Loss of Sexual Interest

Distinguishing Temporary Reduced Desire From Persistent Sexual-Health Concerns

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

Medical and sexual-health literature reviewed and updated through September 2026.

Introduction

One of the most common but misunderstood concerns I hear in sexual-health practice is:

"Doctor, I have lost interest in sex. Is something wrong with me?"

Sometimes the person is a man who previously had a strong libido but now rarely thinks about sex.

Sometimes a woman tells me:

"Earlier I enjoyed intimacy with my husband, but for the last few months I simply do not feel interested."

Another patient may still love their partner, feel emotionally attached and have no major relationship conflict, yet notice that sexual thoughts and motivation have decreased.

Others are not experiencing a true sexual disorder at all. They are simply exhausted after a stressful month, recovering from illness, adjusting after childbirth, going through menopause, taking a medicine that affects sexual function, undergoing infertility treatment or dealing with an emotionally difficult period.

This is why **loss of sexual interest should not automatically be considered a disease**.

Sexual desire is naturally variable.

It can increase.

It can decrease.

It can temporarily disappear.

And it can later return.

The important clinical task is to distinguish a **normal temporary reduction in interest** from a **persistent change that is causing distress or may indicate an underlying medical, hormonal, psychological, sexual or relationship problem**.

The World Health Organization describes sexual health as physical, emotional, mental and social well-being related to sexuality—not merely the absence of sexual dysfunction. WHO also recognizes that sexuality includes desire, pleasure, intimacy, beliefs, values and relationships and that it is influenced by biological, psychological, social, cultural, religious and other factors.

This broad definition is especially useful when discussing reduced sexual interest because **desire is not produced by one hormone or one organ alone**.

It emerges from the interaction of the brain, body, hormones, physical health, emotional state, relationship circumstances, sleep, lifestyle and personal context.

What Is Sexual Interest or Sexual Desire?

Sexual desire is the motivation, interest or inclination toward sexual or intimate activity.

It may appear as sexual thoughts or fantasies, interest in a partner, desire for affectionate or sexual closeness, or motivation to initiate or participate in sexual activity.

However, desire does not always begin with a sudden sexual thought.

Modern sexual-medicine definitions recognize both **spontaneous desire** and **responsive desire**.

Spontaneous desire means:

“I suddenly feel interested in sex.”

Responsive desire means that a person may initially feel neutral but gradually become interested after affectionate or pleasurable intimacy begins.

The 2026 Fifth International Consultation on Sexual Medicine recognizes loss of spontaneous desire, reduced responsive desire and difficulty maintaining interest once sexual activity begins as possible features of clinically significant hypoactive sexual desire disorder.

This distinction is important because a person who rarely experiences spontaneous sexual thoughts may still have a healthy sexual response once intimacy develops.

They should not automatically assume:

“I have lost my libido.”

Is Loss of Sexual Interest a Disease?

Not automatically.

Sexual desire naturally fluctuates.

A person may temporarily lose interest during a demanding period of work, illness, family stress, sleep deprivation, bereavement, pregnancy, postpartum recovery or major emotional change.

A few days or weeks of lower interest therefore usually cannot be interpreted in isolation.

Current international sexual-medicine definitions place much more emphasis on **persistence and personal distress**.

The 2026 ICSM consensus defines hypoactive sexual desire disorder as persistent or recurrent reduction or absence of sexual thoughts, fantasies or motivation, including reduced spontaneous or responsive desire, generally persisting for about six months and causing clinically significant personal distress. ICD-11 uses the broader concept of a pattern persisting for at least several months and associated with significant distress.

Therefore, two questions are extremely important:

How long has the change been present?

and

Is it actually bothering the person?

A person should not automatically be diagnosed with a sexual disorder simply because their partner wants sex more frequently.

Temporary Low Interest Versus a Persistent Concern

More Suggestive of Temporary Reduced Interest	More Suggestive of a Persistent Concern
Started during a stressful or exhausting period	Has continued for several months
Interest occasionally returns	Desire remains consistently very low or absent
Desire appears when circumstances improve	Little spontaneous or responsive interest remains
No major personal distress	Causes frustration, sadness, worry or avoidance
Clearly linked with illness, sleep loss or temporary circumstances	No obvious recovery even after the temporary problem resolves
Relationship remains generally comfortable	Creates ongoing relationship or sexual distress
No other significant symptoms	Accompanied by ED, pain, hormonal symptoms, depression or other health changes

This is not a diagnostic test. It is a practical way of deciding when a problem may deserve professional assessment.

Desire Naturally Changes Throughout Life

Sexual desire should not be thought of as a number that remains constant from adolescence to old age.

The same person may experience very different levels of sexual interest at different stages of life.

Desire can change after:

marriage,

pregnancy,

childbirth,

menopause,

infertility treatment,

chronic illness,

surgery,

relationship changes,

aging,

or major psychological stress.

WHO emphasizes that sexual health remains relevant throughout the lifespan rather than only during reproductive years.

The goal of medicine should therefore not be to make every person maintain the same libido throughout life.

The goal is to determine whether a change is expected, distressing, medically significant or treatable.

There Is No Universal "Normal" Amount of Sexual Desire

Patients frequently ask me:

"How many times should a healthy person want sex?"

Medicine cannot provide one number.

One person may be satisfied with relatively infrequent intimacy.

Another may experience sexual desire much more often.

Both may be healthy.

Frequency alone does not establish disease.

What matters more is whether there has been an important change from the individual's previous pattern and whether the person is experiencing significant distress.

A naturally low level of desire that has existed for years and causes no personal concern is different from a sudden loss of interest in someone who previously had a strong libido.

Loss of Desire Is Not the Same as Desire Mismatch

This distinction is important.

Suppose one partner wants sex three times per week and the other wants it once per week.

That is a **desire mismatch**.

It does not automatically mean that the second person has low libido.

Current European guidance specifically recognizes sexual desire discrepancy as a common part of relationship dynamics and recommends avoiding unnecessary stigmatization of the lower-desire partner.

Loss of sexual interest is different when a person themselves notices:

“This is not my normal pattern. My desire has clearly changed.”

Loss of Interest Does Not Automatically Mean Loss of Love

One of the most painful misunderstandings occurs when a partner concludes:

“If you don't want sex, you don't love me.”

Sexual desire and emotional love overlap, but they are not identical.

A person can love their spouse deeply and still have reduced desire because of:

exhaustion,

depression,

hormonal problems,

pain,

medication,

menopause,

poor sleep,

sexual dysfunction,

or physical illness.

This is why accusations should be avoided until the cause is understood.

Low Desire Is Not the Same as Erectile Dysfunction

In men, this distinction is particularly important.

