Is It Erectile Dysfunction or Just Anxiety?

Understanding Sexual Performance Anxiety, Psychogenic Erectile Dysfunction and the Unani Approach to Restoring Sexual Confidence

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Introduction

There is a saying many of my patients immediately understand:

“Dimagh se haare to dawa bhi asar nahi karegi.”

In simple language, it means that when fear takes control of the mind, the body may stop responding naturally.

This idea captures an important part of sexual performance anxiety, although medically I would not interpret it literally. Anxiety can strongly interfere with erection, but it does **not** mean that medicines can never work. In fact, modern evidence shows that psychological treatment and appropriately prescribed erectile-dysfunction medication can work very well together in selected patients.

The material prepared for this article correctly emphasizes that erection is not simply a mechanical event involving the penis. It depends on a coordinated interaction between the brain, emotions, nerves and blood vessels, and anxiety can disrupt this response.

When a patient tells me:

“Doctor, I get a good erection alone, but when I try intercourse, it becomes weak,”

or:

“Everything was normal until one unsuccessful night, and now I am afraid every time,”

I immediately consider the possibility of **sexual performance anxiety or predominantly psychogenic erectile dysfunction**.

At the same time, I never assume that every erection problem in a young or anxious man is purely psychological.

Current European Association of Urology guidelines emphasize that erectile dysfunction can have vascular, neurological, hormonal, anatomical, drug-related and psychological causes, and importantly, **many patients have more than one factor operating at the same time**. The traditional separation between completely "organic" and completely "psychogenic" ED can therefore be too simplistic.

This distinction is the foundation of good treatment.

What Is Erectile Dysfunction?

Erectile dysfunction (ED) means a persistent difficulty obtaining or maintaining an erection firm enough for satisfactory sexual activity.

A man with ED may:

- sometimes obtain an erection but not consistently;
- obtain an erection that becomes weak before or during intercourse;
- or be unable to obtain an adequate erection.

An occasional unsuccessful sexual experience is **not automatically erectile dysfunction**.

Fatigue, alcohol, stress, inadequate stimulation, distraction, illness or relationship tension can temporarily affect erection in otherwise healthy men.

NIDDK describes ED as difficulty getting or maintaining an erection firm enough for sexual activity and emphasizes that ED can sometimes be a symptom of another health problem.

What Is Psychogenic Erectile Dysfunction?

Psychogenic ED means that psychological, emotional, cognitive or relationship-related factors are playing a major role in interfering with erection.

Examples include:

- fear of sexual failure,
- performance anxiety,
- severe stress,
- depression,
- low self-confidence,

- negative body image,
- relationship conflict,
- previous embarrassing sexual experiences,
- fear of premature ejaculation,
- fear of losing an erection,
- guilt associated with sexual activity,
- or excessive attention to one's own performance.

The 2026 EAU guideline specifically recognizes **performance-related, partner-related and distress-related factors** among psychogenic causes of erectile difficulty.

The European Society for Sexual Medicine's recent position statements also emphasize that anxiety related to sexual dysfunction can take several forms, including **sexual performance anxiety, sexual phobia, sexual distress and attachment-related anxiety**, and that these forms require appropriate assessment rather than being treated as one single problem.

Psychogenic Does Not Mean "Imaginary"

This is one of the most important messages I give patients.

When doctors say a sexual problem has a psychological component, some men hear:

"The doctor thinks I am imagining everything."

That is not what psychogenic ED means.

The erection can genuinely disappear.

The penis genuinely becomes softer.

The patient genuinely cannot complete intercourse.

The physiological effect is real.

The trigger, however, may be excessive activation of the body's stress response rather than severe structural damage to the penis.

A psychological trigger can produce a completely physical result.

How a Normal Erection Happens

To understand performance anxiety, it helps to understand an erection in simple terms.

An erection requires:

sexual stimulation → brain and nerve signalling → relaxation of penile smooth muscle → increased arterial blood flow → trapping of blood inside erectile tissue → penile rigidity.

Nitric oxide plays an important role in this process.

During sexual stimulation, nitric oxide helps increase the production of a signalling molecule called **cyclic guanosine monophosphate, or cGMP**.

cGMP relaxes smooth muscle in the erectile tissue.

More blood enters the penis.

As the erectile chambers expand, veins responsible for draining blood become compressed against surrounding tissue.

This helps maintain the erection.

