

Body Dysmorphia in the Bedroom

Overcoming Self-Consciousness, Weight Anxiety and Sexual Performance Anxiety

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Introduction

In my clinical work in sexual health and infertility, I often meet patients whose laboratory reports are normal, whose reproductive organs appear healthy, and yet whose intimate life has become filled with fear, embarrassment and self-consciousness.

A woman may think:

“My stomach looks unattractive.”

A man may worry:

“What if my partner thinks my body is not masculine enough?”

Someone else may think:

“What if I cannot become aroused?”

“What if I lose my erection?”

“What if my partner compares me with somebody else?”

“What if my body looks different during intimacy?”

These thoughts can become so powerful that a person stops experiencing intimacy and instead begins **observing, judging and monitoring himself or herself during intimacy.**

That is the central theme of what is often informally called **“body dysmorphia in the bedroom.”**

It is important, however, to use this term correctly.



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Feeling insecure about weight, breast size, abdominal fat, scars, genital appearance, hair, skin, ageing or sexual performance does **not automatically mean that a person has Body Dysmorphic Disorder (BDD)**. BDD is a recognized mental-health disorder involving persistent and distressing preoccupation with perceived flaws in appearance, often accompanied by behaviors such as repeated checking, comparison, concealment or avoidance, and it can significantly interfere with work, relationships and daily life.

For many people, the problem is better described as:

- negative body image,
- sexual self-consciousness,
- genital self-image concern,
- weight anxiety,
- appearance-related anxiety,
- or sexual performance anxiety.

The distinction matters because treatment should match the actual problem.

Sexual health itself is much broader than physical sexual performance. The World Health Organization describes sexual health as involving **physical, emotional, mental and social well-being in relation to sexuality**, together with a positive, respectful and safe approach to sexual relationships.

For this reason, body image and sexual confidence deserve to be treated as genuine health concerns rather than dismissed as vanity.

What Is Body Image?

Body image refers to how a person perceives, thinks about and emotionally experiences his or her body.

It is not simply a reflection of actual body size or appearance.

Two people with very similar physical characteristics may experience their bodies completely differently.

One may feel comfortable and confident.

The other may constantly think:

- “I am too fat.”
- “I am too thin.”



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- “My breasts are not attractive.”
- “My penis is too small.”
- “My stomach is embarrassing.”
- “My skin is imperfect.”
- “My body has changed after pregnancy.”
- “I look too old.”
- “My genitals are abnormal.”
- “My partner will judge me.”

Body image is therefore partly physical, but it is also psychological and social.

It may be influenced by:

- upbringing,
- cultural expectations,
- previous criticism,
- teasing or bullying,
- relationship experiences,
- sexual experiences,
- pregnancy and childbirth,
- ageing,
- illness,
- surgery,
- weight changes,
- social media,
- pornography,
- unrealistic beauty standards,
- and repeated comparison with others.

Research consistently links body dissatisfaction with poorer sexual well-being. A review focusing on sexual function in the context of overweight and obesity found that **body-image dissatisfaction predicted lower sexual satisfaction across BMI categories**, suggesting that

the psychological relationship with one's body may matter independently of body weight itself.

A 2025 systematic review likewise found that a more positive genital self-image was associated with better sexual function and greater satisfaction, although the authors also noted limitations in the diversity and design of available studies.

What Does “Body Dysmorphia in the Bedroom” Mean?

In practical sexual-health language, this phrase describes a situation in which worries about appearance become so prominent during intimacy that they interfere with:

- desire,
- arousal,
- erection,
- lubrication,
- orgasm,
- emotional connection,
- comfort,
- sexual communication,
- or willingness to engage in intimacy.

Instead of being mentally present with a partner, a person may become preoccupied with questions such as:

- How does my stomach look?
- Is my partner noticing my stretch marks?
- Are my breasts attractive enough?
- Is my penis large enough?
- Am I taking too long to become aroused?
- Am I performing correctly?
- Will I climax too quickly?
- Will I be able to maintain an erection?
- Does my partner think I am overweight?



- Do I look attractive in this position?

This type of self-monitoring can create what psychologists often describe as **cognitive distraction during sexual activity**.

Research on women has repeatedly found that body-related thoughts and self-consciousness can interfere with several aspects of sexual response and behavior.

The person is physically present but mentally acting as an observer or critic.

The Bedroom Anxiety Cycle

A very common pattern is:

Body concern → self-monitoring → anxiety → reduced arousal → sexual difficulty → greater anxiety next time

For example:

A man may enter intimacy thinking:

“I must maintain a perfect erection.”

