Loss of Libido (Low Sexual Desire): Causes, Diagnosis, Hormonal and Psychological Factors, Modern Treatment and the Unani Approach

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Introduction: "Doctor, I Have Lost Interest in Sex. Is Something Wrong With Me?"

One of the most personal complaints a patient can bring to me is:

"Doctor, earlier I had normal sexual desire, but now I hardly feel interested in sex. Why has my libido disappeared?"

Some patients become immediately worried about testosterone. Others believe that their relationship is failing. Some men start taking erection medicines even though erection is not their main problem. Some women assume that reduced desire after childbirth or menopause must simply be accepted.

The first thing I explain is that **sexual desire naturally changes throughout life**.

Libido can increase or decrease according to age, health, hormones, sleep, emotional state, relationship circumstances, medicines, stress and many other factors. A temporary reduction in desire during illness, exhaustion, bereavement or major stress does not automatically mean that someone has a sexual disorder.

The medical problem becomes more important when the reduction is **persistent, represents a meaningful change for that individual, causes personal distress or creates significant difficulty within the relationship**.

Current European Association of Urology guidance describes male low sexual desire as a complex condition involving biological drive, psychological motivation and social or cultural influences rather than a simple testosterone problem. It recognizes androgen deficiency, hyperprolactinaemia, depression, anxiety, relationship conflict, cardiovascular and kidney disease, erectile dysfunction, some medications and other health conditions among possible causes.

In women, ACOG similarly emphasizes that sexual dysfunction is clinically important when difficulties involving desire, arousal, orgasm or pain cause **personal distress**. Its guidance

continues to recommend a multidimensional approach because biological, psychological and relationship factors frequently interact.

This is exactly why, in my work at Saira Health Care, I do not begin by asking:

“Which libido medicine should I give?”

I begin by asking:

“Why has this person's desire decreased?”

That question usually leads us toward much more useful treatment.

What Is Libido?

Libido simply means **sexual desire or sexual interest**.

It can include interest in sexual activity with a partner, sexual thoughts or fantasies, desire for physical intimacy and, for some people, interest in solitary sexual activity.

Sexual desire is not a fixed quantity that must remain at one level throughout life.

It varies between people and also varies in the same person over time.

One partner may naturally want sex more frequently than the other without either person having a disease.

The EAU increasingly emphasizes this concept of **sexual-desire discrepancy**. Rather than automatically identifying the lower-desire partner as “abnormal,” clinicians are encouraged to consider whether the real problem is simply a difference in desire that has become distressing for the couple.

This is a very humane and clinically useful approach.

When Does Low Libido Become a Medical Problem?

There is no medically correct number of times per week that a person must desire sex.

A patient does not have a disorder simply because:

their partner wants sex more often;

their desire has become lower with age;

they occasionally go through periods without sexual thoughts;

or they prefer less frequent sexual activity than friends or cultural expectations suggest.

A proper diagnosis considers the **person's previous level of desire, duration of the change, circumstances, medical conditions and whether the change causes genuine distress**.

For men, current EAU guidance defines male hypoactive sexual desire disorder as a persistent or recurrent deficiency or absence of sexual thoughts, fantasies or desire for sexual activity, interpreted within the individual's age, health and social circumstances.

Among women, modern terminology is more complicated. DSM-based practice often uses **female sexual interest/arousal disorder**, while the term **hypoactive sexual desire disorder (HSDD)** remains widely used in sexual-medicine research, clinical practice and regulatory indications.

The terminology matters less to patients than the fundamental principle:

Low desire becomes a condition requiring treatment when it is persistent, distressing and not better explained by another obvious medical, psychological, medication-related or relationship factor.

How Common Is Low Sexual Desire?

Low sexual desire is not rare.

Current EAU epidemiological data report a broad estimated prevalence of approximately **3%–28% among men**, depending on the population and definition used. Even men aged 18–29 can report low desire, with published rates in some studies around 6%–19%.

Women also commonly report difficulties with desire. ACOG notes that female sexual dysfunction is relatively prevalent but often under-discussed because many women do not spontaneously raise sexual concerns with their healthcare professionals.

These numbers reinforce an important message:

Low libido is a legitimate health concern, not something patients should feel embarrassed about discussing.

Libido Is Not the Same as Erection

This distinction is extremely important in men.

A man can have:

low libido with completely normal erections.

Another can have:

strong sexual desire but erectile dysfunction.

A third can have both.

Erectile dysfunction means difficulty achieving or maintaining an erection adequate for satisfactory sexual activity. It is therefore principally an **erection disorder**, not a desire disorder.

Sildenafil or tadalafil may improve penile erectile response, but they do not directly create sexual desire in a man whose main problem is depression, testosterone deficiency or relationship distress.

This is why I tell patients:

“An erection medicine is not automatically a libido medicine.”

Libido Is Also Not the Same as Fertility

Another misunderstanding I regularly encounter is:

“My sexual desire is low, so my sperm must also be weak.”

This is not necessarily true.

Sexual desire depends largely on the brain, hormones, emotions and relationship context.

Male fertility depends on sperm production and reproductive function.

A man may have:

excellent libido and severe oligozoospermia;

or very low libido with normal sperm production.

Both systems can be affected by certain hormonal diseases, but they should not be confused.

This distinction is particularly important when testosterone treatment is being considered.

What Controls Sexual Desire?

