Communication and Relationships: Improving How Couples Talk About Desire, Boundaries and Mismatched Sex Drives

Understanding Sexual Desire Discrepancy, Consent, Intimacy, Relationship Communication and an Integrative Unani Approach

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Introduction

One of the most important things I explain to couples in sexual-health practice is that a satisfying intimate relationship does not depend on both partners wanting sex at exactly the same time, with exactly the same frequency and in exactly the same way.

Differences in sexual desire are extremely common.

One person may want sexual intimacy several times in a week while the other feels interested much less often. One partner may experience sexual desire spontaneously, while the other may develop desire only after emotional closeness, affectionate touch or some degree of arousal has already started. Desire may also change with stress, age, illness, pregnancy, parenthood, menopause, sleep, medication, anxiety, erectile difficulties or the quality of the relationship.

This difference is commonly called **sexual desire discrepancy**, **desire disparity** or a **mismatched libido**.

The International Society for Sexual Medicine describes sexual desire discrepancy as a situation in which one partner experiences greater sexual interest than the other and emphasizes that it is common in romantic relationships.

I therefore want couples to understand an essential point from the beginning:

A difference in sexual desire does not automatically mean that either partner is sexually abnormal.

The person who wants more sex is not necessarily “oversexual.”

The person who wants less is not automatically “cold,” unhealthy or uninterested in the relationship.

The clinical issue begins when the difference creates **distress, pressure, resentment, avoidance, conflict or a loss of intimacy**.

Sexual Health Is More Than Sexual Performance

The World Health Organization describes sexual health as physical, emotional, mental and social well-being in relation to sexuality, and emphasizes positive, respectful and safe sexual relationships that are free from coercion, discrimination and violence.

This definition is especially important when discussing desire differences.

Sexual health is not achieved by forcing two people to have identical libidos.

It is achieved when partners can understand each other, communicate respectfully, make choices freely and find forms of intimacy that preserve both **connection and autonomy**.

Pleasure, trust, safety, consent, affection and communication all matter.

The number of times a couple has intercourse each week is only one small part of their sexual relationship.

What Is Sexual Desire?

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

It is not a fixed biological quantity.

Desire can be influenced by the brain, hormones, emotional state, relationship quality, physical health, sexual stimulation, medication, life stage and cultural expectations.

A person's desire can therefore be high during one period of life and lower during another.

This fluctuation is often normal.

The 2024 ISSM guidance on mismatched libido identifies hormonal changes, stress, physical and mental health, medicines, sleep, exercise, body image, self-esteem and relationship dynamics among factors that can influence sexual desire.

This is why I do not like the expression:

“My partner simply has a low sex drive.”

That sentence may describe what is happening, but it does not explain **why**.

Desire Is Not Always Spontaneous

Many people expect sexual desire to work like this:

First I feel strong sexual desire → then I initiate intimacy → then arousal begins.

That certainly happens.

It is called **spontaneous desire**.

But desire can also work in another direction.

A person may initially feel neutral rather than sexually excited. After affectionate conversation, privacy, kissing, touch or other welcomed intimacy, arousal begins and sexual interest develops.

This is commonly called **responsive desire**.

ISSM explains that sexual motivation does not always have to appear before sexual activity; in some individuals, desire can emerge in response to pleasurable stimulation. This concept can be particularly relevant in established long-term relationships.

This understanding can relieve a great deal of unnecessary worry.

A partner who does not frequently think:

"I suddenly need sex right now"

can still have a completely healthy sexual response.

Responsive Desire Must Never Become an Excuse for Pressure

There is an important qualification.

Responsive desire does **not** mean:

"Start sexual activity even if your partner does not want it because eventually they will enjoy it."

That would be a dangerous misunderstanding.

A person may freely choose to begin affectionate or sexual interaction while feeling neutral and see whether desire develops. But they must remain comfortable and free to change their mind.

ISSM specifically emphasizes that nobody should feel pressured into sexual activity simply because responsive desire can occur.

A healthy invitation sounds like:

“Would you like some closeness and see how you feel?”

It does not sound like:

“You must start because eventually you will become interested.”

That distinction protects both intimacy and consent.

What Is Sexual Desire Discrepancy?

Sexual desire discrepancy means that two people in a relationship do not want sexual activity to the same degree or frequency.

