Mismatched Desire in Couples

Understanding Different Levels of Sexual Desire and Building a Healthier, More Satisfying Relationship

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When couples come to me for sexual-health consultation, one of the most frequent concerns is not necessarily erectile dysfunction, infertility or another clearly defined disease.

Sometimes the problem sounds much simpler:

“Doctor, I want sexual intimacy much more often than my partner.”

Or:

“My husband wants sex frequently, but I rarely feel ready.”

Sometimes the opposite occurs. A woman may have considerably more sexual desire than her husband and begin wondering whether he has lost attraction to her.

These situations are commonly described in modern sexual medicine as **sexual desire discrepancy**, or what I prefer to explain to patients in simple terms as **mismatched desire**.

Mismatched desire means that two partners do not want sexual intimacy with the same frequency, at the same time, or with the same intensity.

That difference alone is **not necessarily a disease**.

This point is extremely important because couples often arrive in consultation assuming that the person with lower desire is the “patient” and must somehow be corrected.

Modern sexual medicine takes a different approach.

The European Society for Sexual Medicine advises clinicians to focus on the **difference between partners and the distress surrounding that difference**, rather than automatically treating the lower-desire partner as abnormal. It recommends normalizing natural variations in sexual desire, educating couples about how desire changes through life, improving sexual communication and developing mutually satisfying approaches to intimacy.

In my practice at Saira Health Care, this is also the approach I prefer.

My first question is not:

“Which partner has the problem?”

It is:

“How does desire work for each of you, and what is happening between you because those patterns are different?”

That change in perspective can be the beginning of treatment.

What Is Sexual Desire?

Sexual desire is the motivation, interest or wish to participate in sexual activity.

But desire is not produced by one hormone, one organ or one medicine.

Human sexuality is influenced by biological, psychological, relational and social factors. WHO describes sexuality itself as involving desires, pleasure, intimacy, relationships, attitudes and behaviors, all influenced by biological, psychological, social, economic, cultural and other factors. WHO also emphasizes that healthy sexuality should occur within a framework of respect, safety, consent and freedom from coercion.

This means that libido can change with:

age,

stress,

sleep,

hormones,

physical illness,

medication,

pregnancy,

childbirth,

menopause,

fertility treatment,

relationship quality,

sexual satisfaction,

body image,

mental health,

and life circumstances.

Two healthy people living together should therefore not be expected to maintain perfectly identical sexual desire throughout their relationship.

What Exactly Is Mismatched Desire?

Suppose one partner ideally wants sexual intimacy three times per week and the other is comfortable with once every two weeks.

Neither number automatically indicates disease.

The difficulty lies in the **difference**.

The higher-desire partner may begin feeling rejected.

The lower-desire partner may start feeling pressured.

The higher-desire person then asks more frequently because they are worried about losing intimacy.

The lower-desire person withdraws further because intimacy has begun to feel like an obligation.

A cycle develops.

What began as a relatively ordinary difference in libido can gradually become a major relationship problem.

Recent research confirms that sexual desire discrepancy is common in long-term relationships and may become distressing when couples struggle to adapt to it. A 2024 qualitative study of long-term couples identified changing desire, barriers to sex, relationship satisfaction and coping strategies as important themes in couples experiencing distressing desire discrepancy.

Therefore, the presence of different sexual appetites is not necessarily the disorder.

The distress, misunderstanding and conflict created around the difference are often what require attention.

Mismatched Desire Is Not the Same as Low Libido Disorder

This distinction is essential.

Imagine a woman who is perfectly comfortable having sexual intimacy twice a month and experiences pleasure when she does.

Her husband would prefer sexual activity three times a week.

He describes her as having “very low libido.”

But compared with whom?

Compared with him, her desire is lower.

That does not automatically mean she has a medical disorder.

Current international sexual-medicine consensus emphasizes that a diagnosis such as **Hypoactive Sexual Desire Disorder (HSDD)** involves persistent reduction or absence of spontaneous or responsive desire together with clinically significant personal distress. A desire difference with a partner does not by itself establish the diagnosis.

This is why I do not diagnose sexual weakness simply because one partner wants sex less often.

I want to know:

Is this person's desire lower than **their own previous level**?

Are they personally distressed?

Has sexual pleasure disappeared?

Is the change sudden?

Is there pain?

Are there hormonal symptoms?

Is there depression?