Sexual desire results from interaction between several biological and psychological systems.

The EAU describes three overlapping components: **biological drive, psychological motivation and culturally influenced desire or wish**.

That means libido is influenced by much more than one hormone.

The brain processes attraction, emotional connection, reward, stress and sexual cues.

Hormones including testosterone, prolactin and thyroid hormones can influence sexual function.

Physical health influences energy and comfort.

The relationship affects emotional safety and attraction.

Medicines can alter brain neurotransmitters.

Sleep affects hormones and mental health.

Pain can make sexual activity undesirable.

Therefore, trying to correct every low-libido complaint with one aphrodisiac is medically unrealistic.

Low Testosterone and Loss of Libido in Men

Testosterone is important for male sexual desire.

Loss of libido is one of the more specific symptoms that can occur in male hypogonadism.

However, testosterone levels and sexual desire are **not perfectly proportional**, especially in older men. A man can have testosterone in the reference range and low libido, while another man with moderately reduced testosterone may still report reasonable sexual interest.

Therefore:

Low libido can suggest testosterone deficiency, but it cannot diagnose it.

How Should Testosterone Deficiency Be Diagnosed?

Current EAU guidance defines male hypogonadism as a clinical syndrome involving symptoms together with **biochemical evidence of testosterone deficiency**. Obesity, type 2 diabetes, metabolic syndrome, chronic illness and overall poor health are important contributors, while healthy ageing itself produces only a relatively gradual decline.

When symptoms suggest testosterone deficiency, total testosterone should generally be measured in the morning under appropriate conditions and an abnormal result confirmed before treatment.

Depending on the situation, additional investigations may include LH, FSH, prolactin, SHBG or free-testosterone assessment.

A man should not be diagnosed with “low testosterone” solely because he reports fatigue and reduced sexual desire.

Testosterone Treatment and Libido

When a man has genuine testosterone deficiency together with appropriate symptoms, testosterone therapy can improve sexual desire.

The EAU recommends testosterone treatment when low sexual desire is associated with signs and symptoms of testosterone deficiency.

However, testosterone should not be used as a general sexual-performance enhancer in men with normal testosterone.

This point is particularly important because commercial advertising often suggests that every tired or sexually dissatisfied man needs testosterone.

He does not.

A Major Warning: Testosterone Can Reduce Male Fertility

This is extremely important in my infertility practice.

External testosterone suppresses pituitary LH and FSH.

Those hormones are necessary for normal testicular sperm production.

As a result, testosterone treatment can **substantially suppress spermatogenesis**.

EAU guidance therefore warns against testosterone therapy as treatment for male infertility and in men actively wishing to father children.

This is why I always ask:

“Are you planning a pregnancy?”

before considering hormone treatment.

Improving libido while reducing sperm production would clearly be the wrong outcome for a fertility patient.

High Prolactin and Loss of Libido

Another important hormone is **prolactin**.

Abnormally high prolactin can suppress sexual desire and reproductive hormonal pathways.

The EAU identifies hyperprolactinaemia as an established cause of low sexual desire. A prolactin-secreting pituitary adenoma is one possible cause and can be investigated and treated appropriately.

Symptoms that may increase concern include persistent low libido combined with hormonal abnormalities, headaches, visual symptoms or other endocrine features.

Not every low-libido patient needs a brain MRI.

The investigation should follow the clinical findings.

Thyroid Disorders

Both hypothyroidism and hyperthyroidism may affect sexual function.

Hypothyroidism can cause:

fatigue, low mood, reduced energy and reduced sexual interest.

Hyperthyroidism may produce:

anxiety, sleep disturbance, palpitations and other changes affecting sexual function.

EAU guidance specifically recommends treating accompanying endocrine disorders such as hypo- or hyperthyroidism according to their underlying diagnosis.

Traditional or herbal sexual medicines should never be used as a substitute for appropriate thyroid treatment.

Diabetes

Diabetes can affect sexual health in several ways.

It may contribute to:

vascular disease, neuropathy, erectile dysfunction, fatigue, depressive symptoms and low testosterone in some men.

All of these factors may indirectly reduce sexual desire.

Therefore, if a diabetic patient says:

“Doctor, I have lost my libido,”

the solution may involve improving diabetes and metabolic health rather than simply adding a sexual stimulant.

Cardiovascular Disease and Chronic Illness

Chronic medical disease often changes sexuality.

EAU guidance recognizes coronary artery disease, heart failure, renal failure, stroke and other major illnesses among conditions associated with male low sexual desire.

A person recovering from a heart attack may be physically capable of sex but psychologically afraid.

Someone with kidney disease may be fatigued.

A cancer patient may have treatment-related hormonal changes.

Chronic pain can make intimacy uncomfortable.

Loss of libido in these situations is often the result of the **whole health condition**, not one defective sexual organ.

Depression and Low Libido

Depression is one of the most important psychological causes.

Sexual interest is part of the brain's reward and motivation systems.

When a patient loses interest not only in sex but also in:

social activities, hobbies, food, work or relationships,

I consider depression particularly carefully.

The EAU identifies depression as a common cause of male low sexual desire and advises assessing depressive symptoms during evaluation.

Treating depression can improve sexual well-being.

However, some antidepressants themselves can produce sexual side effects, which creates an additional clinical challenge.

Anxiety and Performance Concerns

Anxiety can reduce libido even when testosterone and physical sexual function are normal.

