Male Performance Anxiety: A Complete Modern and Unani Understanding

Causes, Symptoms, Erectile Dysfunction, Premature Ejaculation, Fertility Impact, Diagnosis, Psychological Treatment and Responsible Integrative Unani Care

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Introduction

One of the most common but least openly discussed problems I encounter in sexual-health practice is the man who tells me:

"Doctor, everything is normal until the moment I have to perform. Then suddenly I lose confidence, the erection becomes weak, or I ejaculate too quickly."

Sometimes the problem appears during a new relationship. Sometimes it begins after one unsuccessful sexual encounter. Sometimes it develops after marriage when a man feels pressure to prove himself sexually. And sometimes I see it during infertility treatment, when intercourse has stopped being spontaneous and has become something that must happen "today because ovulation is occurring."

This pattern is commonly called **male sexual performance anxiety**.

Performance anxiety refers to excessive fear, worry, self-monitoring or anticipation of failure surrounding sexual activity. The International Society for Sexual Medicine describes sexual performance anxiety as anxiety related to sexual activity that can accompany or precede conditions such as erectile dysfunction, premature ejaculation and reduced sexual arousal. It is better regarded as a clinical psychological phenomenon rather than one single stand-alone sexual diagnosis.

This distinction is important because performance anxiety is not synonymous with erectile dysfunction.

A man can experience anxiety without having persistent ED. Another man may have genuine vascular, hormonal or neurological ED and subsequently develop performance anxiety because he is frightened that the erection will fail again. Many patients therefore have a **mixed problem**, where physical and psychological factors interact.

The current 2026 European Association of Urology guideline emphasizes exactly this point: erectile dysfunction can be organic, psychogenic or mixed, and multiple mechanisms frequently coexist. Anxiety, depression, relationship dissatisfaction, unrealistic sexual expectations, poor self-esteem and cognitive distraction can all influence erection quality.

My approach at **Saira Health Care** is therefore never to tell a patient simply, “This is in your mind.”

I want to know:

Why did the anxiety begin?
Is there also a physical sexual problem?
Is infertility or timed intercourse adding pressure?
Is premature ejaculation creating fear of failure?
Are diabetes, hypertension, low testosterone, medicines or cardiovascular factors contributing?
And how can we break the cycle safely and restore confidence, sexual function and intimacy?

My training in Unani medicine adds another useful dimension. Classical Unani literature recognizes psychological factors in male sexual weakness and specifically includes treatment of those psychological influences within its principles of management. The modern opportunity is to combine that traditional whole-person perspective with contemporary psychosexual therapy, medical evaluation and evidence-based treatment.

What Is Male Sexual Performance Anxiety?

Male sexual performance anxiety is excessive concern about whether a man will be able to perform sexually in the way he or his partner expects.

The feared outcome may be different for different men.

One man worries:

“Will I get an erection?”

Another thinks:

“Will I lose it during penetration?”

Another fears:

“What if I ejaculate immediately?”

Another is preoccupied with whether his penis is large enough, whether his partner will be satisfied, whether he will be compared with a previous partner or whether he will be able to perform on the exact fertile day required for conception.

As attention moves from **sexual pleasure and connection** toward **monitoring performance**, normal arousal becomes more difficult.

The man stops experiencing the sexual situation and starts observing himself from the outside.

He may repeatedly ask himself:

“Am I hard enough?”

“Is the erection going?”

“How long have I lasted?”

“Does she look satisfied?”

“Why am I not feeling aroused yet?”

This excessive self-monitoring can itself interfere with sexual response.

Performance Anxiety Is More Common Than Many Men Realize

Sexual performance anxiety is not a rare or unusual experience.

A widely cited clinical review estimated that sexual performance anxiety affects approximately **9–25% of men**, although prevalence varies according to definitions and the population being studied.

More recent research continues to demonstrate that sexual performance anxiety involves feelings of inadequacy, fear of failure and concern about how one's sexual performance is being evaluated, and that these concerns can affect both sexual functioning and relationships.

Many men never seek help because they feel embarrassed.

Some purchase unregulated “sex power” medicines.

Some repeatedly use erection tablets without understanding why they need them.

Some begin avoiding intimacy completely.

Others falsely conclude that they have permanently lost their masculinity.

These reactions frequently make the problem more difficult.

Sexual Performance Is Not a Test of Masculinity

This is one of the first ideas I try to correct.

An occasional erection difficulty does not mean that a man is impotent.

Premature ejaculation does not mean that a man is sexually weak.

Feeling nervous with a new partner does not mean something is permanently wrong.

A man's value, masculinity and fertility cannot be measured by how quickly he gets an erection or how long intercourse lasts.

Unfortunately, unrealistic expectations around masculinity often transform a temporary sexual difficulty into a persistent anxiety cycle.

The man begins thinking:

“A real man should always be ready.”

That belief is biologically unrealistic.

Human sexual arousal varies with sleep, stress, attraction, fatigue, relationship quality, privacy, medications, general health and emotional state.

The expectation of perfect performance every time creates precisely the pressure that can interfere with normal sexual function.

The Performance-Anxiety Cycle

Male performance anxiety frequently develops as a self-reinforcing cycle.

A man first experiences an erection problem or rapid ejaculation.

He becomes embarrassed.

Before the next encounter, he remembers what happened.

He worries that it will happen again.

The worry increases physiological arousal of the stress system.

Instead of focusing on erotic sensations, he monitors his penis.

The erection weakens or ejaculation occurs faster.

He interprets this as confirmation that something is seriously wrong.

His anxiety before the next encounter becomes even stronger.

Thus:

one sexual difficulty → fear of repetition → self-monitoring → impaired sexual response → stronger fear.

Breaking this cycle is often more important than trying to "force" an erection.

How Anxiety Can Interfere With an Erection

An erection is not produced by willpower.

Normal erection depends on coordinated neurological, vascular and psychological processes.