The source material supplied for this article describes this nitric oxide–cGMP and veno-occlusive mechanism in detail.

The Brain Is Part of the Erection

A common mistake is to think:

“If the penis is physically normal, erection should happen whenever I command it.”

That is not how human sexual response works.

You cannot simply order the nervous system:

“Become erect now.”

Trying harder can sometimes make the problem worse.

Sexual arousal generally develops most naturally when a person is:

- interested,
- sufficiently stimulated,
- comfortable,
- emotionally safe,
- and relatively free from excessive performance monitoring.

If instead the mind is filled with:

“Is it hard enough?”

“Will it stay?”

“What if I fail?”

the entire experience can shift from sexual pleasure to a psychological examination.

Parasympathetic Arousal Versus the Fight-or-Flight Response

For patients, I often simplify this using two systems.

The relaxation/arousal system

Sexual arousal benefits from parasympathetic activity, which helps create conditions favouring penile smooth-muscle relaxation and blood inflow.

The stress system

When the brain senses danger, embarrassment or failure, sympathetic activity increases.

Adrenaline and related stress signals prepare the body for action.

This is useful when you are escaping danger.

It is much less useful when you are trying to have relaxed sexual intercourse.

The supplied source describes this contrast between the erection-supporting physiological response and anxiety-related sympathetic activation.

However, one scientific correction is important: anxiety should not be described as if adrenaline simply “switches off” every erection in exactly the same biochemical manner. Human sexual response is considerably more complex, and psychological and vascular mechanisms frequently coexist.

The Performance-Anxiety Cycle

Consider a very common clinical situation.

A healthy man has intercourse after an exhausting day.

His erection becomes weak.

This could happen to almost anybody.

But he interprets that one event as:

“Something is wrong with me.”

Before the next sexual encounter he starts worrying.

His internal conversation becomes:

"Will it happen again?"

He repeatedly checks his erection.

Instead of experiencing his partner's touch, he evaluates his penis.

He notices the erection is slightly less firm.

He becomes frightened.

The erection decreases further.

Now he thinks:

"I knew it—I have ED."

The next time he is even more anxious.

This creates the cycle:

one unsuccessful experience
→ fear of another failure
→ increased monitoring
→ reduced arousal
→ erection difficulty
→ confirmation of the fear
→ greater anxiety during the next encounter.

This self-reinforcing pattern is a central feature of sexual performance anxiety.

"Spectatoring": Watching Yourself Instead of Experiencing Sex

One useful concept in psychosexual medicine is **spectatoring**.

The term became particularly associated with Masters and Johnson's work in sex therapy.

Instead of participating naturally in sexual activity, a person psychologically steps outside the experience and begins monitoring himself.

The patient may think:

"How hard is my erection?"

"Does she think I am weak?"

"Has my erection reduced by 10%?"

"How long have we been having intercourse?"

“Will she compare me with somebody else?”

This mental monitoring redirects attention away from erotic sensations.

The source supplied for this article describes spectatoring and cognitive interference as major contributors to anxiety-related sexual dysfunction.

In everyday language, I explain it like this:

You stop experiencing sex and start examining yourself during sex.

That examination creates pressure.

How to Tell Whether ED May Be Mainly Psychological

There is no single symptom that proves psychogenic ED, but certain patterns make it more likely.

Features that may suggest a major psychological component include:

- sudden rather than gradual onset;
- erection being normal on some occasions but difficult on others;
- good erections during masturbation but difficulty with a partner;
- normal spontaneous or morning erections;
- difficulty mainly with one situation or partner;
- onset after one embarrassing sexual experience;
- strong anticipatory anxiety;
- erection beginning normally and then disappearing when worrying starts;
- recent relationship stress;
- severe fear about penis size, ejaculation or partner satisfaction.

The supplied source contrasts these patterns with the more gradual and consistent presentation sometimes seen in organic ED.

But these clues are **not absolute diagnostic rules**.

For example, a man with early vascular disease may still occasionally have morning erections.

A patient with psychogenic ED may also have diabetes.

Therefore, the diagnosis must consider the whole patient.

Organic Erectile Dysfunction

Organic ED is more strongly associated with an identifiable physical contributor.