A man may think:

“What if my erection fails?”

A woman may think:

“What if intercourse hurts again?”

A fertility patient may think:

“We must have sex tonight because today is ovulation.”

The sexual encounter becomes a test rather than an intimate experience.

EAU evidence shows that negative sexual thoughts, erection concerns, shame and anxiety are associated with low desire in men.

This is why counselling can be a genuine medical treatment.

Relationship Conflict

Sexual desire exists within relationships as well as within the individual.

Unresolved anger, poor communication, loss of trust, feeling emotionally ignored or mismatched expectations can all reduce desire.

Sometimes neither partner has a medical sexual disorder.

They simply have **different levels of desire**.

The EAU specifically encourages a less stigmatizing approach to desire discrepancy, treating the couple's difficulty rather than automatically labelling the lower-desire partner as diseased.

This is an important development in modern sexual medicine.

Stress and Overwork

Modern life frequently involves:

long working hours, financial pressure, mobile-phone overuse, irregular sleep and constant mental stimulation.

When the brain remains under chronic stress, sexual desire can become a lower priority.

Mayo Clinic likewise identifies stress, fatigue, depression, alcohol or drug use and endocrine disorders among common explanations for loss of sex drive in men.

Sometimes the most effective treatment begins not in the pharmacy but with restoring sleep, energy and emotional balance.

Sleep and Libido

Adequate sleep is important for hormonal, metabolic and psychological health.

A patient sleeping four or five hours every night may experience:

fatigue, irritability, reduced physical activity, hormonal disruption and decreased sexual interest.

This should be corrected before declaring that the patient has an incurable sexual weakness.

Medicines That Can Reduce Libido

Medication review is essential.

Certain drugs can affect sexual desire directly or indirectly.

Common examples include some:

antidepressants, antipsychotic medicines, opioids, antiandrogen treatments and other hormone-altering medications.

EAU guidance specifically recognizes antidepressant therapy among common causes of male low sexual desire and recommends considering modification of chronic medicines that negatively affect desire when clinically appropriate.

Patients must not stop important medicines themselves.

The correct question is whether the prescribing clinician can safely change the dose, timing or medication.

Antidepressants and Sexual Function

SSRIs are highly useful medicines, but sexual dysfunction is a recognized adverse effect in some patients.

Possible symptoms include:

reduced desire, delayed orgasm, delayed ejaculation or erectile difficulties.

If depression itself is causing low libido and the medication also produces sexual side effects, treatment needs thoughtful adjustment.

EAU guidance notes that antidepressants with fewer sexual effects may be considered when appropriate and that psychotherapy can enhance overall treatment in depression-related low desire.

The patient should not suddenly stop antidepressants because withdrawal and recurrence of depression can occur.

Alcohol and Recreational Drugs

Alcohol can temporarily reduce anxiety but excessive or chronic use may impair sexual desire, erection, hormonal function and relationships.

Substance misuse can also reduce libido through neurological, psychological and endocrine effects.

Reducing harmful alcohol or drug use therefore forms part of treatment where relevant.

Low Libido in Women

Female sexual desire deserves the same seriousness as male sexual problems.

A woman may experience decreased desire because of:

stress, depression, relationship circumstances, painful intercourse, menopause, vaginal dryness, medications, chronic illness or hormonal changes.

Mayo Clinic recommends evaluating women with low desire through medical history, pelvic examination when indicated, laboratory testing for possible endocrine or metabolic conditions, and consideration of psychological and relationship factors.

ACOG similarly emphasizes that female sexual problems often involve overlapping desire, arousal, orgasm and pain rather than one isolated defect.

Pain Can Reduce Desire

This relationship is very simple but often missed.

If sexual activity repeatedly causes pain, a person's brain naturally becomes less interested in it.

Women with:

vaginal dryness, genitourinary syndrome of menopause, vulvodynia, vaginismus or pelvic pain

may therefore report “low libido” when the primary problem is actually painful intercourse.

ACOG notes that stress, fatigue, fear, guilt and pain can all interfere with sexual response.

Treating the pain may improve desire without needing a specific libido medicine.

Menopause and Low Libido

Menopause can affect sexual health through several mechanisms.

Lower estrogen can lead to:

vaginal dryness, tissue changes and painful intercourse.

Ageing may also coincide with:

sleep disturbance, chronic illness, medication use and relationship changes.

Some women experience reduced desire while others do not.

Therefore, menopause should never be treated as though it automatically ends sexual interest.

Treatment should address the woman's actual symptoms.

Female Hypoactive Sexual Desire Disorder

HSDD in women generally refers to **acquired or persistent low sexual desire associated with clinically meaningful distress and not primarily explained by another medical or psychiatric condition, relationship problem or medication effect**.

This distinction is important because it prevents us from prescribing a “desire drug” when the actual issue is:

untreated depression, painful intercourse, thyroid disease or relationship abuse.

A Major 2025–2026 Update: Flibanserin

An important recent development is that the U.S. prescribing indication for **flibanserin (Addyi)** was broadened in December 2025.

The current FDA label indicates flibanserin for **women younger than 65 years with acquired, generalized HSDD** when the low desire causes marked distress or interpersonal difficulty and is not due to a medical or psychiatric condition, relationship problems, medication or another drug substance. It is not indicated for men or simply to enhance sexual performance.