Sexual arousal activates pathways that allow penile smooth muscle to relax and blood to enter and remain within the erectile tissues.

Anxiety activates a different physiological state.

When a man becomes frightened, pressured or hyper-alert, the sympathetic nervous system—the system involved in the "fight-or-flight" response—becomes more active.

The mind may still want sex, but the body is behaving as though it needs to respond to a threat.

This is why simply telling a man:

"Try harder to get an erection"

usually makes performance anxiety worse.

The harder he tries to consciously control a normally automatic sexual response, the more attention shifts away from erotic experience.

"Spectatoring": Watching Yourself Instead of Experiencing Sex

Sex therapists sometimes describe this phenomenon as **spectatoring**.

Instead of being mentally present with his partner, the man becomes an observer of his own performance.

He evaluates erection hardness.

He worries about his partner's facial expression.

He compares himself with expectations.

He tries to calculate ejaculation timing.

The current EAU guideline specifically recommends assessing dysfunctional sexual expectations, low self-esteem and **cognitive distraction from erotic cues** because these psychological processes can contribute to erectile difficulties.

Treatment therefore often involves teaching the man to move attention away from performance measurement and back toward sensation, intimacy and communication.

Common Psychological Triggers

Performance anxiety does not always have one identifiable cause.

For some men it develops after a single episode of erectile difficulty.

Others have long-standing insecurity about sexual ability.

Common triggers include fear of disappointing a partner, anxiety during a first sexual experience, relationship conflict, previous criticism or rejection, unrealistic beliefs about intercourse duration, concerns about penile size, infertility pressure, previous erectile dysfunction or premature ejaculation, depression, generalized anxiety, religious or cultural guilt surrounding sexuality, or traumatic sexual experiences.

The EAU's 2026 guidance recommends specifically considering life stressors, cultural factors, relationship quality and cognitive beliefs about sexual performance when evaluating ED.

Relationship Factors Can Matter

Sexual function does not occur in isolation.

Relationship dissatisfaction, emotional distance, poor sexual communication and unresolved conflict may contribute to erection difficulties.

Conversely, emotional intimacy can be protective.

The current EAU guideline notes associations between ED and relationship dissatisfaction, poor sexual relationships and emotional disconnection during sex, while intimacy appears protective in some studies.

This is why treating the penis while ignoring the relationship sometimes produces disappointing results.

For selected patients, **couple-based treatment is more effective than treating the man as though his sexual response occurs independently of his partner**.

Performance Anxiety During Infertility Treatment

Performance anxiety becomes particularly important in couples trying to conceive.

ASRM's 2023 guidance on male sexual dysfunction in infertility explains that sexual problems may worsen significantly when couples begin trying for pregnancy.

Psychogenic ED may appear specifically when intercourse becomes scheduled around ovulation. A man may have normal erections in other circumstances yet experience difficulty when he knows:

“We must have intercourse tonight because this is the fertile day.”

ASRM reports that significant infertility-related sexual stress—including loss of sexual enjoyment, pressure to schedule intercourse and loss of sexual self-esteem—has been identified among men undergoing fertility treatment.

This is highly relevant at Saira Health Care because sexual dysfunction and infertility often overlap.

Timed Intercourse Can Turn Intimacy Into a Performance Test

When pregnancy becomes the goal of every sexual encounter, intercourse may gradually change from intimacy into a medical task.

The husband receives a message:

“Today the ovulation test is positive.”

He knows there may be only a short fertility window.

He may already be tired, stressed or not sexually aroused.

Yet he feels that failure to perform could mean losing that month's opportunity for pregnancy.

This pressure can trigger ED even in a man who normally has no erection problem.

I often explain to couples that this does **not** mean he is not attracted to his wife.

It means the reproductive pressure has interfered with sexual spontaneity.

Reducing blame is an important part of treatment.

Performance Anxiety and Erectile Dysfunction

Erectile dysfunction means persistent difficulty achieving or maintaining an erection sufficient for satisfactory sexual activity.

Performance anxiety can cause **psychogenic ED**, but not every ED case is psychological.

The EAU 2026 guideline emphasizes that ED can result from vascular, hormonal, neurological, anatomical, drug-induced and psychological factors and that several pathways frequently coexist.

Physical conditions associated with ED include diabetes, hypertension, cardiovascular disease, obesity, metabolic syndrome, dyslipidaemia, smoking, neurological disease, chronic kidney disease, hormonal abnormalities and certain medicines.

Therefore, a man should not be labelled with anxiety-related ED until an appropriate history and health evaluation has been completed.

How Psychogenic ED Often Appears

Several clues can make a strong psychological component more likely.

The erection difficulty may have appeared suddenly rather than gradually.

It may occur only with a particular partner or during attempted intercourse.

Erections may remain normal during masturbation.

Morning or nocturnal erections may still occur.

The problem may worsen during fertility-timed intercourse.

There may be clear anxiety immediately before penetration.

Performance may vary substantially between encounters.

ASRM explains that situational ED—especially ED developing or worsening after a couple begins trying to conceive—is often psychogenic. Morning erections, erections with self-stimulation and the timing and context of symptom onset are therefore useful parts of the history.

However, these clues are **not absolute proof**.

Many men have mixed psychological and organic ED.

Morning Erections: Useful but Not a Perfect Test

Patients often ask:

“If I still get morning erections, does that prove everything is psychological?”

No.

Preserved morning erections can suggest that the basic erectile system remains capable of functioning and therefore may support a psychogenic component.

But they do not completely exclude physical disease.

Likewise, occasionally missing a morning erection does not diagnose organic ED.

Sleep quality, age, medications and many other factors affect nocturnal erections.

The AUA and ASRM consider morning and nocturnal erection history useful clues, but specialized testing may occasionally be required when the diagnosis remains uncertain.