The difference may concern:

frequency of sex, initiation, types of sexual activity, affection, physical touch, intensity of erotic interest or how much sexual connection each partner wants.

Sometimes the difference is small and causes little difficulty.

Sometimes it becomes one of the most painful issues in the relationship.

The European Society for Sexual Medicine has emphasized that desire discrepancy should generally be **normalized and depathologized**, because sexual desire naturally varies between individuals and across time. Its position statement recommends understanding the dyadic nature of the problem, challenging myths about spontaneous desire, promoting open sexual communication and developing mutually acceptable sexual patterns.

This means the clinical goal should usually not be:

“Which partner must change?”

It should be:

“How can these two people understand and manage their difference without either person feeling rejected, pressured or ignored?”

There Is No Universal “Normal” Amount of Sex

Patients frequently ask me:

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

There is no medically required number.

ISSM similarly emphasizes that there is no single normal sexual frequency that every couple should follow. Couples should focus on what works for their own relationship rather than comparing themselves with friends, pornography, social media or cultural expectations.

A couple having sex once a month may be completely satisfied.

Another may prefer several times a week.

The clinically relevant question is whether both partners are reasonably comfortable with their intimate relationship.

Why Mismatched Desire Can Become So Painful

The sexual issue itself is often only part of the problem.

The meaning partners attach to it can cause much greater distress.

The higher-desire partner may think:

“My partner no longer finds me attractive.”

“I am always being rejected.”

“Sex is important to me, so maybe I am not important to them.”

The lower-desire partner may think:

“Every touch will become a demand for sex.”

“I am disappointing my partner.”

“I cannot show affection without creating expectations.”

“Something must be wrong with me.”

Now the couple is no longer discussing desire.

They are discussing rejection, worth, obligation, love, attractiveness and control without realizing it.

This is how a difference in libido can become a relationship conflict.

The Pursuer–Withdrawer Cycle

A very common pattern develops when one partner repeatedly seeks intimacy and the other repeatedly withdraws.

The higher-desire partner feels rejected and therefore initiates more frequently or becomes more urgent.

The lower-desire partner feels increasingly pressured and therefore pulls back.

The more one pursues, the more the other withdraws.

The more the other withdraws, the more rejected the first partner feels.

Eventually even ordinary affection becomes complicated.

A kiss may no longer feel like a kiss.

The lower-desire partner thinks:

"If I respond warmly, they will expect sex."

So even non-sexual touch decreases.

The higher-desire partner then feels even more abandoned.

Modern sex-therapy approaches increasingly treat desire discrepancy as a **relational process** rather than automatically locating the problem inside whichever partner has lower desire. Contemporary professional training specifically examines pursuit–withdrawal patterns, sexual shame, attachment, communication and the meaning that each partner gives to the desire difference.

Sexual Communication Matters

Research strongly supports the importance of sexual communication.

A major meta-analysis included **93 studies, 209 independent effect sizes and 38,499 people in relationships**.

Better sexual communication was positively associated with both **relationship satisfaction** and **sexual satisfaction**. Importantly, the *quality* of sexual communication had a stronger association with satisfaction than simply how frequently couples talked about sex.

This is a useful message.

Talking more is not necessarily enough.

The quality of the conversation matters.

A ten-minute respectful discussion may accomplish much more than hours of accusation.

How Couples Often Talk About Sex Incorrectly

Consider these statements:

"You never want me."

“All you think about is sex.”

“A normal wife should want her husband.”

“A real man would want sex every day.”

“If you loved me, you would do it.”

These statements do not create desire.

They create defensiveness, guilt and pressure.

The conversation becomes an argument about who is wrong.

ISSM instead recommends compassionate, non-judgmental communication and the use of first-person language such as:

“I feel worried about the difference between our levels of desire,”

rather than:

“You never want sex.”

Speak About Your Experience, Not Your Partner's Character

A useful principle is:

describe your experience rather than diagnosing your partner.

For example:

Instead of saying:

“You don't care about intimacy.”

a partner might say:

“When we go a long time without physical intimacy, I sometimes feel distant and insecure. I would like us to talk about what intimacy means to both of us.”

