

When to Seek Mental-Health or Sex-Therapy Support

Understanding When Sexual Difficulties Need Emotional, Psychological, Relationship or Specialist Psychosexual Care

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Introduction

When patients come to me with erectile difficulty, premature ejaculation, infertility, low sexual desire or another intimate concern, they often expect the entire conversation to be about the body.

They expect questions about hormones, semen, erections, medicines or reproductive organs.

Those questions are certainly important.

But sexual health does not exist separately from emotional health.

A man's erection can be affected by anxiety.

A woman's sexual desire can be affected by depression, relationship conflict or chronic stress.

A couple undergoing infertility treatment may become so focused on conception that intimacy begins to feel like a medical procedure.

A man who experienced erectile difficulty once may become so frightened of repeating the experience that fear itself begins interfering with future erections.

Someone recovering from prostate treatment may be medically stable but feel that his identity as a sexual partner has disappeared.

A patient who survived a heart attack may have adequate cardiovascular recovery but remain afraid that sexual activity could cause another cardiac event.



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Another person may have experienced sexual trauma and find that particular intimate situations produce fear, avoidance or intrusive memories.

In these situations, prescribing another tablet without understanding the psychological component may provide only part of the treatment.

The World Health Organization describes sexual health as involving **physical, emotional, mental and social well-being**, rather than merely the absence of sexual disease or dysfunction.

I consider that definition extremely important.

It reminds us that good sexual medicine must look at the whole person.

Sometimes the most appropriate treatment is medical.

Sometimes psychological treatment is central.

Frequently, the best approach combines both.

And knowing **when to seek mental-health or sex-therapy support** can prevent months or years of unnecessary suffering.

Seeking Psychological Help Does Not Mean the Sexual Problem Is “Imaginary”

This is perhaps the first misunderstanding I want to correct.

When I recommend psychological or psychosexual support, some patients immediately respond:

“Doctor, the problem is real. It is not in my imagination.”

I agree.

Psychological influences create real physiological effects.

Anxiety can increase sympathetic nervous-system activity.

Depression can reduce sexual interest and pleasure.

Relationship conflict can interfere with arousal.

Fear can make the pelvic floor tense.

Performance anxiety can interfere with erections and ejaculation.

Chronic stress can affect sleep, energy, concentration and desire.

Therefore, saying that psychological factors contribute to a sexual difficulty does not mean that the condition is false.

It means that the **brain, emotions, body and relationship are interacting with one another.**

Modern sexual-medicine guidelines recognise this very clearly.

The European Association of Urology notes that psychological distress, anxiety, depression, relationship dissatisfaction, poor sexual communication and dysfunctional expectations about sexual performance can all contribute to erectile difficulties. It recommends cognitive-behavioural therapy when indicated, with partner involvement where appropriate, often alongside medical treatment.

Sexual Difficulties Are Often “Mixed,” Not Purely Physical or Purely Psychological

Patients frequently ask me:

“Doctor, is my problem physical or psychological?”

The answer is often:

Both.

Consider a man with diabetes.

Diabetes may impair penile circulation and nerves.

The first few episodes of erectile difficulty are therefore genuinely physical.

But after those episodes he becomes afraid.

Before intercourse he thinks:

“What if it happens again?”

He begins monitoring his erection continuously.

Instead of concentrating on pleasure, affection and stimulation, his mind is evaluating performance.

The erection becomes weaker.

Now there are two components:

a physical component from diabetes and a psychological component from performance anxiety.

Treating only one may leave the other untreated.

The same pattern can occur after prostate surgery, heart disease, infertility treatment, premature ejaculation, painful sexual intercourse and many other conditions.



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When Is Emotional Distress a Normal Reaction?

Not every period of sadness or worry requires psychiatric treatment.

Human beings naturally experience emotional reactions to difficult circumstances.

It is understandable to feel worried after receiving an infertility diagnosis.

It is understandable for a man to feel disappointed after developing erectile dysfunction.

It is understandable for someone recovering from cancer treatment to worry about body changes.

It is understandable for a couple to become frustrated when fertility treatment repeatedly fails.

Temporary sadness, worry or frustration can therefore be a normal response.

The question is not simply:

“Do I feel upset?”

The more useful questions are:

How intense is the distress?

How long is it continuing?

Is it becoming worse?

Is it interfering with sleep, work, relationships, sexual activity or normal daily functioning?

Am I beginning to feel hopeless?

When emotional distress becomes persistent, severe or functionally disabling, professional assessment becomes increasingly important.

When Should You Consider Mental-Health Support?

I advise patients to consider professional psychological or psychiatric support when distress is no longer simply a temporary emotional response and begins affecting everyday life.

For example, a person may notice persistent sadness, frequent crying, intense anxiety, panic, inability to sleep properly, loss of interest in previously enjoyable activities,



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withdrawal from friends and family, inability to concentrate at work, excessive guilt, hopelessness, persistent irritability or repeated conflict with a partner.

