# Loss of Sexual Excitement During Intercourse

**Understanding Reduced Sexual Arousal, Its Causes, Diagnosis, Treatment and the Unani Approach**

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Sexual excitement or arousal is an important part of a healthy intimate relationship, but it does not always remain at the same level throughout life. A temporary reduction in excitement can occur because of tiredness, stress, illness, relationship problems, hormonal changes or simply because the mind is occupied with other responsibilities.

When patients come to me and say, **"Doctor, I want intimacy, but during intercourse I suddenly lose excitement,"** I first explain that this is not necessarily a sign of weakness or a permanent sexual disorder. Sexual response involves the brain, emotions, hormones, nerves, blood circulation, genital sensation and the relationship between partners. Disturbance in any one or several of these areas may reduce sexual excitement. Modern sexual-medicine literature therefore recommends looking at the problem through a combined biological, psychological and relationship-based, or **biopsychosocial**, approach.

The expression **"loss of excitement during intercourse" is a symptom rather than one single medical diagnosis**. In women it may occur as part of sexual interest/arousal disorder; in men it may appear as loss of sexual interest, difficulty maintaining an erection, reduced sensation or another sexual dysfunction. In either sex, anxiety, depression, medicines, chronic illness, pain, relationship difficulties and inadequate stimulation can contribute.

My purpose in this article is to explain the problem in simple language, discuss what may cause it, and describe how I approach such patients at **Saira Health Care**, including the appropriate role of the Unani system of medicine.

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## What Does "Loss of Sexual Excitement During Intercourse" Mean?

Sexual excitement is not limited to erection in men or lubrication in women. It includes mental interest, emotional involvement, pleasurable physical sensations, genital response and the feeling of being engaged in intimacy.

A person experiencing reduced arousal may begin sexual activity with interest but gradually feel disconnected. Some people report that their mind “switches off.” Others remain mentally interested but notice less physical response.

In women, clinically significant difficulties with sexual interest and arousal may fall within **Female Sexual Interest/Arousal Disorder (FSIAD)**. Current diagnostic descriptions include persistent reductions in sexual interest, erotic thoughts, initiation of sexual activity, pleasure, response to sexual stimulation or genital and non-genital sensations. For a formal disorder, symptoms generally need to persist for around six months and cause significant personal distress.

It is equally important to understand that a person does not need to meet every formal diagnostic criterion before seeking help. If the change is troubling you, affecting confidence or causing difficulty between partners, medical consultation can still be worthwhile.

**Sexual Desire and Sexual Arousal Are Not Exactly the Same**

Patients often use words such as desire, excitement, erection and performance interchangeably, but medically they describe different parts of sexual function.

**Sexual desire** is the interest or motivation for sexual activity.

**Sexual arousal** is the mental and physical excitement that develops in response to appropriate stimulation.

**Orgasm** is another phase of sexual response.

In real life these processes overlap considerably. In women especially, sexual desire does not necessarily have to appear before intimacy begins. Desire may develop after emotional closeness, affection and appropriate stimulation have already started. ACOG's model of female sexual response recognizes this circular and overlapping pattern rather than assuming that every sexual encounter follows the same fixed sequence.

For this reason, saying “I don't feel excited immediately” does not automatically indicate disease.

**Symptoms That May Accompany Loss of Sexual Excitement**

A person may notice less mental excitement, reduced interest during intimacy, difficulty maintaining attention on sexual activity, fewer pleasurable sensations or a feeling of emotional detachment.

Women may notice reduced genital sensation or lubrication, less pleasure despite stimulation, reduced interest in continuing intercourse or discomfort that gradually causes arousal to disappear. Men may notice difficulty maintaining an erection even after initially becoming aroused, reduced firmness, loss of erection during intercourse or reduced subjective excitement.

Some patients develop anxiety because they begin watching themselves closely during sex: “Will I lose my erection again?” or “Will I become excited this time?” That pressure itself can interfere with sexual response and create a repeating cycle.

**Why Does Sexual Excitement Decrease?**

There is rarely one universal cause. During consultation, I try to identify what has changed in the patient's physical health, emotional health, medicines, lifestyle and relationship.

**Stress and Mental Overload**

Stress is one of the most common contributors I see in clinical practice.

A person may physically be in the bedroom while mentally remaining at the office, thinking about money, family responsibilities, business, examinations, children or another problem.

Sexual arousal requires sufficient attention to pleasurable stimulation. Anxiety and distraction can interfere with that process. Depression, low self-esteem and chronic stress are recognized contributors to sexual interest and arousal problems.