Important causes include:

- diabetes mellitus,
- atherosclerosis,
- high blood pressure,
- high cholesterol,
- obesity,
- cardiovascular disease,
- neurological disease,
- pelvic surgery,
- spinal injury,
- Peyronie's disease,
- hypogonadism,
- thyroid disorders,
- kidney disease,
- certain medicines,
- smoking,
- excessive alcohol,
- and recreational drugs.

Both NIDDK and the 2026 EAU guideline identify vascular, neurological, hormonal, drug-related and lifestyle causes as important contributors to ED.

Most Patients Are Not Purely “Psychological” or Purely “Physical”

This is an important update to the traditional discussion.

The supplied report presents organic and psychogenic ED as strongly contrasting categories.

For education, that comparison can be useful.

Clinically, however, the 2026 EAU guideline cautions that **most ED can involve mixed causes**.

A man with mild diabetes may develop a small reduction in erection quality.

He becomes frightened.

Performance anxiety appears.

Now both mechanisms are active.

Treating only his anxiety may be incomplete.

Treating only blood flow may also be incomplete.

This is why I prefer a **biopsychosocial approach**.

Why Erectile Dysfunction Can Be a General Health Signal

Even when anxiety appears important, ED should not automatically be dismissed as psychological.

Current evidence increasingly emphasizes ED as a potential marker of cardiovascular disease.

The 2026 EAU guideline notes that ED is associated with increased cardiovascular risk and incorporates recommendations from the Princeton IV cardiovascular-sexual medicine consensus.

This matters especially for men who have:

- diabetes,
- hypertension,
- high cholesterol,
- obesity,
- smoking history,
- strong cardiovascular family history,
- or persistent unexplained ED.

A good sexual-health consultation may therefore identify health risks extending far beyond the bedroom.

Sexual Performance Anxiety in Younger Men

Younger men are often particularly vulnerable to performance anxiety.

They may have fewer vascular risk factors, but greater pressure about:

- penis size,
- erection hardness,
- intercourse duration,
- pornography-related comparisons,
- premature ejaculation,
- satisfying a partner,
- and “proving masculinity.”

One unsuccessful encounter may therefore feel like a serious personal failure.

This does not mean young men should automatically be diagnosed with psychogenic ED.

Young men can also have diabetes, hormonal problems, congenital conditions, medication effects, obesity, substance use or other medical causes.

Age alone never provides the diagnosis.

Pornography and Erectile Dysfunction: What the Latest Evidence Actually Says

This subject requires particular care.

The supplied source attributes considerable importance to so-called **pornography-induced erectile dysfunction (PIED)** and describes it as if chronic pornography exposure directly causes neurological desensitization leading to ED.

Current evidence is considerably more cautious.

A **2026 systematic review** examining pornography use and male sexual dysfunction found mixed results. Some studies reported associations, while others found no association or even potentially beneficial associations. Importantly, the review concluded that **frequency of pornography viewing alone did not appear to predict sexual dysfunction as strongly as problematic pornography use**, body dissatisfaction, insecurity and related factors.

Earlier large studies have also found inconsistent or weak relationships between ordinary pornography frequency and ED.

Other research does show that **problematic pornography use** may correlate with erectile difficulties in some men.

Therefore, I would not tell a patient:

"Pornography has definitely damaged your dopamine receptors and caused ED."

The more evidence-based discussion is:

"If pornography use has become compulsive, is replacing partnered intimacy, creates unrealistic expectations or is associated with anxiety and reduced responsiveness to real-life sexual situations, we should address that behaviour as part of treatment."

That is scientifically more accurate and less frightening.

Is Brain Imaging Needed to Diagnose Psychogenic ED?

Research using functional neuroimaging has explored differences in brain networks associated with psychogenic ED, including areas involved in emotional processing, attention and cognitive regulation.

The supplied report discusses amygdala and prefrontal-network findings in considerable detail.

These findings are scientifically interesting.

They are **not routine clinical diagnostic tests**.

A patient should not be sent for brain MRI simply because he becomes anxious before intercourse.

Current ED diagnosis still begins with history, physical examination, appropriate laboratory assessment and validated sexual-function questionnaires.

How I Evaluate Erectile Dysfunction

When a patient consults me at Saira Health Care with erection difficulty, my first objective is not to decide whether he needs a "stronger medicine."

I want to determine **why the erection is failing**.

Current EAU recommendations strongly support a comprehensive medical and sexual history for every man presenting with ED and specifically recommend considering life stress, cultural factors and cognitive issues relating to sexual performance.

