Responsive Desire: Understanding How Sexual Desire Works and Why Waiting for the "Mood to Strike" Is Not Always Effective

By 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

Understanding Responsive Sexual Desire

One of the most common concerns I hear in sexual-health consultations is:

"Doctor, I love my partner, but I rarely feel suddenly 'in the mood' anymore. Does this mean my libido has become weak?"

Very often, the answer is **no**.

Many people have been taught to think that healthy sexual desire must always occur spontaneously: first you suddenly feel desire, then you become aroused, and then sexual activity follows.

Human sexuality is frequently more complicated than that.

For many adults—particularly in established relationships—sexual desire can be **responsive** rather than spontaneous. In other words, a person may begin from a neutral state, feel emotionally comfortable and willing to be close to their partner, and only after affection, conversation, touch, kissing or other mutually wanted stimulation does sexual arousal develop. Desire may then appear **after the experience has started rather than before it**.

This pattern is recognized in modern sexual medicine. The American College of Obstetricians and Gynecologists specifically explains that it can be normal not to experience desire until sexual activity has begun. ACOG's female sexual-response model also recognizes that desire or drive may not necessarily be present at the beginning; sexual signals can first generate arousal, which can subsequently develop into desire.

This concept is known as **responsive desire**.

Understanding it can remove a tremendous amount of unnecessary anxiety from couples.

Responsive Desire Is Not a Disease

Before discussing treatment, I want to make one point extremely clear:

Responsive sexual desire itself is not a disorder and does not automatically require treatment.

Some people experience considerable spontaneous desire. Others experience more responsive desire. Many people experience a mixture of both, and the balance may change with age, relationship duration, pregnancy, parenthood, stress, menopause, chronic disease or changing circumstances.

The modern understanding of sexual health does not require everyone to experience sexuality in exactly the same way. WHO describes sexual health broadly as physical, emotional, mental and social well-being related to sexuality, emphasizing respectful, safe and pleasurable sexual experiences free from coercion.

Therefore, when a patient comes to me saying:

“I do not randomly think about sex as often as I used to, but once my partner and I become affectionate, I begin enjoying intimacy,”

I do not automatically diagnose low libido.

That may simply be the patient's normal sexual-response pattern.

The clinical question is not:

“Do you feel desire before every intimate encounter?”

The better questions are:

“Can desire develop when the circumstances are right?”

“Do you experience pleasure and arousal?”

“Are you distressed by your sexual response?”

“Is pain, fear, relationship conflict or another medical problem preventing healthy intimacy?”

These questions lead to much more accurate assessment.

Spontaneous Desire Versus Responsive Desire

The distinction is easiest to understand through two simplified patterns.

Spontaneous desire

With spontaneous desire, sexual interest seems to appear without much external stimulation.

A person might suddenly think:

“I want to be intimate with my partner.”

That desire motivates affectionate or sexual interaction, after which arousal increases.

This is the pattern commonly presented in films, advertisements and popular culture.

Responsive desire

Responsive desire works differently.

The person may initially feel neither strongly interested nor strongly uninterested.

Perhaps the couple has some privacy. They talk, relax, sit together or become physically affectionate. The person feels emotionally comfortable and willingly participates.

Touch or affection produces arousal.

Then desire develops.

The sequence may therefore look more like:

Emotional connection → willingness → stimulation → arousal → desire → increased intimacy → satisfaction.

The influential sexual-response model described by Rosemary Basson emphasized this responsive component, particularly in women and long-term relationships, and was developed partly to prevent normal variations in sexual response from being incorrectly diagnosed as dysfunction.

More recent research continues to investigate responsive desire. A 2024 study published in *The Journal of Sexual Medicine* examined how genital arousal can relate to different forms of responsive desire among women with and without symptoms of sexual interest/arousal disorder.

Does Responsive Desire Occur Only in Women?

No.

Most of the historical clinical literature on responsive desire has focused on women, because older sexual-response models often fitted women's experiences poorly.

But clinically, I also see responsive patterns in men.