Sexual-health problems may also begin dominating the person's thinking.

A man may spend most of the day worrying about whether his erection will work that night.

A couple undergoing infertility treatment may find that every conversation now concerns ovulation, semen reports or pregnancy tests.

A person with premature ejaculation may begin refusing all intimacy because of embarrassment.

A woman experiencing painful intercourse may become frightened even by non-sexual affection because she believes it will inevitably lead to painful penetration.

When a health concern begins controlling the person's emotional life in this way, seeking help early is often better than waiting until the situation becomes severe.

Depression and Sexual Health

Depression and sexual function frequently influence each other.

Depression can lead to:

reduced sexual desire, reduced interest in intimacy, difficulty becoming aroused, difficulty achieving orgasm, fatigue, loss of pleasure and withdrawal from a partner.

Sexual dysfunction can also contribute to depression.

A person may begin thinking:

“I will never be normal again.”

“My partner will leave me.”

“I have failed as a husband or wife.”

“My infertility means my life is incomplete.”

These thoughts can gradually become more negative and persistent.

NICE guidance recommends careful assessment of depression that includes mood, relationships, lifestyle, stressful life events, loneliness and social isolation, and states that suicidal thoughts should be assessed directly when depression is present.

If sadness or hopelessness is continuing and interfering substantially with daily life, it deserves proper assessment rather than simply being labelled “stress.”



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Anxiety and Sexual Performance

Anxiety is one of the most common psychological factors I encounter in sexual medicine.

Sex requires a certain degree of psychological safety, attention and relaxation.

Anxiety does the opposite.

It makes the person alert for danger.

The mind starts monitoring:

“Am I becoming erect?”

“Am I lasting long enough?”

“Is my partner satisfied?”

“Will penetration be painful?”

“Will I reach orgasm?”

“What if I fail?”

Sexual activity then becomes an examination.

This is often called **spectatoring**—the person mentally watches and evaluates his or her own performance rather than participating naturally in the experience.

That constant monitoring can interfere with arousal.

The Performance-Anxiety Cycle

I often explain the cycle to patients in very simple terms.

A sexual problem occurs once.

The person remembers it.

Before the next sexual encounter, fear develops.

The person begins monitoring performance.

Anxiety increases.

Natural sexual response becomes more difficult.

Another unsuccessful experience occurs.

The fear becomes stronger.



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Eventually the patient begins believing:

“This will happen every time.”

The original difficulty may have been temporary.

The anxiety can make it persistent.

This is one reason psychological intervention can be extremely important even when medical treatment is also required.

For erectile dysfunction, current EAU guidance strongly recommends cognitive-behavioural therapy when appropriate, including the partner where suitable, in combination with medical treatment to improve outcomes.

Premature Ejaculation and Psychological Distress

Premature ejaculation can generate considerable psychological pressure.

The patient may experience:

embarrassment, reduced confidence, avoidance of intimacy, fear of disappointing a partner and increasing performance anxiety.

The partner may also feel frustrated or emotionally disconnected.

Current EAU guidance recognises behavioural, cognitive and couple-based psychosexual approaches as useful components of treatment. These approaches can focus on confidence, anxiety, communication and problem-solving within the relationship. Combining psychological approaches with medical treatment may provide better results than treating only one component in selected patients.

Therefore, a patient who repeatedly changes medicines but continues to experience intense performance anxiety may benefit from adding psychological treatment rather than simply increasing medication.

Delayed Ejaculation and Difficulty Reaching Orgasm

Some men can maintain an erection but have great difficulty reaching ejaculation or orgasm.

Others can ejaculate easily during masturbation but not during partnered sex.

Sometimes medication, neurological disease, hormonal abnormalities or other physical causes are involved.

But psychological factors can also contribute.



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Anxiety, excessive control, particular masturbation patterns, relationship circumstances, sexual expectations or difficulty becoming sufficiently mentally aroused may all play a role.

The EAU recognises psychological and behavioural strategies for delayed ejaculation and anorgasmia, including addressing performance anxiety, intimacy, stimulation patterns and sexual expectations.

Again, this does not mean that every case is psychological.

Medical causes should be considered first or alongside therapy.

Erectile Dysfunction: When Sex Therapy May Help

Sex therapy can be particularly useful when erectile difficulties are associated with:

performance anxiety, fear of failure, relationship tension, negative sexual beliefs, loss of confidence, persistent self-monitoring, depression, anxiety, a major health diagnosis or difficulty adapting after prostate or other pelvic treatment.

A man may be taking sildenafil correctly and obtaining a partial erection, yet the moment intercourse is attempted he becomes frightened and loses it.

Increasing the medicine alone may not solve the problem.

The psychological component needs attention.

Sex therapy may help the individual or couple rebuild confidence while medical treatment addresses the biological component.

Low Sexual Desire

Reduced sexual desire is not always a hormone problem.

Hormonal disorders certainly need consideration.

But sexual desire is affected by many other factors.