The medicine requires careful prescribing because it can cause dizziness, sedation, hypotension and syncope. Its label also includes important interactions with alcohol, CYP3A4 inhibitors and hepatic impairment.

This is a good example of why specific sexual medicines require professional assessment rather than casual self-treatment.

Bremelanotide

Bremelanotide (Vyleesi) is another prescription option in the United States for selected **premenopausal women with acquired, generalized HSDD**.

It is used as an injection before anticipated sexual activity and is not indicated for men or for general enhancement of sexual performance.

It can temporarily increase blood pressure and has additional adverse-effect considerations, so patient selection matters.

Testosterone in Women

Testosterone is sometimes discussed for female sexual desire, especially after menopause.

The International Society for the Study of Women's Sexual Health guideline supports appropriately dosed **systemic transdermal testosterone** for selected women with HSDD—particularly postmenopausal women—when the problem is not primarily due to modifiable relationship or mental-health factors.

The guideline describes the overall therapeutic benefit as moderate and emphasizes that long-term safety data remain incomplete. It also states that a woman's testosterone level should **not be used to diagnose HSDD**, although testosterone measurements are useful for monitoring treatment.

In many countries this remains an off-label treatment.

Therefore, testosterone should not be promoted as a universal female libido enhancer.

How I Diagnose Low Libido

When a patient consults me, I begin with conversation.

Sexual desire is not something that can be diagnosed from one laboratory report.

I want to understand:

When did the change begin?

Was desire normal previously?

Is desire absent in every situation or only with one partner?

Are sexual fantasies also reduced?

Is masturbation desire preserved?

Is erection normal?

Is intercourse painful?

Can orgasm occur?

Is the patient depressed?

Are there relationship difficulties?

Which medicines are being taken?

Are diabetes, thyroid disease or chronic illness present?

How is sleep?

Is pregnancy being planned?

This history helps distinguish a hormonal condition from a relationship problem, medication effect, sexual pain disorder or psychological cause.

Physical Examination

Physical examination is not required in exactly the same way for every low-desire complaint.

However, depending on symptoms, it may reveal:

signs of androgen deficiency, obesity, thyroid disease, genital abnormalities or another medical problem.

EAU guidance recommends physical assessment in men with low desire, particularly to identify associated sexual dysfunction or anatomical abnormalities.

In women, pelvic examination may be appropriate when vaginal pain, dryness or vulvovaginal changes are present.

Blood Tests

Laboratory tests should answer a clinical question.

In a man with low libido, testing may include:

morning testosterone and, where indicated, prolactin, thyroid hormones and other endocrine investigations.

The EAU gives a strong recommendation to exclude endocrine disorders in men with persistent low sexual desire.

For women, testing may be appropriate when symptoms suggest thyroid disease, diabetes or another medical condition, but there is **no universal libido blood test**.

Psychological Assessment

Depression, anxiety, trauma and relationship factors should be evaluated sensitively.

This does not mean telling the patient:

“It is all in your mind.”

The brain is a biological organ and sexual desire is strongly influenced by emotional state.

EAU evidence supports cognitive and behavioural approaches in selected men and recognizes mindfulness as a potentially useful strategy, although evidence specifically for male low-desire treatment remains less extensive than for some other sexual disorders.

Treatment Begins With the Cause

I do not believe in a universal libido treatment.

Consider several patients.

A man with low testosterone requires one strategy.

A woman with painful intercourse after menopause requires another.

A patient whose libido fell after starting an SSRI needs medication review.

A couple with unresolved relationship conflict may benefit from therapy.

A diabetic obese man with fatigue and ED requires metabolic treatment.

The symptom is the same:

“My desire is low.”

The disease is not.

Treating Testosterone Deficiency

When male hypogonadism is correctly diagnosed, testosterone therapy can improve sexual desire in suitable patients.

But I repeat two important conditions:

The testosterone deficiency must be real.

And fertility goals must be considered.

External testosterone should not be used for a man trying to father children because spermatogenesis can be suppressed.

Treating High Prolactin

If elevated prolactin is genuinely responsible, treatment depends on the cause.

A prolactin-producing pituitary adenoma may respond to dopamine-agonist therapy and appropriate endocrine follow-up.

Giving a sexual tonic without correcting significant hyperprolactinaemia would miss the actual disease.

Treating Thyroid Disease

When hypothyroidism or hyperthyroidism is contributing to low desire, appropriate thyroid treatment comes first.

Once thyroid function and overall health improve, sexual symptoms may also improve.

Unani therapy can be considered as supportive care where appropriate, but necessary endocrine treatment should not be stopped.

Treating Depression and Anxiety

Depression-related low libido can improve when depression is successfully treated.

This may involve:

psychotherapy, medication or both.

If medication itself is creating sexual adverse effects, the treating clinician can determine whether another antidepressant strategy is appropriate.

Relationship or performance anxiety may benefit from **psychosexual counselling and couple therapy**.

Improving Lifestyle

Lifestyle medicine is not a guaranteed libido treatment, but it often improves several of the systems required for healthy sexuality.

Regular physical activity may improve:

energy, cardiovascular health, metabolic health, mood and body confidence.

Adequate sleep can improve fatigue.

Weight management can improve metabolic and hormonal health.

Stopping tobacco supports vascular health.

Reducing excessive alcohol improves general and sexual health.