Men may notice less spontaneous sexual thinking during periods of:

- stress,
- sleep deprivation,
- chronic illness,
- relationship pressure,
- demanding work,
- aging,
- infertility treatment,
- parenthood,
- medication use,
- or anxiety about sexual performance.

A man may not walk into the bedroom already feeling strong desire, yet affectionate contact and emotional comfort can increase arousal and desire.

Human sexual response should therefore not be reduced to the stereotype that **men always experience spontaneous desire while women always experience responsive desire**.

Individuals vary substantially.

Why Waiting for the Mood to Strike Can Become a Problem

This is where understanding responsive desire becomes very practical.

Some couples tell me:

“We decided not to force anything. We will have intimacy whenever both of us automatically feel in the mood.”

That sounds reasonable.

But months later they may discover that intimacy has almost disappeared.

Why?

Because modern adult life is full of powerful competing signals:

work deadlines, children, phones, social media, financial worries, housework, fatigue, illness, family responsibilities and poor sleep.

Spontaneous desire does not always overpower all of these distractions.

For someone whose desire is primarily responsive, waiting indefinitely for sexual motivation to appear **before creating any intimate context** can produce a circular problem:

No spontaneous desire → no intimate contact → no opportunity for arousal → no responsive desire → even less intimacy.

The patient then concludes:

"My libido has disappeared."

Sometimes the actual issue is that the circumstances in which desire normally appears have disappeared.

ACOG therefore advises approaches such as addressing relationship problems, focusing more on emotional closeness, improving sexual knowledge, making time for one another and allowing adequate time for arousal.

Planning time for intimacy is not necessarily artificial.

A couple schedules holidays, meals, family events and important conversations because those things matter.

Making protected time for emotional and physical closeness can be equally reasonable.

Responsive Desire Does Not Mean Forcing Yourself to Have Sex

This distinction is essential.

Responsive desire should **never** be interpreted as:

"Start sexual activity even when you do not want it, because eventually you might enjoy it."

That would be a dangerous misunderstanding.

Healthy responsive desire begins from a state of **willingness, safety and genuine consent**.

The person may not initially feel strong sexual desire, but they are comfortable exploring closeness because they want to see whether desire develops.

That is completely different from participating because of:

- fear,
- guilt,
- pressure,
- threats,

- obligation,
- coercion,
- or concern that a partner will become angry or leave.

Consent remains essential at every stage.

A person can change their mind at any moment.

If affection or stimulation does not become enjoyable, there is no obligation to continue.

WHO emphasizes that sexual health requires safe and pleasurable experiences **free of coercion, discrimination and violence**.

So I tell couples:

Responsive desire means allowing desire an opportunity to develop—not overriding your boundaries.

Willingness Is Not the Same as Desire

This concept can transform how couples communicate.

Imagine a person finishing a normal evening without feeling strong sexual thoughts.

Their partner expresses affection.

The person thinks:

"I am not particularly aroused right now, but I feel close to my partner and I would enjoy cuddling and seeing where this goes."

That is willingness.

After affectionate contact, arousal begins.

Desire follows.

That is responsive desire.

Compare this with:

"I do not want this, I feel uncomfortable, but I am afraid to say no."

That is not responsive desire.

It is a boundary or consent issue and should never be medically reframed as something the person should push through.

The Traditional Linear Model Does Not Fit Everyone

For many years, sexual response was often described as a fairly predictable progression:

Desire → arousal → orgasm → resolution.

This model can describe some sexual experiences well.

But it does not describe every person or every encounter.

Modern models recognize that desire and arousal can overlap and occur in different orders.

ACOG's current patient guidance acknowledges directly that some people may not experience desire until sexual activity has begun. Its clinical bulletin also illustrates a circular model in which reasons for sexual activity may exist before sexual desire, with desire potentially emerging after sexual signals generate arousal.

This understanding can be particularly reassuring for couples in long-term relationships.

Why Desire Often Changes in Long-Term Relationships

A new relationship frequently contains:

- novelty,
- anticipation,
- uncertainty,
- frequent romantic attention,
- fewer established routines,
- and strong emotional excitement.

These can support spontaneous desire.