**Performance Anxiety**

Performance anxiety is particularly important.

A man who once loses his erection may become worried that it will happen again. During the next encounter, instead of experiencing intimacy naturally, he begins monitoring his erection. Anxiety increases, relaxation decreases and erection may again become difficult.

Women can experience a similar cycle by worrying about whether they will become sufficiently aroused, lubricated or reach orgasm.

The more sexual activity becomes an examination of performance, the harder it can become to experience natural excitement.

**Depression and Anxiety**

Depression can reduce interest and pleasure across many areas of life, including sexual activity. Anxiety may make it difficult for the nervous system and mind to relax enough for satisfying arousal.

Modern clinical guidance therefore includes psychological assessment as an important component of sexual-dysfunction evaluation. Cognitive behavioural approaches, mindfulness-based therapy, sex therapy and other psychological interventions may be appropriate for selected patients.

**Relationship Difficulties**

Sexual excitement does not exist separately from the relationship.

Unresolved arguments, emotional distance, mistrust, lack of communication, different expectations regarding intimacy or dissatisfaction with previous sexual experiences may all affect arousal.

In such situations, medicine alone is unlikely to provide a complete solution.

Improving communication and understanding what each partner finds comfortable and pleasurable are recognized components of treatment for sexual interest and arousal difficulties.

**Physical Causes**

Sexual arousal also depends on the body's physical systems.

Diabetes, cardiovascular disease, neurological disorders, hormonal disturbances, chronic pain, fatigue, menopause and certain other illnesses can affect sexual response.

For men, erection requires coordinated functioning of the brain, hormones, nerves and blood vessels. Diabetes, high blood pressure, vascular disease, obesity, smoking, neurological disorders and low testosterone can contribute to erectile difficulties.

Diabetes is particularly important because long-term high blood sugar can damage nerves and blood vessels involved in erection. Updated Mayo Clinic guidance published in March 2026 continues to emphasize the association between diabetes and erectile dysfunction.

Persistent erectile difficulty should therefore not automatically be dismissed as “mental weakness.” In some men it can be an early clue to cardiovascular or metabolic disease. Erectile dysfunction and cardiovascular disease share risk factors such as diabetes, hypertension, high cholesterol, obesity and smoking.

**Hormonal Factors**

Hormones influence sexual function, but I advise patients not to assume that every sexual problem is simply a testosterone or estrogen deficiency.

Hormonal changes can occur with menopause, pregnancy, breastfeeding, thyroid disease, elevated prolactin and certain medical conditions.

In women, declining estrogen during menopause can contribute to **genitourinary syndrome of menopause**, including vaginal dryness or pain. When sexual activity becomes uncomfortable, arousal may naturally decrease.

In men, clinically significant testosterone deficiency can sometimes contribute to low desire or erectile difficulty, but diagnosis should be based on appropriate symptoms and medical assessment rather than taking testosterone products without evaluation.

**Pain During Sexual Activity**

Pain is a major reason for losing excitement.

If intercourse repeatedly causes pain, burning or discomfort, the brain may begin associating intimacy with an unpleasant experience rather than pleasure.

In women, vaginal dryness, vulvar disorders, pelvic-floor problems, infections, endometriosis, fibroids and menopausal changes may contribute to painful intercourse. Effective treatment of pain can sometimes improve sexual interest and arousal considerably.

**Medicines Can Affect Sexual Function**

Another important question I ask patients is: **Did this problem start after beginning a new medicine?**

Some antidepressants, particularly SSRIs, as well as certain blood-pressure medicines, antiseizure medicines, opioids and other drugs may interfere with sexual desire or arousal.

However, patients should never stop antidepressants, blood-pressure tablets or other prescription medicines suddenly.

Instead, discuss the sexual side effect with the prescribing physician. Sometimes the dose, timing or medicine can be reviewed safely.

**Alcohol, Smoking and Substance Use**

Excess alcohol may reduce sexual desire and performance. Smoking damages blood vessels and is an important risk factor for erectile dysfunction. Recreational drugs may also interfere with sexual response and mental well-being.

A healthy sexual system depends upon healthy blood vessels, nerves and overall physical health.

**Poor Sleep and Fatigue**

Sometimes the most important treatment is not an aphrodisiac—it is sleep.

A person who is continuously exhausted may simply not have the physical or mental energy necessary for satisfying intimacy.

Poor sleep can also worsen stress, irritability and relationship conflict.