Is medication involved?

Or is this primarily a difference between two otherwise healthy individuals?

Those are very different situations.

There Is No Universal “Normal” Frequency of Sex

Couples often ask:

“Doctor, how many times per week should a normal married couple have sex?”

There is no medically correct universal number.

A couple can be sexually satisfied with relatively infrequent sex.

Another couple can be satisfied with very frequent sex.

The important questions are whether the relationship is consensual, satisfying and comfortable for both partners.

Sexual health should not be judged simply by comparing your marriage with another person's marriage.

WHO's contemporary approach to sexual health emphasizes well-being, pleasure, safety, dignity and consensual relationships rather than a prescribed sexual frequency.

A healthy sexual relationship therefore cannot be reduced to:

“How many times?”

The better question is:

“Does our intimate life work for both of us?”

Desire Changes During Relationships

Sexual desire is not fixed.

A couple may experience high spontaneous desire during the early stage of a relationship.

Later, responsibilities increase.

There may be children.

Work becomes demanding.

Parents become older.

Financial commitments grow.

Health conditions appear.

Privacy decreases.

Sleep becomes worse.

Sexual desire may therefore become less spontaneous and more dependent upon context.

The European Society for Sexual Medicine specifically recommends educating couples about the natural **ebb and flow** of sexual desire and recognizing that desire discrepancy is relative, dyadic and influenced by age and relationship circumstances.

A mismatch may also reverse.

The partner who had higher desire at age thirty may have lower desire at fifty.

The woman who had little sexual interest while caring for a newborn may later develop stronger desire than her husband.

One person should therefore not be permanently labelled:

“the low-libido partner.”

Human sexuality changes.

Spontaneous Desire and Responsive Desire

Understanding **responsive desire** is especially useful for couples with mismatched libido.

Some people experience spontaneous desire.

They suddenly think:

“I want sex.”

Then they approach their partner.

Other people frequently experience **responsive desire**.

They may initially feel neutral rather than sexually motivated. But after emotional closeness, privacy, affectionate touch and mutually wanted stimulation begin, arousal develops and desire follows.

ACOG notes that it can be completely normal not to feel sexual desire until sexual activity has begun. It also advises couples dealing with desire concerns to work on relationship issues, emotional closeness, sexual knowledge and making time for one another.

This concept often transforms a couple's understanding.

The higher-desire partner may be waiting for the other person to initiate spontaneously.

The responsive-desire partner may rarely feel spontaneous urges.

Both conclude that attraction has disappeared.

But the lower-desire partner may still enjoy intimacy once a comfortable context has been created.

That is not fake desire.

It is simply a different pattern of desire.

Responsive Desire Must Never Be Used to Pressure a Partner

This requires an equally important warning.

Responsive desire does **not** mean:

“Have sex when you don't want to, because you might start enjoying it.”

Healthy responsive desire begins with genuine willingness.

A person may say:

“I don't feel strongly sexual right now, but I would enjoy being close and seeing whether desire develops.”

That is different from saying:

“I don't want sexual activity but feel unable to refuse.”

Consent remains essential.

No relationship, marriage or medical concept gives one partner entitlement to the other's body.

WHO places consent, dignity and freedom from coercion at the center of sexual health.

Therefore, the goal is not compulsory sexual activity.

The goal is creating opportunities for mutually desired intimacy.

How Desire Mismatch Turns Into Conflict

The emotional meaning attached to sex often differs between partners.

One person may experience sexual intimacy primarily as a way of feeling loved and connected.

The other may require emotional closeness **before** sexual desire develops.

This can create a painful cycle.

The higher-desire partner thinks:

“We need sex to feel close.”

The lower-desire partner thinks:

“I need to feel close before I want sex.”

Both want connection.

But they are approaching it from opposite directions.

Without communication, each may interpret the other's behavior negatively.

The higher-desire partner may experience rejection.

The lower-desire partner may experience pressure.

Pressure reduces desire.

Reduced desire creates more rejection.

More rejection creates more pursuit.

And the cycle continues.

This is why modern sexual-medicine guidance emphasizes treating sexual desire discrepancy as a **couple dynamic**, rather than simply increasing the libido of one individual.

Rejection Can Become Emotionally Difficult for Both Partners

Being declined sexually can hurt.

But how a couple responds to that moment matters greatly.