Years later, life may include:

- household responsibilities,
- children,
- demanding jobs,
- health issues,
- financial responsibilities,
- predictable routines,
- and much less private time.

This does not necessarily mean that attraction or love has disappeared.

The conditions surrounding desire have changed.

A 2024 study examining couples in long-term relationships described desire discrepancy as a common and potentially distressing aspect of sexual relationships. Other recent research similarly shows that couples use communication and different strategies to manage differences in affectionate and sexual desire.

The European Society for Sexual Medicine has recommended normalizing variation in sexual desire, challenging the assumption that spontaneous desire is the only normal form, improving sexual communication and helping couples build mutually satisfying sexual patterns.

Desire Is Context Sensitive

One of the most important things I explain to patients is that desire does not exist in isolation.

A person's brain is continuously processing signals that either encourage or inhibit sexual interest.

Imagine trying to become sexually interested while simultaneously thinking about:

- tomorrow's unpaid bill,
- a crying child,
- an argument earlier that evening,
- fear of pregnancy,
- pain during intercourse,
- erectile failure,
- infertility pressure,
- an elderly parent's illness,
- or a phone constantly buzzing beside the bed.

The problem may not be a lack of sexual ability.

There may simply be too many **sexual brakes** and too few conditions supporting arousal.

Responsive desire becomes much easier to understand when we consider context.

Emotional Connection and Partner Responsiveness

For many people, emotional connection contributes strongly to sexual interest.

Feeling:

- understood,
- valued,
- listened to,
- respected,
- emotionally safe,
- and cared for

can create a context in which desire develops more easily.

Research on partner responsiveness has found important links between feeling understood and cared for by one's partner and the sexual side of romantic relationships.

This does not mean everyone needs deep romance before every sexual interaction.

Individual differences are enormous.

But when sexual desire has declined, the quality of the relationship should be considered rather than concentrating only on hormones.

Stress and Responsive Desire

Stress is one of the most common sexual suppressors I encounter clinically.

A person may still love their partner and have normal hormones but arrive home mentally exhausted.

Under chronic stress, even enjoyable activities can begin feeling like another responsibility.

That is why asking:

“Why don't I want sex?”

may sometimes be less useful than asking:

“What is occupying so much of my mental and physical energy that desire has little opportunity to develop?”

Stress reduction cannot solve every sexual disorder, but it is often an important component of treatment.

Sleep and Sexual Interest

Sleep is equally important.

A person who is chronically exhausted may not experience much spontaneous desire simply because the body is prioritizing rest.

This is particularly relevant in:

- parents of young children,
- shift workers,
- people with insomnia,
- people with sleep apnea,
- and individuals caring for sick relatives.

If intimacy is repeatedly attempted only at midnight after both partners are exhausted, the couple may incorrectly conclude that attraction has disappeared.

Sometimes changing **when** intimacy occurs is more useful than changing medication.

Pregnancy, Childbirth and Breastfeeding

Sexual desire commonly changes during pregnancy and after childbirth.

A new mother may be dealing with:

- disrupted sleep,
- breastfeeding,
- hormonal changes,
- vaginal dryness,
- healing following childbirth,
- concerns about body image,
- fear of discomfort,
- childcare demands,
- and limited privacy.

Expecting spontaneous sexual desire to immediately return under these circumstances can create unnecessary distress.

Responsive desire may become more relevant as the couple gradually restores affection, comfort and time together.

Pressure usually makes this process harder rather than easier.

Menopause and Responsive Desire

Menopause can affect sexual experience through both physical and psychological pathways.

Lower estrogen levels may contribute to:

- vaginal dryness,
- tissue sensitivity,
- discomfort,
- and genitourinary symptoms.

At the same time, sleep problems, hot flashes, chronic illness, relationship circumstances and changing body image may influence desire.

If intercourse hurts, waiting for more libido is unlikely to solve the problem.

The pain must be treated.

ACOG emphasizes that inadequate arousal can contribute to pain and recommends appropriate lubrication, adequate time for arousal and medical evaluation of persistent painful sex.