Instead of:

“You're always pressuring me.”

someone might say:

“When sexual initiation happens repeatedly after I have said I am tired, I start feeling tense and I find it harder to enjoy affection. I would like us to find another way to communicate about sex.”

This creates a conversation rather than a courtroom.

Talk About Sex Outside the Bedroom

One of my practical recommendations is:

Do not wait until immediately after rejection to discuss the entire sexual relationship.

That is usually the worst moment.

One person is hurt.

The other may feel guilty or defensive.

Instead, choose a neutral time.

Perhaps over tea, during a quiet evening or during a planned relationship check-in.

The aim is not to negotiate tonight's sex.

The aim is to understand the relationship.

ISSM recommends regular check-ins about intimacy rather than discussing sex only when conflict arises.

Ask Better Questions

Instead of asking:

“Why don't you want sex?”

I encourage couples to explore more useful questions.

What helps you feel close to me?

What makes sexual intimacy enjoyable?

What tends to switch desire off?

What kinds of touch feel comforting?

When do you feel most relaxed?

Does any sexual activity cause discomfort?

Do you need more emotional connection before sexual interaction?

Do you feel pressured when I initiate?

What does sexual rejection mean to you?

What makes you feel desired?

What type of intimacy do you miss?

These questions create curiosity.

Curiosity is usually more productive than accusation.

Desire Has "Accelerators" and "Brakes"

Sexual desire is often easier to understand when couples stop asking only:

"How can we increase libido?"

and start asking:

"What is applying the brakes?"

Common accelerators may include feeling emotionally connected, feeling attractive, privacy, affectionate touch, novelty, adequate rest and feeling understood.

Common brakes may include fatigue, stress, resentment, pain, fear of pregnancy, sexual dysfunction, body-image concerns, childcare responsibilities, depression, anxiety and pressure to perform.

Sometimes the most effective way to improve desire is not adding another stimulant.

It is removing the brake.

The Role of Feeling Understood

Relationship responsiveness matters.

Research has found that when people perceive their partner as understanding, validating and caring, this can contribute to intimacy and, in some circumstances, sexual desire.

This does not mean:

"Be nice so your partner owes you sex."

That would completely miss the point.

Responsiveness helps create emotional conditions in which intimacy may flourish.

Sex should never become payment for good behaviour.

Understanding Sexual Boundaries

A healthy sexual relationship requires boundaries.

A boundary communicates:

"This is what I am comfortable with, what I am not comfortable with, and what I need in order to feel safe."

Boundaries may concern:

when sexual activity happens, which activities are comfortable, privacy, contraception, pornography, sexual messaging, initiation, pain, pregnancy concerns, frequency or other areas of intimate life.

Boundaries are not evidence of rejection.

They are information that allows intimacy to occur safely.

WHO's sexual-health framework specifically emphasizes that sexual experiences should be safe, respectful and free from coercion.

Consent Is Not a One-Time Permission

Consent should not be treated as:

"You agreed at the beginning, therefore everything afterward is automatically permitted."

A person may be interested in one type of intimacy and not another.

They may change their mind.

They may initially agree and then become uncomfortable.

Respecting that change strengthens trust.

A healthy intimate relationship allows both partners to say:

yes, no, not today, slower, stop, or something different

without fear of punishment or emotional retaliation.

Marriage Does Not Remove Sexual Autonomy

Marriage or a committed relationship creates emotional and practical responsibilities, but it does not mean that either partner loses bodily autonomy.

A partner's sexual needs deserve respect.

So do the other partner's boundaries.

The goal in managing mismatched desire is therefore **not forced compromise**.

It is collaborative problem-solving.

Healthy sexual wellbeing requires experiences that are free from coercion.

Rejection Should Also Be Communicated Kindly

Respect must operate in both directions.

The lower-desire partner is entitled to decline sex.

But where the relationship is otherwise healthy, rejection can still be communicated with warmth.

Compare:

“Leave me alone.”

with:

“I'm exhausted tonight and don't want sex, but I still want to be close to you. Can we cuddle for a while?”

The second response protects the boundary while also protecting connection.

However, nobody is required to offer another type of touch simply because they declined sex.

The Higher-Desire Partner Is Not Automatically the Problem

Sometimes discussions of consent become so focused on pressure that the distress of the higher-desire partner gets ignored.

That is also unhelpful.