Performance Anxiety and Premature Ejaculation

Performance anxiety can also interact strongly with **premature ejaculation (PE)**.

A man worried about losing his erection may rush intercourse.

He may increase stimulation too quickly.

He may become excessively aware of approaching ejaculation.

After ejaculating rapidly, he begins worrying before the next encounter.

The 2026 EAU sexual-health guideline notes that a significant proportion of men with ED also experience PE and specifically warns that **high performance anxiety related to ED can worsen premature ejaculation**, creating a risk that the PE is treated while the underlying ED-related anxiety is missed.

Therefore, when ED and PE occur together, I assess **which problem began first**.

That can substantially change treatment.

Performance Anxiety and Delayed Ejaculation

Not every anxious man ejaculates too quickly.

Some experience the opposite.

Excessive self-monitoring can reduce arousal so much that ejaculation becomes delayed or impossible.

The man may maintain an erection but feel unable to reach orgasm during intercourse.

He may then increase stimulation aggressively, become frustrated and create additional pressure.

Again, treatment should focus on the full sexual response rather than simply prescribing an erection medicine.

Reduced Libido Can Also Occur

Performance anxiety can gradually reduce desire.

Initially the man wants sex but fears failure.

After repeated stressful encounters, he begins avoiding situations that could lead to intercourse.

He may stop initiating affection because even a hug feels as though it might create an expectation of sex.

Eventually he describes “low libido,” when the deeper problem may be **avoidance of anxiety rather than loss of biological sexual desire**.

This distinction is clinically important.

True low desire may also arise from depression, testosterone deficiency, medication effects and relationship problems.

Psychological Symptoms

A man with performance anxiety may experience self-doubt, fear of rejection, shame, embarrassment, racing thoughts, inability to concentrate on erotic sensations, constant comparison with other men, excessive concern about his partner's satisfaction or persistent fear that sexual failure will damage the relationship.

Some men report anticipatory anxiety hours before sexual activity.

Others feel perfectly relaxed until penetration is attempted.

The severity can range from mild nervousness to complete avoidance of intimacy.

Physical and Sexual Symptoms

Physical manifestations may include difficulty obtaining an erection, losing erection before or during penetration, premature ejaculation, delayed ejaculation, reduced subjective arousal, rapid heartbeat, sweating, trembling or muscular tension.

These symptoms do not necessarily mean there is a purely psychological disorder.

They should trigger a proper sexual and medical assessment.

Behavioural Changes

Some men respond by avoiding sexual situations.

Others use alcohol before intercourse.

Some repeatedly take erectile medicines without medical supervision.

Some begin checking erections throughout the day.

Others repeatedly masturbate to “test whether everything still works.”

These behaviours can temporarily reduce uncertainty but often strengthen the anxiety cycle.

A particularly common pattern is **testing the erection rather than experiencing arousal**.

Does Pornography Cause Male Performance Anxiety?

This subject deserves a careful and evidence-based answer.

The relationship between pornography and sexual dysfunction is much more complicated than social-media claims often suggest.

A 2026 systematic review found **mixed evidence**. Some studies reported associations between pornography and sexual difficulties, while others found no association or even some beneficial effects. Importantly, simple frequency of pornography viewing did not appear to predict sexual dysfunction as strongly as **problematic or compulsive use**, body dissatisfaction, insecurities and other psychological factors. The review concluded that merely watching pornography should not automatically be considered a cause of sexual dysfunction.

Therefore, I do not tell every patient with ED to blame pornography.

But I do ask about it when use is compulsive, creates unrealistic expectations, replaces partnered intimacy, contributes to guilt or causes the man to require very specific stimulation that is difficult to reproduce with a partner.

Treatment should address the actual pattern rather than make a moral judgment.

Unrealistic Sexual Expectations

Pornography is only one possible source of unrealistic expectations.

Friends, social media, movies and exaggerated advertising may create the belief that:

an erection should appear instantly,

an erection should remain perfectly rigid indefinitely,

intercourse must last for a long time,

multiple rounds are expected,

penile size determines satisfaction,

and the man is solely responsible for the partner's orgasm.

None of these assumptions accurately represents normal human sexuality.

Correcting unrealistic expectations is often an important part of treatment.

Past Sexual Experiences and Trauma

Previous negative experiences can also contribute.

A man who was mocked after erection difficulty may anticipate humiliation.

A man with a painful sexual experience may become hypervigilant.

Someone with a history of coercion or abuse may experience anxiety during intimacy.

These situations require sensitivity.

When trauma is relevant, treatment may require a clinician or therapist trained in trauma-informed psychosexual care.

Aphrodisiac treatment alone is unlikely to address the actual problem.

Religious and Cultural Concerns

Cultural and religious values can have positive roles in relationships and sexual ethics.

But some individuals grow up receiving messages that create intense fear or guilt surrounding sexuality.

After marriage or entry into a committed relationship, the person may intellectually accept sexual activity while the body continues to respond with anxiety.

The AUA and ISSM recognize psychological conflict, beliefs and cultural factors as potential contributors to psychogenic sexual dysfunction.

Treatment should respect the patient's values rather than ridicule them.

Performance Anxiety After One Episode of Erectile Failure

One temporary erection problem can occur for completely ordinary reasons.

The man may be exhausted.

He may have consumed excessive alcohol.

There may be insufficient privacy.

The couple may have argued.

He may simply not have been sufficiently aroused.

The real problem sometimes begins **afterward**.

The man concludes:

“Something is wrong with me.”

At the next encounter, he checks constantly whether the erection is present.

That anxiety then produces a second failure.

By the third attempt, he is no longer approaching sex as intimacy.

He is taking an examination.

Early reassurance can sometimes prevent this cycle from becoming persistent.

Performance Anxiety After Premature Ejaculation

A similar sequence occurs with premature ejaculation.

One rapid ejaculation may be completely situational.

The man becomes embarrassed.