These include:

depression, anxiety, chronic illness, poor sleep, fatigue, relationship dissatisfaction, unresolved resentment, pain, medication side effects, body-image concerns and fear of sexual performance.

Therefore, when someone reports low libido, the correct approach is not automatically:

“Take a testosterone medicine.”



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A detailed history is needed.

If emotional or relationship factors are prominent, psychological or psychosexual support may be an important part of treatment.

Sexual Pain and Fear of Penetration

Sexual pain should always be taken seriously.

Pain may result from physical conditions requiring gynaecological, urological, dermatological or pelvic-floor assessment.

But pain also affects the brain's expectations.

If intercourse has repeatedly caused pain, the person understandably begins anticipating pain before penetration even occurs.

Anticipation leads to fear.

Fear can increase muscle tension.

Tension can make penetration more difficult and painful.

Another negative experience reinforces the fear.

Sex therapy, psychological treatment and pelvic-floor physiotherapy may therefore be used alongside medical treatment in selected patients.

Current EAU chronic-pelvic-pain guidance recommends early relationship and sexual counselling for many couples dealing with pelvic pain and strongly recommends focused psychological treatment when significant psychological distress accompanies chronic pelvic pain.

When Infertility Begins Affecting Mental Health

Infertility is not simply a reproductive diagnosis.

It can become an emotional journey involving hope, disappointment, uncertainty, financial pressure, family questions, social comparison and relationship stress.

A couple may repeat the same monthly cycle:

treatment,

ovulation,

waiting,



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pregnancy test,
disappointment,
and starting again.

Over time, this can become exhausting.

The World Health Organization's 2025 infertility guideline specifically recognises that infertility can cause depression, anxiety and social isolation and emphasises the need for continuing psychosocial support for affected individuals and couples.

I therefore encourage fertility patients to seek psychological support when treatment is beginning to consume their emotional life.

It is not necessary to wait until there is severe depression.

When Fertility Treatment Begins Damaging the Relationship

I sometimes see couples whose marriage has gradually become a fertility project.

They no longer speak normally.

Every discussion concerns:

medication,

ovulation,

semen testing,

ultrasound,

IVF,

pregnancy.

Sex occurs only because the calendar says it should happen.

Affection becomes associated with obligation.

The husband develops performance anxiety during the fertile period.

The wife begins feeling that intercourse is another medical procedure.

If this pattern develops, couple-based counselling or psychosexual therapy can be very valuable.

Treatment should help build a family without destroying the relationship in which that family is supposed to grow.



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Sexual Difficulties After Prostate Treatment or Cancer

Prostate treatment can change:

erections,

ejaculation,

orgasm,

penile appearance,

sexual confidence,

body image.

A man may intellectually understand that surgery saved his life but emotionally struggle with the changes that followed.

He may avoid intimacy because he feels embarrassed about erectile dysfunction, dry orgasm or urinary leakage.

His partner may mistakenly interpret avoidance as loss of attraction.

This is an excellent example of a condition where medical treatment and psychosexual support can complement each other.

The erection may require tablets, injections, vacuum therapy or another urological intervention.

But psychological support may be needed to help the man and his partner adapt to a new pattern of intimacy.

Sexual Anxiety After a Heart Diagnosis

After a heart attack or another major cardiovascular diagnosis, some patients become frightened of sexual activity.

Even after the cardiologist confirms that the cardiovascular condition is stable, the patient thinks:

“What if sex triggers another heart attack?”

Fear itself can produce erectile difficulty.

The partner may become equally frightened.



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In such cases, clear cardiology advice combined with psychological reassurance or sex therapy may restore confidence.

The treatment is not simply “more erection medicine.”

The fear needs to be addressed.

When Chronic Illness Changes Sexual Identity

Diabetes, cancer, neurological illness, chronic pain, surgery, infertility and other health conditions can change the way people see themselves.

Some patients begin thinking:

“My body has betrayed me.”

“I am no longer attractive.”

“I am no longer sexually capable.”

“My partner deserves someone healthier.”

These beliefs can damage sexual confidence even when some physical function remains.

Psychological therapy can help patients separate a medical condition from their entire personal identity.

Body Image and Sexual Confidence

Body-image concerns can interfere substantially with intimacy.

Weight change, scars, mastectomy, prostate treatment, genital concerns, hair loss, infertility treatment and ageing can all affect confidence.

Sometimes the concern is understandable and proportionate.

Sometimes the preoccupation becomes so intense that the person spends hours examining perceived defects, avoids mirrors, repeatedly seeks reassurance or avoids all intimacy.

When body-image concerns are producing significant distress or obsessive preoccupation, mental-health assessment is appropriate.

Repeated cosmetic or sexual procedures do not necessarily resolve a psychological body-image disorder.

Sexual Trauma, Coercion and Abuse

Some sexual difficulties develop after traumatic experiences.

A person may experience:

fear during intimacy,
flashbacks,
nightmares,
emotional numbness,
avoidance,
pain,
difficulty trusting a partner,
panic,
or dissociation.