The thought increases sympathetic nervous-system arousal and tension.

He repeatedly checks whether the erection is strong enough.

Normal fluctuations in erection are interpreted as failure.

Anxiety increases further.

The erection becomes more difficult to maintain.

He then thinks:

“I knew something was wrong.”

The next encounter begins with even greater fear.

A woman may experience a similar cycle:

“I look unattractive” → self-consciousness → inability to relax → reduced arousal or lubrication → discomfort or avoidance → stronger negative beliefs about her sexuality.

Over time, the original concern about appearance may become a broader fear of intimacy.

The Three Major Problems

1. Self-Consciousness During Intimacy



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Self-consciousness means being excessively aware of how one appears to another person.

During intimacy, this may involve worrying about:

- abdominal shape,
- breasts,
- thighs,
- skin,
- scars,
- stretch marks,
- body hair,
- smell,
- ageing,
- genital appearance,
- erection,
- lubrication,
- facial expressions,
- or sexual movements.

Some people prefer:

- complete darkness,
- remaining covered,
- avoiding certain sexual positions,
- avoiding undressing,
- avoiding mirrors,
- refusing oral sex,
- avoiding being touched in particular areas.

These behaviors may temporarily reduce anxiety but can gradually reinforce the belief:

“My body is unacceptable and must be hidden.”

2. Weight Anxiety



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Weight anxiety deserves special consideration because it can affect both physical health and psychological sexual well-being.

It may occur in people who are:

- overweight,
- underweight,
- average weight,
- muscular,
- or medically healthy.

The number on the scale does not tell us how somebody feels about their body.

Some people at a higher body weight have very positive sexual confidence.

Others who are medically within a typical weight range may experience severe body shame.

Research therefore suggests that sexual well-being cannot be reduced simply to BMI. Body satisfaction and psychological factors can independently influence sexual satisfaction.

At the same time, when overweight or obesity is accompanied by diabetes, cardiovascular disease, hormonal problems or other metabolic illness, these conditions can contribute physiologically to sexual dysfunction as well.

Therefore, we must distinguish:

Medical weight-related sexual dysfunction

from

Appearance-related weight anxiety

They may occur together, but they are not the same problem.

3. Sexual Performance Anxiety

Performance anxiety occurs when intimacy begins to feel like an examination.

The person feels pressure to achieve a specific result.

Men may worry about:

- erection quality,
- erection duration,
- ejaculation timing,



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- penis size,
- stamina,
- partner satisfaction,
- fertility.

Women may worry about:

- becoming aroused quickly enough,
- lubrication,
- orgasm,
- body attractiveness,
- vaginal appearance,
- sexual pain,
- being “good enough” sexually.

A person may become so focused on the outcome that normal pleasure disappears.

The central question changes from:

“What am I experiencing?”

to:

“Am I performing correctly?”

That change alone can significantly alter the sexual experience.

Body Image and Female Sexual Health

Women may experience body-image concerns related to:

- breast size or shape,
- abdominal fat,
- hips and thighs,
- skin,
- stretch marks,
- vulval or genital appearance,
- weight changes,



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- pregnancy,
- childbirth,
- menopause,
- surgery,
- ageing.

Research across multiple studies indicates that body and genital self-image are associated with aspects of female sexual function, although the strength and direction of the relationship vary between populations and studies.

A woman who feels uncomfortable with her body may find it difficult to relax during intimacy.

She may avoid:

- being seen naked,
- certain positions,
- initiating sex,
- expressing desire,
- receiving touch,
- or communicating her preferences.

This does not necessarily mean that there is a primary hormonal or gynecological disorder.

Sometimes the barrier is psychological attention being directed toward appearance rather than sensation.

Genital Self-Image in Women

Women sometimes worry that the vulva or vagina is:

- too large,
- too small,
- too dark,
- uneven,
- unattractive,
- “loose,”



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- or abnormal.

Many of these concerns result from unrealistic comparisons.

Normal female genital anatomy varies substantially between individuals.

When the concern becomes intense, a woman may avoid intimacy or repeatedly compare herself with idealized online images.

A 2025 systematic review found that positive genital self-image tends to be associated with better sexual function and satisfaction.

Importantly, cosmetic appearance should never be used as the sole measure of genital health or sexual function.

Body Image and Male Sexual Health

Men also experience body-image anxiety, even though it may be discussed less openly.