A large prospective study published in 2025 examined couples dealing with sexual interest/arousal disorder and found that resentful or insecure responses to sexual rejection were associated with poorer sexual and relationship outcomes, while understanding responses showed more constructive relationship associations.

Research in men with clinically low desire has similarly found that more supportive partner responses were associated with greater sexual satisfaction, while negative responses were associated with poorer satisfaction.

Therefore, when one partner says no, the other partner's response matters.

A respectful response protects intimacy.

Anger, humiliation, threats or silent punishment can make future sexual approach feel unsafe.

At the same time, the lower-desire partner should understand that repeated rejection without affection, explanation or discussion may leave the other partner lonely.

Both people's emotional experiences matter.

Communication Is One of the Strongest Practical Tools

Sexual communication is not simply talking about how many times to have intercourse.

It means discussing:

what makes each person feel close,

what increases desire,

what decreases desire,

what type of affection feels comfortable,

what creates pressure,

what sexual expectations exist,

and what each partner considers satisfying intimacy.

Research involving people in romantic relationships has found that better-quality sexual communication is associated with greater sexual satisfaction and lower perceived desire discrepancy.

A 2024 study examining how adults actually manage mismatched sexual and affectionate desire identified communication, alternative forms of closeness and other negotiated responses among the strategies couples use.

I therefore tell couples:

Do not begin the conversation when one partner has just initiated sex and the other has just refused.

That is usually the most emotionally charged moment.

Discuss the issue at a neutral time.

Instead of:

“You never want me.”

try:

“I miss feeling close to you. Can we understand what is making intimacy difficult?”

Instead of:

“You only care about sex.”

try:

“When I feel pressure, my desire becomes even lower. Can we find a way of being close that works for both of us?”

The words we use matter.

Stop Treating the Lower-Desire Partner as the Problem

This is perhaps the most important therapeutic shift.

If a husband wants intimacy five times per week and his wife wants it once per week, we could label the woman as “low desire.”

But if she married someone who preferred intimacy once a month, she might now be considered the higher-desire partner.

The difference is relational.

This is why the ESSM position statement explicitly recommends focusing on **mismatch rather than absolute desire** and considering the couple rather than automatically identifying the lower-desire partner as the patient.

Blame usually makes the discrepancy worse.

The lower-desire partner becomes defensive.

The higher-desire partner becomes resentful.

The sexual relationship turns into a negotiation over obligation.

Healthy treatment should reduce that adversarial pattern.

Neither Partner Should Have to “Win”

Some couples approach treatment with incompatible goals.

The higher-desire partner says:

“Make my partner want sex more.”

The lower-desire partner says:

“Make my partner stop asking.”

Neither objective creates partnership.

The goal should be:

“Can we build a sexual relationship in which both people feel respected, wanted and free?”

That may involve increasing opportunities for intimacy.

It may also involve accepting that one partner will not always say yes.

Compromise in sexuality must remain voluntary.

Broadening the Meaning of Intimacy

Another common problem is what sexual-medicine researchers call a rigid **sexual script**.

The couple believes that sexual intimacy must always follow the same sequence and must always end in intercourse.

If one person does not want intercourse, the couple concludes that intimacy cannot occur at all.

Research in long-term couples suggests that greater flexibility in sexual scripts when navigating sexual challenges may be associated with better sexual well-being.

Clinically, this means couples may benefit from remembering that closeness includes more than one behavior.

Affection, conversation, holding one another, massage, kissing and mutually acceptable sensual contact can sometimes restore connection without creating the immediate pressure that intercourse must occur.

Reducing performance demands may allow desire to re-emerge more naturally.

Schedule Connection, Not Obligation

Couples with busy lives sometimes object to planning intimate time.

They say:

“If we schedule it, it isn't romantic.”

But waiting indefinitely for both partners to spontaneously feel desire at exactly the same time can be ineffective, especially when one person experiences primarily responsive desire.

The ESSM position statement includes scheduling intimacy among possible therapeutic approaches for distressed desire discrepancy, alongside education, communication and expanding the couple's sexual repertoire.

The important distinction is this:

Scheduling **time for connection** is different from scheduling compulsory intercourse.

For example:

“Friday evening is our private time. No work, no phones, no outside commitments. We will spend time together and see what feels comfortable.”

Either partner still has the right to stop.

The schedule creates opportunity, not obligation.