Erectile Dysfunction Can Change Desire Too

Responsive desire is often discussed in women, but a similar interaction between sexual function and motivation occurs in men.

A man who previously experienced erection failure may start thinking:

“If I initiate intimacy, what happens if I fail again?”

His brain begins associating intimacy with anxiety rather than pleasure.

He may stop initiating sex and report that his desire has disappeared.

In such cases we must distinguish:

- true loss of libido,
- fear of erectile failure,

- relationship avoidance,
- and a combination of these problems.

Treating erectile dysfunction appropriately and reducing performance pressure may allow desire to recover.

Infertility Treatment and Scheduled Intercourse

This issue is particularly important in my work with infertility patients.

Couples trying for pregnancy may initially enjoy intercourse normally.

After several months, everything becomes tied to fertility:

“Ovulation is today.”

“We must have intercourse tonight.”

“Do not miss the fertile window.”

Sex may begin to feel like a medical procedure rather than intimacy.

The couple may gradually stop experiencing spontaneous desire.

That does not necessarily mean that their sexual relationship is permanently damaged.

It often means that reproductive pressure has taken over the context in which sexuality occurs.

At Saira Health Care, I consider this overlap between **infertility and sexual health** particularly important.

Couples sometimes need permission to preserve forms of affection and intimacy that are not exclusively aimed at conception.

Responsive Desire and Desire Discrepancy Between Partners

One partner may experience spontaneous desire much more frequently than the other.

This creates what sexual medicine calls **sexual desire discrepancy**.

The higher-desire partner may think:

“If my partner loved me, they would want sex as often as I do.”

The responsive-desire partner may think:

“Something must be medically wrong with me because I rarely initiate.”

Both assumptions may be incorrect.

The problem may be difference rather than disease.

Modern sexual-medicine literature recommends avoiding automatic pathologization of the lower-desire partner.

The couple instead needs to understand:

How does each person's desire work?

What helps desire?

What blocks it?

What frequency feels realistic?

How can initiation happen without pressure?

How can rejection be handled respectfully?

These questions can be far more productive than searching for somebody to blame.

When Responsive Desire Becomes Low Desire Disorder

Responsive desire is normal.

However, **loss of both spontaneous and responsive desire** may sometimes represent a genuine sexual dysfunction.

The latest international consensus published in 2026 recognizes Hypoactive Sexual Desire Disorder (HSDD) as involving decreased or absent spontaneous desire, decreased or absent responsive desire to erotic cues or stimulation, inability to maintain desire once sexual activity begins, or loss of motivation to participate in sexual activity. Importantly, the condition must also cause clinically significant personal distress.

So a person who rarely experiences spontaneous sexual thoughts but becomes interested and enjoys intimacy once affectionate stimulation begins **does not automatically meet criteria for HSDD**.

By contrast, assessment becomes more important when:

- spontaneous desire is absent,
- responsive desire is also absent,
- sexual pleasure has markedly decreased,
- the change has persisted,

- and the person is personally distressed.

Current international guidance continues to emphasize a **biopsychosocial evaluation** rather than diagnosis based on a single hormone test or questionnaire.

Medical Causes Should Not Be Missed

Although responsive desire can be completely normal, a significant change in sexual interest deserves proper evaluation when accompanied by other symptoms.

Possible contributors include:

- depression,
- anxiety,
- thyroid disorders,
- diabetes,
- high prolactin,
- hormonal changes,
- chronic pain,
- cancer treatment,
- neurological disease,
- relationship problems,
- vaginal dryness or sexual pain,
- erectile dysfunction,
- medications such as certain antidepressants,
- alcohol or drug use,
- pregnancy,
- breastfeeding,
- menopause,
- and severe sleep deprivation.

ACOG specifically notes that sexual arousal and desire can be influenced by stress, anxiety, depression, medications, insufficient sleep, alcohol or drugs and relationship difficulties.

Therefore, education about responsive desire should never become an excuse to ignore genuine disease.

How I Evaluate Responsive Desire at Saira Health Care

When a patient tells me:

“Doctor, I don't feel desire anymore,”

I try to determine what that statement actually means.