Common concerns include:

- penis size,
- erection hardness,
- chest size,
- abdominal fat,
- muscularity,
- hair loss,
- height,
- body hair,
- premature ejaculation,
- low sperm count,
- infertility.

Men may compare themselves with:

- pornography,
- social media,
- gym culture,
- other men,



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- unrealistic sexual expectations.

This can create performance pressure.

A man may begin checking his erection repeatedly during intercourse.

This checking itself can interfere with arousal.

He may then mistakenly assume that he has serious erectile disease.

Penis-Size Anxiety

One of the most common male sexual appearance concerns is penis size.

Many men who worry intensely about size may actually fall within the broad range of normal anatomy.

The psychological problem is often not the measurement itself but the belief:

“My partner cannot be satisfied unless I look a certain way.”

When penis-size concern becomes excessive, repetitive and disabling, assessment for BDD or related anxiety may be appropriate.

The solution should not automatically be:

- pills,
- injections,
- stretching devices,
- unregulated oils,
- or surgery.

The first question should be:

Is there actually an anatomical abnormality, or is the main difficulty the patient's perception of his body?

Appearance Anxiety and Infertility

Infertility creates another important form of body and sexual anxiety.

Men sometimes interpret an abnormal semen report as evidence that they are:

- less masculine,
- sexually weak,



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- or sexually inadequate.

Women may interpret difficulty conceiving as evidence that:

- their body has failed,
- they are incomplete,
- or they are no longer desirable.

These beliefs are emotionally painful, but medically they are incorrect.

Fertility and sexual worth are not the same thing.

A man can have excellent erections but abnormal sperm parameters.

A man can have reduced erection quality but entirely normal sperm production.

A woman can have normal sexual desire and still experience an ovulatory, tubal or reproductive problem.

At Saira Health Care, one of the most important educational points we emphasize is separating **fertility diagnosis from personal identity and sexual self-worth**.

Body Dysmorphic Disorder: When Concern Becomes a Mental-Health Disorder

Body Dysmorphic Disorder is more than ordinary insecurity.

The NHS describes BDD as a condition in which a person spends substantial time worrying about perceived appearance flaws that are often minor or not noticeable to other people. Common patterns include repeated comparison, excessive mirror checking or mirror avoidance, concealment and attempts to correct the perceived defect. BDD can significantly affect relationships, social life and daily functioning.

Possible signs include:

- thinking about one perceived flaw for long periods,
- repeatedly checking mirrors,
- avoiding mirrors entirely,
- repeatedly asking others for reassurance,
- constantly comparing one's body with other people,
- excessive grooming,
- concealing specific body areas,
- avoiding sexual relationships,



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- repeatedly seeking cosmetic procedures,
- becoming convinced that a normal body part is abnormal,
- severe anxiety or depression related to appearance.

BDD can affect both women and men.

Ordinary Insecurity vs BDD

The difference is usually one of **intensity, persistence and impairment**.

A person may occasionally think:

“I wish my stomach were flatter.”

That is not automatically BDD.

Concern becomes more clinically significant when it begins to:

- dominate thinking,
- cause severe distress,
- disrupt relationships,
- cause avoidance,
- affect employment or education,
- lead to repeated checking or concealment,
- or produce dangerous thoughts or behaviors.

A proper psychological assessment is therefore essential before using the diagnosis.

Body Dysmorphia and Depression

BDD can coexist with:

- depression,
- anxiety disorders,
- obsessive-compulsive symptoms,
- social anxiety,
- eating disorders.



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It is also associated with a significant risk of suicidal thinking and behavior. A systematic review and meta-analysis found substantially increased odds of suicidal ideation and suicide attempts among people with BDD, although the authors noted limitations in the underlying evidence.

For that reason, severe appearance distress should never be dismissed as vanity.

What Causes Body and Performance Anxiety?

Usually there is no single cause.

Several factors may interact.

Social Comparison

Repeated exposure to idealized bodies can create unrealistic standards.

People may compare real bodies with:

- edited photographs,
- filtered images,
- curated social media,
- pornography,
- celebrity bodies.

A systematic review found an association between greater pornography exposure and more negative body and sexual-body image in both heterosexual men and women, though the evidence does not establish that pornography is the sole cause of these concerns.

Negative Comments From a Partner

Statements such as:

- “You have gained weight.”
- “Your breasts are different.”
- “Your penis is small.”
- “My previous partner was better.”
- “Why can't you perform?”

can become deeply internalized.



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Even one humiliating sexual experience may influence future confidence.

Previous Sexual Difficulty

One episode of erectile difficulty or delayed arousal may become the beginning of performance anxiety.