Stress management allows attention to return from constant worry toward intimacy.

These measures are particularly valuable when low libido is part of broader poor health.

Communication With the Partner

Sometimes the treatment begins with a conversation between partners.

A lower-desire partner may feel pressured.

The higher-desire partner may feel rejected.

Both may incorrectly assume the other person no longer loves them.

Open, non-accusatory communication can reduce pressure and allow intimacy to become pleasurable again.

The modern concept of **desire discrepancy** is useful here because it avoids turning one partner into “the patient” simply because their preferred frequency is lower.

The Unani Concept of Loss of Libido

The Unani system of medicine has long recognized diminished sexual desire.

The Central Council for Research in Unani Medicine's **Standard Unani Medical Terminology** defines **Du‘f al-Bah** as a condition involving weakness or reduction of sexual drive, impaired erection and lack of sexual desire, and gives **anaphrodisia/loss of libido** as its possible modern equivalent.

CCRUM's broader overview of Unani medicine also lists **loss of libido** among sexual disorders traditionally managed within Unani practice.

This gives us a clear traditional framework.

However, I consider one academic distinction extremely important.

Du'f al-Bah is a traditional Unani clinical concept. It should not automatically be equated with every modern diagnosis of HSDD, testosterone deficiency or female sexual interest/arousal disorder.

Modern sexual medicine and Unani medicine use different physiological models.

Both can be respected without pretending they are identical.

Mizaj and Sexual Desire

Mizaj, or temperament, is one of the fundamental concepts in Unani medicine.

The individual constitution is assessed rather than treating every patient as physiologically identical.

Classical Unani thinking examines qualities traditionally described in terms of:

heat, coldness, moisture and dryness.

These traditional concepts are then considered alongside:

age, general health, digestion, sleep, lifestyle and psychological state.

For loss of libido, this encourages individualized treatment.

A physically exhausted patient with digestive weakness is not automatically treated like a highly anxious patient with normal physical health.

This personalization remains one of the major strengths of Unani clinical philosophy.

Humoral Theory: How It Should Be Explained Today

Classical Unani medicine also uses the concept of **Akhlat**, or humours.

Traditional physicians considered disturbances in temperament and humoral balance when evaluating sexual weakness.

However, I do **not** tell patients that modern low testosterone, depression or vascular disease is literally the same thing as "too much phlegm" or "too little blood."

These explanatory systems developed in different historical periods.

Modern laboratory medicine can measure testosterone, prolactin and thyroid hormones.

Unani medicine contributes a traditional constitutional model.

Responsible integrative medicine can use both appropriately without creating false equivalence.

Asbab Sitta Daruriyya: Six Essential Factors

A particularly practical part of Unani medicine is its emphasis on the **six essential factors of life and health**, including environment, diet, movement and rest, psychological activity, sleep and bodily retention or elimination.

These principles are highly relevant to low sexual desire.

Poor sleep can reduce energy.

Inactivity can worsen metabolic health.

Chronic psychological stress can suppress sexual interest.

Unhealthy diet can contribute to obesity and diabetes.

This is where traditional Unani lifestyle management and modern biopsychosocial sexual medicine can complement each other very naturally.

The Major Unani Treatment Modes

CCRUM describes Unani treatment through several broad approaches including **Ilaj-bil-Ghiza (dietotherapy), Ilaj-bil-Tadbir (regimental therapy), Ilaj-bil-Dawa (pharmacotherapy) and Ilaj-bil-Yad (surgical treatment where applicable)**.

For low libido, the most relevant components are usually diet, lifestyle/regimen, psychological well-being and individualized pharmacotherapy.

I do not consider libido treatment to be simply the prescription of one aphrodisiac.

Ilaj-bil-Ghiza: Dietotherapy

Diet should support the patient's actual medical condition.

For an overweight diabetic man, a large amount of sugar, honey and calorie-dense “sexual food” may worsen metabolic disease.

For a nutritionally depleted patient, improved calories and protein may be useful.

For someone with high cholesterol, cardiovascular health matters.

Therefore, I recommend **individualized nutrition**, not one universal libido diet.

Foods such as nuts, fruits and other nutrient-dense items can form part of a healthy diet, but no food can guarantee restoration of sexual desire.

Ilaj-bil-Tadbir: Regimental and Lifestyle Treatment

For low libido, regimental care may involve attention to:

physical activity, sleep, stress, emotional well-being and healthy routine.

Patients whose desire has disappeared because of exhaustion may need restoration of physical and psychological balance.

Those with anxiety may benefit from relaxation and counselling.

Those with obesity need metabolic care.

The purpose is to strengthen general health so that healthy sexual interest has an environment in which it can return.

Psychological Factors in Unani Care

A strong feature of traditional Unani sexual-health thinking is recognition that **mental and emotional factors can influence sexual function**.

This should be taken seriously.

I do not consider counselling incompatible with Unani medicine.

On the contrary, when anxiety, depression, fear or relationship difficulties are responsible, psychological treatment addresses the actual cause much more directly than simply adding another tonic.

Ilaj-bil-Dawa: Unani Pharmacotherapy

Traditional medicines can form part of individualized management.

The aim may include supporting:

general vitality, nervous-system wellness, psychological calm, reproductive health or associated sexual dysfunction.

However:

The medicine should be selected after understanding why libido is low.

A patient with untreated hyperprolactinaemia requires very different care from a patient whose primary difficulty is chronic stress.