These symptoms require sensitivity.

The objective should never be to force someone to become sexually active before they feel safe.

Sex therapy should always respect consent and personal boundaries.

AASECT explicitly states that sexual activity must be freely chosen and that sexual coercion, manipulation, pressure and violence are unacceptable.

When active abuse, coercion or violence is present, the immediate priority is safety.

The situation should not simply be presented as a “couple communication problem.”

Trauma-informed individual support may be necessary.

When Relationship Counselling May Help

Not every sexual problem belongs to one individual.

Sometimes the difficulty exists within the interaction between partners.

Couples may benefit from relationship or psychosexual counselling when there is:

persistent sexual misunderstanding, desire discrepancy, resentment, avoidance, poor communication, difficulty discussing sexual preferences, loss of intimacy after illness or repeated conflict about sexual frequency.



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A couples therapist does not decide who is “right.”

The goal is usually to help both partners communicate more clearly, understand one another and develop realistic, mutually acceptable goals.

However, couple therapy is not a substitute for safety intervention when there is active violence or coercion.

What Exactly Is Sex Therapy?

Many people have heard the term but do not understand what it means.

Sex therapy is a specialised form of psychological therapy focused on sexual concerns, sexual function, intimacy and relationships.

It may be conducted individually or with a couple.

A properly trained sex therapist may address concerns such as:

erectile difficulties, performance anxiety, premature or delayed ejaculation, orgasm difficulties, low desire, mismatched desire between partners, adjustment after illness or surgery, sexual pain in collaboration with medical professionals, body-image concerns and communication problems.

Sex therapy is normally based upon conversation, assessment, psychoeducation and psychological or behavioural strategies.

Depending on the condition, structured exercises may be assigned for the individual or couple to practise privately at home.

What Sex Therapy Is Not

There is an important misconception that I want to remove completely.

Legitimate clinical sex therapy does not involve the therapist having sexual contact with the patient.

AASECT states clearly that certified sex therapists do not observe clients having sex and do not engage in sexual activity with clients. Such conduct breaches professional ethics.

The therapist's role is therapeutic, educational and psychological.

If someone calling himself or herself a “sex therapist” asks for sexual contact, sexual touching for personal gratification or sexual activity as part of ordinary psychotherapy, that is a serious warning sign.



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Certain licensed healthcare professionals such as physicians or pelvic-floor physiotherapists may perform medically appropriate physical examinations within their professional scope, but that is completely different from sexual activity.

Who Is Qualified to Provide Sex Therapy?

Training matters.

Having an interest in sexuality does not automatically make someone a qualified sex therapist.

AASECT's current 2026 certification standards provide one international example of rigorous professional training. Applicants for sex-therapist certification require an advanced clinical background, psychotherapy qualifications, specialist sexuality education and sex-therapy training, extensive supervised clinical work and formal professional supervision.

Different countries have different professional systems, so an AASECT credential is not the only acceptable qualification.

The practical principle is this:

Choose someone who is appropriately qualified in mental-health care or another relevant regulated health profession and who has specific training and experience in psychosexual problems.

For complex conditions, collaboration between a physician and psychosexual therapist is often preferable to either professional working alone.

Psychologist, Psychiatrist, Sex Therapist or Doctor—Whom Should I See?

Patients understandably become confused.

A physician experienced in sexual medicine evaluates medical causes of sexual dysfunction.

This may involve diabetes, cardiovascular disease, hormones, medications, neurological conditions, prostate problems, semen abnormalities or other physical factors.

A psychologist or psychotherapist primarily treats emotional, behavioural and psychological concerns through therapy.

A psychiatrist is a medical doctor specialising in mental-health conditions and can evaluate conditions such as significant depression, anxiety disorders and other



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psychiatric illnesses, including situations where psychiatric medication may be required.

A sex therapist has additional training focused specifically on sexual concerns and psychosexual treatment.

A couples therapist focuses particularly on relationship patterns and communication.

These roles often overlap.

The correct question is not:

“Which one professional is best?”

It is:

“Which combination of expertise does my particular problem require?”

Why Medical Evaluation Should Not Be Skipped

There is another danger at the opposite extreme.

A patient may be told:

“Your sexual difficulty is psychological,”

when an underlying physical condition has never been evaluated.

That is also inappropriate.

Erectile dysfunction may be associated with diabetes, vascular disease, hormonal disorders, neurological disease or medication.

Low desire may have hormonal or medical contributors.

Painful sex may have gynaecological, dermatological or pelvic-floor causes.

Delayed ejaculation may be related to medication, neurological disease or endocrine abnormalities.

Therefore, psychological treatment should complement appropriate medical investigation rather than replace it when a physical cause is possible.

What Happens During the First Mental-Health or Sex-Therapy Consultation?

Many patients are anxious because they imagine they will be asked embarrassing questions immediately.

A good clinician usually begins by trying to understand the problem in context.

You may be asked:

When did the difficulty begin?

Did it develop suddenly or gradually?