I may ask:

- When did the problem begin?
- Was the onset sudden or gradual?
- Is erection absent or only difficult to maintain?

- Is sexual desire normal?
- Are morning erections present?
- Are erections normal during masturbation?
- Does the problem happen with every partner or situation?
- Did anything stressful happen before it began?
- Is premature ejaculation also present?
- Is there penile pain or curvature?
- Is there diabetes or hypertension?
- Which medicines are being taken?
- Does the patient smoke or drink heavily?
- Is there depression or anxiety?
- Is the relationship causing significant distress?
- Is the patient trying to conceive?

These questions are often more informative than an expensive test package.

Validated Questionnaires

The **International Index of Erectile Function (IIEF)** and its shorter versions can help evaluate erectile function objectively over time.

The EAU guideline recommends validated questionnaires because they assess not merely erection but other sexual domains such as:

- desire,
- orgasm,
- intercourse satisfaction,
- and overall sexual satisfaction.

These tools do not replace clinical judgement but can improve consistency of assessment.

Physical Examination and Basic Tests

Even when anxiety appears obvious, a physical-health evaluation may still be appropriate.

The current EAU guideline recommends a focused physical examination and assessment of metabolic and hormonal risk factors. Basic evaluation may include, as appropriate:

- blood pressure,
- body weight or waist circumference,
- fasting glucose or HbA1c,
- lipid profile,
- early-morning total testosterone.

Other tests are selected according to symptoms and clinical findings rather than ordered automatically.

This is particularly important because anxiety and physical disease can coexist.

Morning Erections: Useful, but Not a Perfect Test

Patients often ask:

"If I get morning erections, does that prove everything is psychological?"

No.

Preserved morning or spontaneous erections can support the possibility that erectile structures remain capable of functioning, particularly when partnered ED is highly situational.

But morning erections alone cannot completely exclude organic disease.

The entire clinical picture matters.

Nocturnal Penile Tumescence and Rigidity Testing

The source material describes the **Nocturnal Penile Tumescence (NPT/NPTR) test** in detail and portrays it as a definitive method of distinguishing psychological from organic ED.

Modern guidance is more nuanced.

During NPTR testing, devices such as **RigiScan** measure erection episodes during sleep, including rigidity and duration.

According to the current EAU guideline, an erectile event reaching at least 60% tip rigidity for ten minutes or more can indicate a functional erectile mechanism.

However, the guideline also emphasizes limitations, including:

- sleep quality,
- depression,
- age,
- situational factors,
- differences between nocturnal and sexually stimulated erections,
- and variation in the definition of abnormal results.

Therefore, NPTR can help differentiate causes in selected cases but **does not provide perfect or definitive proof** and is not necessary for most patients.

This is an important correction to older or overly absolute descriptions of NPT.

Penile Doppler Ultrasound

Dynamic penile Doppler ultrasound may be helpful where significant vascular ED is suspected.

For example:

- diabetes,
- multiple cardiovascular risk factors,
- known vascular disease,
- poor response to properly used oral medication,
- or selected younger patients with trauma.

The EAU guideline describes Doppler as a second-level investigation rather than a routine test for every man with ED.

Even Doppler results can sometimes be affected by anxiety during testing.

Psychological Assessment

A proper ED assessment should also examine:

- anxiety,
- depression,
- relationship satisfaction,
- sexual expectations,

- self-esteem,
- body image,
- distracting thoughts during sex,
- previous sexual trauma,
- and performance pressure.

EAU guidance specifically identifies psychological distress, relationship factors, cognitive expectations and distraction from erotic cues as relevant areas for evaluation.

This is why sexual medicine is not purely urology.

Treatment: The First Step Is Understanding the Cause

There is no single best treatment for all erectile dysfunction.

A man with severe diabetic vasculopathy needs a different approach from a man whose erections disappear only because he becomes frightened during intercourse.

At the same time, a patient may have **both problems**.

My treatment philosophy is therefore:

diagnose first → identify contributing factors → reduce reversible risks → restore confidence → use medical treatment where appropriate → review progress.

Psychoeducation

Education is not merely an optional extra.

The current EAU guideline describes patient education as an important early intervention and recommends explaining normal psychological and physiological sexual response in language the patient and partner can understand.

I explain to patients:

Your erection does not need to remain exactly the same hardness throughout every moment of intimacy.