Libido asks:

“Do I want sexual activity?”

Erectile function asks:

“Can I obtain and maintain an erection?”

A man can have strong desire and erectile dysfunction.

Another man may have normal erections but little desire.

The problems can also coexist.

Current male sexual-health guidance specifically treats low desire and erectile dysfunction as distinct conditions while acknowledging that one may contribute to the other.

Therefore, erection medicines do not automatically solve low libido.

Loss of Interest Is Not the Same as Infertility

Sexual desire and fertility are also different biological functions.

A man may have:

normal libido,

excellent erections,

and low sperm count.

Another man may have low desire and normal sperm production.

Likewise, a woman may have low sexual interest while remaining completely capable of ovulation and conception.

Infertility requires reproductive assessment.

Libido cannot tell us whether sperm, ovulation or fallopian tubes are normal.

This distinction is extremely important because patients sometimes turn a fertility diagnosis into a judgment about their entire sexuality.

The Most Important Causes of Loss of Sexual Interest

In modern sexual medicine, reduced desire is best understood using a **biopsychosocial model**.

The 2025 Fifth International Consultation on Sexual Medicine specifically recommends assessing sexual difficulties across biological, psychological and interpersonal domains rather than searching for one universal explanation.

In practical terms, loss of interest may arise from several overlapping areas: medical disease, hormones, medication, psychological health, relationship circumstances,

sexual dysfunction, sleep and lifestyle, reproductive stress, and normal life-stage changes.

For many patients, two or three of these factors occur together.

Stress and Mental Overload

One of the commonest temporary causes is stress.

A person may be dealing with:

financial pressure,

work deadlines,

family responsibilities,

illness in the family,

examinations,

business problems,

or caregiving.

The brain is constantly occupied with responsibilities.

There is little psychological space left for sexual thoughts.

The patient concludes:

“My libido is gone.”

Sometimes nothing is fundamentally wrong with the sexual system.

The nervous system is simply overwhelmed.

When the stress decreases, interest may gradually return.

Chronic Stress Can Become a Persistent Problem

Temporary stress and chronic stress are different.

If a person remains under intense pressure for months, several secondary problems may appear.

Sleep becomes poor.

Mood deteriorates.

Relationship communication worsens.

Fatigue increases.

Exercise decreases.

Weight may change.

Sex becomes another responsibility.

Now the original stress has created a wider environment in which desire is difficult to experience.

Treatment therefore may require more than:

“Just relax.”

The underlying stressors and lifestyle consequences need attention.

Depression Is a Major Cause of Reduced Interest

Depression can reduce interest in activities that were previously pleasurable, including sexuality.

A patient may lose:

interest in sex,

motivation,

energy,

enjoyment,

and emotional responsiveness.

The person may also feel worthless or disconnected from their partner.

The 2026 International Consultation on Sexual Medicine review of psychiatric disorders emphasizes that psychiatric illness can significantly impair sexuality and that psychotropic treatments themselves may also affect sexual function.

When a patient loses interest in **everything**, not merely sex, I become particularly interested in mood.

Sexual treatment alone may not be sufficient.

Anxiety Can Reduce Desire in a Different Way

Anxiety does not always eliminate sexual interest directly.

Sometimes the person still wants intimacy but becomes afraid of what will happen.

A man thinks:

“What if my erection fails?”

Another worries:

“What if I ejaculate too soon?”

A woman thinks:

“What if intercourse hurts?”

The person starts avoiding sexual situations.

After months of avoidance they begin describing the problem as:

“I don't feel interested anymore.”

The primary issue may actually be **fear of sexual activity**, not absence of sexual desire.

This distinction can completely change treatment.

Sexual Performance Anxiety

A man who has experienced repeated erectile difficulty may gradually stop initiating sex because every attempt feels like an examination.

At first:

“I want sex but I am worried.”

Later:

“I would rather avoid it.”

Eventually:

“I don't feel much sexual interest anymore.”

In such a patient, treating erectile dysfunction and performance anxiety can sometimes allow desire to return.

Current sexual-medicine guidance recognizes negative sexual thoughts, erection concerns, anxiety and shame as important contributors to male low desire.

Sexual Shame and Guilt

Another patient may have normal biological sexual interest but feel ashamed whenever desire appears.

They may have learned:

“Sexual thoughts are dirty.”

“Expressing desire is inappropriate.”

“Good people should not think about sex.”

Over time, desire may become associated with guilt rather than pleasure.

This does not mean cultural or religious values are unhealthy.

A patient may freely choose boundaries based on deeply held beliefs.

The clinical issue is different when the person wants intimacy within their own accepted values but experiences severe fear, shame or self-rejection.

WHO explicitly recognizes cultural, religious and spiritual factors as genuine influences on sexuality.

Healthcare should therefore respect values while correcting misinformation and unnecessary shame.

Relationship Conflict

Sexual desire occurs within a relationship context.

Unresolved anger can reduce interest.

So can:

criticism,

resentment,

betrayal,

emotional distance,

poor communication,

or chronic conflict.

A person may have normal sexual thoughts in other contexts but almost no desire within the relationship.

This is clinically different from generalized low libido.

A sexual tonic cannot resolve unresolved resentment.

The couple may need relationship-focused care.

Intimacy Problems

Some people do not lack biological desire.

They lack emotional safety.

A patient may say:

“I can become physically aroused, but I don't feel comfortable being close.”

Past betrayal, attachment difficulties, sexual trauma or relationship conflict may create avoidance.

In such cases, treatment aimed only at increasing libido can miss the real problem.

Sometimes intimacy must feel safe before desire can reappear.

Pain Can Look Like Loss of Interest

This is one of the most important principles in female sexual-health assessment.

If intercourse causes pain, reduced desire may be protective.

The brain learns:

“Sex = pain.”

Naturally, sexual interest decreases.

Possible causes include vaginal dryness, genitourinary syndrome of menopause, pelvic-floor dysfunction, vulvodynia, infection and other gynecological conditions.

The correct treatment is not simply to increase libido.

The pain needs diagnosis and treatment.

Erectile Dysfunction Can Look Like Low Desire

The same principle applies in men.

A man with repeated ED may begin avoiding intimacy.

His spouse says:

“He has lost interest.”

He says:

“I don't feel like having sex.”

But underneath is the thought:

“I don't want another erection failure.”

The apparent libido problem may therefore be secondary to ED.

Premature Ejaculation Can Reduce Future Interest

Premature ejaculation can also transform sexuality from something pleasurable into something stressful.

A man repeatedly experiences ejaculation earlier than desired.

He becomes embarrassed.

His partner may become disappointed.