Does it occur every time?

What happens during masturbation compared with partnered activity?

How is your relationship?

Do you experience anxiety or depression?

Have there been major life events?

Are there medical illnesses?

What medicines are you taking?

Is there pain?

Are there fertility concerns?

Have you experienced sexual trauma?

What would you consider successful treatment?

The aim is not to judge the patient's sexual life.

The purpose is to understand why the problem is happening.

Confidentiality and Dignity Matter

Sexual-health treatment requires a high level of trust.

Patients frequently discuss information they have never shared with anyone.

They deserve:

privacy,

respect,

professional language,

clear consent,

and freedom from humiliation.

No patient should be mocked because of erectile dysfunction, premature ejaculation, infertility, low desire, orgasm difficulties or any other sexual concern.



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The clinical environment should make it easier—not harder—to speak honestly.

What Treatments May Be Used in Sex Therapy?

The exact approach depends upon the problem.

One common method is **cognitive-behavioural therapy**, often called CBT.

CBT can help identify thoughts such as:

“If I lose my erection once, I am a failure.”

“My partner will leave me if I cannot perform perfectly.”

“Sex is successful only if penetration happens.”

“I must satisfy my partner every time.”

Such rigid beliefs create enormous pressure.

Therapy helps patients replace them with more realistic thinking and change behaviours that maintain anxiety.

Modern EAU guidance regards CBT, alone or with a partner and often combined with medical treatment, as an important component of evidence-based management for appropriate ED patients.

Other therapy may focus on communication, mindfulness, reducing performance monitoring, rebuilding intimacy, behavioural exercises or trauma-related treatment depending upon the diagnosis.

Why Partner Involvement Can Help

Sexual difficulties affect relationships.

Therefore, when appropriate and with consent, including the partner can be extremely useful.

Suppose a man has erectile difficulty.

His partner believes:

“He no longer finds me attractive.”

He believes:

“She thinks I am not a real man.”

Neither statement may be true.



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But because neither person discusses it, both suffer.

A therapist can help them replace assumptions with communication.

Partner involvement is specifically recommended in modern psychosexual approaches for several male sexual dysfunctions when appropriate.

Therapy Is Not About Blaming the Partner

Some patients resist couples therapy because they worry:

“The therapist will say my wife caused my ED.”

or:

“The therapist will blame my husband for my lack of desire.”

Good therapy does not need a guilty person.

Sexual problems are frequently created or maintained by interacting biological, psychological and relationship factors.

The goal is to understand the pattern and change it.

Do I Have to Tell My Partner Everything?

Therapy should respect privacy and consent.

Some individual matters may need to be explored privately.

When a couple attends together, the therapist should explain clearly how confidentiality is handled.

Patients should understand the therapist's confidentiality policy before disclosing sensitive information.

The objective is safe, ethical communication—not forced disclosure.

What If My Partner Refuses Therapy?

Treatment can still begin individually.

One partner may work on:

anxiety,

self-esteem,



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sexual expectations,
communication,
depression,
coping,
or behavioural patterns.

Sometimes the other partner becomes willing to participate later after seeing that therapy is respectful and practical.

Do not assume that couple-based treatment is impossible simply because only one person is initially willing.

How Long Does Sex Therapy Take?

There is no universal number of sessions.

A relatively simple performance-anxiety problem may improve with brief focused intervention.

Longstanding relationship difficulties, severe depression, trauma or multiple medical problems may require more prolonged treatment.

Progress also depends upon:

the diagnosis,
motivation,
medical factors,
relationship circumstances,
and whether recommended exercises or strategies are followed.

Therapy should have clear goals and periodically review whether treatment is helping.

How Will I Know Therapy Is Working?

Success does not always mean:

“I now perform perfectly every time.”

Improvement may first appear as:

less fear,



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better communication,
more confidence,
less avoidance,
greater emotional closeness,
reduced self-monitoring,
improved sexual satisfaction,
or improved response to medical treatment.

Sexual health is broader than one performance measurement.

When Psychiatric Medication May Be Needed

Some patients have significant depression, anxiety or another mental-health condition that requires psychiatric assessment.

Psychological therapy may still be important, but medication may also be appropriate.

There is an important sexual-medicine consideration here:

some psychiatric medicines can affect sexual desire, erection, ejaculation or orgasm.

This should be discussed with the prescribing psychiatrist.

However:

Do not stop antidepressant or psychiatric medication suddenly because of sexual side effects.

Abrupt discontinuation may worsen the underlying condition or cause withdrawal symptoms.

The safer approach is to discuss the sexual side effect with the treating clinician so that treatment can be reviewed appropriately.

When Mental-Health Symptoms Become Urgent

There are situations where routine counselling appointments are not enough.

Urgent professional help is needed when someone has:

thoughts of suicide,

plans to harm themselves,



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recent self-harm,
intent to harm another person,
severe loss of contact with reality,
or an immediate inability to remain safe.