During the next encounter he tries aggressively to prevent ejaculation.

He monitors every sensation.

He becomes more tense.

The added anxiety reduces his sense of control.

The problem then reinforces itself.

This is why treatment frequently involves both sexual techniques and anxiety management rather than focusing exclusively on ejaculation time.

Performance Anxiety in Newly Married Men

This is particularly relevant in cultures where sexual experience may begin after marriage.

The wedding night can carry enormous expectations.

The man may believe he must demonstrate masculinity immediately.

The woman may also be anxious.

There may be no privacy.

Both partners may be exhausted after wedding ceremonies.

Sometimes penetration itself is difficult because the female partner is frightened or experiencing pelvic-floor tightening.

If the man then loses his erection, both may assume he has permanent impotence.

Frequently, what the couple needs first is **education, reassurance, privacy, gradual intimacy and reduction of performance pressure**.

Forcing repeated penetration attempts can worsen anxiety in both partners.

Male Performance Anxiety and Inability to Consummate Marriage

Persistent inability to consummate marriage deserves careful couple-based assessment.

Possible contributors include male performance anxiety, ED, premature ejaculation before penetration, severe female pain, vaginismus or genito-pelvic penetration difficulty, lack of sexual knowledge, relationship conflict, trauma or combinations of these problems.

Treating only the husband without understanding the couple may therefore fail.

At Saira Health Care, I consider this an area where sexual counselling can be as important as pharmacological treatment.

Male Performance Anxiety and Infertility

Performance anxiety can affect fertility when it prevents effective intercourse during the fertile period or when ejaculation cannot occur intravaginally.

It does **not usually damage sperm merely because a man feels anxious**.

The main fertility effect is often behavioural and sexual: intercourse does not occur, erection fails during timed intercourse or ejaculation becomes difficult.

ASRM specifically advises fertility clinicians to assess erectile dysfunction, ejaculatory dysfunction and reduced libido because these problems may interfere with natural conception and even with collection of a semen specimen for IUI or IVF.

Performance Anxiety When Giving a Semen Sample

Some men have no difficulty ejaculating at home but cannot produce a sample in a fertility clinic.

The knowledge that the sample is required for a semen analysis, IUI or egg-retrieval day creates intense performance pressure.

This is a genuine medical issue.

ASRM recommends recognizing this possibility early and, in appropriate fertility-treatment situations, discussing strategies such as advance sperm banking when there is concern that ejaculation may not be possible on the required day.

This is another reason sexual-health counselling belongs within infertility treatment.

A Proper Diagnosis Is Essential

I do not diagnose performance anxiety simply because the patient is young.

Young men can have diabetes.

Young men can have hormonal disorders.

Young men can have medication-related ED.

Young men can smoke heavily, have obesity or have vascular risk factors.

Current EAU guidance recommends a comprehensive **medical and sexual history, physical examination and appropriate laboratory testing** for men presenting with ED.

The purpose is to identify psychological factors without overlooking important physical disease.

What I Ask During Evaluation

A useful sexual history explores when the problem began, whether it occurs every time or only in specific situations, whether erections occur during masturbation, whether spontaneous or morning erections remain present, whether libido is normal, whether the main problem is achieving or maintaining an erection, whether premature or delayed ejaculation is also present, and whether the symptoms began during infertility treatment or after a particular sexual event.

I also review medicines, tobacco, alcohol or recreational substances, previous surgery, diabetes, blood pressure, cardiovascular history, depression, anxiety and relationship factors.

These questions are not intrusive curiosity.

They are how psychogenic, organic and mixed sexual problems are distinguished.

General Health Examination Matters

Erectile dysfunction can occasionally be an early marker of broader vascular or metabolic disease.

The current EAU guideline notes that ED is associated with cardiovascular disease, coronary disease, stroke and other health risks, particularly when ED appears unexpectedly in younger men.

Therefore, persistent ED should not simply be hidden with an over-the-counter erection tablet.

Blood pressure, metabolic health and cardiovascular risk may deserve evaluation.

Treating sexual function can become an opportunity to improve a man's overall health.

Laboratory Investigation

Not every man requires dozens of blood tests.

Current EAU guidance recommends considering **glucose or HbA1c, lipid profile and early-morning total testosterone** as part of the basic medical evaluation of ED, with additional tests selected according to symptoms and clinical findings.

The aim is not to find an abnormal number simply because a test was ordered.

The aim is to identify reversible medical factors that genuinely influence sexual function.

Psychological ED and Organic ED Frequently Coexist

I avoid telling men:

“You have psychological ED, therefore your body is normal.”

Many cases are mixed.

A man may have mild vascular ED that creates one episode of erection loss.

Anxiety about that episode then magnifies the difficulty.

Treating only the vascular component may leave the fear untouched.

Treating only anxiety may overlook diabetes or cardiovascular risk.

The best treatment often addresses **both the physical vulnerability and the psychological amplification**.

This mixed model is explicitly recognized in current EAU sexual-health guidance.

Treatment Begins With Education

One of the most underestimated treatments is accurate explanation.

When a man understands that occasional erection changes are common and that anxiety itself can interfere with sexual arousal, shame begins to decrease.

ASRM notes that reassurance is an important component of psychogenic ED treatment and emphasizes explaining to both partners that erection difficulty does not imply loss of attraction or affection.

This explanation can itself reduce the sense of catastrophe around the next sexual encounter.

Cognitive Behavioural Therapy

Cognitive behavioural therapy (CBT) is one of the most evidence-supported psychological approaches for sexual dysfunction involving anxiety.

CBT helps identify and modify thoughts such as:

“If I lose the erection once, I am impotent.”

“If she doesn't orgasm, I have failed.”

“I must stay completely hard from beginning to end.”

“My partner will leave me if this happens.”

The current 2026 EAU guideline recommends cognitive and behavioural therapy, including partner involvement where appropriate, and notes that combining CBT with medical treatment can maximize outcomes.