A patient taking an SSRI needs medication review.

A woman with painful vaginal dryness requires treatment of the pain and tissue changes.

A traditional formulation should support appropriate care—not hide the underlying disease.

Saffron (Zafran): Traditional Use and Modern Evidence

Zafran, or saffron, is an important traditional medicinal substance and has attracted contemporary research in sexual function.

A systematic review and meta-analysis of small clinical studies found a positive signal for saffron across several measures of sexual dysfunction, although only five studies involving 173 participants were included and further research was recommended.

A 2024 randomized trial in women also found improvement in several sexual-function domains—including libido—when saffron was added to vitamin E compared with vitamin E alone. The study was relatively small, so it should be considered supportive rather than definitive evidence.

I therefore consider saffron a **promising traditional ingredient with some human evidence**, but I would not describe it as a guaranteed treatment for HSDD.

Asgandh / Ashwagandha

CCRUM recognizes **Asgandh (Withania somnifera)** within Unani materia medica as a nervine and general tonic traditionally used in states including general weakness and psychological stress.

Contemporary research has also become increasingly interesting.

A recent placebo-controlled study in healthy men reported improvements in sexual-desire and sexual-function measures with a standardized Ashwagandha root extract.

A 2025 systematic review likewise found growing clinical research concerning Ashwagandha and reproductive/sexual outcomes, although formulations and study populations vary considerably.

This distinction is essential:

Evidence for one standardized extract does not prove that every Ashwagandha product or every compound formulation produces the same effect.

Zanjabeel / Ginger

Ginger has a long traditional use and several interesting modern reproductive studies.

However, its direct evidence as a standard clinical treatment for low libido remains limited.

One experimental human study suggested that ginger may influence sexual arousal under specific laboratory conditions, but that is not equivalent to proving it treats HSDD.

I therefore regard ginger primarily as a traditional supportive ingredient rather than a replacement for diagnosis-specific libido treatment.

Natural Does Not Mean Side-Effect Free

This is one of the principles I emphasize most strongly.

Herbs are biologically active.

If an herb can have a therapeutic effect, it can also potentially:

interact with medicines, produce allergies, affect blood pressure or glucose, or be unsuitable for certain medical conditions.

Safety depends on:

the correct substance, quality, preparation, dose, duration and patient.

The strongest traditional medicine is **responsibly prescribed traditional medicine**.

How I Treat Loss of Libido at Saira Health Care

At Saira Health Care, my approach can be summarized as **diagnosis first, individualized treatment second**.

I begin by distinguishing low sexual desire from:

erectile dysfunction, premature ejaculation, orgasmic difficulty, sexual pain and infertility.

I then consider whether the cause is primarily:

hormonal, metabolic, medication-related, psychological, relationship-related or mixed.

Where indicated, I evaluate:

testosterone, prolactin, thyroid function, diabetes and other relevant conditions.

I assess sexual and fertility goals.

Then I perform an individualized Unani assessment involving:

Mizaj, diet, sleep, digestion, general strength, emotional state and lifestyle.

Treatment may subsequently involve a combination of:

appropriate medical management, counselling, correction of lifestyle, treatment of endocrine disease, management of associated ED or sexual pain and physician-selected Unani supportive pharmacotherapy.

This is consistent with Saira Health Care's published philosophy of combining traditional Unani assessment, individualized care, lifestyle guidance and contemporary diagnostic understanding.

Why I Do Not Give the Same Libido Medicine to Everyone

Consider four patients.

A 35-year-old man has low sexual interest, loss of morning erections and repeatedly confirmed low testosterone.

A 30-year-old man has normal hormones but severe depression after losing his job.

A 47-year-old woman has desire but avoids intercourse because menopause-related vaginal dryness makes sex painful.

A 32-year-old woman developed generalized distressing low desire despite satisfactory health and relationship circumstances.

All four may tell me:

“My libido is low.”

But their treatments should be completely different.

That is individualized sexual medicine.

Libido and Erectile Dysfunction Together

Some men lose desire because they repeatedly experience erection failure.

They begin associating intimacy with embarrassment.

Eventually they avoid sex.

EAU guidance recognizes erectile dysfunction itself as one of the common conditions associated with male low sexual desire.

In these patients, successful ED treatment may indirectly improve libido by restoring confidence.

However, I still evaluate whether desire was low **before** the erection problem started.

Libido and Premature Ejaculation

Premature ejaculation can also affect desire indirectly.

A man who experiences repeated distress or relationship conflict because of ejaculation may gradually avoid intercourse.

Likewise, his partner may lose interest because sexual encounters become stressful.

Therefore, restoring sexual confidence and addressing PE may improve desire in some couples.

This does not mean PE biologically causes all low-libido cases.

Libido and Infertility

Infertility can itself reduce sexual desire.

Couples trying for pregnancy sometimes stop having spontaneous intimacy.

Sex becomes scheduled around ovulation.

A husband begins worrying about sperm count.

The wife worries about her fertile window.

Every sexual encounter feels like a medical procedure.

This can reduce desire even when both partners are physically healthy.

In such cases, counselling and restoring intimacy outside the fertility timetable may be very valuable.

Low Libido After Childbirth

Pregnancy and childbirth can change female sexual desire.