The next sexual encounter feels threatening.

Eventually he stops initiating.

Again, treatment should address the underlying ejaculatory problem rather than automatically diagnosing primary loss of libido.

Medication-Related Loss of Sexual Interest

Medication review is an essential part of assessment.

Psychotropic medicines are particularly important.

A 2026 ICSM consensus review confirms that both psychiatric disorders and medicines used to treat them can adversely affect sexual functioning.

A 2026 systematic review and meta-analysis of randomized trials examining SSRIs found clear increases in orgasmic dysfunction and reduced sexual satisfaction; the evidence for reduced desire itself was less statistically certain, illustrating how sexual medication effects can involve several different domains rather than libido alone.

Other medicines can also affect hormones or sexual response depending on the individual.

The correct approach is:

“Tell your doctor about the change.”

It is **not**:

"Stop the medicine immediately."

Abrupt discontinuation of psychiatric or other prescribed medication can be dangerous.

Prostate Medicines Can Affect Sexuality

Some medicines used for prostate and urinary symptoms can affect sexual function.

The 2026 Fifth International Consultation on Sexual Medicine concluded that 5-alpha-reductase inhibitors are associated with sexual adverse effects including reduced desire, erectile dysfunction and ejaculatory problems and recommended informing patients about these risks before treatment.

Again, this does not mean such medicines should never be used.

It means sexual side effects should form part of informed medical decision-making.

Testosterone and Male Sexual Interest

Testosterone plays an important role in male sexual desire.

The 2025 international hormonal consensus describes testosterone as a major regulator of male sexual desire and arousal but also emphasizes that male sexual response involves several hormones and neurotransmitters rather than testosterone alone.

A man with genuinely low testosterone may report:

reduced libido,

fewer morning erections,

erectile dysfunction,

low energy,

and reduced motivation.

When several of these occur together, hypogonadism becomes more clinically relevant.

But low libido alone does not prove testosterone deficiency.

Testosterone Deficiency Requires Both Symptoms and Laboratory Evidence

A patient should not be diagnosed with hypogonadism simply because he says:

“I don't feel interested in sex.”

Current expert recommendations define male hypogonadism as a combination of **compatible symptoms and confirmed biochemical testosterone deficiency**.

The reason is simple.

Low libido can also result from:

depression,

poor sleep,

relationship conflict,

medication,

obesity,

chronic illness,

or stress.

Hormonal treatment should follow diagnosis—not assumptions.

Testosterone Is Not a General Sexual-Energy Medicine

If testosterone is normal, giving more testosterone should not be treated as a general method of increasing sexual power.

The 2025 ICSM hypogonadism recommendations explicitly advise against testosterone therapy in eugonadal men.

Testosterone is a medical treatment for appropriately selected patients with confirmed deficiency.

It should not become a cosmetic or motivational drug.

A Critical Fertility Warning for Men

This is particularly important for patients at Saira Health Care because many are seeking infertility treatment.

External testosterone can suppress sperm production.

The latest international recommendations strongly advise against testosterone therapy in men seeking fatherhood. Testosterone treatment suppresses gonadotropins and can substantially reduce spermatogenesis, sometimes causing azoospermia.

Therefore, a man trying for pregnancy should never start testosterone casually simply because he has fatigue or low libido.

Sexual symptoms and fertility goals must be considered together.

Prolactin and Other Hormonal Causes

Testosterone is not the only hormone that matters.

High prolactin can contribute to reduced sexual desire.

Thyroid disorders can also influence sexual function.

Pituitary disease is uncommon, but in selected patients with significant hormonal abnormalities, headache or visual symptoms, specialist endocrine evaluation may be required.

Current EAU guidance includes androgen deficiency and hyperprolactinemia among recognized biological causes of low male sexual desire and recommends endocrine testing when clinically indicated.

The lesson is not that every patient needs dozens of blood tests.

It is that persistent unexplained desire loss sometimes deserves medical investigation.

Female Sexual Desire Is Equally Multifactorial

Women may experience reduced sexual interest because of:

mental-health factors,

pain,

relationship circumstances,

medication,

pregnancy,

postpartum recovery,

menopause,

body image,

sleep,

chronic illness,

or hormonal changes.

The 2026 Fifth International Consultation on Sexual Medicine emphasizes that female hypoactive sexual desire disorder should be evaluated and treated through a **biopsychosocial approach**, with psychological, nonhormonal and hormonal treatment options considered according to the individual.

This means women's low desire should not automatically be dismissed as:

“It is just hormones.”

Nor should it automatically be blamed on the relationship.

Menopause and Loss of Sexual Interest

Menopause is one of the common life stages in which desire may change.

But the explanation is more complex than falling estrogen.

A 2026 scoping review of sexual desire during menopause identified biological, psychological and social influences. Important factors included vaginal dryness and pain, sleep disruption, general health, anxiety, depression, body image, relationship dissatisfaction and relationship duration.

A 2025 clinical review likewise emphasizes that menopausal sexual changes are multifactorial and may involve desire, lubrication, orgasm, satisfaction and pain.

This distinction matters because a woman may describe:

“I have lost my libido.”

But the actual sequence may be:

menopause → dryness → painful intercourse → anxiety → avoidance → reduced interest.

Treating the pain may be more useful than simply trying to stimulate desire.

Indian Midlife Women and Sexual Health

This subject is particularly important in India because sexual difficulties may be underreported.

The **Indian Menopause Society's 2026 clinical practice guidelines** describe midlife female sexual dysfunction as multifactorial, involving biological, psychological and relationship factors, and note that stigma and lack of awareness can contribute to underreporting in India.

Therefore, a woman should not be expected to tolerate loss of sexual well-being simply because she is aging.

Menopause is a life transition—not an automatic end to intimacy.

Testosterone in Women Requires Specialist Judgment

Interest in testosterone treatment for postmenopausal women with carefully diagnosed hypoactive sexual desire disorder has grown, and contemporary expert guidance recognizes a role for testosterone in selected postmenopausal women after a proper biopsychosocial assessment. However, long-term evidence, product availability, dosing and regulatory approval differ between countries.

Therefore, testosterone should not be marketed to women as a general anti-aging, energy or libido product.

The diagnosis and treatment plan should be individualized.

Pregnancy and Sexual Interest

Pregnancy can also change desire.

Some people experience increased interest.

Others experience less.

Physical discomfort, fear, hormonal changes, nausea, fatigue, body changes and relationship circumstances can all contribute.

Changes are often different across trimesters.

Reduced interest during pregnancy is therefore not automatically a sexual disorder.

Postpartum Loss of Sexual Interest

The period after childbirth deserves particular sensitivity.