This is a strong contemporary guideline recommendation.

Psychosexual Therapy

Psychosexual therapy addresses the sexual situation more specifically.

It may include education about normal sexual response, reducing self-monitoring, improving communication, changing unrealistic expectations, gradual exposure to intimacy and restoring pleasure-focused rather than performance-focused sexuality.

The AUA recommends considering referral to a mental-health or sexuality professional specifically to **reduce performance anxiety and integrate ED treatment into the sexual relationship**.

This is particularly valuable when ED is situational.

Sensate-Focus-Type Approaches

One traditional sex-therapy approach involves temporarily taking penetration and performance goals out of sexual contact.

Instead of asking:

“Did I get hard enough?”

the couple focuses on:

“What feels pleasant?”

Touch initially has no requirement to produce an erection, penetration or orgasm.

This can gradually retrain sexual contact from **test situation** back into **safe intimate experience**.

The technique is often incorporated into contemporary psychosexual or behavioural therapy.

It should be individualized, particularly when trauma, pain or relationship conflict is present.

Couple Counselling

Performance anxiety rarely affects only one person.

The partner may think:

“He doesn't find me attractive.”

The man may think:

“She is disappointed in me.”

Neither says this openly.

Anxiety increases.

Couple counselling can help replace assumptions with communication.

The EAU explicitly includes marital therapy, psychosexual education and couple-format CBT among recommended psychosocial interventions for ED.

Partner involvement is particularly important when infertility or timed intercourse is driving the problem.

Mindfulness and Attention Training

Mindfulness approaches aim to shift attention away from self-evaluation and toward present-moment sensations.

A man may learn to notice anxiety without interpreting it as proof that failure is inevitable.

Research specifically targeting male sexual performance anxiety remains less extensive than research on CBT and ED, but clinical reviews and expert guidance consider mindfulness a potentially useful strategy for performance-related anxiety.

I view it as an adjunct—not as a substitute for medical evaluation where ED is persistent.

Online CBT and Digital Therapy

Psychological treatment does not always require face-to-face therapy.

A 2026 systematic review of internet-based CBT, digital counselling and online psychoeducation for male sexual dysfunction found improvements in erectile function and sexual satisfaction across several studies, with some studies also reporting reductions in performance anxiety and improved sexual confidence. However, adherence to online programmes was an important limitation.

For appropriately selected men, telehealth can therefore provide a practical route to treatment, especially when embarrassment or geographical access prevents in-person psychosexual therapy.

Medical Treatment: PDE5 Inhibitors

Medicines such as phosphodiesterase type-5 inhibitors can be appropriate for some men with erectile dysfunction, including selected patients whose ED has a strong psychogenic component.

The purpose can be twofold.

The medicine assists erection physiologically, while successful sexual experiences may also help break the cycle of fear and loss of confidence.

ASRM notes that a trial of a PDE5 inhibitor may help restore confidence in psychogenic ED, while the EAU recommends evidence-based ED pharmacotherapy according to individual clinical circumstances.

However, these are **prescription medicines**, not confidence tablets.

They require appropriate assessment.

PDE5 Medicines Should Not Be Taken Casually

Erection medicines may interact dangerously with certain cardiovascular medications.

EAU guidance identifies concomitant use of organic nitrates or nitric-oxide donors as an **absolute contraindication** to PDE5 inhibitors because blood pressure can fall unpredictably.

This is one reason purchasing sildenafil-like products from unknown online sources is unsafe.

Treatment should be medically supervised.

Medication Alone May Not Solve Performance Anxiety

A tablet may produce a stronger erection while leaving the underlying fear unchanged.

Some men then develop a new belief:

“I can only perform if I take the tablet.”

This can create psychological dependence even when the man may no longer physiologically need medication.

For this reason, combining appropriate medical treatment with psychological or psychosexual intervention is often more effective than medication alone when anxiety is central.

The EAU describes CBT combined with medical treatment as a best-practice approach in suitable ED patients.

Treating Premature Ejaculation When It Coexists

When premature ejaculation is present, treatment should depend on whether PE is lifelong or acquired and whether underlying ED is contributing.

The current EAU guideline emphasizes that anxiety and ED can worsen PE.

Treatment may include education, behavioural/psychosexual approaches and evidence-based medical treatment when clinically indicated.

The important point is not to treat ejaculation time while ignoring the fear driving the cycle.

Lifestyle and General Sexual Health

Lifestyle modification is not a cure for every performance-anxiety case, but general health influences erectile function.

The AUA and EAU recommend addressing modifiable factors such as physical inactivity, obesity, smoking, diabetes, blood pressure and other cardiovascular risks in men with ED.

Regular activity, appropriate body weight, good sleep and reduced tobacco exposure can support general and sexual health.

But a healthy lifestyle should complement—not replace—psychosexual treatment when the main problem is anxiety.

Alcohol Is Not a Treatment for Sexual Anxiety

Some men discover that alcohol temporarily reduces nervousness.

They begin drinking before intercourse.

Small amounts may reduce inhibition, but greater alcohol exposure can impair erections, judgement and sexual response.

More importantly, using alcohol as the required condition for sexual activity creates another dependency.

A safer strategy is to treat the anxiety itself.

Testosterone Is Not a Treatment for Performance Anxiety

Men frequently assume that sexual anxiety or one erection problem means testosterone must be low.

That is not necessarily true.

Testosterone should be evaluated when symptoms and clinical findings justify it.

And there is an especially important fertility warning:

external testosterone can suppress sperm production.

For a man trying to conceive, indiscriminate testosterone injections can worsen fertility.

Sexual-performance treatment should therefore be individualized rather than based on assumptions about “male hormone weakness.”

Unani Understanding of Male Performance Anxiety

Classical Unani medicine does not necessarily use the modern English term “performance anxiety,” but its literature clearly recognizes **psychological influences on male sexual function**.