Normal sexual arousal can rise and fall.

A temporary reduction in rigidity does not mean sexual failure.

The more you treat every variation as a medical emergency, the more pressure you create.

Cognitive Behavioural Therapy

Cognitive behavioural therapy (CBT) can be particularly useful in anxiety-related ED.

CBT helps a patient identify thoughts such as:

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

and replace them with more realistic thinking:

“Erection naturally varies. My body has responded normally at other times. One change in firmness does not predict permanent failure.”

It can also help reduce:

- catastrophic thinking,
- compulsive erection checking,
- avoidance of intimacy,
- fear of partner judgement,
- unrealistic expectations,
- and shame.

The latest EAU recommendations give a **strong recommendation** to use CBT when indicated, including the partner where appropriate, and to combine it with medical treatment when this maximizes outcomes.

Psychological Treatment Plus ED Medication

This is where contemporary evidence differs significantly from one claim in the supplied source.

The source argues that severe anxiety may make PDE5 inhibitors effectively useless.

It is correct that PDE5 inhibitors require sexual stimulation and are **not aphrodisiacs that automatically manufacture sexual desire**.

However, it is too strong to say that psychological ED neutralizes the medication.

A systematic review of 13 studies involving 597 men found that combining psychological interventions with PDE5 inhibitors produced better erectile-function and long-term sexual-satisfaction outcomes in psychogenic ED than either approach alone in several studies.

Current EAU guidance similarly recommends CBT plus medical treatment when appropriate.

So for selected patients, medication may provide sufficient erectile confidence to help break the anxiety cycle while therapy addresses the underlying fear.

PDE5 Inhibitors

Common PDE5 inhibitors include:

- sildenafil,
- tadalafil,
- vardenafil,
- avanafil.

They improve the nitric oxide–cGMP pathway and increase erectile responsiveness to sexual stimulation.

The 2026 EAU guideline continues to recommend PDE5 inhibitors as **first-line medical therapy** for ED.

They do not automatically produce erection in the absence of sexual stimulation.

They also do not solve every relationship or anxiety problem.

This is why correct diagnosis matters.

Why Some Patients Think Sildenafil "Does Not Work"

Before declaring treatment failure, several questions should be checked.

Did the patient:

- use an appropriate prescribed dose?
- take it at the correct time?
- understand that stimulation is still needed?
- take sildenafil after a very heavy meal?
- use a genuine licensed medicine?
- allow an adequate treatment trial?

The current EAU guideline specifically states that improper use and inadequate education are major contributors to apparent PDE5-inhibitor failure and that re-education regarding dose, timing and sexual stimulation can restore response in some apparent non-responders.

Important Safety Point: Nitrates and ED Medicines

PDE5 inhibitors must **not** be casually self-prescribed.

Their use with organic nitrate medicines can produce a dangerous fall in blood pressure.

The current EAU guideline identifies concurrent nitrate or nitric-oxide-donor use as an **absolute contraindication** to PDE5 inhibitors.

Patients with important cardiovascular disease should be appropriately evaluated before treatment and before resuming sexual activity where clinically indicated.

Treat the Underlying Health Problem

Treatment may also involve controlling:

- diabetes,
- hypertension,
- high cholesterol,
- obesity,
- smoking,
- excessive alcohol,
- sleep disorders,
- hormonal deficiency,
- cardiovascular disease.

NIDDK recommends lifestyle changes such as physical activity, healthy weight management, smoking cessation and reduction of excessive alcohol as part of ED care.

If depression, anxiety or another psychological condition is contributing, that condition deserves treatment in its own right.

Sensate Focus and Reducing Performance Pressure

Sensate focus is a psychosexual technique associated historically with Masters and Johnson.

The fundamental principle is very useful: temporarily remove the demand to “perform.”

Instead of making every intimate encounter a test of penetration and erection, the couple can focus on:

- non-demand touch,
- sensation,
- affection,
- closeness,
- communication,
- gradual arousal.

The purpose is to help the brain relearn:

intimacy = safety and pleasure

rather than:

intimacy = examination and possible failure.

The source material appropriately emphasizes sensate-focus principles and present-moment attention as approaches to performance anxiety.

Mindfulness and Relaxation

Relaxation strategies can help some patients become less reactive to anxious thoughts.

Useful general approaches include:

- slower breathing,
- mindfulness,
- attention to bodily sensations,
- progressive relaxation,
- grounding,
- reducing compulsive checking.