A 2026 systematic qualitative review found that postpartum women commonly described diminished sexual desire together with pain, fear, body-image concerns and contextual or relationship pressures.

A 2025 systematic review of postpartum sexual dysfunction similarly found that perineal pain or injury, breastfeeding, body image and partner or family support can influence sexual outcomes during the first year after childbirth.

In practical terms, consider the realities of a new mother:

she may be healing physically,

breastfeeding,

sleep-deprived,

emotionally overwhelmed,

caring for an infant around the clock,

and adjusting to dramatic body and identity changes.

Simply saying:

“Why is your libido low?”

misses the entire clinical picture.

Postpartum Desire Often Requires Patience, Not Pressure

A partner may worry:

“It has been months since the birth. Why has intimacy not returned to normal?”

There is no universal timetable.

Some couples recover relatively quickly.

Others require much longer.

Pain, pelvic-floor issues, breastfeeding, fatigue and emotional adjustment may all affect timing.

Pressure can make the problem worse.

Postpartum sexual-health care should include recovery, communication and appropriate medical evaluation when symptoms persist.

Chronic Illness Can Reduce Sexual Interest

Chronic disease often affects sexuality indirectly as well as directly.

The 2026 Fifth International Consultation on Sexual Medicine review of chronic illness and cancer emphasizes that chronic disease and its treatments can substantially affect sexual function, relationships and quality of life.

The mechanisms may include:

fatigue,

pain,

hormonal changes,

neurological problems,

vascular disease,

body-image changes,

depression,

medications,

and fear about physical activity.

A patient with chronic illness deserves sexual-health care just as much as a healthy young adult.

Cancer and Cancer Treatment

Cancer treatment can affect sexuality through surgery, radiation, chemotherapy, endocrine therapy, body-image changes and psychological stress.

A 2026 review describes reduced desire as one of several sexual problems that can occur after cancer, alongside erectile problems, vaginal changes, pain, orgasm difficulties and fertility-related distress.

Sexual rehabilitation after cancer should therefore be multidisciplinary.

The patient survived a serious disease.

They should not be told that their sexual-health concerns are trivial.

Prostate Treatment and Sexual Interest

Men undergoing prostate-cancer treatment may experience changes in erections, ejaculation, hormones and sexual confidence.

Some men retain desire but cannot obtain erections.

Others experience reduced desire, particularly when androgen-deprivation therapy is involved.

Still others gradually lose interest because repeated sexual attempts are frustrating.

These mechanisms need to be separated.

Treatment after prostate disease should therefore address the **specific sexual change**, not simply label everything "low libido."

Cardiovascular and Metabolic Disease

Diabetes, obesity, cardiovascular disease and metabolic illness can affect sexual health through vascular, hormonal, neurological and psychological pathways.

In men, metabolic disease may contribute to erectile dysfunction and testosterone deficiency.

In both sexes, poor general health and fatigue can reduce sexual interest.

A patient whose physical health has deteriorated may therefore require broader health optimization rather than a single libido medicine.

Obesity and Body Image

Weight can influence desire indirectly.

A person may have:

poor metabolic health,

reduced mobility,

lower energy,

body-image concerns,

sleep apnea,

or hormonal changes.

The sexual problem may be partly physiological and partly psychological.

Weight management can therefore sometimes support sexual health, but it should never be presented as a guarantee that libido will return.

Sleep Is an Underestimated Sexual-Health Factor

A patient sometimes tells me:

"My sexual desire is completely gone."

Then I learn they are sleeping four or five hours every night.

Sleep affects:

energy,

mood,

stress tolerance,

metabolism,

and hormonal regulation.

A 2025 review in women describes sleep disorders as potentially affecting sexual desire, arousal and satisfaction through physiological and psychosocial pathways.

Poor sleep is not the explanation for every case.

But it should not be ignored.

Infertility Can Transform Desire

This is particularly relevant to my work.

A couple begins trying for pregnancy.

Initially, intercourse is affectionate and spontaneous.

Then ovulation is tracked.

Every fertile day becomes important.

The husband hears:

“Today we have to try.”

The wife thinks:

“We cannot miss this month.”

Sex becomes scheduled.

The man may develop performance anxiety.

The woman may become emotionally exhausted.

Gradually one partner loses interest.

The 2026 International Consultation on Sexual Medicine specifically recognizes that sexual dysfunction in infertile men is often neglected and that infertility and sexual dysfunction can influence each other in both directions.

Therefore, fertility care should not focus only on laboratory reports.

Infertility Does Not Mean Sexual Failure

A low sperm count does not mean low masculinity.

Reduced ovarian reserve does not mean a woman has failed as a partner.

A fertility diagnosis describes reproductive biology.

When patients turn fertility results into judgments about sexual worth, desire and confidence can deteriorate further.

I believe one important part of fertility care is therefore helping couples separate:

reproductive function

from

sexual and emotional worth.

Preserve Some Intimacy Outside the Fertility Calendar

When possible, couples undergoing fertility treatment can benefit from preserving moments of closeness that are not always tied to ovulation or pregnancy.

This does not replace medically timed intercourse when it is part of treatment.

It simply prevents the couple's entire intimate relationship from becoming a reproductive procedure.

Sexuality is broader than conception.

Aging and Sexual Interest

Sexual desire may change with age, but age alone should not be used to dismiss symptoms.

Older adults may experience:

chronic illness,

medication changes,

loss of a partner,

menopause,

erectile problems,

prostate treatment,

pain,

or reduced mobility.

WHO explicitly emphasizes that sexual health remains relevant into older age.

Therefore:

“You are old, so loss of sexual interest is normal”

is not a complete clinical assessment.

Normal Age-Related Change Versus Disease

A gradual reduction in spontaneous interest may be acceptable for one patient.

A sudden major change may be different.

For example, a 68-year-old man who says:

“My libido has slowly become somewhat lower over several years, but I am comfortable”

may not require treatment.

Another says:

“Until three months ago I had normal desire. Now it has almost completely disappeared, my morning erections are gone and I am constantly exhausted.”

That deserves investigation.

Context matters more than age alone.

How Do I Assess Loss of Sexual Interest?

When a patient comes to Saira Health Care with this concern, I try to understand the **story of the change**.

I want to know whether the problem is new or lifelong.

Whether desire is absent everywhere or only within the relationship.

Whether spontaneous thoughts have decreased.

Whether responsive desire still develops.

Whether there is ED, PE, pain, dryness or orgasm difficulty.

Whether medication changed.

Whether sleep has deteriorated.

Whether depression or anxiety is present.

Whether pregnancy, postpartum recovery or menopause is relevant.

Whether infertility treatment has made sex stressful.