Repeated sexual rejection can create:

loneliness, insecurity, sadness, frustration and fear that the relationship has lost an important form of connection.

These feelings deserve to be heard.

The solution is not shame.

A healthy conversation can recognize both realities simultaneously:

“I understand that you do not owe me sex.”

and

“Sexual intimacy is important to me, and its absence is emotionally difficult.”

Both can be true.

The Lower-Desire Partner Is Not Automatically the Patient

This is one of the biggest mistakes couples make.

The higher-desire partner often says:

“Please fix my partner's libido.”

But if the lower-desire person is personally comfortable and has no individual distress, the medical problem may not be “low libido.”

The problem may be **desire discrepancy within the couple**.

The ESSM position statement specifically recommends treating sexual desire discrepancy as dyadic and relative rather than automatically pathologizing one partner.

This distinction prevents unnecessary medicalization.

When Low Desire May Need Medical Assessment

At other times, an individual genuinely notices:

“This is not normal for me. My desire has changed significantly.”

Then medical evaluation may be appropriate.

A clinician should consider factors such as hormonal changes, menopause, postpartum changes, chronic disease, pain, depression, anxiety, medication effects, sleep disturbance, erectile dysfunction, premature ejaculation or relationship distress.

ISSM similarly recommends investigating physical, hormonal, mental-health, medication and relationship contributors when libido changes.

Sudden or persistent change deserves more attention than simply comparing one partner with another.

Erectile Dysfunction Can Reduce Desire

Sometimes a man appears to have “low libido” because he has become afraid of erection failure.

He may avoid initiation because he thinks:

“What if I cannot perform?”

His partner may interpret avoidance as lack of attraction.

The real problem is performance anxiety or ED.

Treating the erection problem and associated anxiety may restore willingness to engage in intimacy.

Premature Ejaculation Can Also Affect Intimacy

A man who repeatedly ejaculates sooner than desired may feel embarrassed and begin avoiding sex.

His partner may believe he has lost interest.

Similarly, one partner may stop initiating because they fear another disappointing sexual encounter.

This illustrates why communication difficulties and sexual dysfunction frequently interact.

Pain and Dryness Should Never Be Treated as a Relationship Failure

A partner who repeatedly experiences pain with sexual activity will understandably develop less desire for that activity.

Possible causes can include vaginal dryness, menopause-related changes, pelvic-floor disorders, infection, endometriosis, vulvovaginal conditions or other causes requiring appropriate medical evaluation.

The solution is not:

“Try harder to want sex.”

The cause of the discomfort needs attention.

Stress, Parenthood and Daily Mental Load

Sexual desire does not exist independently of everyday life.

A person who is managing employment, childcare, poor sleep, household duties, financial pressure and emotional responsibilities may find that sexual desire has less space to emerge.

This can occur in any gender.

Couples sometimes interpret a stress-related decline in libido as a decline in love.

Those are not the same thing.

The more productive question is:

“What conditions would make intimacy easier for us?”

Desire Changes With Life Stages

Sexual relationships evolve.

Desire may change during:

new relationships, pregnancy, after childbirth, breastfeeding, parenting, menopause, illness, ageing, bereavement, major career stress and retirement.

The goal is not to recreate exactly how sex felt during the first months of the relationship.

The goal is to develop an intimate relationship that remains meaningful in the couple's current stage of life.

Gender Stereotypes Can Damage Sexual Communication

One dangerous stereotype is:

“Men always want sex and women always want less.”

Reality is much more varied.

The woman may be the higher-desire partner.

A man may have naturally low desire.

Both partners may have high desire or both may have low desire.

A 2025 study of 829 women in relationships found that stronger adherence to traditional heterosexual scripts—including the belief that men's sex drive should inherently be higher than women's—was associated with lower reported female desire. The authors argued that cultural sexual expectations can themselves influence how desire is experienced.

Gender stereotypes can therefore create unnecessary shame for both partners.

What Research Shows Couples Actually Do

A 2024 study examined 300 adults experiencing differences in sexual or affectionate desire.

Participants described multiple approaches, including communication, alternative behaviours, doing nothing, engaging despite differences and allowing one partner more

control over decisions. The effectiveness varied according to whether the couple saw the discrepancy as problematic.