The patient begins anticipating failure.

The expectation itself creates anxiety.

Pregnancy and Childbirth

Pregnancy may change:

- breasts,
- abdomen,
- skin,
- weight distribution,
- pelvic-floor function.

These changes are biologically normal, but some women experience significant distress adapting to a changed body.

Menopause and Ageing

Ageing can affect:

- body composition,
- skin,
- hormones,
- vaginal tissues,
- erections,
- energy,
- libido.

The goal of healthy sexuality should not be to maintain the body of a 20-year-old forever.



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It should be to understand and support sexual health appropriate to the individual's stage of life.

Medical Conditions

Body and sexual confidence may also change after:

- cancer treatment,
- mastectomy,
- hysterectomy,
- prostate surgery,
- infertility treatment,
- major weight changes,
- chronic illness,
- skin disease,
- scars,
- accidents.

In such cases, sexual rehabilitation may require both physical and psychological care.

How Body Anxiety Affects Sexual Response

Sexual arousal depends partly upon attention.

When attention is repeatedly directed toward fear or self-evaluation, it is harder to remain connected with erotic sensations.

This may contribute to:

In women

- reduced desire,
- difficulty becoming aroused,
- reduced lubrication,
- delayed orgasm,
- sexual avoidance,
- distress.



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In men

- difficulty developing an erection,
- difficulty maintaining erection,
- rapid ejaculation associated with anxiety,
- delayed ejaculation in some cases,
- loss of spontaneous confidence.

A 2026 network meta-analysis of psychological interventions in women found benefits from approaches including sexual education, CBT, mindfulness-based interventions and sexual counseling compared with usual care, supporting the role of psychological treatment in appropriate sexual-function concerns.

Performance Anxiety Does Not Mean “The Problem Is Imaginary”

This is an important point.

Psychological sexual dysfunction is real.

The brain is part of the sexual-response system.

Anxiety affects:

- attention,
- autonomic nervous-system activity,
- muscle tension,
- vascular responses,
- sexual motivation.

Therefore, telling a patient simply to:

“Stop thinking about it.”

is rarely useful.

The anxiety cycle needs to be understood and treated.

Medical Evaluation Still Matters

Not every sexual problem should automatically be attributed to anxiety.

For example, erectile difficulty may also result from:



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- diabetes,
- cardiovascular disease,
- hypertension,
- low testosterone,
- medication effects,
- neurological disease,
- smoking,
- sleep disorders.

Female sexual symptoms may involve:

- hormonal changes,
- vaginal dryness,
- pelvic-floor disorders,
- pain,
- endometriosis,
- infection,
- medication effects,
- menopause.

A professional evaluation helps separate:

body-image anxiety

from

a genuine physical sexual-health condition

and frequently the two may coexist.

Treatment: The First Goal Is Not “Perfect Appearance”

The goal is not to convince a patient:

“You look perfect.”

That approach can become another form of reassurance-seeking.

The healthier goal is:



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to reduce the power that appearance-based thoughts have over life, relationships and sexuality.

Cognitive Behavioural Therapy

When genuine Body Dysmorphic Disorder is present, **cognitive behavioural therapy (CBT)** is an established treatment.

NICE recommends CBT that specifically addresses the features of BDD, including exposure and response-prevention elements; depending on severity, treatment may involve CBT alone, an SSRI, or combined treatment.

CBT may help patients identify beliefs such as:

“Nobody can find me attractive because of my abdomen.”

and examine the assumptions behind them.

Treatment may also gradually reduce behaviors such as:

- mirror checking,
 - reassurance seeking,
 - comparison,
 - concealment,
 - avoidance.
-

Medication for Body Dysmorphic Disorder

For clinically diagnosed BDD, selective serotonin reuptake inhibitors may be considered by appropriately qualified mental-health professionals.

NICE guidance includes SSRIs among treatment options, especially for moderate or severe impairment or when CBT alone is insufficient.

These medicines should not be self-prescribed.

Medication decisions require consideration of:

- symptoms,
- depression,
- anxiety,
- other medicines,



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- side effects,
- suicide risk,
- age.

Sexual Counseling and Sex Therapy

When body self-consciousness is primarily affecting intimacy, sexual counseling can be extremely important.

Treatment may address:

- unrealistic expectations,
- sexual myths,
- communication,
- fear of judgment,
- erection anxiety,
- orgasm anxiety,
- avoidance,
- partner criticism.