Medical Causes Must Still Be Investigated

Normal desire discrepancy should not be over-medicalized.

But neither should every major change in desire be dismissed as a relationship issue.

If someone previously had normal sexual interest and experiences a marked reduction, medical evaluation may be appropriate.

The 2026 International Consultation on Sexual Medicine recommends a biopsychosocial evaluation of persistent low desire and highlights potentially relevant factors including chronic disease, pregnancy or postpartum changes, menopause, medication, poor sleep, anxiety, chronic stress, depression and relationship problems.

Therefore, if a couple tells me:

“We have always had slightly different levels of desire,”

that is different from:

“Six months ago my husband's desire suddenly disappeared completely.”

The second situation deserves more investigation.

Depression, Anxiety and Stress

Depression can reduce interest in activities that previously brought pleasure, including sexual intimacy.

Anxiety can make sexual situations feel like performance tests.

Chronic stress leaves little psychological space for sexuality.

If one partner is mentally occupied by employment problems, debt, family illness or other persistent concerns, desire may decline without any loss of attraction to the partner.

Psychological factors should therefore be discussed without stigma.

Current ICSM recommendations support psychological interventions such as sex therapy, cognitive-behavioral therapy and mindfulness-based treatment for clinically significant low desire where appropriate.

Medicines Can Affect Sexual Desire

Certain medicines can contribute to lower sexual interest or other sexual difficulties.

Common examples include some antidepressants and certain other medications, although the effect varies greatly between individuals.

A medicine may affect:

desire,

arousal,

erection,

lubrication,

ejaculation,

or orgasm.

Current sexual-medicine recommendations specifically include medication review when assessing persistent low desire.

Patients should **never stop essential medication themselves**.

The prescribing doctor may sometimes adjust the dose, change treatment or manage the sexual side effect separately.

Hormonal Factors

Hormones influence sexual desire, but low libido should not automatically be called a hormonal deficiency.

In women, pregnancy, breastfeeding and menopause may change sexual response.

In men, clinically significant testosterone deficiency may contribute to reduced desire.

Thyroid disorders and high prolactin can also affect sexuality.

But a hormone test should be interpreted in the context of symptoms.

Giving hormones simply because one partner wants more sex is not appropriate medical practice.

Pain Can Look Like Low Desire

A woman experiencing painful intercourse may gradually stop initiating intimacy.

Her partner concludes that she has low libido.

But perhaps the body has learned that sexual activity predicts pain.

Conditions such as vaginal dryness, menopausal changes, pelvic-floor dysfunction and other gynecological problems may contribute.

ACOG notes that medical conditions, medications and relationship problems can all interfere with sexual response and that painful intercourse deserves proper evaluation.

In these cases, increasing desire is not the first treatment.

Treating the pain is.

Erectile Dysfunction Can Create Apparent Low Desire

The same principle applies to men.

A man who repeatedly loses his erection may stop initiating sex.

His wife says:

“He has no interest in me anymore.”

But internally he may still feel desire.

He is avoiding intimacy because he fears another erection failure.

This pattern is especially common when erectile dysfunction becomes associated with embarrassment or performance anxiety.

Therefore, I separate:

desire,

erection,

ejaculation,

orgasm,

and sexual confidence

during consultation.

Calling every male sexual difficulty “low libido” leads to poor treatment.

Pregnancy, Childbirth and Parenthood

The arrival of a child can dramatically alter desire discrepancy.

One partner may return to sexual interest relatively quickly.

The other may be dealing with:

physical healing,

breastfeeding,

sleep deprivation,

hormonal changes,

body-image concerns,

parenting demands,

and reduced privacy.

Treating this as rejection can create unnecessary conflict.

Sexual desire often needs time and context to recover.

Pressure generally makes that recovery harder.

Menopause

Menopause can affect sexual relationships through multiple pathways.

A woman may continue loving and desiring her husband but develop dryness, discomfort or slower arousal.

Another woman may experience a genuine reduction in desire.

Sleep disturbance and hot flashes may also affect energy.

A couple may then experience what appears to be a growing desire discrepancy.

The correct approach should investigate physical symptoms as well as relationship concerns.

Chronic Illness and Aging

Diabetes, cardiovascular disease, chronic kidney disease, neurological disorders, chronic pain and cancer treatment can influence sexual functioning through fatigue, vascular changes, nerve changes, medications, mood and altered body image.