An earlier mixed-method study found that strategies involving the partner were associated with higher sexual and relationship satisfaction than purely individual strategies, highlighting the value of treating the issue collaboratively.

The lesson is not that one technique works for everybody.

It is that **desire discrepancy usually needs ongoing negotiation rather than one permanent solution**.

"Scheduled Sex": Helpful or Unromantic?

Some couples dislike the term because they think sex should always happen spontaneously.

But almost everything important in adult life eventually requires time and space.

A scheduled period of intimacy does not have to mean:

"Sex must occur at 9 PM whether we want it or not."

It can mean:

"Friday evening is protected time for us to reconnect without phones, work or childcare interruptions. We may talk, cuddle, kiss or become sexual depending on what feels good."

That creates opportunity without obligation.

ISSM includes planned conversations and broadening intimacy among practical approaches for mismatched libido.

Expand the Meaning of Intimacy

Couples sometimes define sex so narrowly that every intimate interaction becomes a yes-or-no decision about intercourse.

That can create tremendous pressure.

Intimacy may also involve affectionate conversation, holding hands, kissing, cuddling, massage, playful touch or other mutually welcomed forms of closeness.

ISSM specifically recommends expanding the concept of intimacy beyond intercourse when couples are managing different levels of desire.

The important word is **mutually welcomed**.

Non-intercourse activities should not become another obligation.

Avoid "Duty Sex" as the Main Long-Term Solution

A person may occasionally choose sexual activity primarily because they value closeness with their partner even when spontaneous desire is not strong.

That choice can be healthy if it is genuinely voluntary and the person expects the experience to be comfortable or enjoyable.

It becomes concerning when sexual activity repeatedly occurs because of:

fear, guilt, emotional punishment, threats, obligation or pressure.

If someone begins associating sexual activity with dread, resentment or loss of autonomy, desire may decrease further.

The aim should be willing participation, not simply increasing frequency.

Stop Using Sex as a Relationship Scorecard

Some couples begin treating sexual frequency as proof of whether the relationship is healthy.

This can be misleading.

Frequent sex does not automatically mean the relationship is emotionally secure.

Less frequent sex does not automatically mean love has disappeared.

A better assessment asks about:

sexual satisfaction, emotional safety, communication, affection, consent, pleasure and whether each partner's concerns can be discussed honestly.

The Importance of Sexual Communication Quality

The meta-analysis of nearly 38,500 people provides an especially useful insight: **how couples communicate about sex matters more than simply how often the discussion occurs**.

Good sexual communication generally contains curiosity instead of accusation.

It allows embarrassment.

It allows different preferences.

It allows a partner to answer without punishment.

And it recognizes that neither person has to "win."

When Communication Alone Is Not Enough

I also caution couples against the belief:

"If we just communicate better, every sexual problem will disappear."

Communication is essential, but it cannot cure every medical or psychological condition.

If someone has:

painful intercourse, severe depression, erectile dysfunction, premature ejaculation, hormonal disease, medication-induced sexual dysfunction or significant trauma,

that underlying problem may require its own treatment.

The best approach is often **biopsychosocial**—body, mind and relationship together.

Sex Therapy and Couples Therapy

Professional help can be useful when the same conversation repeatedly ends in conflict.

Sex therapy does not mean that the therapist observes sexual activity.

It is generally a form of counselling in which sexual history, relationship patterns, psychological factors and medical contributors are discussed and a treatment plan is developed.

AASECT notes that mismatched desire, arousal difficulties, sexual satisfaction problems, medical conditions affecting sexuality and other intimacy concerns are common reasons people seek sex therapy.

In appropriate cases, therapists may work together with physicians or other clinicians.

Current Thinking in Sex Therapy

A 2025 qualitative study interviewed 46 sex therapists regarding low desire and desire discrepancy.

Psychological and behavioural approaches were frequently preferred, while concepts such as **responsive desire, autonomy and differentiation between partners** played an important role in how therapists conceptualized the problem.

This study does not establish one universally superior treatment.

But it reflects an important shift in contemporary clinical thinking:

the objective is not simply to make the lower-desire partner want more sex.

Treatment may instead involve changing expectations, communication, sexual context and the way the couple manages difference.

The Unani Perspective on Desire, Relationships and Sexual Wellbeing

As a physician trained in Unani medicine, I believe Unani principles can make a useful contribution when they are used appropriately.