Factors may include:

fatigue, sleep deprivation, breastfeeding-related hormonal changes, vaginal discomfort, body-image concerns and the emotional demands of caring for a newborn.

This is often a multidimensional situation rather than evidence of a permanent sexual disorder.

Persistent pain, significant depression or severe distress should be evaluated appropriately.

Ageing and Libido

A gradual change in desire can occur with ageing, but sexual interest does not automatically disappear.

Mayo Clinic notes that many men continue to maintain sexual interest into their 60s and 70s, even though gradual decline varies between individuals. Sudden or marked loss of sex drive should prompt assessment for medical, psychological or medication-related causes.

Older women similarly vary considerably.

Age alone should never be used to dismiss a patient's sexual-health concern.

Common Myths About Loss of Libido

“Low libido always means low testosterone.”

No.

Testosterone deficiency is one possible cause in men, but depression, anxiety, relationship conflict, chronic disease, medication, sleep problems and other conditions are also important.

“If I can achieve an erection, my libido must be normal.”

No.

Erection and desire are different functions.

“Sildenafil or tadalafil will increase my sexual desire.”

Not necessarily.

These medicines improve the erectile response; they are not primary treatments for low desire.

“Low libido means infertility.”

No.

Sexual desire and sperm production are different biological processes.

“Testosterone improves male fertility.”

External testosterone can actually suppress sperm production.

“Women naturally stop wanting sex after menopause.”

No.

Some women experience reduced desire, others do not. Pain, dryness, relationship factors and general health should be evaluated individually.

“One partner wanting less sex means that partner has a disease.”

Not necessarily.

Natural desire discrepancy is common in relationships.

“Herbal medicines cannot have side effects.”

Incorrect.

Traditional medicines contain biologically active substances and require appropriate professional use.

Frequently Asked Questions

Is low libido a disease?

Not always.

Sexual desire naturally varies. It becomes clinically important when the change is persistent, distressing or associated with an underlying medical or psychological condition.

Can stress completely remove sexual desire?

Yes, significant chronic stress can substantially reduce libido.

Can low testosterone cause low libido?

Yes. It is an important cause in men, but diagnosis requires symptoms plus appropriate laboratory confirmation.

Should every man with low libido take testosterone?

No.

EAU guidance supports testosterone when compatible symptoms are associated with genuine testosterone deficiency, not when testosterone is normal.

Can high prolactin reduce libido?

Yes. Hyperprolactinaemia is a recognized cause and sometimes results from pituitary disease.

Can thyroid disease reduce sex drive?

Yes. Both hypo- and hyperthyroidism can affect sexual function, and the underlying thyroid condition should be treated appropriately.

Can antidepressants reduce libido?

Some can. Medication should be reviewed with the prescribing doctor rather than stopped suddenly.

Can women receive medical treatment for HSDD?

Yes, selected women may be candidates for treatment after proper assessment. Current U.S. options include flibanserin for women under 65 with acquired generalized HSDD and bremelanotide for appropriate premenopausal women.

Can testosterone be used in women?

Selected women, particularly postmenopausal women with properly diagnosed HSDD, may be considered for carefully monitored transdermal testosterone under specialist guidance. It is not diagnosed by a low testosterone number alone, and long-term safety data remain incomplete.

Can Unani medicine help with loss of libido?

Yes, I consider Unani medicine particularly valuable as an **individualized supportive system** that considers Mizaj, general vitality, diet, sleep, psychological health and lifestyle alongside traditional pharmacotherapy. CCRUM itself recognizes Du'f al-Bah/anaphrodisia and loss of libido within Unani medical terminology.

However, significant endocrine, psychiatric, cardiovascular or medication-related causes should also receive appropriate modern evaluation.

Dr. Nizamuddin Qasmi and My Work in Sexual Disorders & Infertility

I am **Dr. Nizamuddin Qasmi**, Founder and Chief Physician of **Saira Health Care**, with a focused clinical practice in **sexual disorders and infertility**.

My professional education and training for this article 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

Saira Health Care's public professional profile confirms BUMS, MD, CGO, Certificate in Infertility and **Certificate in Urology – London, UK**, and describes my focused clinical work in

sexual disorders and infertility, including concerns such as erectile dysfunction, premature ejaculation, loss of libido and male reproductive disorders.

MasterHealthPro publicly lists a six-month **Male Infertility Masters** course and also offers training in sexual medicine, psychosexual medicine, desire disorders and related male reproductive-health areas.

This combined sexual-health and infertility perspective is important because loss of libido can exist together with:

hormonal abnormalities, erectile dysfunction, ejaculation problems and fertility concerns.

These conditions must be separated before appropriate treatment can be planned.

Contribution of Saira Health Care in Sexual Disorders and Infertility

At Saira Health Care, I believe our contribution should extend beyond simply providing medicines.

Sexual-health patients frequently arrive with fear and misinformation.

A man may believe he has permanently lost masculinity because his desire declined.

A woman may think she must tolerate painful intercourse.

A fertility patient may believe low libido proves low sperm count.

Another patient may buy testosterone without checking hormones.

Someone else may stop an antidepressant because of sexual side effects.

Good sexual medicine begins by replacing such confusion with **accurate diagnosis and education**.

Saira Health Care describes its model as patient-centered and non-judgmental, combining individualized Unani treatment, nutrition and lifestyle guidance with contemporary research and diagnostic understanding.