A therapist may encourage couples to temporarily shift attention away from “performance” and toward:

- touch,
- comfort,
- communication,
- sensation,
- emotional connection.

This removes the idea that every intimate encounter must end with intercourse, erection or orgasm.

Mindfulness-Based Approaches

Mindfulness teaches a person to notice thoughts without automatically following them.

For example:



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“My stomach looks unattractive.”

can be recognized as a thought rather than treated as an objective fact.

During intimacy, mindfulness aims to redirect attention toward present-moment experiences such as:

- touch,
- warmth,
- breathing,
- emotion,
- affection,
- pleasure.

A 2024 meta-analysis found that mindfulness-based cognitive approaches were associated with improved sexual function and reduced sexual distress in women, although there was substantial variation between studies.

More recent systematic reviews have also reported potentially beneficial effects in selected female populations, while emphasizing that research remains heterogeneous and further high-quality trials are needed.

A Simple Mindful Intimacy Exercise

A patient can practice:

Notice

“What thought appeared?”

Name

“This is an appearance-anxiety thought.”

Breathe

Take slow, comfortable breaths.

Return

Bring attention back to:

- touch,
- affection,



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- warmth,
- breathing,
- physical sensation.

The objective is not to force the thought away.

It is to stop allowing the thought to control the entire experience.

Stop Treating Intimacy Like an Examination

Many couples unknowingly measure sexual success through:

- erection hardness,
- duration,
- number of orgasms,
- penetration time,
- sexual frequency.

This can transform intimacy into a performance test.

A healthier definition includes:

- comfort,
 - pleasure,
 - affection,
 - consent,
 - communication,
 - emotional closeness,
 - mutual satisfaction.
-

Weight Management Without Body Shame

If a patient medically needs weight management, it should be approached through health rather than humiliation.

Healthy goals can include:

- improved cardiovascular fitness,



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- better diabetes control,
- increased mobility,
- improved sleep,
- balanced nutrition,
- sustainable activity.

The message should not be:

“You must become thin before you deserve sexual confidence.”

Body-image satisfaction can influence sexual well-being independently of actual weight change.

Exercise and Sexual Confidence

Appropriate physical activity can support:

- cardiovascular health,
- metabolic health,
- mood,
- mobility,
- strength,
- confidence.

However, exercise should not become compulsive punishment for the body.

The aim is:

health and capability—not obsessive pursuit of an impossible appearance.

Communication With Your Partner

Healthy communication can reduce performance anxiety significantly.

Instead of guessing:

“My partner must think I look terrible.”

ask and communicate.

Helpful discussions may include:



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- what feels comfortable,
- what creates anxiety,
- what type of reassurance is helpful,
- what language is hurtful,
- what type of intimacy feels safe.

A partner should not use sexual insecurity as a weapon during conflict.

What the Partner Should Avoid

Avoid:

- criticizing body shape during intimacy,
- comparisons with previous partners,
- jokes about genital size,
- mocking erection problems,
- criticizing weight during sexual situations,
- pressuring someone to undress,
- repeatedly demanding sexual performance.

Sexual confidence grows in an atmosphere of emotional safety.

Rebuilding Confidence Gradually

Recovery is often gradual.

A practical progression may involve:

1. Becoming more comfortable with one's own body.
2. Reducing repeated checking and comparison.
3. Learning accurate sexual-health information.
4. Communicating fears with a partner.
5. Engaging in affectionate touch without performance pressure.
6. Gradually increasing intimacy.
7. Addressing any physical sexual dysfunction separately.



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8. Seeking professional psychological help if distress persists.

Unani Understanding of Mind–Body Balance

The Unani system of medicine has traditionally viewed physical and psychological health as interconnected rather than completely separate.

CCRUM describes Unani medicine as a holistic system that considers biological, psychological, social, environmental and constitutional factors, with **Mizaj**, or temperament, forming an important organizing concept.

For sexual-health problems influenced by stress, self-consciousness or performance anxiety, this broad view can be useful as a **supportive framework**.

However, an important distinction must be made:

Classical Unani medicine did not describe modern Body Dysmorphic Disorder using today's psychiatric diagnostic criteria.

Therefore, it would not be scientifically appropriate to claim that a particular humour or temperament is “the cause of BDD.”

Mizaj – Individual Temperament

In Unani medicine, **Mizaj** reflects the individual's constitutional characteristics.

This encourages the physician to consider:

- sleep,
- diet,
- emotional condition,
- activity,
- digestion,
- physical health,
- environment,
- lifestyle.