CCRUM's Standard Unani Treatment Guidelines for **Zu'f-i-Bah (sexual debility)** list *Umur Wahmiyya*—psychological factors—among possible causes.

Importantly, one of the official treatment principles is **Izala-i-'Awariz Nafsani**, meaning treatment or removal of psychological disturbances.

This is highly relevant.

It demonstrates that traditional Unani sexual medicine itself does not regard every sexual problem as merely a weakness of the penis or deficiency of semen.

Psychological factors were recognized within its clinical framework.

Zu'f-i-Bah Is Broader Than Performance Anxiety

The Unani term **Zu'f-i-Bah** refers broadly to reduced sexual capacity or sexual debility and may encompass several different presentations.

CCRUM's treatment guidance describes reduced sexual desire or ability and recognizes factors including penile flaccidity, reproductive weakness and psychological causes.

Therefore, performance anxiety should not simply be translated as Zu'f-i-Bah as though the two terms are identical.

A contemporary patient may have predominantly psychological performance anxiety without general sexual debility.

Using both the Unani and modern frameworks allows greater precision.

Quwwat-e-Bah and Sexual Function

Classical Unani medicine uses **Quwwat-e-Bah** to describe sexual faculty or sexual potency.

Traditional theory relates sexual function to the overall condition of important organs and the individual's *Mizaj*.

Historical Unani literature also recognizes the interaction between sexual weakness, premature ejaculation and psychological distress. CCRUM publications describe the broad Unani sexual-health framework and acknowledge psychological associations with premature ejaculation and sexual debility.

The modern value of this concept lies in its holistic orientation.

But it should not be claimed that one traditional organ “causes” performance anxiety in the modern neurobiological sense.

Harakat-o-Sukoon Nafsani: Mental Activity and Peace

Among the **Asbab Sitta Daruriyya**, or Six Essential Factors, Unani medicine includes **Harakat-o-Sukoon Nafsani—mental activity and peace**.

CCRUM's official terminology defines this as one of the essential factors influencing health and emphasizes the importance of balance in psychological activity and mental repose.

This traditional principle fits naturally with contemporary management of performance anxiety.

Chronic worry, fear and mental overactivation can interfere with sexual experience.

The Unani approach therefore encourages attention to emotional balance alongside physical treatment.

Asbab Sitta Daruriyya and Sexual Health

The Six Essential Factors include air/environment, food and drink, physical movement and rest, mental activity and peace, retention and evacuation, and sleep and wakefulness.

For performance anxiety, these principles can be translated practically.

Healthy food supports general health.

Physical activity supports vascular and metabolic health.

Adequate sleep supports mood and sexual function.

Mental repose reduces the burden of anticipatory anxiety.

Avoiding tobacco and excessive substance use protects vascular health.

This is where Unani preventive philosophy can genuinely complement modern sexual medicine.

Ilaj Nafsani: Psychological Treatment in Unani Medicine

Contemporary CCRUM educational material recognizes **Ilaj-e-Nafsani**, or psychological/psychotherapeutic treatment, within the Unani mental-health framework.

In a modern integrative sexual-health setting, this supports the use of conversation, reassurance, behavioural advice, emotional regulation and psychosexual counselling rather than relying only on aphrodisiac medicines.

This is particularly appropriate for performance anxiety.

Ilaj-bil-Ghiza: Dietotherapy

Unani medicine formally recognizes **Ilaj-bil-Ghiza**, or dietotherapy, as a treatment modality.

A balanced diet can support general metabolic and vascular health, and this may indirectly support erectile function.

However, I do not claim that one particular food will cure performance anxiety.

Milk, nuts, dates, eggs or other traditional strengthening foods may be nutritionally useful where appropriate, but they cannot by themselves correct maladaptive sexual thoughts, relationship conflict or fear of failure.

Diet is **supportive**, not the central psychological treatment.

Unani Pharmacotherapy: Where It May Fit

Unani pharmacotherapy includes traditional formulations historically used for sexual debility.

CCRUM's official treatment guidance documents such medicines within management of Zu'f-i-Bah.

However, performance anxiety requires particular caution.

If the primary problem is fear and self-monitoring, repeatedly increasing “sexual power” medicines may reinforce the patient's belief that his body is fundamentally defective.

I therefore consider Unani medicines only after understanding whether the patient also has low desire, general debility, ED, premature ejaculation or another relevant clinical problem.

Medicines should support an individualized plan—not substitute for psychological treatment.

Herbal Aphrodisiacs Are Not Automatic Anxiety Treatments

A plant traditionally classified as *Muqawwi-e-Bah* may be used for sexual weakness in selected Unani contexts.

That does not prove it treats sexual performance anxiety.

Likewise, a herb that has antioxidant or adaptogenic properties should not be advertised as a guaranteed cure for psychogenic ED.

Current international ED guidelines place much stronger evidence behind **psychosexual assessment, CBT and established ED therapy** than behind herbal treatments for performance anxiety.

I therefore use the Unani system where its individualized and whole-person strengths are useful, while keeping claims proportional to evidence.

Why Simply Giving a "Sex Power" Medicine Can Sometimes Make Anxiety Worse

Suppose a young man has normal erections when alone but loses his erection during attempted intercourse because he fears failure.

If he is immediately told:

"You are weak. You need a powerful tonic,"

the message he receives is:

"My body really is defective."

His confidence may fall further.

A more useful approach may be:

"Your history suggests that your erectile system can work. We should check important health factors, reduce pressure, address the anxiety cycle and use medical support only if needed."

The language used by the clinician can itself influence recovery.

Integrative Treatment: What I Consider Most Useful

For a man whose symptoms are predominantly performance-related, I prefer an integrative plan involving accurate diagnosis, reassurance, correction of unrealistic expectations, psychosexual or cognitive-behavioural strategies, partner communication and treatment of any coexisting ED or PE.