Unani medicine views health holistically and considers factors such as:

Mizaj or temperament, physical health, diet, movement and rest, sleep, emotional state and psychological wellbeing.

One of the important Unani frameworks is **Asbab-e-Sitta Zarooriya**, the six essential factors considered important for maintaining health.

This includes factors related to food and drink, physical activity and rest, psychological activity and repose, sleep and wakefulness and other aspects of daily living.

These principles are useful because sexual desire is affected by many of the same areas.

Psychological Factors Are Recognized in Unani Sexual Medicine

The Central Council for Research in Unani Medicine's official guidance on **Zuf-i-Bah**, traditionally translated as sexual debility, describes reduced sexual desire and capability and specifically includes **Umūr Wahmiyya—psychological factors** among traditional contributors.

This is clinically significant.

Responsible Unani sexual healthcare should therefore not mean giving an aphrodisiac whenever a patient says:

“My sex drive is low.”

The psychological, relational and lifestyle context deserves attention.

Harkat wa Sukoon Nafsani: Psychological Activity and Repose

Within the broader Unani lifestyle framework, psychological activity and repose are considered important aspects of health.

In practical contemporary terms, this provides a useful way to discuss:

stress, chronic mental pressure, anger, anxiety, emotional exhaustion and the importance of psychological rest.

A patient whose mind remains occupied with financial stress, relationship conflict or performance anxiety may naturally have difficulty experiencing desire.

Reducing the psychological burden may therefore be more important than adding a sexual stimulant.

Sleep and Sexual Desire

The Unani emphasis on **Naum wa Yaqza—sleep and wakefulness—** is also relevant.

Chronic inadequate sleep can affect:

energy, mood, endocrine health, stress and interest in intimacy.

If a patient sleeps five hours every night and is exhausted by work, simply prescribing a libido-enhancing medicine without correcting sleep is unlikely to address the complete problem.

This is where Unani's whole-person approach can complement contemporary sexual medicine.

Diet and General Health

Ilaj bil Ghiza, or dietotherapy, is another important Unani principle.

But I do not believe that every person with low desire requires large quantities of “strengthening foods,” sweet Majuns, honey or calorie-dense tonics.

Diet should match the patient's health.

Someone with diabetes, obesity or metabolic syndrome requires a different plan from an undernourished patient.

The purpose is to support overall wellbeing rather than create unrealistic expectations that one food will repair a relationship or instantly produce sexual desire.

Physical Activity and Rest

Regular appropriate physical activity can support general cardiovascular health, body confidence, mood and energy.

But again, sex-drive discrepancy is not simply a fitness problem.

Exercise may support the individual.

Communication manages the relationship.

Both may matter.

The Role of Unani Pharmacotherapy

Traditional Unani pharmacotherapy may sometimes be considered when an individual patient has a defined complaint that fits an appropriate clinical indication.

However, I make an important distinction:

A mismatched libido between partners is not itself evidence that the lower-desire partner requires medicine.

The goal should never be to pharmacologically increase somebody's desire simply so that it matches their partner's expectations.

If an individual personally experiences unwanted loss of libido, then possible causes can be investigated and appropriate treatment considered.

That treatment may include lifestyle management, psychological intervention, treatment of another medical condition and, where appropriate, supervised Unani therapy.

Unani Medicine Cannot Replace Relationship Communication

This deserves to be stated clearly.

No herbal formulation can teach a couple how to express boundaries.

No tonic can replace consent.

No medicine can solve unresolved resentment on its own.

And no aphrodisiac should be used to override a person's genuine lack of interest in a particular sexual activity.

Unani care contributes most responsibly when it supports the **individual's physical and emotional health** while communication and relationship concerns are addressed directly.

My Clinical Approach at Saira Health Care

At **Saira Health Care**, when couples or individuals consult me about low desire, intimacy problems or mismatched sex drives, I try not to begin with:

“Who has the problem?”

Instead, I want to understand the complete picture.

I ask whether desire was always different or recently changed.

I want to know whether there is pain, erectile dysfunction, premature ejaculation, hormonal illness, diabetes, medication use, depression or chronic stress.

I also want to understand whether affection has decreased, whether one partner feels pressured, whether the other feels rejected and whether sexual conversations have become associated with arguments.