CCRUM continues scientific research into Unani concepts such as Mizaj and their relationship to physiological and pathological parameters.

From my perspective, the most useful lesson here is **individualization**.



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Two patients with the same statement—

“I don't feel attractive during intimacy.”

—may have completely different problems.

One may have mild insecurity.

Another may have depression.

Another may have true BDD.

Another may have sexual pain.

Another may have erectile dysfunction.

Another may be experiencing partner criticism.

Treatment must therefore be personalized.

Asbab-e-Sitta Zarooriyah – The Six Essential Factors

Unani medicine places great importance on six broad lifestyle domains, traditionally called **Asbab-e-Sitta Zarooriyah**.

CCRUM describes these essential factors as a foundational part of health preservation within Unani medicine.

They include concepts related to:

- environment and air,
- food and drink,
- physical movement and rest,
- psychological movement and rest,
- sleep and wakefulness,
- retention and evacuation.

In body-image and sexual-anxiety management, several are particularly relevant.

Harkat-o-Sukoon-e-Nafsani – Psychological Activity and Rest

This is perhaps the most relevant traditional concept.

Unani medicine recognizes that emotional states influence physical health.

Modern medicine likewise recognizes that:



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- anxiety,
- depression,
- chronic stress,
- relationship conflict

can influence sexual function.

Therefore, counseling, emotional regulation, relaxation and healthy relationship communication fit naturally into a broader mind-body approach.

Naum-o-Yaqzah – Sleep and Wakefulness

Chronic sleep deprivation can worsen:

- mood,
- anxiety,
- energy,
- attention,
- stress tolerance.

A patient experiencing performance anxiety should therefore not ignore basic health factors such as sleep.

Harkat-o-Sukoon-e-Badani – Physical Activity and Rest

Balanced exercise can improve general health and self-confidence.

Extreme inactivity may worsen physical and psychological well-being.

At the opposite extreme, compulsive exercise driven by body dissatisfaction can itself become unhealthy.

Balance is therefore essential.

Ilaj-bil-Ghiza – Dietotherapy

Nutrition is an established component of the Unani therapeutic framework. CCRUM lists **Ilaj-bil-Ghiza**, or dietotherapy, among the main modes of Unani treatment.

For body-image concerns, the goal should be:



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- adequate nutrition,
- metabolic health,
- sustainable weight management where medically appropriate,
- avoidance of crash dieting.

Food should not become another source of shame.

Ilaj-bil-Tadbir – Regimental Therapy

CCRUM also recognizes **Ilaj-bil-Tadbir**, or regimental therapy.

In contemporary integrated care, supportive lifestyle measures may include:

- appropriate physical activity,
- healthy sleep,
- relaxation,
- structured routines,
- stress reduction.

These approaches may support overall well-being but should not be described as stand-alone cures for clinical BDD.

Does Unani Medicine Cure Body Dysmorphic Disorder?

There is currently insufficient clinical evidence to say that Unani medicines alone cure **Body Dysmorphic Disorder**.

If a patient has clinically significant BDD, established treatments such as **BDD-focused CBT and, when appropriate, psychiatric medication** should not be delayed.

Unani care may instead be used responsibly to support:

- general health,
- sleep,
- diet,
- stress management,
- lifestyle,
- individual constitutional assessment,



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provided this occurs alongside necessary psychological or psychiatric treatment.

This distinction is extremely important.

Dr. Nizamuddin Qasmi's Approach at Saira Health Care

At **Saira Health Care**, when a patient says:

"I am not comfortable with my body during intimacy,"

my approach is not to immediately prescribe a sexual medicine.

I first try to determine **what the patient is actually experiencing**.

Step 1: Confidential Consultation

The consultation may explore:

- the specific body concern,
- when it started,
- whether it occurs only during intimacy,
- relationship circumstances,
- sexual confidence,
- previous sexual difficulties,
- fertility concerns,
- anxiety,
- depression,
- previous criticism or humiliation,
- medication use,
- medical conditions.

Sexual-health consultations should always be respectful and confidential.

Step 2: Is This Body Dissatisfaction or True BDD?

I consider:

- how many hours are spent thinking about appearance,

- mirror checking,
- comparison,
- concealment,
- avoidance,
- interference with relationships,
- effects on work and normal life.

When BDD is suspected, referral to a qualified mental-health professional is appropriate.

Step 3: Evaluate the Sexual Problem Separately

If a man reports erectile difficulty, it should not automatically be attributed to anxiety.