Whether chronic disease or surgery has occurred.

And most importantly:

“Does the patient themselves feel distressed by this change?”

That last question is essential.

There Is No Single Blood Test for Libido

Many patients ask:

“Which blood test tells me why my sexual interest has gone?”

There is no single test.

Sexual desire is too complex.

Laboratory investigations are selected according to the clinical history.

A man with suspected hypogonadism may need properly timed testosterone testing and additional endocrine assessment.

A patient with symptoms suggestive of thyroid disease may need thyroid testing.

Prolactin may be relevant in selected patients.

Diabetes or metabolic testing may be appropriate when risk factors exist.

But a laboratory panel cannot measure emotional intimacy, relationship resentment, sexual shame or chronic stress.

Good diagnosis combines medical investigation with conversation.

Assessment in Men

For men, I pay particular attention to the combination of:

low desire,

reduced morning erections,

and erectile dysfunction.

The 2025 international hypogonadism consensus states that this combination is particularly suggestive of testosterone deficiency and deserves proper evaluation.

If testosterone is tested, interpretation should be performed clinically rather than treating one result in isolation.

And if the patient wants children, fertility must be discussed before hormonal therapy.

Assessment in Women

In women, I want to understand whether low interest is occurring alone or together with:

pain,

dryness,

difficulty becoming aroused,

orgasm problems,

pregnancy or postpartum changes,

menopause,

body-image concerns,

medication,

or relationship stress.

The latest 2026 female HSDD recommendations emphasize individualized biopsychosocial assessment rather than relying on a single hormone result.

A woman's sexual interest cannot be diagnosed through testosterone alone.

Distinguishing “I Don't Want Sex” From “I Don't Want Pain”

This distinction can completely change the consultation.

A woman may say:

“I have no desire.”

Further questioning reveals:

“Intercourse has been painful for six months.”

Her reduced desire may be a normal response to anticipated pain.

Another patient says:

“I have no sexual interest.”

Further discussion reveals:

“I am frightened that my erection will fail.”

Again, the primary disorder may not be desire.

Good sexual medicine identifies what the patient is actually avoiding.

Distinguishing Loss of Interest From Relationship-Specific Loss of Interest

Another important question is:

“Is sexual interest reduced generally, or only with this partner?”

A person may still have sexual thoughts and solitary desire but feel no interest within the relationship.

This does not automatically mean the relationship must end.

It may reflect:

resentment,

poor intimacy,

unresolved betrayal,

repeated criticism,

or relationship-specific anxiety.

Such cases require different treatment from generalized low desire caused by hormones or depression.

Distinguishing Low Desire From Asexuality

Low sexual desire disorders should also not be confused automatically with an asexual orientation or a lifelong pattern of very low sexual attraction that the person does not experience as a medical problem.

Modern sexual diagnoses require distress.

Medicine should not turn a person's stable identity or comfortable lifelong variation into a disorder simply because society expects more sexual interest.

When Loss of Interest Deserves Professional Evaluation

A temporary reduction during an exhausting week usually does not require extensive testing.

I become more interested in formal assessment when the change persists for months, represents a substantial decline from the person's previous pattern, causes personal distress, damages relationships or occurs together with another sexual or medical symptom.

Prompt medical or mental-health assessment is especially appropriate when low desire occurs with severe depression, self-harm thoughts, substantial unexplained hormonal symptoms, major neurological symptoms, or significant physical illness.

The purpose is not to frighten patients.

It is to avoid dismissing an important symptom.

Treatment: The Cause Matters More Than the Symptom

There is **no universal treatment for loss of sexual interest**.

This is the most important therapeutic principle.

If the cause is sleep deprivation, improve sleep.

If it is pain, investigate pain.

If it is depression, treat depression.

If a medication is responsible, review it safely.

If confirmed hypogonadism exists, manage the hormonal disorder appropriately.

If relationship resentment is central, work on the relationship.

If ED is creating avoidance, treat ED.

If infertility pressure has made intimacy mechanical, address fertility and sexual well-being together.

Treatment follows the cause.

Sexual Education Can Itself Be Therapeutic

Some patients believe they have lost libido simply because they no longer feel the intense spontaneous desire they experienced in a new relationship.

They assume:

“Something is wrong.”

Learning about normal variations in desire and responsive desire can reduce unnecessary anxiety.

Education can help people understand that long-term sexuality may require different conditions from early-relationship sexuality.

That does not mean accepting severe or distressing loss of interest without investigation.

It means using realistic expectations.

Treating Medical Causes

When a genuine medical condition is contributing, treatment should address it.

Examples include:

proper management of hypogonadism;

treatment of endocrine disorders;

better diabetes control;

management of chronic pain;

treatment of vaginal dryness or painful intercourse;

sexual rehabilitation after cancer or prostate treatment;

and treatment of erectile or ejaculatory dysfunction.

Improving the underlying condition may allow desire to recover naturally.

Psychological Treatment

When anxiety, depression, sexual shame, trauma or self-esteem problems are important, psychological treatment can become central.

Depending on the patient, this may include:

cognitive behavioural approaches,

psychosexual counselling,

trauma-informed therapy,

or other evidence-based psychological care.

The 2025 ICSM psychological consensus supports a biopsychosocial approach in which psychological and interpersonal dimensions are assessed alongside medical causes.

This is not saying:

“The problem is imaginary.”

Psychological conditions produce real changes in sexual motivation.

Couple-Based Treatment

Sometimes the best patient is not one individual.

It is the couple.

A partner may have become afraid to initiate.

The other has begun feeling pressured.

Affection has disappeared because every touch is interpreted sexually.

A therapist can help the couple rebuild communication without deciding that one person's libido is correct.

The aim is not necessarily identical desire.

It is a relationship in which differences can be discussed without shame or coercion.

Treat Pain Before Demanding Desire

If intimacy hurts, the first objective should not be increased frequency.

It should be comfort.

This is particularly important after childbirth and during menopause.

Treating dryness, pelvic-floor dysfunction or another cause of pain can sometimes allow interest to re-emerge without directly treating desire itself.

The latest menopause literature strongly supports this biopsychosocial understanding.

Treat Erectile Problems Before Assuming Libido Is Gone

The same principle applies in men.

If the patient has stopped initiating because of ED, improving erection reliability may reduce anxiety and avoidance.

But persistent ED itself should receive proper assessment because it may be associated with cardiovascular, metabolic, hormonal, neurological or medication-related factors.

Medication Review

If the timing suggests a medicine may be contributing, I discuss the issue with the patient and advise coordination with the prescriber.

Sometimes adjustment is possible.

Sometimes changing medication would be inappropriate because the current treatment is medically essential.