Only then can treatment become truly individualized.

The Specialized Role of Dr. Nizamuddin Qasmi

My professional focus is on **sexual disorders and infertility**, with training that 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

In relationship-related sexual difficulties, my aim is to distinguish between three broad situations.

The first is **normal relationship variation**, where neither person has a disease but the couple needs better communication.

The second is **individual sexual or medical dysfunction**, where low desire may reflect another health problem.

The third is a **mixed situation**, where medical, psychological and relationship factors are interacting.

These situations should not all receive the same treatment.

Contribution of Saira Health Care to Sexual and Reproductive Health

At Saira Health Care, one of the major contributions we aim to make in the field of sexual disorders and infertility is **reducing misinformation and making difficult conversations easier**.

Many couples never openly discuss sex until the relationship has already accumulated years of resentment.

Others believe that sexual dissatisfaction automatically means erectile dysfunction, hormonal deficiency or “sexual weakness.”

Some partners blame themselves.

Others blame each other.

My aim is to help patients understand that sexual health often requires discussion of both **medicine and relationships**.

This means creating a confidential environment where patients can discuss:

desire, erection, ejaculation, pain, intimacy, fertility, anxiety, expectations and relationship concerns without embarrassment.

A Practical Communication Framework for Couples

When I advise couples to talk about a mismatched sex drive, I usually encourage them to follow one central principle:

The purpose of the conversation is understanding—not obtaining consent for sex that night.

A productive discussion should answer several questions over time.

Each partner should be able to explain what intimacy means to them, what makes desire easier or harder, how they prefer sexual initiation to occur, which boundaries matter, what makes them feel loved or desired, what forms of affection they value and what changes they would realistically like to make.

Couples do not need to solve every question in one conversation.

Research from 2024 describing how adults handle desire differences appropriately described it as an **ongoing discussion about desire** rather than a one-time negotiation.

Create a Difference Between Affection and Sexual Initiation

This is especially helpful for couples caught in a pressure cycle.

If every hug becomes an invitation to sex, the lower-desire partner may eventually begin avoiding hugs.

Couples can agree that some forms of affection are simply affection.

A hug may mean:

“I love you.”

It does not always need to mean:

“I want intercourse.”

Restoring safe non-demand affection can sometimes rebuild closeness.

Develop a Respectful Way to Initiate Sex

Initiation itself can become a major source of tension.

Couples can develop language that feels safe.

For example:

“Would you be interested in some intimate time tonight?”

allows much more freedom than:

“Are we finally going to have sex tonight?”

The first is an invitation.

The second can feel like a complaint.

Develop a Respectful Way to Decline

Declining does not need to humiliate the initiating partner.

A person might say:

“I don't feel sexual tonight, but I appreciate you asking.”

Where genuinely desired, they might also add:

“I'd still enjoy being close.”

The goal is to communicate that:

“No to sex” does not necessarily mean “no to you as a person.”

Understand the Meaning Behind Sexual Initiation

One partner may initiate because sex means:

love.

Another may see it primarily as pleasure.

Another may use it to feel emotionally connected.

Another may want reassurance that they remain attractive.

If partners do not understand these meanings, they can easily misinterpret each other.

The sexual disagreement may actually be an emotional disagreement written in the language of sex.

Do Not Keep Score

A damaging pattern is:

“I initiated three times and you initiated only once.”

Or:

“We had sex twice last month, so this relationship is failing.”

Numbers can sometimes help describe a problem.

But relationships deteriorate when intimacy becomes accounting.

Quality, willingness and connection matter at least as much as frequency.

When Couples Should Seek Professional Help

Professional help is advisable when conversations repeatedly turn into arguments, one person feels persistently pressured, resentment is increasing, intimacy has almost completely disappeared, sexual problems are causing major distress or either partner suspects a medical or psychological condition.

A clinician or qualified sex therapist may help distinguish relationship-level desire discrepancy from an individual disorder and identify medical contributors where necessary.

Recent research continues to describe desire discrepancy as one of the most common and potentially distressing issues in couples' sexual health.

When Medical Evaluation Is Especially Important

A clinical evaluation is particularly appropriate when desire changes suddenly or is accompanied by erectile dysfunction, premature ejaculation, genital pain, vaginal dryness or pain, significant fatigue, marked mood changes, menopausal symptoms, hormonal concerns or medication changes.