I may consider:

- cardiovascular health,
- diabetes,
- hormones,
- medication,
- sleep,
- smoking,
- psychological factors.

Similarly, in women we may need to consider:

- pain,
 - dryness,
 - hormonal changes,
 - infection,
 - pelvic problems,
 - medication effects.
-

Step 4: Fertility Assessment When Necessary



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If body anxiety has developed because of infertility, the fertility problem should be evaluated separately.

For men this may include:

- semen analysis,
- sperm concentration,
- motility,
- morphology,
- hormone assessment,
- ultrasound where indicated.

This allows us to explain the medical problem without turning it into a judgment about masculinity.

Step 5: Psychological and Sexual Counseling

Where appropriate, I encourage:

- CBT,
- psychological counseling,
- sexual counseling,
- mindfulness,
- couple communication.

A qualified clinical psychologist, psychiatrist or trained sex therapist may be included depending on severity.

Step 6: Individualized Unani Support

Where appropriate, supportive Unani management can focus on:

- sleep,
- nutrition,
- daily routine,
- physical activity,
- stress,



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- general constitutional health.

The objective is not simply to “increase sexual power.”

The objective is to restore **overall physical and emotional balance**.

The Contribution of Saira Health Care

At **Saira Health Care**, sexual health is approached as more than a problem of erection, ejaculation or fertility reports.

Our focused work includes education and clinical assessment in areas such as:

- Male sexual disorders
- Erectile difficulties
- Premature ejaculation
- Performance anxiety
- Male infertility
- Semen and sperm-related concerns
- Female sexual-health concerns
- Sexual counseling
- Body-image-related sexual anxiety
- Fertility counseling
- Reproductive-health education

A major part of this work involves helping patients understand the difference between:

physical disease

and

anxiety about physical disease.

Sometimes both exist simultaneously.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi is Founder and Chief Physician of **Saira Health Care**, with a focused clinical practice in **Sexual Disorders and Infertility**.

His qualifications and professional training include:



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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

His approach emphasizes:

- confidential consultation,
- sexual-health education,
- individualized evaluation,
- infertility assessment,
- responsible Unani supportive care,
- modern medical investigations where appropriate,
- psychological or specialist referral when required.

Practical Advice for Patients

Reduce Comparison

Your partner is interacting with **you**, not a digitally edited image.

Repeated comparison trains the mind to search for flaws.

Reduce Mirror Checking

Checking the body repeatedly often increases rather than decreases anxiety.

For patients with BDD, reduction of checking and reassurance-seeking may form part of structured CBT.

Focus on Function

Instead of asking:

“How does my body look?”

try asking:



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“What can my body experience?”

- affection,
 - movement,
 - warmth,
 - pleasure,
 - connection.
-

Do Not Delay Intimacy Until Your Body Is “Perfect”

The idea:

“I will become sexually confident after I lose weight.”

can turn into:

“After another 5 kg.”

and then:

“After another 5 kg.”

Confidence cannot always be postponed until an imagined future body appears.

Challenge Mind Reading

You may think:

“My partner is judging my stomach.”

Ask yourself:

What evidence do I actually have?

Anxiety frequently converts assumptions into apparent facts.

Be Careful With Social Media

Curated photographs rarely represent ordinary bodies in ordinary situations.

Reduce exposure to content that consistently makes you feel:

- inadequate,
- ashamed,



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- sexually inferior.

Communicate During Intimacy

You can say:

“I sometimes become self-conscious, so I may need time to relax.”

A supportive partner will usually respond better to honest communication than to unexplained avoidance.

Stop Measuring Every Sexual Encounter

Not every encounter requires:

- penetration,
- erection,
- orgasm,
- a specific duration.

Removing performance requirements can help restore intimacy.

Frequently Asked Questions

Is body dysmorphia the same as being unhappy with your body?

No.

Ordinary dissatisfaction is common.

BDD involves persistent preoccupation, repetitive behaviors and significant distress or impairment.

Can body-image anxiety cause erection problems?

Anxiety and cognitive distraction can contribute to erectile difficulties in some men.

However, recurrent erectile dysfunction also deserves medical evaluation because physical causes may coexist.

Can body image affect female arousal?



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Yes.

Research has found associations between negative body or genital self-image and several aspects of female sexual function.

Will losing weight automatically cure sexual anxiety?

Not necessarily.

Weight reduction may improve some medical factors associated with sexual function in appropriate patients, but body dissatisfaction itself can influence sexual well-being independently of BMI or weight change.

Can mindfulness help?