A mismatch that develops after illness should therefore be approached compassionately.

The person with lower desire may not be rejecting their partner.

Their body and life may have changed.

Infertility Can Create Desire Discrepancy

This is particularly important in my clinical work.

Couples experiencing infertility often begin with a normal sexual relationship.

Then intercourse becomes connected with ovulation calculations.

The conversation becomes:

“Today is the fertile day.”

“The doctor told us to try tonight.”

“We cannot miss this cycle.”

Sex becomes a reproductive assignment.

One partner may remain interested.

The other begins experiencing anxiety.

Over time, desire falls.

The couple then has two problems:

infertility and sexual distress.

At Saira Health Care, because our clinical work includes both **sexual disorders and infertility**, I pay particular attention to this overlap.

Fertility treatment should not unnecessarily destroy the couple's intimate relationship.

Couples trying for pregnancy need medically appropriate timing, but they also benefit from preserving affectionate intimacy that is **not solely focused on conception**.

Different Desire Does Not Mean Different Love

This misconception damages many relationships.

The higher-desire partner thinks:

“If my partner really loved me, they would want me more.”

The lower-desire partner thinks:

“If my partner really loved me, they would stop asking.”

Sexual desire and emotional love are connected for many people, but they are not identical.

A person may deeply love their spouse while experiencing low desire because of exhaustion, medication or hormonal change.

Another person may experience frequent sexual desire as an important expression of emotional closeness.

Both realities can exist simultaneously.

The challenge is learning each other's emotional language without turning sex into either a duty or a weapon.

How Couples Respond Matters More Than Simply Eliminating the Difference

Research increasingly suggests that adaptation may be just as important as reducing the numerical difference in desire.

A mixed-method study of long-term relationships found that partnered strategies for dealing with desire discrepancy were associated with greater sexual and relationship satisfaction than more isolated coping approaches.

A 2024 study similarly identified communication and alternative behaviors among the strategies adults use when managing desire differences.

The practical lesson is important:

A couple does not necessarily have to develop identical libidos to become sexually satisfied.

They need a healthier way of managing difference.

A Practical Strategy I Discuss With Couples

When I counsel couples with mismatched desire, I usually work through the following sequence:

1. **Stop blaming either partner.** We establish that difference in desire is common and that lower desire does not automatically mean disease.
2. **Identify whether the discrepancy is longstanding or new.** A sudden change may require medical investigation.
3. **Understand each person's desire pattern.** Is desire spontaneous, responsive, situational, stress-sensitive or affected by pain?
4. **Identify sexual and nonsexual barriers.** These may include fatigue, lack of privacy, resentment, medication, infertility pressure, erectile difficulty or vaginal pain.
5. **Improve communication outside the bedroom.** Couples need language for initiation, acceptance and rejection that does not produce shame.

6. **Create protected time for connection without compulsory intercourse.** This can help responsive desire develop while preserving consent.
7. **Broaden intimacy and increase flexibility.** Sexual connection should not depend upon one rigid script.
8. **Treat genuine medical conditions.** Hormonal disorders, depression, sexual pain, erectile dysfunction and medication effects should not be ignored.
9. **Use couple or psychosexual therapy where necessary.** Persistent conflict frequently requires more than medication.
10. **Follow up.** Desire changes over time, and treatment should adapt with the couple rather than end after one prescription.

This is not a formula guaranteeing that both partners will eventually want exactly the same amount of sex.

The goal is something more realistic:

mutual understanding, less pressure, better communication and a sexual relationship that respects both people.

Professional Sex Therapy and Couple Therapy

Some couples become trapped in a cycle that is difficult to change alone.

In such cases, qualified psychosexual or couple therapy can help.

The 2026 International Consultation on Sexual Medicine supports evidence-based psychological approaches for clinically significant low desire, including sex therapy, CBT and mindfulness-based approaches. It also notes that because desire discrepancy is a common issue within committed relationships, involving both partners in at least some sessions may be beneficial.

Treatment may involve education, communication exercises, work on anxiety, improvement of emotional connection and structured intimacy exercises.

These interventions should always remain consensual and tailored to the couple.

Sexual Script Flexibility

Many couples have a very narrow definition of successful sexual activity.

Sex must happen at night.

One person must initiate.

Both partners must immediately become aroused.

Intercourse must occur.

Orgasm must happen.