One clarification is important.

Techniques such as “4-7-8 breathing” or “5-4-3-2-1 grounding,” mentioned in the supplied source, are general anxiety-management strategies.

They should **not** be advertised as clinically proven specific treatments that instantly activate the vagus nerve and cure psychogenic ED.

They may be useful tools within a broader psychological treatment programme.

Partner Communication

Many performance-anxiety problems become worse because nobody discusses them.

The man thinks:

“She thinks I am not attracted to her.”

The partner thinks:

“Maybe he no longer finds me attractive.”

Neither speaks openly.

Anxiety increases.

A simple conversation can sometimes change the emotional environment dramatically.

For example:

“Sometimes I become anxious about my erection. It isn't because I am not attracted to you. I want us to take the pressure away and enjoy being close.”

The current EAU guideline encourages partner involvement where appropriate, and psychological intervention studies suggest that treating the interpersonal context can improve outcomes.

The Unani Perspective on Sexual Performance Anxiety and Erectile Dysfunction

Unani medicine takes a traditionally holistic view of health.

Its conceptual framework includes:

- **Mizaj** – temperament,
- **Akhlat** – humours,
- organ function,
- psychological state,
- diet,
- activity,
- sleep,
- and other lifestyle factors.

Official Ministry of Ayush material describes four classical humours:

Dam – blood
Balgham – phlegm
Safra – yellow bile
Sauda – black bile.

Within traditional Unani theory, health is associated with appropriate balance of these humours and temperament.

These concepts are part of traditional Unani medical theory. They should not be presented as if they are identical to modern measurements of testosterone, nitric oxide, blood glucose or vascular disease.

Psychological Factors Are Recognized in Unani Sexual Medicine

An interesting point is that Unani sexual-health literature does not regard every problem as purely physical.

The CCRUM treatment resource on **Zuf-i-Bah**, or sexual debility, includes **Umūr Wahmiyya—psychological factors** among traditionally described contributors.

This gives us an important bridge between Unani and contemporary sexual medicine:

the patient's mind, emotional state and lifestyle should not be ignored when evaluating sexual function.

Asbab-e-Sitta Zarooriya and Sexual Health

Unani medicine places considerable emphasis on the **Six Essential Factors**, or Asbab-e-Sitta Zarooriya.

Official Ayush and CCRUM sources describe these broadly as:

- air/environment,
- food and drink,
- physical movement and rest,
- psychological movement and repose,
- sleep and wakefulness,
- retention and elimination.

These principles offer a traditional framework for discussing several issues that are also relevant in modern sexual medicine:

sleep: chronic sleep disturbance can worsen mood and general health;

physical activity: cardiovascular fitness matters for erectile health;

psychological balance: severe stress and anxiety can worsen sexual function;

nutrition: metabolic and cardiovascular health influence erection;

daily routine: alcohol, smoking and inactivity can contribute to ED.

This is where Unani care can provide a valuable holistic structure when used responsibly.

What Can Unani Treatment Contribute?

For me, responsible Unani treatment of ED should never mean prescribing one “power medicine” to every patient.

Treatment should first establish whether the main problem is:

- performance anxiety,
- vascular ED,
- diabetes-related ED,
- hormonal deficiency,
- medication-related dysfunction,
- relationship distress,
- premature ejaculation,
- mixed ED,
- or another problem.

Once important medical causes have been considered, an individualized Unani programme may focus on:

- regulation of diet and daily routine;
- adequate rest and sleep;
- suitable physical activity;
- reduction of excessive psychological stress;
- management of associated general-health complaints;

- and carefully selected traditional pharmacotherapy where appropriate.

This approach can complement—not replace—appropriate contemporary diagnostic and psychological care.

What Does Current Research Say About Unani Medicines for ED?

Clinical research in this area is developing but remains much smaller than the evidence base supporting established ED treatments.

A **2025 randomized open-label comparative study** evaluated an oral and topical Unani polyherbal regimen in 36 men with ED. Both study groups showed improvement in erection-related symptoms and IIEF-15 scores, with no statistically significant difference between the compared treatments.

This is encouraging as preliminary research.

But the study had important limitations:

- only 36 participants;
- short treatment duration;
- no placebo group;
- open-label design;
- and comparison with another herbal intervention rather than an established standard-treatment control.