WHO advises people who believe they are in immediate danger of harming themselves to contact emergency services or a crisis service. Warning signs can include severe mood changes, withdrawal, expressing a wish to die, making plans or saying goodbye.

NICE similarly recommends urgent specialist mental-health referral when someone presents a considerable immediate risk to themselves or other people.

In India, **Tele-MANAS can be reached on 14416 or 1800-89-14416** for mental-health support. The Government of India's national emergency number **112** can be used when immediate emergency assistance is required.

Do not leave a person alone when there is an immediate serious risk of self-harm.

The Unani Perspective on Mind, Sexual Health and Wellbeing

As a physician trained in the **Unani system of medicine**, I find it important that traditional Unani literature does not view sexual health purely as a mechanical genital function.

Classical Unani thinking considers the individual as a whole.

Physical health, temperament, nutrition, sleep, emotional state, general vitality and reproductive health can influence one another.

This is particularly relevant in sexual medicine.

The Central Council for Research in Unani Medicine's standard treatment guidance for **Zu'f-i-Bah**, or sexual debility, specifically recognises psychological factors among possible contributors to sexual weakness and includes addressing psychological influences among traditional principles of management.

This is an important point.

It shows that recognising a mind–body relationship in sexual function is not merely a modern concept.

Asbab-e-Sitta Zarooriya and Emotional Wellbeing



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Unani medicine traditionally gives importance to the **Asbab-e-Sitta Zarooriya**, the essential factors involved in maintaining health.

These include attention to:

environment,

food and drink,

movement and rest,

psychological activity and rest,

sleep and wakefulness,

and appropriate bodily regulation.

In modern language, many of these principles overlap with healthy lifestyle counselling.

Regular sleep, appropriate exercise, balanced nutrition, reduced tobacco use, healthy daily routines and stress management can support both general and sexual wellbeing.

This does not mean that lifestyle measures alone treat severe depression, trauma or another mental-health disorder.

But they can form an important supportive foundation.

How I Use the Unani Approach at Saira Health Care

When a patient presents with a sexual disorder, I do not want to treat only a symptom.

I try to understand:

physical health,

sexual function,

reproductive health,

sleep,

digestion,

energy,

lifestyle,

emotional stress,

relationship circumstances,

and relevant medical conditions.



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If the main problem appears predominantly medical, appropriate medical management is required.

If psychological factors are contributing, those factors should be addressed rather than hidden.

If significant depression, anxiety, trauma or another mental-health condition is suspected, referral to an appropriately qualified mental-health professional is an important part of responsible care.

This does not weaken Unani practice.

It strengthens patient care.

Can Unani Medicine Treat Depression or Anxiety Associated With Sexual Problems?

Unani medicine has traditional concepts and therapeutic approaches relating to psychological wellbeing, and modern researchers are increasingly examining these areas.

A 2025 review of depression from a Unani perspective described traditional approaches as potentially complementary but also emphasised the need for further clinical trials and stronger scientific validation.

Therefore, I believe in a balanced approach.

Selected Unani measures may be used to support:

sleep,

general wellbeing,

stress regulation,

nutrition,

physical health,

and associated functional complaints,

where clinically appropriate.

But a patient with major depression, suicidal thoughts, severe anxiety, psychosis, trauma-related illness or another significant psychiatric disorder should not be told:

“Take herbal medicine and do not see a mental-health specialist.”

That would be medically irresponsible.



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Herbal Medicines and Psychiatric Medicines

Patients should tell every treating clinician what medicines they are taking.

Herbal and traditional medicines may interact with:

antidepressants,

anti-anxiety medicines,

sleep medication,

blood-pressure medicines,

anticoagulants,

diabetes treatment,

and other drugs.

Do not assume that “natural” automatically means that interactions are impossible.

At Saira Health Care, my preference is that patients disclose their complete medication history before treatment decisions are made.

Mental-Health Treatment and Unani Care Can Work Alongside Each Other

Patients sometimes believe they must choose:

“Either Unani medicine or psychological treatment.”

I do not consider that necessary.

If a patient has erectile dysfunction with performance anxiety, for example, he may require medical evaluation, appropriate erection-directed treatment, psychosexual therapy and lifestyle management.

Different treatments are addressing different mechanisms.

The objective should be:

What does this individual patient need?

not:

Which medical system should win?

Saira Health Care's Approach to Sexual Problems With Psychological Components



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At **Saira Health Care**, I believe the first responsibility is to listen.

Sexual symptoms are often difficult for patients to describe.

A person may have lived with the problem for years before seeking help.

My clinical approach is therefore to distinguish several possibilities.

Is there primarily a physical sexual disorder?

Is there a significant psychological component?

Is the problem mixed?

Is infertility producing sexual-performance pressure?

Is the partner relationship worsening the condition?

Is there depression or anxiety?

Is there a history of trauma?

Is medication contributing?

Is specialist psychiatric or psychosexual referral required?

This type of assessment allows treatment to become safer and more individualised.