Unani principles can contribute through **Harakat-o-Sukoon Nafsani, sleep regulation, healthy daily routine, dietotherapy, physical activity, Mizaj-based individualization and selected supervised pharmacotherapy where genuinely indicated**.

This approach is much more comprehensive than simply telling a patient either:

“It's purely psychological,”

or:

“You need a sexual-strength medicine.”

Dr. Nizamuddin Qasmi's Specialized Approach

As **Founder & Chief Physician of Saira Health Care**, with a focused practice in sexual disorders and infertility, I consider male performance anxiety a condition that requires confidentiality, patience and careful differentiation between psychological and physical factors.

My first question is not:

“Which medicine should I prescribe?”

My first question is:

“What happens before, during and after the sexual difficulty?”

I review how the problem started.

I ask whether morning erections occur.

I ask whether erection is normal during masturbation.

I assess libido.

I determine whether the principal difficulty is erection, premature ejaculation, delayed ejaculation or fear itself.

I consider relationship circumstances, infertility pressure, previous sexual experiences, pornography patterns where relevant and the patient's expectations about sexual performance.

At the same time, I do not ignore physical health.

Blood pressure, metabolic risk, diabetes, medications, tobacco exposure, cardiovascular symptoms and hormonal factors may need attention.

This balanced assessment allows me to avoid two common mistakes:

calling every sexual problem psychological, and treating every psychological sexual problem with medication alone.

My Approach When Infertility Is Also Present

When the couple is trying to conceive, the treatment needs additional sensitivity.

I consider whether timed intercourse itself is causing the anxiety.

If the man repeatedly loses erection only on fertile days, we address the fertility pressure.

If PE prevents vaginal sperm deposition, that becomes part of the fertility treatment.

If he is unable to produce a semen sample in the clinic, this is anticipated rather than treated as embarrassment.

ASRM emphasizes early identification and treatment of male sexual dysfunction within infertility care because ED, ejaculatory problems and reduced libido can directly interfere with conception and assisted-reproduction procedures.

This is one reason sexual medicine and infertility care work closely together at Saira Health Care.

Contribution of Saira Health Care in Sexual Disorders and Infertility

At **Saira Health Care**, we aim to provide a setting where men can discuss sexual difficulties without humiliation.

Many patients have already spent months searching the internet or taking unregulated products before they finally speak openly.

Our role is broader than prescribing a sexual medicine.

We aim to help patients understand whether their symptoms are predominantly psychological, physical or mixed; identify relevant medical risk factors; address erectile and ejaculatory disorders; recognize the effects of infertility pressure; involve the partner where appropriate; and use Unani supportive care responsibly alongside contemporary sexual-health management.

When specialist psychological, psychiatric, cardiological, endocrinological or urological care is required, appropriate referral is part of responsible treatment.

The patient should not be kept indefinitely on medication when the central problem requires counselling.

A Practical Comparison of Modern and Unani Approaches

Area	Modern sexual medicine	Responsible Unani contribution
Understanding anxiety	Performance anxiety, cognitive distraction, sympathetic arousal, relationship factors	*Harakat-o-Sukoon Nafsani*, psychological factors within *Zu'f-i-Bah*
Diagnosis	Medical/sexual history, questionnaires, physical exam, targeted labs	Mizaj and whole-person constitutional assessment
Psychological treatment	CBT, psychosexual therapy, couple therapy, education	*Izala-i-'Awariz Nafsani*, *Ilaj Nafsani*, emotional balance
Erectile support	PDE5 inhibitors and other ED treatment when indicated	Supportive individualized treatment; not a replacement for established ED care
Lifestyle	Exercise, metabolic health, smoking cessation, sleep	*Asbab Sitta Daruriyya*, diet, movement/rest, sleep/wakefulness
Relationship component	Partner communication and couple therapy	Holistic attention to psychological and relational wellbeing
Infertility setting	Assess ED, ejaculation and libido as part of fertility evaluation	Supportive counselling while preserving couple intimacy
Severe/persistent symptoms	Sexual-medicine, mental-health or urological referral	Complementary rather than substitute care

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Important Myths About Male Performance Anxiety

"If I lose my erection once, I have permanent ED."
No. Occasional erection variation is common.

"If I get morning erections, there can be no medical problem."
Not necessarily. Morning erections are useful information but do not completely exclude physical contributors.

"Performance anxiety is imaginary."
No. Anxiety produces genuine physiological changes that can affect sexual response.

“If ED is psychological, medicine should never be used.”
Incorrect. Selected men may benefit from combined psychological and medical therapy.

“Erection tablets permanently cure performance anxiety.”
Not by themselves. They may assist erections while the underlying anxiety still requires attention.

“Pornography is always the cause of ED in young men.”
Current evidence does not support such a simple conclusion. Problematic use may be relevant in some men, but mere viewing is not established as a universal cause.

“Performance anxiety means my testosterone is low.”
No. Testosterone deficiency is only one possible medical factor and should be diagnosed appropriately.

“Taking testosterone will improve fertility and sexual confidence.”
External testosterone can suppress sperm production and can be particularly problematic in men trying to conceive.

“An aphrodisiac alone will remove performance anxiety.”
Not necessarily. When fear, self-monitoring or relationship difficulties are central, psychological and couple-based approaches are important.

Frequently Asked Questions

What is male performance anxiety?

It is excessive fear or worry about sexual performance that interferes with arousal, erection, ejaculation, sexual enjoyment or confidence. It commonly accompanies ED or PE rather than functioning as one isolated formal diagnosis.

Can anxiety really cause erection loss?

Yes. Anxiety can redirect attention away from erotic stimulation and activate physiological stress responses that interfere with erection.

How can I know whether my ED is psychological?

Sudden, situational ED with preserved erections at other times may suggest a psychogenic component, but persistent ED deserves medical assessment because physical and psychological causes frequently coexist.