I may ask:

Do sexual thoughts still occur?

Does desire appear after affection begins?

Does the patient enjoy intimacy once it starts?

Is there adequate arousal?

Is there vaginal dryness or pain?

Is erection normal?

Is orgasm possible?

Is the patient under pressure?

Has the relationship changed?

Is sleep poor?

Did symptoms begin after starting medication?

Is there depression or anxiety?

Are infertility treatments affecting the relationship?

Are hormonal symptoms present?

The answers determine whether I am dealing with:

normal responsive desire, true low libido, another sexual dysfunction, a relationship problem, or a medical condition affecting sexuality.

This distinction prevents unnecessary treatment.

Practical Ways to Work With Responsive Desire

The objective is not to manufacture sexual desire by force.

It is to create conditions in which desire has a reasonable opportunity to appear.

One useful principle is:

Do not always wait for desire before creating connection. Create healthy connection and see whether desire follows.

For couples who are mutually comfortable, helpful strategies may include:

- protecting private time together,
- reducing phone and screen interruptions,
- talking before physical intimacy,
- restoring affectionate touch without making intercourse compulsory,
- allowing more time for arousal,
- varying routine,
- choosing times when both partners are less exhausted,
- communicating what feels pleasurable and what does not,
- treating pain or erectile problems,
- improving sleep,
- and reducing unnecessary performance expectations.

The key word is **invitation**, not pressure.

Intimacy Should Not Always Have a Performance Goal

Many couples unintentionally create a rule:

If we start being physically affectionate, we must complete intercourse.

That can discourage the responsive-desire partner from allowing any closeness.

They may avoid even hugging because they fear it creates an obligation.

I often encourage couples to separate affection from compulsory performance.

A couple can:

sit close,

hold hands,

talk,

embrace,

or share affectionate touch

without guaranteeing what happens next.

When pressure falls, genuine desire may have more room to develop.

Make Time Without Making Sex Mandatory

Scheduling intimacy is sometimes misunderstood.

It should not mean:

“Tuesday at 10:00 pm—we must have intercourse.”

It can mean:

“Tuesday evening is protected time for us to reconnect without phones, work or outside responsibilities.”

What happens during that time remains mutually chosen.

For someone with responsive desire, this type of protected connection can be much more effective than waiting for a sudden urge during the busiest part of the week.

Longer Arousal Time Is Not Failure

Another common misunderstanding is that desire should appear immediately.

Bodies change.

Relationships change.

Age changes.

Hormones change.

What produced rapid arousal five years ago may require more time today.

ACOG recommends increased time for foreplay or stimulation when addressing arousal difficulties.

Taking longer to become interested does not necessarily mean something is wrong.

Address Sexual Pain First

Responsive desire should never be used to persuade someone to continue painful activity.

Repeated pain naturally teaches the brain to avoid the activity producing it.

A woman with:

- vaginal dryness,
- vaginismus,
- pelvic-floor dysfunction,
- vulvodynia,
- endometriosis,
- infection,
- menopausal tissue changes,
- or another cause of dyspareunia

may lose interest because her body expects discomfort.

ACOG recommends medical evaluation when sexual pain is frequent or severe.

In these patients, treating pain is often more important than trying to increase libido.

Psychological and Sex-Therapy Approaches

When responsive desire has become difficult because of anxiety, avoidance, low confidence or relationship problems, psychological treatment can be very useful.

The most recent international HSDD recommendations support psychological interventions including **sex therapy, cognitive-behavioral therapy and mindfulness-based treatment**.

A 2025 systematic review and meta-analysis similarly found that mindfulness-based CBT improved several dimensions of female sexual function, including desire and arousal, while established medications produced benefits for appropriately diagnosed patients.

Psychological treatment is not a suggestion that the symptoms are “imaginary.”

Sexuality involves the brain, emotions, body and relationship simultaneously.

When Medication May Be Appropriate

Responsive desire itself does not require medication.

Medication becomes a consideration only when there is a diagnosable sexual desire disorder or another medical condition that requires treatment.