Mindfulness-based approaches have shown benefits for sexual function or sexual distress in several studies, particularly among women, although study populations and outcomes vary.

Is CBT useful for body dysmorphic disorder?

Yes.

BDD-focused CBT, including exposure and response-prevention strategies, is an established treatment recommended by NICE.

Can medication be required?

Sometimes.

SSRIs may be used in clinically diagnosed BDD, particularly for moderate or severe symptoms, under appropriate medical supervision.

Can Unani medicine help?

Unani medicine may be valuable as **supportive, individualized care** focusing on lifestyle, sleep, nutrition, stress management and overall health.

It should not replace psychological or psychiatric treatment when clinical BDD or another mental-health disorder is present.



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When Should You Seek Professional Help?

Consult a healthcare or mental-health professional when:

- appearance thoughts occupy large parts of the day,
 - intimacy is repeatedly avoided,
 - you continually check or hide your body,
 - you are unable to enjoy sexual relationships,
 - anxiety is causing recurrent sexual dysfunction,
 - body dissatisfaction causes depression,
 - you repeatedly seek unnecessary cosmetic procedures,
 - relationship problems are becoming severe,
 - dieting or exercise becomes compulsive.
-

When Is Urgent Mental-Health Support Needed?

Seek urgent professional help if body-related distress is accompanied by:

- thoughts of self-harm,
- thoughts of suicide,
- feeling that life is not worth living,
- severe depression,
- inability to function normally.

BDD is associated with an elevated risk of suicidal thoughts and attempts and should be treated seriously.

A Personal Message to My Patients

When patients tell me:

“Doctor, I don’t feel attractive enough for my partner,”

I remind them that sexual health is not a beauty competition.

Your value as a partner cannot be measured by:

- waist size,



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- breast size,
- penis size,
- body weight,
- stretch marks,
- hair,
- one episode of erectile difficulty,
- or one fertility report.

At the same time, I do not dismiss the suffering caused by body-image anxiety.

If these thoughts are interfering with intimacy, they deserve proper assessment and treatment.

Sometimes the solution is medical.

Sometimes it is psychological.

Sometimes relationship counseling is needed.

Sometimes lifestyle needs attention.

And often, several of these factors must be addressed together.

The purpose of treatment is not to turn every human body into an idealized body.

It is to help patients live more comfortably **within their own bodies** and experience intimacy without continuous fear, judgment or performance pressure.

Conclusion

Body dysmorphia in the bedroom is best understood as a spectrum ranging from ordinary body insecurity and sexual self-consciousness to clinically significant Body Dysmorphic Disorder.

Common concerns include:

- weight anxiety,
- genital self-image,
- breast or body-shape concerns,
- ageing,
- infertility-related insecurity,



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- erection anxiety,
- orgasm anxiety,
- sexual-performance pressure.

Research increasingly supports a relationship between body image and sexual well-being, and psychological interventions—including CBT, sexual counseling and mindfulness-based approaches—can be valuable in appropriate patients.

When true BDD is present, evidence-based psychological treatment and, where clinically indicated, appropriately prescribed medication remain central to care.

The **Unani system of medicine** can contribute a useful holistic framework through its emphasis on individualized temperament, lifestyle, sleep, psychological balance, diet and regimental care. CCRUM officially describes Unani medicine as a holistic system and recognizes **Ilaj-bil-Tadbir, Ilaj-bil-Ghiza, Ilaj-bil-Dawa and Ilaj-bil-Yad** among its therapeutic modes.

At **Saira Health Care**, the appropriate approach is therefore not to treat every sexual-confidence concern with a tonic or every appearance concern as a psychiatric illness.

The better approach is to identify:

what is physical, what is psychological, what is relationship-related, what requires investigation, and what can be improved through individualized supportive care.

Sexual confidence grows when attention moves away from:

“How am I being judged?”

and returns to:

“Am I safe, connected, comfortable and present?”

That shift can be an important step toward healthier sexuality, stronger relationships and better emotional well-being.

Medical Disclaimer

This article is intended for general education and sexual-health awareness. It does not replace individual medical, psychological or psychiatric evaluation.

“Body dysmorphia” is sometimes used casually to describe body dissatisfaction, but **Body Dysmorphic Disorder is a specific mental-health condition requiring appropriate professional assessment.**



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Do not start antidepressants, anxiety medicines, hormonal treatments, sexual medicines or Unani/herbal medicines solely on the basis of this article.

Patients experiencing severe depression, self-harm thoughts or suicidal thoughts should seek urgent professional mental-health assistance.



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