Sometimes the underlying illness itself is producing the sexual problem.

The decision should therefore be individualized.

Patients should not experiment with abruptly stopping antidepressants, hormonal medicines or other prescribed therapy.

Improving Sleep and General Health

Sleep, physical activity, metabolic health and stress management form an important foundation.

This does not mean:

“Exercise cures low libido.”

It means that sexuality functions within the health of the entire body.

For an exhausted, sedentary patient with uncontrolled diabetes and poor sleep, improving general health may help several parts of sexual functioning simultaneously.

Treatment Should Not Aim for Maximum Libido

Patients sometimes ask:

“How can I make my desire extremely strong again?”

The goal of treatment is not maximum sexual drive.

The goal is a level of interest that is healthy, comfortable and appropriate for the person and their relationship.

Very high desire is not automatically healthier than moderate desire.

Sexual health is about well-being, not competition.

The Unani Perspective on Loss of Sexual Interest

The Unani system of medicine traditionally takes a holistic view of health.

Rather than isolating one symptom from the rest of the individual, it considers physical health, mental state, diet, sleep, activity, rest and individual constitution together.

Official Ministry of AYUSH material describes Unani medicine as placing considerable emphasis on prevention, health promotion, individualized lifestyle and diet, while WHO's benchmark for Unani practice sets standards intended to promote safe, qualified and quality-assured clinical practice.

This whole-person perspective can be particularly useful when reduced sexual interest is associated with:

fatigue,

poor sleep,

stress,

metabolic disease,

general weakness,

or another sexual-health problem.

The Six Essential Factors in Unani Medicine

Traditional Unani medicine places importance on the **Asbab-e-Sitta Zarooriya**, or six essential factors involved in maintaining health.

These include broad areas such as nutrition, physical activity and rest, sleep and wakefulness, environmental influences, elimination and retention, and psychological or emotional balance.

Traditional CCRUM material also describes **Ilaj Nafsani**, or psychological treatment, and discusses the relationship of mental processes, sleep and psychosomatic health.

These concepts make the Unani model particularly compatible with a broad lifestyle and mind-body discussion around sexual interest.

But traditional concepts should be integrated responsibly with modern diagnosis.

Ilaj bil Ghiza — Dietotherapy

CCRUM recognizes **Ilaj-bil-Ghiza**, or dietotherapy, as one of the principal treatment approaches within Unani medicine.

Diet can be relevant when reduced sexual interest occurs alongside:

obesity,

poor metabolic health,

diabetes,

fatigue,

or cardiovascular risk.

A balanced nutritional plan may support general well-being and metabolic health.

But I do not tell patients that one particular food will automatically restore sexual desire.

There is no scientifically established “libido food” capable of treating every cause.

Ilaj bil Tadbir — Regimenal and Lifestyle Care

CCRUM also formally recognizes **Ilaj-bil-Tadbir**, or regimenal therapy, within Unani practice.

In contemporary sexual-health care, lifestyle-focused treatment may involve appropriate physical activity, rest, weight management and better daily routine.

These interventions may be especially useful when poor general health is contributing to sexual dysfunction.

They support health.

They should not be marketed as guaranteed cures.

Sleep and Wakefulness in Unani Care

The Unani emphasis on sleep is particularly relevant.

A chronically exhausted person may have:

low energy,

irritability,

poor mood,

reduced interest in intimacy,

and inconsistent sexual function.

Addressing sleep fits naturally within both traditional Unani health principles and contemporary sexual medicine.

But if the patient has severe depression, hypogonadism or painful intercourse, improving sleep alone will not address everything.

Psychological and Emotional Balance

Traditional Unani medicine recognizes psychological influences on physical health.

CCRUM's description of **Ilaj Nafsani** includes psychological and verbal approaches as part of management of psychosomatic illness.

This is especially relevant when reduced sexual interest is associated with:

stress,

fear,

shame,

relationship tension,

or performance anxiety.

In modern practice, significant depression, anxiety disorders, trauma or other mental-health conditions should also receive appropriate evidence-based psychological or psychiatric care.

Unani treatment should complement that care rather than replace it.

Can Unani Medicines Help Loss of Sexual Interest?

This requires a balanced answer.

Traditional Unani medicine has long used individualized pharmacological approaches for various states of reduced vitality and sexual complaints.

However, **there is not strong modern evidence that one particular Unani herbal formulation universally cures loss of sexual interest regardless of cause**.

This is important because “low libido” can mean very different things.

A patient with testosterone deficiency is different from one with depression.

A postpartum woman is different from a man avoiding sex because of ED.

A menopausal woman with painful intercourse is different from a couple experiencing relationship resentment.

One medicine cannot logically be expected to correct all of these situations.

Where Unani Treatment Can Be Most Useful

In my clinical approach, Unani medicine can contribute most responsibly as part of an **individualized integrative plan**.

For example, a patient may simultaneously have:

poor sleep,

fatigue,

poor diet,

stress,

weak general health,

and reduced sexual interest.

Addressing those broader lifestyle factors may improve overall well-being.

If an associated sexual-health condition is present and an appropriately qualified Unani physician considers pharmacotherapy suitable, treatment can be individualized.

But if the patient has a significant hormonal, psychiatric, urological, gynecological or relationship problem, that condition should also receive the appropriate form of care.

Why I Do Not Treat Every Patient With a Sexual Tonic

When a patient tells me:

“Doctor, I have no interest in sex,”

it would be very easy to prescribe something immediately.

But that is not how I prefer to practise sexual medicine.

Suppose the patient's real problem is severe depression.

A tonic will not replace depression treatment.

Suppose a woman has painful vaginal dryness after menopause.

The pain must be addressed.

Suppose a man has high prolactin or true hypogonadism.

He needs endocrine evaluation.

Suppose infertility has created overwhelming performance pressure.

The couple needs fertility and sexual-health support.

Suppose resentment is destroying intimacy.

Medicine cannot replace communication.

The diagnosis determines the treatment.

My Clinical Approach at Saira Health Care

At **Saira Health Care**, I approach loss of sexual interest as a symptom that needs to be understood rather than simply stimulated.

When a patient presents with low interest, I examine several dimensions:

sexual desire,

erection or arousal,

ejaculation or orgasm,

pain,

fertility,

medical conditions,

medications,

hormonal symptoms,

sleep,

stress,

emotional health,

relationship circumstances,

and lifestyle.

I then ask one important question:

“What changed around the time your sexual interest changed?”

That question can sometimes reveal more than a large laboratory panel.

Special Treatment Approach by Dr. Nizamuddin Qasmi

My approach is individualized according to the likely cause.