Why My Training in Sexual Disorders and Infertility Is Relevant

My focused clinical work is in **sexual disorders and infertility**, two areas in which physical and psychological factors frequently overlap.

My professional education and training include:

BUMS – Hamdard University, Delhi

MD

CGO

Certificate in Infertility – MGBIMS, Delhi

Certificate in Urology – London, UK

Masters in Male Infertility – MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health – ISRH, UNFPA

Through this focused practice at Saira Health Care, my objective is to evaluate sexual and reproductive complaints without stigma and to recognise when another professional—such as a urologist, gynaecologist, psychiatrist, psychologist, pelvic-



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health specialist or appropriately trained sex therapist—should become part of the patient's care.

Good medicine does not mean trying to do everything alone.

Good medicine means knowing what the patient needs.

Questions Patients Commonly Ask Me

“Doctor, does seeing a sex therapist mean my problem is psychological?”

No.

You may have a physical condition and still benefit from therapy.

For example, a man can have genuine vascular ED and secondary performance anxiety.

The medical treatment addresses erection physiology.

Therapy addresses fear, confidence and relationship effects.

Both can be important.

“Can stress really cause erectile difficulty?”

Yes.

Anxiety and psychological distress can contribute substantially to erection difficulties.

Current EAU guidance recognises psychological and relationship factors in ED and recommends CBT with partner involvement when appropriate.

“Can sex therapy treat premature ejaculation?”

Psychosexual approaches can be useful, particularly for associated performance anxiety, confidence, communication and behavioural patterns.

EAU guidance supports behavioural, cognitive and couple approaches, often in combination with appropriate medical treatment.

“Will the therapist watch us having sex?”

No.



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A legitimate clinical sex therapist does not watch clients have sex or participate sexually with clients.

AASECT explicitly prohibits this.

“Does my partner need to attend?”

Not necessarily.

Individual therapy can be helpful.

Partner involvement may improve treatment in many conditions, but it should occur when appropriate and with consent.

“Can therapy help infertility?”

Therapy cannot open blocked tubes or directly correct severe sperm-production failure.

But psychological support can help couples cope with infertility, treatment stress, sexual pressure and relationship difficulties.

WHO's current infertility guidance specifically recognises the need for psychosocial support.

“Can counselling help after prostate treatment?”

Yes.

Medical rehabilitation may address erections, while psychosexual counselling can help the patient and partner adapt to changes in orgasm, ejaculation, body image, confidence and intimacy.

“Can therapy help after a heart attack?”

Yes, especially when the cardiovascular condition is medically stable but fear of sexual activity remains.

The patient should first receive appropriate cardiovascular guidance regarding the safety of sexual activity.

Psychological treatment can then help with persistent fear or performance anxiety.



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“I have low libido. Do I need testosterone or counselling?”

Possibly neither, possibly one, or sometimes both medical and psychological evaluation.

Low desire can result from hormonal, medical, medication-related, psychological and relationship factors.

Diagnosis should come before treatment.

“Can Unani medicine replace psychotherapy?”

Not when psychotherapy or specialist psychiatric treatment is clinically necessary.

Unani care may provide valuable supportive attention to lifestyle, sleep, nutrition, general health and selected symptoms, but significant mental-health conditions should receive appropriate mental-health treatment.

How to Choose a Good Mental-Health or Sex-Therapy Professional

Choose a professional who treats you with dignity, explains their qualifications, respects confidentiality and consent, understands the medical aspects of sexual dysfunction, and is willing to collaborate with your treating doctor when necessary.

A reputable therapist should not:

promise a guaranteed sexual cure,

humiliate you,

pressure you into sexual activity,

ask you to engage sexually with the therapist,

or tell you to discontinue medically necessary treatment without coordination with the prescribing doctor.

AASECT's professional standards emphasise licensure or equivalent professional qualification, specialist education, supervised clinical practice, ethics and referral/collaboration skills.

When Should You Seek Help Rather Than Continue Waiting?

I encourage patients not to postpone professional support merely because they think the problem is “not serious enough.”



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Consider seeking help when:

the same sexual concern keeps returning,

you are avoiding intimacy,

your relationship is being affected,

you are constantly anxious before sexual activity,

sexual problems are damaging your confidence,

infertility is dominating your emotional life,

you are becoming depressed or socially withdrawn,

or medical treatment is not providing the expected benefit because anxiety or relationship stress appears to be interfering.

Early intervention may prevent a relatively manageable problem from becoming deeply established.

When Treatment Should Involve More Than One Professional

Some of the best outcomes in sexual medicine occur through multidisciplinary care.

For example:

A man with erectile dysfunction and diabetes may need a sexual-health physician, diabetes management and psychosexual support.

A woman with painful intercourse may need gynaecological assessment, pelvic-floor physiotherapy and psychological care.

A couple with infertility may need fertility treatment and counselling.

A prostate-cancer survivor may need urological rehabilitation and psychosexual support.

A patient with severe depression and sexual dysfunction may need psychiatry combined with sexual-health management.