Anything less is treated as failure.

This creates pressure.

Research on long-term couples suggests that greater flexibility in sexual scripts when confronting sexual challenges is related to better sexual well-being.

I therefore encourage couples to move away from a performance examination.

Sexual satisfaction is not a test with one correct sequence.

How to Handle Sexual Rejection Respectfully

One of the most important skills for couples with desire discrepancy is learning how to hear **“not now”** without translating it into:

“I don't love you.”

The partner declining intimacy can also communicate warmth:

“I'm exhausted tonight, but I still want to be close to you.”

The person receiving the rejection should avoid retaliation, anger or humiliation.

Recent prospective research suggests that resentful responses to sexual rejection are associated with poorer sexual and relationship outcomes, reinforcing the value of more understanding responses.

A respectful “no” protects the possibility of a genuine future “yes.”

The Higher-Desire Partner Also Deserves Compassion

Discussions about mismatched desire sometimes focus entirely on protecting the lower-desire partner.

That is incomplete.

Repeated sexual rejection can create:

loneliness,

self-doubt,

frustration,

feelings of unattractiveness,

and emotional distance.

Those feelings deserve acknowledgement.

But acknowledging them does not create an entitlement to sex.

The healthier approach is:

“Your need for closeness matters, and your partner's autonomy matters too. We need a solution that respects both.”

That is a true couple-centered approach.

The Lower-Desire Partner Also Deserves Compassion

Being constantly identified as the problem can be equally damaging.

The lower-desire partner may feel:

defective,

guilty,

pressured,

or frightened that affection will always lead to a request for sex.

Eventually they may avoid even ordinary touch.

That worsens the problem.

The purpose of treatment is therefore not to force the lower-desire partner to “catch up.”

It is to understand what desire requires for that individual.

The Role of Unani Medicine in Mismatched Sexual Desire

As a physician trained in Unani medicine, I believe the Unani system offers a useful **whole-person framework** for many sexual-health complaints.

However, scientific accuracy is important.

Mismatched desire itself is a **relationship pattern**, not a single disease that can be cured with one herbal medicine.

The greatest strength of Unani medicine in such situations lies in its attention to the patient's overall health, lifestyle, sleep, diet, physical activity, mental state and individual constitution.

CCRUM describes Unani treatment as incorporating **Ilaj-bil-Tadbir** or regimental therapy, **Ilaj-bil-Ghiza** or dietotherapy, **Ilaj-bil-Dawa** or pharmacotherapy and other modalities. It emphasizes lifestyle regulation and gives preference to appropriate diet and regimental approaches before medication when suitable.

This is highly relevant when sexual desire is being affected by fatigue, poor sleep, obesity, metabolic illness, chronic stress or an unhealthy daily routine.

Unani Understanding of Sexual Debility

Classical Unani literature discusses **Zu'f-i-Bah**, broadly translated as sexual debility.

Official CCRUM treatment guidelines describe it as involving reduced sexual desire or sexual capability and importantly recognize **psychological factors** among potential contributors. The classical principles of treatment include addressing psychological causes as well as physical concerns.

This is important because it demonstrates that Unani physicians did not necessarily view sexual health as purely mechanical.

The mental and emotional state was also considered.

At the same time, modern clinicians must distinguish classical *Zu'f-i-Bah* from ordinary sexual desire discrepancy.

If one spouse simply wants sex more often than the other, that alone does not prove that either person has sexual debility.

Lifestyle Management in the Unani System

Official CCRUM descriptions of Unani medicine emphasize regulating factors such as diet, physical movement and rest, sleep and wakefulness, environmental influences and psychological states according to individual circumstances.

In practical sexual-health care, these principles direct my attention toward very relevant questions:

Is the patient sleeping adequately?

Is stress overwhelming?

Is there obesity or diabetes?

Is there physical inactivity?

Is there chronic fatigue?

Is the patient mentally exhausted?

Does the couple have privacy?

Are there unresolved psychological concerns?

For some patients, correcting these factors can improve general vitality and create better conditions for sexual desire.

Ilaj-bil-Ghiza — Dietotherapy

I do not tell couples that one food can equalize their sexual desire.

There is no scientific basis for saying that a particular nut, herb, fruit or spice will make two partners suddenly develop identical libido.

A better use of dietotherapy is to support:

metabolic health,

healthy weight,

energy,

diabetes management,

cardiovascular health,

and general well-being.