If low testosterone is suspected in a man, appropriate hormonal assessment is considered rather than prescribing testosterone blindly.

If the patient wishes to father a child, fertility is protected and external testosterone is avoided because of its suppressive effect on sperm production.

If depression or severe anxiety is present, mental-health care is incorporated.

If a medicine is contributing, I recommend coordinated review with the prescribing clinician.

If ED or PE has produced avoidance, the sexual dysfunction is addressed.

If a woman has pain, vaginal dryness or menopausal symptoms, appropriate gynecological evaluation may be necessary.

If pregnancy or postpartum recovery explains the change, reassurance, recovery and symptom-directed care may be more appropriate than automatically prescribing libido medication.

If relationship conflict is central, counselling may be needed.

Where Unani diet, lifestyle, regimenal or individualized supportive treatment is appropriate, these measures can complement the broader plan.

Dr. Nizamuddin Qasmi's Professional Focus

My clinical work at Saira Health Care is focused on **sexual disorders and infertility**.

My professional profile includes:

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

The professional profile currently published by Saira Health Care lists this same focused practice and training background.

This combined sexual-health, infertility, reproductive-health and Unani background supports an approach in which low sexual interest is not automatically reduced to either a hormone problem or a psychological problem.

Both possibilities—and many others—deserve consideration.

Saira Health Care's Contribution to Sexual Disorders & Infertility

One of the most important challenges in sexual medicine is that patients frequently suffer silently.

A man may feel ashamed to say:

“I no longer feel interested in my wife.”

A woman may believe:

“After childbirth I am supposed to return to normal immediately.”

A menopausal patient may assume:

“Sexual interest is finished now.”

An infertile couple may become so focused on pregnancy that neither recognizes how much their intimacy has changed.

At Saira Health Care, my aim is to create a confidential environment where these concerns can be discussed medically and respectfully.

The contribution of a sexual-health clinic should therefore include not only treatment, but also:

accurate diagnosis,

sexual-health education,

infertility evaluation,

lifestyle and Unani supportive care where appropriate,

couple communication,

and referral to urology, gynecology, endocrinology, psychology or psychiatry when necessary.

What I Tell Male Patients

When a man tells me:

“My libido is low, so my testosterone must be low,”

I explain that this may or may not be true.

Testosterone is important.

But sexual desire also depends on:

mental health,

relationship context,

sleep,

medications,

physical health,

sexual confidence,

and other hormones.

The correct approach is investigation rather than assumption.

What I Tell Female Patients

When a woman tells me:

“I have lost my interest in intimacy,”

I do not automatically say:

“It is psychological.”

Nor do I automatically say:

“It is hormonal.”

I ask about:

pain,

dryness,

menopause,

pregnancy,

postpartum recovery,

medications,

mental health,

sleep,

body image,

relationship factors,

and whether responsive desire still appears.

Women's sexual desire is complex and deserves the same clinical seriousness as men's sexual concerns.

What I Tell Couples

When one partner says:

“They don't want me anymore,”

I encourage both people to delay that conclusion.

First understand whether:

the person's health has changed,

sex has become painful,

a medication was started,

infertility has created pressure,

sleep has deteriorated,

there is ED or another sexual dysfunction,

or emotional conflict is present.

The lower-desire partner should not automatically be labelled defective.

The higher-desire partner should not be told their needs are irrelevant.

Both experiences matter.

Restoring Desire Is Not the Same as Forcing Desire

One of the worst ways to deal with reduced sexual interest is repeated pressure.

A person begins thinking:

“I must feel desire.”

Their partner asks:

“Do you want sex now?”

The patient becomes increasingly self-conscious.

Desire turns into an examination.

Sexual interest cannot always be commanded.

Treatment should remove barriers and create conditions in which desire can develop naturally.

Consent Remains Essential

Loss of sexual interest can create conflict, particularly in marriage.

But no treatment should involve forcing someone into sexual activity.

WHO's sexual-health framework emphasizes safe and respectful sexual relationships free from coercion.

A partner may choose intimacy even without strong spontaneous desire and later experience responsive desire.

That can be entirely healthy when the choice is voluntary.

It is different from participating because of threats, guilt or fear.

The Goal Is Not to Return Every Patient to Their Younger Libido

A 60-year-old man does not have to experience desire exactly as he did at age 20.

A woman after childbirth does not have to immediately return to her pre-pregnancy sexual pattern.

A menopausal woman does not have to pretend nothing has changed.

The objective is:

the best possible sexual well-being for the person's present body, health, relationship and life stage.

That is a much more realistic clinical goal.

Frequently Asked Questions

Is it normal to temporarily lose interest in sex?

Yes. Desire can temporarily decrease during stress, illness, sleep deprivation, pregnancy, postpartum recovery, emotional distress or relationship difficulties. A temporary reduction does not automatically indicate a disorder.

When does low interest become medically concerning?

Persistent reduction lasting several months, especially when it represents a significant change and causes distress, deserves assessment. Current 2026 sexual-medicine definitions generally require sustained symptoms plus clinically significant personal distress before diagnosing HSDD.

Does low libido always mean low testosterone?

No. Testosterone deficiency is only one possible cause. Depression, anxiety, medication, relationship problems, chronic illness, poor sleep and sexual dysfunction can also reduce desire.

Can women have a true sexual-desire disorder?

Yes. Contemporary sexual medicine recognizes clinically significant female HSDD, but diagnosis requires a careful biopsychosocial evaluation rather than assuming every low-desire period is disease.

Is loss of interest normal after childbirth?

A reduction can be common during postpartum recovery. Recent 2025–2026 systematic reviews identify pain, breastfeeding, fatigue, body image, fear and relationship or support factors as important influences.

Does menopause permanently end sexual desire?

No. Menopause can affect desire and sexual function, but changes are highly individual and multifactorial. Vaginal dryness, pain, sleep, mood, body image and relationship factors may all contribute and can often be addressed.

Can depression cause loss of sexual interest?

Yes. Depression itself can reduce desire, and some psychiatric medications can also affect sexual function. Both factors should be considered.

Can antidepressants affect sexuality?

Yes. Sexual adverse effects can occur. The exact pattern differs between medicines and individuals, and patients should discuss symptoms with their prescriber rather than stopping treatment abruptly.

Can ED make a man lose interest in sex?

Yes. Some men begin avoiding sexual activity because they fear erection failure. Treating ED and associated performance anxiety may help restore sexual engagement.

Can infertility reduce desire?

Yes. Fertility testing, repeated disappointment and timed intercourse can make sex feel pressured. The latest ICSM recommendations specifically recognize the interaction between infertility and male sexual dysfunction.

Should men trying for pregnancy take testosterone for low libido?