For example, in appropriately selected women diagnosed with acquired generalized HSDD, pharmacological options may be considered depending on age, country, contraindications and individual medical circumstances.

The U.S. FDA's 2025 labeling for flibanserin indicates it for women younger than 65 years with acquired, generalized HSDD causing significant distress or interpersonal difficulty when the low desire is not explained by another medical or psychiatric condition, relationship problems or medication effects. The label specifically states that the medicine is **not intended simply to enhance sexual performance**.

Medication should therefore never be prescribed because someone merely says:

“I rarely feel spontaneous desire.”

Diagnosis comes first.

The Unani Understanding of Sexual Desire

As a physician trained in the Unani system, I find responsive desire particularly interesting because Unani medicine traditionally approaches sexual function as part of the health of the **whole person** rather than as an isolated genital function.

Classical Unani literature refers to **Quwwat-i-Bah**, broadly understood as the faculty related to sexual potency and libido. CCRUM literature describes Quwwat-i-Bah as relating to sexual function and desire and discusses its connection with general bodily health.

This traditional perspective has an important similarity with modern biopsychosocial sexual medicine:

sexual desire is influenced by much more than one organ.

That does not mean historical Unani concepts and modern neurobiology are identical.

But the whole-person orientation can be very useful clinically.

Asbab Sitta Daruriyya and Responsive Desire

Unani medicine gives great importance to the essential determinants of health, traditionally known as **Asbab Sitta Daruriyya**.

These include broad areas such as:

- food and drink,
- physical activity and rest,
- sleep and wakefulness,

- psychological activity and repose,
- environment,
- and normal processes of retention and elimination.

For a patient struggling with sexual desire, these principles direct attention to questions modern clinicians also consider:

Is sleep sufficient?

Is stress excessive?

Is physical activity adequate?

Is metabolic health poor?

Is the patient emotionally exhausted?

Is there chronic illness?

Is daily life leaving any room for intimacy?

This is where Unani principles can be particularly valuable as **supportive lifestyle medicine**.

Ilaj-bil-Ghiza — Dietotherapy

A patient sometimes asks me:

“Doctor, which food will immediately increase desire?”

I do not believe that is the right question.

There is no single food scientifically proven to switch responsive desire on instantly.

A more useful objective is nutritional support for:

- healthy body weight,
- diabetes control,
- cardiovascular health,
- energy,
- adequate nutrition,
- and general well-being.

A person who feels chronically unwell or fatigued is less likely to experience healthy sexual responsiveness.

Unani dietotherapy can therefore be individualized according to the patient's general health and constitution.

Ilaj-bil-Tadbir — Regimental and Lifestyle Support

CCRUM describes **Ilaj-bil-Tadbir**, **Ilaj-bil-Ghiza**, **Ilaj-bil-Dawa** and **Ilaj-bil-Yad** among the established therapeutic approaches of Unani medicine.

For responsive desire, lifestyle-oriented care may focus on:

regular sleep,

appropriate exercise,

stress reduction,

balanced routine,

time for rest,

and improving general physical health.

These interventions do not “cure responsive desire,” because responsive desire is not a disease.

Instead, they help reduce conditions that can suppress healthy sexual responsiveness.

Emotional Balance in Unani Care

Traditional Unani medicine recognizes psychological states as important contributors to health.

Modern sexual medicine reaches a similar practical conclusion.

Anxiety, resentment, depression, fear, shame and performance pressure can all inhibit sexual response.

For this reason, when I use an integrative approach, I do not separate emotional health from sexual treatment.

Sometimes a patient needs:

- reassurance,
- education,
- couple communication,
- counseling,

- psychological treatment,
- or psychiatric care

more than they need a sexual medicine.

The Role of Unani Medicines

Classical Unani medicine includes medicines traditionally categorized as **Muqawwi-i-Bah**, meaning preparations used historically for sexual debility or sexual vitality. CCRUM publications document such traditional uses.

However, I want to make an important scientific distinction.

There is currently no high-quality evidence showing that a particular Unani medicine is required to treat normal responsive desire.

Normal responsive desire should not be medicalized.