It therefore cannot establish that a particular Unani formulation universally cures ED.

Additional 2025 Unani research has reported potentially beneficial responses with traditional formulations, while the authors themselves acknowledge that underlying mechanisms require further confirmation with larger and stronger trials.

This is the scientifically appropriate way to discuss Unani evidence:

promising, worthy of further study, but not a licence to promise guaranteed permanent cure.

Why Herbal Does Not Automatically Mean Safe

Patients frequently assume:

“Natural medicine cannot cause harm.”

That assumption is unsafe.

Any biologically active substance can potentially:

- produce adverse effects,
- interact with prescribed medicines,
- affect blood pressure,
- affect liver or kidney function,
- or be inappropriate for particular medical conditions.

Traditional medicines should therefore be:

- correctly identified,
- quality controlled,
- prescribed in an appropriate formulation,
- and used under qualified supervision.

This is especially important when a patient has diabetes, hypertension, cardiovascular disease or is taking several medicines.

My Approach at Saira Health Care

When a patient comes to **Saira Health Care** with erection difficulties, I prefer not to ask only:

"Which sexual-strength medicine should we give?"

I first want to know:

Is this really erectile dysfunction?

Is it mainly performance anxiety?

Is erection normal during sleep or masturbation?

Is the patient afraid of premature ejaculation?

Is there diabetes or vascular risk?

Is sexual desire normal?

Is there relationship stress?

Is the patient comparing himself with pornography?

Is there genuine hormonal deficiency?

Is he trying to conceive?

Has he become psychologically dependent on sexual medicines?

This evaluation is particularly important in patients who have taken multiple tablets and supplements without ever establishing the cause of the problem.

The Individualized Approach of Dr. Nizamuddin Qasmi

My clinical focus at Saira Health Care is sexual disorders and infertility, supported by my training in Unani medicine and additional professional education in infertility, urology, male infertility and sexual and reproductive health.

My professional profile for publication is:

Dr. Nizamuddin Qasmi
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My treatment philosophy is based on **individualization**.

For one man, the most important treatment may be anxiety reduction.

For another, it may be proper diabetic control.

For another, treatment of erectile dysfunction plus counselling.

For another, reduction of unrealistic sexual expectations.

For another, an individualized Unani programme supporting general health and sexual function.

The objective is to determine **why the patient is struggling**, not simply prescribe the same tonic for everyone.

Saira Health Care's Contribution to Sexual Disorders and Infertility

One of the greatest problems in sexual healthcare is not lack of medicine.

It is **lack of reliable information**.

Men may suffer for years because they are afraid to say:

- “My erection becomes weak.”
- “I ejaculate early.”
- “I become anxious before sex.”
- “I am worried about my penis size.”
- “I can perform during masturbation but not with my wife.”
- “I am afraid I am infertile.”

At Saira Health Care, an important part of our work is to make these conversations easier and more professional.

Our educational approach emphasizes:

- confidentiality;
- reduction of sexual myths;
- responsible evaluation of ED;
- awareness of male infertility;
- realistic expectations regarding sexual performance;
- avoidance of unsafe self-medication;
- and referral or investigation where another medical condition requires it.

I believe that good sexual medicine should reduce shame rather than increase it.

Erectile Dysfunction and Fertility Are Different

Another common misunderstanding is:

“If my erection becomes weak, my sperm must also be weak.”

Not necessarily.

Erectile function and sperm production are different processes.

A man can have:

- excellent erection but abnormal semen parameters;
- weak erection but normal sperm production;
- or problems in both areas.

Therefore, infertility should not be diagnosed from erection quality alone.

Likewise, ED medication does not automatically treat male infertility.

When Performance Anxiety Becomes Severe

A man should seek professional help when anxiety begins causing:

- repeated avoidance of intimacy,
- panic before intercourse,
- persistent inability to maintain erection,
- relationship conflict,
- depressed mood,
- obsessive erection checking,
- dependence on sexual medicines,
- loss of self-esteem,
- or major distress.

The earlier the cycle is addressed, the easier it may be to prevent one temporary sexual difficulty from becoming a long-term psychological pattern.

Frequently Asked Questions

I have strong morning erections but lose my erection during intercourse. Is it anxiety?

It **may** suggest a significant psychological or situational component, especially when the problem is sudden and erections remain normal in other settings.

It does not completely exclude physical disease.