These factors can influence sexual health indirectly.

Diet should therefore be individualized rather than marketed as a universal aphrodisiac cure.

Ilaj-bil-Tadbir — Regimental and Lifestyle Therapy

Regimental therapy in Unani practice includes lifestyle regulation and non-pharmacological approaches.

CCRUM describes *Ilaj-bil-Tadbir* as a systematic approach involving modification of lifestyle and, depending on the illness, measures such as physical exercise and other regimens intended to support health.

For couples with desire discrepancy, the most relevant supportive elements are often simple:

better sleep,

appropriate exercise,

reduced stress,

adequate rest,

and healthier routine.

These measures may not solve relationship differences directly, but they can remove biological barriers suppressing desire.

Psychological Well-Being and Unani Care

CCRUM also recognizes **Ilaj Nafsani**, or psychological treatment, within Unani therapeutic thinking.

This is particularly relevant because mismatched desire frequently becomes a psychological and relational cycle.

When appropriate, I combine Unani lifestyle principles with:

patient education,

communication guidance,

management of sexual anxiety,

and referral for professional psychological or couple therapy.

Traditional and contemporary care do not have to compete.

They can complement one another when their roles are understood correctly.

Unani Medicines: When Are They Appropriate?

Classical Unani practice includes pharmacotherapy for selected sexual problems.

But I want patients to understand an important distinction:

Medicine should treat a diagnosed problem—not a difference between two personalities.

If one partner has clinically significant low libido caused by illness, individual treatment may be appropriate.

If there is erectile dysfunction, it should be evaluated.

If there is chronic fatigue, metabolic illness or another relevant complaint, appropriate supportive Unani management may have a role.

But if two otherwise healthy people simply have different desired frequencies of intimacy, prescribing sexual tonics to the lower-desire partner may completely miss the real issue.

The primary treatment may instead be education, communication and couple-centered adaptation.

Dr. Nizamuddin Qasmi's Specialized Integrative Approach

At **Saira Health Care**, I prefer a structured approach to couples presenting with mismatched desire.

First, I determine whether the discrepancy represents normal variation or whether one partner has developed a genuine sexual dysfunction.

Second, I investigate possible medical causes when appropriate.

Third, I assess sexual difficulties that may be indirectly suppressing desire, including erection problems, ejaculation concerns, painful intercourse, vaginal dryness and infertility-related performance pressure.

Fourth, I evaluate important lifestyle factors through both modern preventive-health principles and the holistic framework of Unani medicine.

Fifth, I help the couple understand spontaneous and responsive desire, communication, initiation and sexual rejection.

Finally, when the problem has become deeply established, I recommend appropriate psychosexual, couple, gynecological, urological, endocrine or psychiatric care as required.

The treatment is individualized because every couple's mismatch has a different story.

Contribution of Saira Health Care to Sexual Disorders and Infertility

At Saira Health Care, we regularly address the overlap between:

sexual desire,

sexual performance,

infertility,

relationship anxiety,

erectile dysfunction,

ejaculatory problems,

female sexual health,

and chronic medical conditions.

Patients frequently arrive believing that they have one isolated sexual symptom.

Detailed discussion may reveal a larger pattern.

A man with “low libido” may actually fear erection failure.

A woman believed to have “low desire” may have painful intercourse.

A couple complaining of mismatched libido may actually be exhausted by infertility treatment.

Another couple may simply have different normal sexual styles and need education rather than medication.

Our aim is therefore to treat the **person and couple rather than just the symptom**.

About Dr. Nizamuddin Qasmi

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

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

This background informs an integrative approach combining Unani principles with contemporary sexual and reproductive-health assessment.

The objective is not to make unrealistic promises about instant sexual performance.

It is to determine **why sexual desire differs, what is creating distress, whether disease is present and how the couple can build a healthier relationship around those differences**.

Frequently Asked Questions

Is mismatched sexual desire normal?

Yes. Some degree of difference in sexual desire is common in romantic relationships, particularly over long periods. It becomes clinically relevant mainly when the discrepancy produces persistent distress, conflict or dissatisfaction.

Does the partner with lower desire have a sexual disorder?

Not necessarily. Modern sexual-medicine guidance specifically recommends focusing on the discrepancy rather than automatically pathologizing the lower-desire partner.

Can desire levels change over time?