If genuine low libido exists because of another condition, selected Unani medicines may be considered as part of individualized supportive care when clinically appropriate—but they should not replace diagnosis or necessary evidence-based treatment.

If the problem is:

thyroid disease,

major depression,

high prolactin,

sexual pain,

significant hormonal disorder,

severe diabetes,

or medication-induced dysfunction,

the underlying condition must be addressed.

Traditional medicine is most useful when integrated responsibly rather than used to hide an undiagnosed disease.

Dr. Nizamuddin Qasmi's Integrative Approach

At Saira Health Care, my approach to responsive desire and low sexual interest begins with a fundamental principle:

Do not treat normal variation as disease, but do not ignore genuine dysfunction either.

I first determine whether the patient experiences:

spontaneous desire,

responsive desire,

both,

or neither.

Then I evaluate whether sexual activity remains:

pleasurable,

comfortable,

wanted,

and emotionally satisfactory.

Next, I assess physical and psychological factors that might be interfering with the response.

Depending on the findings, management may include:

sexual-health education,

relationship guidance,

sleep and lifestyle correction,

management of performance anxiety,

appropriate medical investigations,

treatment of associated sexual dysfunction,

selected Unani supportive measures,

and referral to gynecology, urology, endocrinology, psychiatry or qualified psychosexual therapy where necessary.

This individualized approach is more appropriate than giving everyone the same so-called “libido medicine.”

Contribution of Saira Health Care in Sexual Disorders and Infertility

At **Saira Health Care**, our continuing focus in sexual disorders and infertility has shown us how closely sexual desire, reproductive health and relationships are connected.

Couples may approach us for:

low libido,

erectile dysfunction,

premature ejaculation,

male infertility,

female infertility,

painful intercourse,

sexual performance anxiety,

relationship-related sexual problems,

or loss of intimacy during fertility treatment.

But the initial complaint does not always reveal the full problem.

A couple may say:

“There is no desire.”

Further discussion may reveal that they are exhausted by infertility treatment.

Another person may report low libido when the real issue is sexual pain.

Another may believe their desire has disappeared simply because it has changed from spontaneous to responsive.

Sexual-health care therefore requires time, privacy and careful listening.

About Dr. Nizamuddin Qasmi

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

Qualifications and Professional Training:

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

My approach combines my background in Unani medicine with contemporary understanding of sexual and reproductive health.

The purpose is not simply to increase the frequency of intercourse.

The aim is to help patients develop **healthy, safe, consensual and satisfying sexual relationships while identifying and treating genuine medical problems when present**.

Common Myths About Responsive Desire

“If I don't spontaneously want sex, I must have low libido.”

Not necessarily.

ACOG specifically notes that it can be normal for desire to appear after sexual activity has begun.

“If I have to make time for intimacy, the relationship is no longer romantic.”

Not necessarily.

Adult life requires intentional time for many valued activities. Creating space for intimacy can support responsive desire.

“Responsive desire means agreeing to sex even when I don't want it.”

No.

Responsive desire requires willingness and consent. It never justifies coercion, guilt or pressure.

“If my partner does not initiate sex, they are no longer attracted to me.”

Not necessarily.

Some people rarely experience spontaneous initiation but develop strong desire once affectionate interaction begins.

“A libido medicine will solve responsive desire.”

Usually not.

Normal responsive desire does not require medication.

“My partner and I should always have the same level of desire.”

That is unrealistic for many couples.

Desire discrepancy is common and does not automatically mean either partner is abnormal.

When Should You Seek Professional Help?

Responsive desire is usually normal, but consultation is advisable when there is a persistent and distressing change in sexual functioning.

Particularly important reasons for evaluation include:

- complete loss of both spontaneous and responsive desire,
- sudden unexplained change in libido,
- persistent inability to become aroused,
- painful intercourse,
- vaginal dryness associated with significant symptoms,
- erection difficulties,
- absent periods or other hormonal symptoms,
- severe fatigue,
- major depression or anxiety,
- relationship distress,
- sexual symptoms beginning after medication,
- infertility accompanied by sexual difficulties,
- symptoms developing after surgery or cancer treatment,
- or sexual concerns causing significant personal distress.