I therefore consider sleep history very important when assessing sexual complaints.

**Inadequate or Inappropriate Stimulation**

Every individual's sexual response is different.

What produces arousal for one person may not work for another. Inadequate preparation, rushing intercourse, lack of privacy, fear of interruption or insufficient emotional connection may reduce excitement.

Modern clinical guidance recognizes inadequate sexual stimulation and an unsuitable setting as possible contributors to arousal disorders.

This is one reason communication between partners is so important.

**How I Evaluate a Patient With Loss of Sexual Excitement**

When a patient comes to me with this complaint, I do not immediately start treatment with a so-called “power medicine.”

First, I want to know whether the problem involves desire, physical arousal, erection, lubrication, orgasm, pain or a combination of these.

I ask when the problem started, whether it happens every time or only occasionally, whether sexual excitement is present during other situations, whether there is morning erection in men when relevant, whether intercourse is painful, whether there are relationship difficulties, whether the patient is under unusual stress and what medicines are being taken.

I also consider diabetes, blood pressure, thyroid problems, hormonal disorders, neurological conditions, depression, anxiety, sleep problems and other illnesses.

In women, pelvic examination may sometimes be necessary when pain, dryness or other gynecological symptoms are present. Depending on the history, blood tests may also be appropriate to investigate diabetes, thyroid disease or selected hormonal abnormalities.

The important point is that investigations should be selected according to the individual patient. Every person does not require every hormone test.

**Loss of Sexual Excitement According to Unani Medicine**

The Unani system of medicine approaches health through concepts such as **Mizaj (temperament), Akhlat (humours), Quwa (faculties), A'za (organs), Arwah and Af'al (functions)**.

Classical Unani medicine recognizes four major humours: **Dam (blood), Balgham (phlegm), Safra (yellow bile) and Sauda (black bile)**. Health is traditionally understood in relation to the balance and functional harmony of these elements and the individual's temperament.

Sexual weakness or reduced sexual function has historically been discussed in Unani literature under different functional concepts rather than being exactly equivalent to modern psychiatric or sexual-medicine diagnoses.

Therefore, I do not believe it is scientifically correct to simply translate every modern sexual disorder into one classical Unani term.

Instead, I use Unani principles to understand the patient's constitution, general strength, digestion, sleep, mental state, diet and associated symptoms while also evaluating the patient according to contemporary clinical medicine.

**Why the Unani Approach Can Be Useful**

One of the valuable features of Unani medicine is its emphasis on treating the **person rather than a symptom in isolation**.

Official Ministry of AYUSH descriptions of Unani medicine identify the six essential factors of life—**Asbab-e-Sitta Zarooriya**—including air, food and drink, physical activity and rest, mental activity and rest, sleep and wakefulness, and appropriate retention and elimination.

These areas are highly relevant when treating many sexual-health complaints.

A person sleeping four hours every night, living under severe stress, eating poorly and suffering from uncontrolled diabetes cannot reasonably expect a sexual stimulant alone to correct the entire problem.

Unani medicine traditionally uses several therapeutic approaches. **Ilaj-bil-Ghiza** involves dietary management, **Ilaj-bil-Dawa** involves medicines and **Ilaj-bit-Tadbir** involves appropriate regimental measures. CCRUM officially describes these as established modes of treatment within the Unani system.

For sexual complaints, I use these principles selectively according to the patient's condition rather than prescribing the same formulation for everyone.

**Unani Medicines and Herbal Support**

Herbal medicines have traditionally been used to support vitality, reproductive health and general well-being in several South Asian medical systems.

Patients frequently ask me about herbs such as Ashwagandha, Safed Musli and similar products.

I always explain that **“herbal” does not automatically mean that a medicine is suitable for every patient**.

Ashwagandha provides an example of why evidence must be interpreted carefully. A randomized pilot study involving 50 women reported improvement in several domains of female sexual function with a standardized Ashwagandha extract compared with placebo. Another randomized study involving 80 women also reported improvement in Female Sexual Function Index scores. These findings are encouraging, but the studies were relatively small and involved specific standardized extracts; they do not prove that every Ashwagandha preparation or every traditional formulation will successfully treat every sexual disorder.

Research continues to develop. A 2026 randomized study also reported improvements in women's sexual-health measures with standardized Shatavari preparations, alone or in

combination with Ashwagandha. Such studies are interesting, but larger independent trials and longer safety data are still important before broad conclusions can be made.