If I have normal morning erections but lose erection during intercourse, what does that mean?

It can support the possibility of a strong psychological component but does not prove that no physical factor exists.

Can performance anxiety cause premature ejaculation?

Yes. Anxiety can worsen PE, and current EAU guidance specifically notes that ED-related performance anxiety may aggravate premature ejaculation.

Can performance anxiety cause infertility?

It does not usually cause male infertility by directly damaging sperm. However, it can make conception difficult if erection, penetration or ejaculation cannot occur effectively during the fertile period.

Can timed intercourse cause performance anxiety?

Yes. ASRM recognizes that infertility-related sexual pressure and scheduled intercourse can worsen psychogenic ED and other sexual problems.

Is performance anxiety curable?

Many men improve substantially when the underlying factors are identified and treated. Outcome depends on whether the problem is predominantly psychological or mixed with physical ED, PE, relationship issues or other medical factors.

What treatment has the strongest evidence?

Psychosexual education, CBT and treatment of any associated ED or PE are important evidence-based approaches. Current EAU guidance strongly recommends CBT with partner involvement when indicated, combined with medical treatment where appropriate.

Can sildenafil or tadalafil help?

PDE5 inhibitors can help selected men with ED, including some men with psychogenic ED, but they require medical assessment and do not independently treat every psychological component. They must not be combined with nitrates.

Does pornography cause performance anxiety?

Problematic or compulsive use may contribute to insecurity or sexual difficulties in some individuals. However, a 2026 systematic review found mixed evidence and did not support the claim that pornography viewing itself universally causes male sexual dysfunction.

Does masturbation cause permanent ED?

Masturbation itself does not generally cause permanent erectile dysfunction. The pattern, context, psychological meaning and use of highly specific stimulation may deserve discussion in selected men.

Can Unani medicine help?

Yes, particularly through its **whole-person framework**, including psychological balance, sleep, lifestyle, diet, traditional Mizaj assessment and carefully selected supportive care.

Official CCRUM treatment guidance for *Zu'f-i-Bah* itself recognizes psychological factors and includes their treatment among management principles.

Can Unani medicine replace counselling?

No. When performance anxiety is the main problem, psychological and psychosexual treatment can be central. Unani supportive care should complement, not replace, appropriate therapy.

Should my partner be involved?

Often this is very helpful. Partner involvement can reduce misunderstanding, decrease pressure and improve communication. EAU guidance specifically supports couple-based CBT and other psychosocial interventions.

When should I seek medical help?

Seek evaluation when erection or ejaculation difficulties persist, recur frequently, cause significant distress, prevent intercourse, interfere with fertility or occur alongside symptoms such as reduced libido or important medical risk factors.

My Final Message to Men With Performance Anxiety

Whenever a man comes to me because he is frightened that he will not perform sexually, I want him to understand one thing first:

Anxiety-related sexual difficulty does not mean that you have lost your masculinity.

Your erection is not an examination.

Your ejaculation time is not a measure of your worth.

And one unsuccessful sexual experience does not determine what will happen for the rest of your life.

But I also do not want men to assume that every erection difficulty is “only stress.”

If ED becomes persistent, we should look at the whole picture.

Your blood pressure matters.

Your blood sugar matters.

Your cardiovascular health matters.

Hormones may matter.

Medicines may matter.

Smoking and other substances may matter.

Your emotional state matters.

Your relationship matters.

And, particularly during infertility treatment, the pressure to perform at an exact time can matter tremendously.

My Unani training teaches me to consider **Mizaj, Quwwat-e-Bah, Harakat-o-Sukoon Nafsani, Naum-o-Yaqzah, diet, physical activity and the overall constitutional health of the patient**.

It is particularly meaningful that official Unani guidance for *Zu'f-i-Bah* explicitly recognizes **psychological factors** and includes **Izala-i-'Awariz Nafsani—addressing those psychological disturbances—among the principles of treatment**.

Modern sexual medicine gives us additional tools: medical evaluation, CBT, psychosexual counselling, couple therapy and effective ED or PE treatment when required.

At **Saira Health Care**, I believe the strongest approach is to combine these perspectives intelligently.

First identify whether the problem is psychological, physical or mixed.
Reduce fear and unrealistic expectations.
Treat associated ED or PE appropriately.
Protect the couple from blame.
Address infertility-related pressure when present.
Use Unani supportive care where it genuinely adds value.
And involve an appropriate mental-health, urology or other specialist when necessary.

The goal is not merely to produce an erection for one night.

The real goal is to restore **sexual confidence, comfort, intimacy and healthy function without dependence on fear, secrecy or false promises**.

About Dr. Nizamuddin Qasmi

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

BUMS – Hamdard University, Delhi
MD
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Certificate in Infertility – MGBIMS, Delhi
Certificate in Urology – London, UK

Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

Dr. Nizamuddin Qasmi's clinical work at **Saira Health Care** has a focused emphasis on sexual disorders and infertility, including erectile and ejaculatory difficulties, male reproductive concerns, fertility-related sexual dysfunction, couple counselling and individualized integration of Unani supportive care with appropriate modern assessment.

Website: www.sairahealthcare.com

Medical Disclaimer

This article is intended for **general education and public awareness**. It is not an individual diagnosis, prescription or guarantee of treatment outcome.

Persistent erectile dysfunction can occasionally indicate metabolic, hormonal, cardiovascular, neurological, medication-related or other medical conditions and should not automatically be attributed to anxiety.

Unani medicines, herbal sexual tonics and prescription ED medicines should not be self-used as substitutes for appropriate medical and psychosexual assessment. Men using nitrate medicines or with significant cardiovascular disease require particular caution with PDE5 inhibitors.

Patients experiencing severe anxiety, depression, trauma symptoms, major relationship distress or other significant psychological problems should receive appropriate professional mental-health care.