Medicine becomes stronger when the professionals communicate.

Sexual Health Should Never Be Reduced to Performance

One of the most harmful ideas in sexual medicine is that a person's worth depends upon sexual performance.



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A man is not defined by:

how quickly he becomes erect,
how long intercourse lasts,
or whether every sexual encounter is perfect.

A woman is not defined by:

how often she wants sex,
how easily she reaches orgasm,
or whether intercourse is always comfortable.

Sexual function is influenced by health, emotions, relationships, age, medication and life circumstances.

The objective of treatment should not be creating a “perfect performer.”

The objective should be restoring:

health,
confidence,
comfort,
connection,
safety,
and satisfactory sexual wellbeing.

My Message to Patients

If you are struggling with a sexual difficulty and you are beginning to feel that the problem is taking control of your life, please do not keep suffering because of embarrassment.

There is no shame in saying:

“I am anxious.”

There is no shame in saying:

“My infertility is affecting my mental health.”

There is no shame in admitting:

“I am afraid to have sex because I might lose my erection.”



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or:

“My partner and I cannot discuss intimacy without arguing.”

These are real health concerns.

Sometimes medicine is needed.

Sometimes counselling is needed.

Sometimes sex therapy is needed.

Sometimes relationship therapy is needed.

Sometimes several approaches need to work together.

The important thing is to identify the problem correctly.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi

Founder & Chief Physician – Saira Health Care

Focused Practice in Sexual Disorders & Infertility

Dr. Nizamuddin Qasmi's clinical focus includes male sexual disorders, infertility, reproductive health and related concerns in which physical, psychological and relationship factors frequently interact.

His stated professional qualifications and training include **BUMS from Hamdard University, Delhi; MD; CGO; Certificate in Infertility from MGBIMS, Delhi; Certificate in Urology – London, UK; Masters in Male Infertility from MasterHealthPro (HealthPro); and Integrated Sexual and Reproductive Health training through ISRH, UNFPA.**

Through **Saira Health Care**, the aim is to provide a professional and confidential environment where patients can discuss concerns such as erectile difficulties, premature ejaculation, libido changes, ejaculation disorders, infertility, semen abnormalities and sexual anxiety without shame.

Where significant psychological or psychiatric concerns are identified, collaboration or referral to appropriately qualified mental-health and psychosexual professionals should form part of comprehensive care.

Final Words From Dr. Nizamuddin Qasmi



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During years of speaking with patients about sexual and reproductive problems, I have learned something important.

Patients frequently tolerate emotional suffering far longer than physical suffering.

A man may seek medical help quickly for pain.

But he may spend five years silently worrying about erectile dysfunction.

A couple may undergo repeated infertility treatment while never discussing the emotional damage the process is causing.

Someone may continue avoiding intimacy after cancer treatment because they are embarrassed to ask for help.

Another patient may take repeated sexual medicines when the major factor maintaining the problem is performance anxiety.

This should change.

Sexual health is not just:

erections,

ejaculation,

sperm,

or intercourse.

It also includes the mind.

It includes relationships.

It includes confidence.

It includes safety.

It includes emotional wellbeing.

This understanding is consistent with the World Health Organization's broad approach to sexual health as physical, emotional, mental and social wellbeing.

As a Unani physician working with sexual disorders and infertility, I value the traditional emphasis on the whole person—sleep, nutrition, temperament, mental state, general vitality and lifestyle.

At the same time, responsible medicine requires me to recognise that some patients need professional psychotherapy, some need psychiatric care, some need specialist sex therapy and some need urgent mental-health intervention.

These approaches should not compete with one another.



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They should serve the patient.

So my message is simple:

Seek help when a sexual problem begins affecting your mental health.

Seek help when emotional distress begins affecting your sexual health.

Seek help when you and your partner can no longer solve the difficulty alone.

And seek urgent help whenever there is a danger of self-harm or harm to another person.

Asking for psychological support is not an admission that the problem is imaginary.

It is an acknowledgement that human health includes both the body and the mind.

And in sexual medicine, treating both is often what allows genuine recovery.

Important Medical and Mental-Health Disclaimer

This article is intended for general patient education and awareness. It does not replace individual medical, psychiatric or psychological assessment.

Sexual dysfunction may have physical, hormonal, neurological, cardiovascular, medication-related, psychological and relationship causes. Appropriate medical investigation should not be omitted simply because psychological factors are suspected.

Unani treatment can be used as supportive and individualized care where appropriate, but it should not replace clinically necessary psychotherapy, psychiatric treatment, emergency mental-health services or treatment of an underlying medical condition.

Never discontinue antidepressants, anti-anxiety medicines, cardiovascular medicines, hormonal medicines or other prescribed treatment without discussing the change with the prescribing clinician.

If you or another person is at immediate risk of suicide, self-harm or serious harm to someone else, obtain urgent emergency assistance. In India, **112** is the national emergency number. **Tele-MANAS is available on 14416 or 1800-89-14416** for mental-health support.



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