This is why I prefer **individualized treatment instead of self-medication**.

A herb appropriate for one patient may be unnecessary or unsuitable for another depending on pregnancy, breastfeeding, diabetes, liver or kidney disease, blood pressure, other medicines or the actual cause of the sexual problem.

**My Line of Treatment at Saira Health Care**

At **Saira Health Care**, my first objective is to determine whether the patient primarily has a problem of desire, arousal, erection, ejaculation, orgasm, pain, hormonal health, psychological stress or relationship factors.

From there, treatment is individualized.

When Unani treatment is appropriate, I may focus on correction of diet and routine, improvement of general vitality, sleep, stress reduction and individualized Unani medication according to the patient's Mizaj and overall clinical picture.

At the same time, I do not ignore modern investigation.

If a patient requires diabetes testing, thyroid assessment, hormonal evaluation, gynecological assessment, cardiovascular evaluation, psychological counselling or another specialist opinion, that becomes part of responsible treatment.

This combination of careful diagnosis and individualized management is particularly important because modern reviews consistently show that female sexual dysfunction is multifactorial and that medication alone does not reliably resolve every sexual problem.

**Treatment in Modern Sexual Medicine**

Treatment should be directed toward the identified cause.

If anxiety or depression is important, counselling or psychological treatment may help. If relationship conflict is contributing, couples counselling or sex therapy may be useful. Mindfulness-based cognitive therapy has also shown benefit for some women with sexual-interest and arousal difficulties.

If vaginal dryness or menopausal changes are responsible, appropriate treatment of genitourinary syndrome of menopause can make intercourse more comfortable and may indirectly improve arousal. Local estrogen and other options may be considered for suitable patients after medical evaluation.

For appropriately selected postmenopausal women with hypoactive sexual desire disorder, expert guidelines recognize evidence supporting systemic testosterone therapy in carefully

monitored circumstances. This is not a treatment that women should start themselves, and it is not appropriate for every type of reduced arousal.

For men whose principal problem is erectile dysfunction, treatment may include correction of diabetes or cardiovascular risk factors, counselling when psychological factors are important and, where suitable, prescription PDE5 inhibitors such as sildenafil or tadalafil. These medicines increase the erectile response to sexual stimulation rather than automatically creating sexual desire. They are not safe for everyone, particularly people using nitrate medicines for chest pain, and should be taken with medical guidance.

**The Importance of the Partner**

I frequently tell couples that treatment works better when the problem is approached as **"our difficulty" rather than "your defect."**

Blaming the partner can increase anxiety and reduce intimacy further.

Healthy communication includes discussing comfort, timing, privacy, emotional connection and what type of affection or stimulation each person prefers.

Sometimes a couple has spent months worrying about sexual performance when the actual issue is insufficient communication.

**Loss of Excitement Is Not Always "Weakness"**

The word "weakness" is used very commonly in sexual-health discussions, but it can be misleading.

A healthy young person may experience temporary loss of excitement because of work pressure or performance anxiety.

A person with diabetes may experience the same symptom because of nerve and vascular changes.

A woman approaching menopause may lose arousal because intercourse has become uncomfortable.

Another person may be taking an antidepressant that is interfering with sexual response.

These situations require different treatments.

The symptom is similar, but the cause is different.

**Possible Complications When the Problem Is Ignored**

Persistent sexual difficulties can affect confidence, emotional closeness and relationship satisfaction.

A person may begin avoiding intimacy because of fear of failure. Their partner may misinterpret that avoidance as rejection.

Repeated unsuccessful experiences may then increase performance anxiety, creating a cycle in which anxiety produces sexual difficulty and sexual difficulty produces even greater anxiety.

Depression, frustration, low self-esteem and relationship tension may develop in some patients. Erectile dysfunction can also occasionally be an indicator of underlying metabolic or cardiovascular disease, making proper assessment particularly important in men with persistent symptoms.

**Can This Condition Be Successfully Treated?**

In many patients, meaningful improvement is possible once the contributing factors are identified.

However, I avoid giving patients an artificial “90% cure rate” or promising that one medicine will permanently solve every case.

Scientific evidence does not support a single fixed cure percentage because reduced sexual excitement can arise from many different conditions.

A patient with severe relationship stress has different treatment needs from someone with diabetes-related erectile dysfunction. A woman with menopausal vaginal pain needs a different approach from a woman whose symptoms began after an antidepressant.

Good treatment begins with identifying the cause.