Not without specialist evaluation. External testosterone can suppress sperm production and is strongly discouraged in men seeking fatherhood.

Can poor sleep reduce sexual interest?

It can contribute through fatigue, mood, metabolic health and hormonal effects. Sleep problems should therefore be considered during sexual-health evaluation.

Can chronic disease cause loss of interest?

Yes. Chronic illness and cancer can affect sexual function directly through disease and treatment and indirectly through pain, fatigue, hormones, body image and psychological distress.

Can Unani medicine help?

Unani medicine can make a useful **supportive contribution** through individualized attention to diet, physical activity, rest, sleep, psychological well-being and general health. WHO and official Indian sources describe Unani practice as a whole-person traditional medical system with formal standards for safe practice.

However, no single herbal formulation can be considered a universal evidence-based cure for every cause of loss of sexual interest.

A Message From Dr. Nizamuddin Qasmi

When a patient tells me:

“Doctor, my interest in sex has disappeared,”

my first question is not:

“Which medicine should we give?”

I ask:

“What changed?”

That question is extremely important.

Did the problem begin after a new medication?

After childbirth?

After menopause?

After an episode of erectile dysfunction?

During infertility treatment?

After major financial stress?

After relationship conflict?

After depression?

After an illness?

Along with loss of morning erections and energy?

Sexual desire has a history.

Understanding that history often tells us where to look.

Not Every Temporary Change Needs Treatment

I also want patients to understand that the body does not have to function identically every month of life.

If somebody is recovering from influenza, sleeping poorly and dealing with a family emergency, temporary low interest may be completely understandable.

Medicine becomes necessary when we mistake every normal fluctuation for disease.

Sometimes the correct advice is:

“Allow yourself time to recover.”

But Persistent Loss Should Not Simply Be Ignored

The opposite mistake is also common.

A patient may say:

“It has been one year, but perhaps this is normal.”

Meanwhile they have:

severe fatigue,

no morning erections,

marked depression,

painful intercourse,

or a new medication.

These symptoms deserve attention.

Good sexual medicine should avoid both overdiagnosis and neglect.

Libido Is Not a Measure of Masculinity or Femininity

A man's worth cannot be calculated from how frequently he wants sex.

A woman's femininity is not determined by how sexually interested she feels.

A change in desire is a health or relationship concern when it causes distress.

It is not a moral verdict.

This distinction can remove enormous unnecessary shame.

A Partner's Lower Desire Is Not Automatically Rejection

I also advise couples not to personalize every change.

The statement:

“I don't feel sexual tonight”

is not automatically:

“I don't love you.”

Partners who understand this are often better able to talk about the real problem.

Treatment Should Restore Well-Being, Not Produce Sexual Pressure

The goal of treatment is not to make a patient satisfy another person's preferred frequency.

Nor is it to create unusually high sexual drive.

Successful treatment might mean:

a depressed person gradually regains interest as mood improves;

a man with true testosterone deficiency improves after appropriate medical management;

a menopausal woman becomes more interested once painful dryness is treated;

a postpartum woman gradually regains intimacy after healing and sleep improve;

an infertile couple restores affection outside the fertility schedule;

or a healthy patient learns that their naturally lower level of desire is not actually a disease.

Each can be a successful outcome.

Final Perspective

Loss of sexual interest is not one disease with one cause and one treatment.

Sometimes it is a normal temporary response to stress, fatigue, illness or life change.

Sometimes it reflects a medical condition.

Sometimes it is hormonal.

Sometimes it develops because sexual activity has become painful.

Sometimes ED or PE makes sex stressful.

Sometimes depression removes interest from every area of life.

Sometimes medication plays a role.

Sometimes childbirth, menopause, aging or cancer treatment changes the body.

Sometimes infertility converts intimacy into a reproductive task.

And sometimes the problem exists primarily inside the relationship.

The latest 2026 international sexual-medicine consensus reinforces an important principle: a clinically significant desire disorder requires more than occasional low libido. The pattern must be persistent and accompanied by meaningful personal

distress, and assessment must consider other medical, psychological and relationship explanations.

For men, current guidance emphasizes the role of psychological factors, endocrine disease, relationship conflict, medication, chronic illness and erectile dysfunction in reduced desire.

For women, the latest 2026 international recommendations similarly emphasize a biopsychosocial evaluation and individualized psychological, medical, nonhormonal and hormonal management where appropriate.

Recent research also makes clear that major life stages require context. Postpartum loss of desire can involve pain, breastfeeding, fatigue, body image and support; menopausal desire can be influenced by genitourinary symptoms, sleep, mood and relationships; chronic illness and cancer can affect sexual well-being through physical, hormonal, psychological and interpersonal mechanisms.

The **Unani system of medicine** can add a useful whole-person perspective through attention to nutrition, activity and rest, sleep and wakefulness, mental well-being and individualized health. Official CCRUM material recognizes dietotherapy and regimenal therapy as formal Unani approaches, while WHO has established benchmarks intended to promote safe and quality-assured Unani practice.

But responsible integrative medicine also requires honesty about evidence:

A herbal tonic cannot substitute for identifying the cause of persistent loss of sexual interest.

If depression is present, treat depression.

If intercourse hurts, investigate the pain.

If testosterone deficiency is suspected, diagnose it properly.

If the patient wants children, protect fertility before considering hormonal treatment.

If medication is contributing, review it professionally.

If the relationship is distressed, address the relationship.

If sleep and general health are poor, improve them.

And when individualized Unani supportive treatment is suitable, use it as part of a comprehensive plan rather than as a substitute for necessary medical care.

At **Saira Health Care**, this is the approach I prefer:

understand the patient first, identify the reason for the change, and then select treatment according to the actual cause.

My final message to patients is:

Do not panic because your sexual interest has temporarily changed. But do not suffer silently when a persistent change is affecting your health, confidence or relationship.

Sexual desire is not a switch that must remain permanently on.

It is a sensitive part of human health that responds to the body, mind, relationship and circumstances of life.

The best treatment begins by understanding **why it changed**.

About the Author

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

Medical Disclaimer

This article is intended for general sexual-health education and patient awareness. Loss of sexual interest can have medical, hormonal, psychological, medication-related, relationship-related or mixed causes. It should not be diagnosed or treated solely from online information. Persistent low desire, significant distress, erectile dysfunction, painful intercourse, severe mood symptoms, infertility or other associated concerns should be evaluated individually. Unani or herbal medicines should be used under appropriate professional supervision and should not replace necessary endocrine, urological, gynecological, reproductive or mental-health treatment. Men who wish to father children should not start external testosterone without specialist advice because it can suppress sperm production.