I consider that particularly appropriate for libido disorders because sexual desire is inherently **biological, psychological and relational**.

My Special Treatment Philosophy

When a patient consults me for loss of libido, my objective is not simply to increase the frequency of sexual thoughts.

My objective is to understand whether the patient is healthy, comfortable and satisfied with his or her sexual life.

I first determine whether the problem is truly low desire.

I then separate it from erection, ejaculation, orgasm and fertility disorders.

I evaluate endocrine and medical causes where indicated.

I review medications.

I assess stress, depression, relationship circumstances and sleep.

I discuss pregnancy goals where relevant.

I assess the patient according to Unani principles, including Mizaj and broader lifestyle factors.

Only then do I develop an individualized treatment plan.

The treatment may involve **one or several approaches**, but it should always correspond to the cause.

That is the difference between merely prescribing an aphrodisiac and practising comprehensive sexual medicine.

Prognosis

The prognosis for low libido is often good when the underlying cause can be identified.

A man with genuine testosterone deficiency may experience improved desire after appropriate treatment.

A patient whose sexual interest declined during depression may improve as mental health recovers.

A couple with desire discrepancy may improve substantially after communication and counselling.

A woman avoiding sex because of vaginal pain may experience renewed desire once intercourse becomes comfortable.

A patient whose libido fell because of medication may improve after professionally supervised adjustment.

A chronically exhausted person may improve after restoring sleep and general health.

More complex cases may require longer-term treatment.

The key predictor is therefore not the label **“low libido”** but the reason behind it.

Conclusion

Loss of libido is one of the most misunderstood sexual-health complaints because patients often assume that one hormone or one organ must be responsible.

Modern sexual medicine tells us something much more important.

Sexual desire is biopsychosocial.

Current EAU guidance describes male sexual desire as the interaction of biological drive, psychological motivation and social or cultural influences. Common contributing conditions include androgen deficiency, hyperprolactinaemia, depression, anxiety, relationship conflict, chronic illness, erectile dysfunction and medication effects.

Testosterone has an important role, but libido does not correspond perfectly to one blood level. Genuine hypogonadism requires symptoms together with biochemical evidence of testosterone deficiency.

In women, low sexual desire also requires a multidimensional evaluation. Pain, menopause-related changes, emotional health, medicines and relationship factors may all contribute. ACOG continues to emphasize that clinically meaningful female sexual dysfunction is defined not simply by a symptom but by the **distress associated with it**.

Modern pharmacological options are also evolving. As of the December 2025 FDA label update, flibanserin is indicated for women under 65 with appropriately diagnosed acquired generalized HSDD, while bremelanotide remains an option for selected premenopausal women. These treatments have specific eligibility criteria and safety considerations and are not general sexual-performance enhancers.

The **Unani system of medicine** provides a particularly valuable complementary perspective.

CCRUM's standardized terminology recognizes **Du'f al-Bah** as sexual weakness associated with diminished desire and gives anaphrodisia/loss of libido as its possible modern equivalent. CCRUM also specifically identifies loss of libido among disorders addressed within Unani medicine.

Traditional Unani care evaluates the patient through **Mizaj, general vitality, psychological health, diet, sleep, lifestyle and associated bodily functions**, rather than treating desire as an isolated genital symptom.

Several traditional ingredients also have emerging modern research. Saffron has shown encouraging signals in small clinical studies of sexual dysfunction, while newer research on standardized Ashwagandha extracts has reported improvements in sexual-desire measures. These findings are promising but should not be extrapolated into a guarantee that every herbal product or compound formulation will treat HSDD.

At **Saira Health Care**, my approach as **Dr. Nizamuddin Qasmi** is therefore based on one central principle:

I do not treat low libido simply by trying to stimulate sexual desire. I first determine why desire has changed. I evaluate hormonal, medical, psychological, medication-related and relationship factors; distinguish libido from erection and fertility problems; assess the patient's Mizaj and overall health; and then create an individualized treatment plan using appropriate modern medical care together with responsibly supervised Unani diet, lifestyle and pharmacotherapy where suitable.

For patients, my most important message is:

A decrease in sexual desire does not automatically mean that your hormones are permanently damaged, that your relationship is failing, or that your sexual life is over. Libido naturally changes, and persistent low desire can have many treatable causes. The correct approach is not embarrassment or random self-medication—it is to understand the cause and treat the whole person.

Medical Disclaimer

This article is intended for **general medical education and sexual- and reproductive-health awareness**. It does not replace an individualized consultation, physical examination, psychological assessment or appropriate laboratory investigation.

Low sexual desire can result from hormonal disease, depression, anxiety, medication effects, relationship difficulties, chronic illness, sexual pain or other factors.

Do not start testosterone solely because libido is reduced. Testosterone therapy should be considered only after appropriate diagnosis and can suppress sperm production in men who wish to father children.

Do not stop antidepressants, thyroid medicine, diabetes treatment or other prescribed therapies because of sexual side effects without consulting the treating clinician.

Flibanserin and bremelanotide are prescription medicines with specific indications, contraindications and adverse effects. They are not general sexual-performance enhancers.

Unani, herbal and traditional medicines contain biologically active ingredients. They should not be assumed to be universally free from adverse effects, quality concerns or drug interactions.

No hormone, conventional drug, herb, Unani formulation, supplement, food or counselling programme can responsibly guarantee restoration of libido or identical results in every patient.