**Contribution of Saira Health Care in Sexual Disorders and Infertility**

At **Saira Health Care**, our work is focused on helping patients discuss sexual and reproductive concerns in a respectful and confidential environment.

Sexual problems are often surrounded by embarrassment, misinformation and exaggerated advertising. Many patients delay consultation because they are uncomfortable discussing the subject or because they have already tried multiple unverified products.

My approach is to bring sexual-health problems into normal medical conversation.

A patient should be able to discuss erection, sexual desire, ejaculation, genital discomfort, infertility or loss of arousal in the same way that they would discuss diabetes or blood pressure.

Through Saira Health Care, our focus in sexual disorders and infertility includes careful clinical assessment, individualized Unani management where appropriate, lifestyle and dietary guidance, fertility evaluation, patient education and referral or modern investigation whenever clinically required.

The objective is not simply to increase sexual performance temporarily. The objective is to understand and treat the factors affecting the patient's overall sexual and reproductive health.

**When You Should Consult a Doctor**

You should seek medical evaluation particularly if:

- the problem continues repeatedly or has lasted for several months;
- erection repeatedly disappears or cannot be maintained;
- there is persistent pain, vaginal dryness or bleeding during intercourse;
- sexual desire has suddenly changed without an obvious explanation;
- you also have diabetes, high blood pressure, heart disease or thyroid disease;
- symptoms began after starting a medicine;
- depression, anxiety or severe stress is present;
- there is marked fatigue, unexplained weight change or other hormonal symptoms;
- fertility problems are present along with sexual dysfunction;
- the difficulty is causing significant distress or relationship problems.

**A Message From Dr. Nizamuddin Qasmi**

When patients discuss this condition with me, I want them to understand one important point:

**Loss of excitement during sexual intercourse is not something that should automatically be labelled as permanent sexual weakness.**

Sexual response is influenced by the entire person—the brain, emotions, relationship, hormones, nerves, blood circulation, physical health and lifestyle.

Sometimes the solution is relatively simple: better sleep, less stress, improved communication or treatment of pain.

Sometimes we discover diabetes, hormonal disturbance, medicine-related sexual dysfunction or another medical condition requiring specific treatment.

In selected cases, an individualized Unani approach can provide valuable support by addressing temperament, lifestyle, nutrition, sleep, mental well-being and general vitality alongside appropriate medicines. But good Unani practice also requires us to recognize when investigation or another form of medical treatment is necessary.

My philosophy is simple: **we should treat the cause, not merely suppress the symptom.**

**Frequently Asked Questions**

**Is loss of excitement during intercourse a disease?**

Not necessarily. It is usually a symptom. Occasional changes are common. Persistent symptoms associated with distress may represent a sexual dysfunction and deserve evaluation.

**Can stress cause loss of erection or arousal?**

Yes. Stress and performance anxiety can interfere with both mental and physical sexual response.

**Can diabetes cause sexual difficulties?**

Yes. Diabetes can damage nerves and blood vessels and is an important cause of erectile dysfunction in men. It can also contribute to sexual difficulties in women.

**Can medicines reduce sexual excitement?**

Yes. Certain antidepressants, blood-pressure medicines, antiseizure medicines and other drugs can contribute. Do not discontinue them without consulting the prescribing clinician.

**Can Unani medicine help?**

An individualized Unani approach may be useful as part of comprehensive care, particularly through its attention to diet, lifestyle, sleep, stress, temperament and appropriately selected medicines. However, the underlying cause should first be identified, and treatment should not replace necessary medical or psychological care.

**Does everyone need a sexual-power medicine?**

No. In many patients the main problem may be stress, depression, diabetes, pain, hormonal change, relationship difficulty or a medication side effect. Treatment should match the cause.

**Can the condition improve?**

Yes, many causes are manageable. The outcome depends upon correct diagnosis, underlying health conditions and appropriate treatment rather than one universal medicine.

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**Consult Dr. Nizamuddin Qasmi**

For persistent loss of sexual excitement, erectile difficulties, reduced sexual desire, premature ejaculation, painful intercourse, infertility or other sexual and reproductive health concerns, patients may consult:

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

**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**

For consultation and appointment information, visit **Saira Health Care** at www.sairahealthcare.com.

**Medical Disclaimer:** This article is intended for general health education and awareness. Sexual dysfunction can have physical, psychological, medication-related and relationship causes. Diagnosis and treatment should be individualized by a qualified healthcare professional. Herbal, hormonal and prescription sexual-health treatments should not be started solely on the basis of online information.