A proper assessment is still advisable if the problem persists.

My erection is normal during masturbation but weak with my partner. What does it mean?

This pattern commonly points toward situational factors such as performance anxiety, relationship issues, differences in stimulation or excessive self-monitoring.

It is an important clinical clue but not absolute proof of psychogenic ED.

Does one episode of erectile failure mean I have ED?

No.

Occasional erection difficulty can occur because of fatigue, stress, alcohol, distraction or illness.

ED refers to a persistent or recurrent problem.

Can anxiety really make a strong erection disappear?

Yes.

Anxiety can interfere with attention, arousal and autonomic sexual response.

Anxiety, depression and stress are recognized contributors to ED by both NIDDK and current European guidelines.

Does psychogenic ED mean my penis is completely healthy?

Not necessarily.

A psychological factor may be dominant, but mild physical contributors can coexist.

Current guidelines emphasize that mixed ED is common.

Do I need a RigiScan or nocturnal erection test?

Usually not.

Most patients can be evaluated through history, physical examination, appropriate blood tests and questionnaires.

NPTR testing is mainly useful in selected complex cases and has recognized limitations.

Does watching pornography cause erectile dysfunction?

Ordinary pornography viewing has **not been proven to directly cause ED in all users**.

A 2026 systematic review found mixed results and suggested that problematic use, insecurity and related psychosocial factors may matter more than viewing frequency alone.

If pornography use is compulsive or is interfering with real-life intimacy, addressing it may still be helpful.

Can sildenafil cure performance anxiety?

Sildenafil improves erectile physiology but does not directly remove fear, relationship conflict or dysfunctional expectations.

For some patients, combining a PDE5 inhibitor with psychological therapy is more effective than either approach alone.

Can anxiety make sildenafil fail?

Severe anxiety can interfere with sexual arousal and treatment experience, but it is inaccurate to say that sildenafil necessarily becomes completely ineffective.

Incorrect dosing, timing, inadequate stimulation, counterfeit medication, physical disease and other factors can also explain poor response.

Can Unani medicine help psychogenic ED?

Unani medicine can contribute through a holistic programme addressing sleep, diet, physical activity, psychological balance and individualized traditional treatment.

For significant performance anxiety, however, counselling, CBT or psychosexual intervention should not be ignored.

Current evidence for individual Unani ED formulations remains preliminary compared with established conventional treatments.

Can sexual performance anxiety be permanently overcome?

Many patients improve significantly once they understand the cycle, reduce performance pressure and receive appropriate treatment.

However, there is no responsible way to promise a permanent cure for every person.

Long-term improvement usually depends on addressing both the sexual symptom and the factors that maintain the anxiety.

A Message From Dr. Nizamuddin Qasmi

If you have erection problems, please do not immediately conclude:

“I have become impotent.”

And please do not immediately assume:

"It is only anxiety, so I do not need a medical evaluation."

Both extremes can be harmful.

A healthy erection depends on the **brain, nerves, hormones, blood vessels, general health, sexual stimulation, emotions and relationship environment**.

Sometimes one factor dominates.

Very often several factors interact.

If you have normal erections in some situations but lose them when pressure begins, sexual performance anxiety may be playing an important role.

If your problem is gradually worsening in every situation, or you also have diabetes, high blood pressure, obesity, cardiovascular risk or reduced morning erections, physical causes deserve particular attention.

My approach is therefore simple:

understand first, investigate when necessary, treat the cause, restore confidence and avoid unnecessary fear.

For some patients, modern ED medicine is useful.

For others, CBT or psychosexual counselling is central.

For selected patients, both work best together.

And when Unani care is used, I believe it should be individualized, scientifically responsible and integrated with proper medical assessment.

The goal is not merely a stronger erection.

The goal is **better sexual health, confidence, communication and overall well-being.**

About the Author

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Medical Disclaimer

This article is intended for **health education and public awareness**. It does not replace an individual medical consultation, examination, diagnosis or treatment.

Persistent ED deserves professional assessment because it can be associated with psychological distress as well as diabetes, cardiovascular disease, hormonal disorders, neurological illness, medicines and other health problems.

Do not begin or stop prescription ED medicines independently. PDE5 inhibitors must not be combined with nitrate medicines or nitric-oxide donors because the combination can cause dangerous hypotension.

Unani and herbal medicines should also be used under appropriately qualified supervision.