Yes. Desire may rise or fall with relationship stage, age, stress, health, pregnancy, childbirth, menopause, medication and other circumstances.

Does less desire mean less love?

No. Sexual desire and emotional love are related but are not identical.

Can the higher-desire partner also suffer?

Absolutely. Repeated rejection can produce loneliness, insecurity and frustration. Their emotional experience should be acknowledged while still respecting the other partner's autonomy.

Should the lower-desire partner have sex simply to satisfy the relationship?

No person should be pressured into unwanted sexual activity. Consent should remain voluntary throughout the relationship. Couples can work toward compromise, intimacy and responsive desire without coercion. WHO identifies consent, respect and freedom from coercion as fundamental to sexual health.

Is scheduling intimacy useful?

For some couples, yes. Scheduling protected time for connection can be particularly useful where busy lifestyles or responsive desire make spontaneous intimacy uncommon. The goal should be creating opportunity rather than compulsory intercourse.

Can better communication improve the problem?

Research suggests that higher-quality sexual communication is associated with greater sexual satisfaction and lower perceived desire discrepancy.

Can menopause create a mismatch?

Yes. Physical and hormonal changes, sleep disturbance, vaginal dryness and changing arousal can influence desire and sexual frequency.

Can infertility treatment affect sexual desire?

Yes. Repeated timed intercourse and performance pressure can interfere with the couple's spontaneous sexual relationship.

Can Unani medicine help?

Unani medicine can contribute supportive lifestyle management through diet, exercise, sleep regulation, stress management and individualized attention to general health. Classical Unani literature also recognizes psychological influences on sexual function. However, mismatched desire itself is not one disease with one herbal cure; medical and couple-based causes should be identified before treatment.

When Should Couples Seek Professional Help?

Professional consultation is worthwhile when desire discrepancy has begun causing repeated arguments, emotional withdrawal, resentment or fear of intimacy; when one partner experiences a persistent and personally distressing loss of desire; when there is painful intercourse, vaginal dryness, erectile dysfunction or another sexual problem; when desire changes suddenly after medication, illness or surgery; when depression or severe anxiety is present; or when infertility treatment has begun damaging the couple's sexual relationship.

The 2026 International Consultation on Sexual Medicine recommends a comprehensive biopsychosocial approach when low desire is clinically distressing, including attention to health, medications, psychological factors and partner relationships.

My Final Message to Couples

When partners have different sexual appetites, the easiest reaction is to ask:

“Who is normal?”

I believe that is usually the wrong question.

A better question is:

“How can two different people build an intimate relationship that respects both?”

You do not need identical desire to have a satisfying marriage.

You need communication.

You need respect.

You need consent.

You need to understand how your partner experiences closeness.

You need flexibility.

And sometimes you need medical or psychological help.

The person who wants sex more often is not automatically selfish.

The person who wants it less often is not automatically sexually weak.

Problems develop when difference turns into blame, pressure, rejection or silence.

Modern sexual medicine increasingly supports this couple-centered view. The European Society for Sexual Medicine recommends normalizing desire variation, challenging myths about spontaneous desire, improving communication, developing mutually satisfying sexual scripts and addressing relationship needs rather than focusing only on the lower-desire individual.

At **Saira Health Care**, my approach is to combine this contemporary understanding with the holistic principles of Unani medicine—looking at sleep, diet, physical health, mental well-being, sexual function, reproductive health and relationships together.

For some couples, treatment requires medical investigation.

For others, it requires counseling.

Some need help with erectile dysfunction or painful intercourse.

Some need support during infertility treatment.

And some simply need to understand that **two loving people can genuinely have different levels of sexual desire without either person being defective**.

The purpose of treatment is not to force both partners to become identical.

The purpose is to help them create a relationship in which **sexuality remains voluntary, respectful, pleasurable, emotionally safe and mutually satisfying**.

That, in my view, is the healthier definition of sexual compatibility.

Medical Disclaimer

This article is intended for general health education and does not replace individualized medical, psychological, gynecological, urological or psychosexual consultation. Sexual desire discrepancy by itself is not necessarily a disorder. Persistent or sudden loss of libido, painful intercourse, erectile dysfunction, significant hormonal symptoms, severe depression or distressing relationship conflict should be professionally assessed. Any sexual activity must remain voluntary and consensual, regardless of relationship or marital status.