, I no longer feel attractive,”

I do not consider that statement superficial.

Sometimes that one sentence explains why the patient has stopped initiating intimacy, why erection has become unreliable, why desire has fallen or why a relationship has become distant.

The body changes throughout life.

Weight changes.

Skin changes.

Hair changes.

Pregnancy changes the body.

Menopause changes the body.

Aging changes the body.

Illness and surgery can change the body.

None of these automatically means that a person has lost sexual value.

I often tell patients:

Your partner is not experiencing you as a photograph.

They experience your:

presence, affection, personality, communication, touch and relationship.

At the same time, I do not want to dismiss genuine medical concerns.

If weight gain is related to diabetes or endocrine disease, treat it.

If a man has ED, investigate it.

If a woman has menopausal sexual pain, treat it.

If infertility has damaged confidence, address the fertility problem and its emotional consequences.

If body dysmorphic disorder is present, psychological treatment becomes essential.

As a physician trained in Unani medicine, I value its whole-person philosophy.

The concepts of **Mizaj**, balanced lifestyle, **Ilaj bil Ghiza**, **Ilaj bit Tadbir**, proper sleep and **Harkat wa Sukoon Nafsani** remind us that health is not simply the appearance of the body.

Psychological health is part of health.

But responsible Unani care also requires recognizing its boundaries.

No herb should be presented as a cure for severe body shame.

No sexual tonic should be used to reinforce the belief that the patient's body is defective.

And no cosmetic procedure should be presented as a guaranteed route to sexual happiness.

At **Saira Health Care**, my approach is to help the patient move from:

shame → understanding

comparison → realistic self-perception

performance pressure → healthy intimacy

and, where a genuine sexual or reproductive disorder exists,

fear → proper diagnosis and individualized treatment.

The goal is not to make every patient look younger.

The goal is to help them achieve **better physical health, stronger sexual confidence, healthier relationships and a more respectful relationship with their own body.**

About the Author

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

BUMS – Hamdard University, Delhi
MD
CGO
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At **Saira Health Care**, the clinical focus includes confidential and individualized assessment of sexual disorders, sexual-confidence problems, body-image-related sexual distress and infertility, using a holistic approach that respects Unani principles while incorporating appropriate contemporary sexual and psychological healthcare.

Medical Disclaimer

This article is intended for **public education and general sexual-health information**. Body-image dissatisfaction is not itself a single medical disease and should not automatically be treated with medication.

Persistent low self-esteem or appearance-related shame may coexist with depression, anxiety, eating disorders, body dysmorphic disorder or sexual dysfunction and may require professional psychological or medical assessment.

Unani and herbal medicines should be selected under appropriately qualified supervision and should not replace established mental-health treatment when a significant psychological disorder is present.