Current 2026 international consensus states that HSDD assessment requires focused clinical history and a biopsychosocial approach; psychological interventions including sex therapy, CBT and mindfulness-based therapy have supporting evidence.

Frequently Asked Questions

Is responsive desire normal?

Yes. For many people, desire emerges after affectionate or sexual stimulation begins rather than appearing beforehand. ACOG recognizes this as a normal sexual-response pattern.

Is it more common in women?

The responsive-desire model was developed primarily from research into women's sexuality and has particular relevance to women in long-term relationships. However, men can also experience desire that depends strongly on context and stimulation.

Does responsive desire mean low libido?

No.

A person may have little spontaneous desire but strong responsive desire and a satisfying sexual life.

What if desire never appears even after stimulation?

If this is persistent, distressing and represents a change from your normal experience, professional assessment may be appropriate. Current international criteria for HSDD include reduced responsive desire as well as reduced spontaneous desire.

Should couples schedule sex?

It may be more helpful to schedule **time for connection** rather than mandatory intercourse.

The purpose is to remove distractions and create an opportunity for intimacy while maintaining complete freedom for either partner to stop or choose another form of closeness.

Can relationship problems suppress responsive desire?

Yes.

Relationship satisfaction, emotional safety, unresolved conflict and partner responsiveness can influence sexual experience.

Can stress reduce responsive desire?

Yes.

Chronic mental load and exhaustion can interfere with attention, arousal and sexual motivation.

Can menopause affect responsive desire?

Yes.

Hormonal changes, vaginal dryness, painful intercourse, sleep disturbance and other menopause-related factors may alter sexual response.

Can infertility treatment reduce desire?

Yes.

Timed intercourse and repeated fertility-related pressure can make sexuality feel task-oriented, causing anxiety and reducing spontaneous interest.

Can Unani medicine help?

Unani medicine can provide a useful supportive framework through individualized attention to sleep, activity, diet, emotional balance and general health. Classical Unani literature also recognizes sexual vitality within broader systemic health. However, normal responsive desire is not a disease and does not require herbal treatment. Genuine persistent low libido should be medically evaluated before assuming that a tonic or aphrodisiac is required.

My Message to Couples

I often tell couples:

Do not judge the health of your relationship only by how frequently desire appears spontaneously.

A person can deeply love their partner and still not experience sudden sexual urges very often.

A person can begin an evening feeling neutral, become emotionally connected, then physically aroused and finally experience strong sexual desire.

That is not fake desire.

It is **responsive desire**.

At the same time, healthy intimacy requires freedom.

Never use the concept of responsive desire to pressure yourself or your partner.

The goal is not:

“Start sex whether you want it or not.”

The healthier message is:

“When both partners feel safe and willing, create space for closeness without demanding an outcome, and allow desire an opportunity to develop.”

If it develops, enjoy the experience.

If it does not, respect that response.

And if desire has disappeared persistently and the change causes distress, investigate why rather than immediately blaming yourself, your partner or your hormones.

Modern sexual medicine increasingly recognizes that desire is dynamic and context-dependent. The latest international consensus also distinguishes healthy variation from genuine HSDD by considering spontaneous desire, responsive desire, persistence and personal distress.

At **Saira Health Care**, our goal is to combine responsible modern sexual-health assessment with the holistic strengths of Unani medicine—considering physical health, mental well-being, sleep, lifestyle, reproductive health and relationships together.

Because healthy sexuality is not simply about waiting for a mood to arrive.

Sometimes healthy desire begins when a couple creates the **right conditions for connection, comfort, safety and affection**.

Medical Disclaimer

This article is intended for general health education and does not replace individualized medical evaluation. Responsive desire itself is a normal sexual-response pattern and should not automatically be diagnosed as sexual dysfunction. Persistent loss of both spontaneous and responsive desire, sexual pain, erectile dysfunction, major hormonal symptoms, severe depression or other significant changes should be evaluated by an appropriately qualified healthcare professional. Sexual activity must always be consensual, voluntary and free of pressure or coercion.