Relationship counselling should not substitute for treating genuine disease.

Likewise, medicine should not substitute for repairing a relationship problem.

Frequently Asked Questions

Is mismatched sexual desire a disease?

Usually not by itself.

Different levels of desire are common in relationships. Treatment becomes relevant when the difference creates significant distress or when one person has an individual sexual or medical problem. The ESSM specifically recommends normalizing and depathologizing ordinary variation in sexual desire.

Who is normal—the higher-desire or lower-desire partner?

Potentially both.

Sexual desire varies widely.

The person wanting more sex is not necessarily abnormal, and the person wanting less is not automatically unhealthy.

How often should a married couple have sex?

There is no medically correct number.

ISSM specifically advises couples not to compare themselves with a universal frequency because no single amount of sex is appropriate for every relationship.

Does lower desire mean my partner no longer loves me?

Not necessarily.

Stress, sleep, health, hormones, medications, relationship dynamics, pain and many other factors influence libido.

The meaning should be discussed rather than assumed.

Can sexual communication really improve relationships?

Research strongly suggests an association.

A meta-analysis involving nearly 38,500 individuals found better sexual communication was associated with greater relationship and sexual satisfaction, and communication quality appeared particularly important.

Is scheduling intimacy healthy?

It can be.

Scheduling protected time for connection may reduce practical barriers, provided it creates an **opportunity rather than an obligation**.

Should a lower-desire partner sometimes agree even without spontaneous desire?

A person may freely choose to explore intimacy while initially feeling neutral, particularly if they experience responsive desire.

But they should never feel obligated or pressured, and they remain free to stop.

What if one partner never wants sex?

If the pattern is persistent and distressing, it deserves assessment.

The question should include physical health, mental health, medication, pain, relationship factors, hormonal changes and whether the individual personally experiences the low desire as a problem.

Does higher libido mean high testosterone?

Not necessarily.

Sexual desire is influenced by many biological and psychological factors.

A high or low libido cannot by itself diagnose a testosterone level.

Can stress cause a mismatch in sex drive?

Yes.

Stress, fatigue and poor sleep can significantly influence desire, and partners may respond differently to the same stressful circumstances.

Can erectile dysfunction look like low desire?

Yes.

Some men avoid sexual intimacy because they fear erection failure.

Treating ED and performance anxiety can sometimes restore sexual engagement.

Can Unani medicine help improve sexual desire?

Unani medicine can support an **individualized holistic approach** through attention to diet, sleep, activity, general health and psychological wellbeing.

CCRUM's own sexual-debility framework recognizes both reduced desire and psychological factors.

However, relationship-level desire discrepancy cannot responsibly be treated simply by giving the lower-desire partner an aphrodisiac.

Can medicine fix a mismatched libido?

Sometimes an underlying medical condition can be treated.

But there is no medicine that replaces communication, boundaries, consent and relationship work.

A Message From Dr. Nizamuddin Qasmi

When a couple comes to me and says:

“Our sex drives don't match,”

I do not immediately ask:

“Which partner needs medicine?”

I first want to understand the relationship.

Perhaps one person experiences spontaneous desire while the other experiences responsive desire.

Perhaps one partner is exhausted.

Perhaps sexual activity has become painful.

Perhaps erectile dysfunction or premature ejaculation has created avoidance.

Perhaps the couple has stopped communicating.

Perhaps the lower-desire partner feels pressured.

Perhaps the higher-desire partner feels repeatedly rejected.

Often, both partners are hurting in different ways.

My message is that neither partner should become the enemy.

The higher-desire partner's need for closeness deserves respect.

The lower-desire partner's autonomy and boundaries deserve equal respect.

The solution is usually not to force one partner upward or the other downward.

The goal is to create a sexual relationship that feels **safe, willing, affectionate, pleasurable and mutually meaningful**.

As a physician trained in Unani medicine and focused on sexual disorders and infertility, I also believe we should look beyond the bedroom.

Sleep matters.

Stress matters.

Physical health matters.

Psychological health matters.

Diet and lifestyle matter.

Hormonal and sexual disorders sometimes matter.

These are areas where the holistic principles of Unani medicine can complement modern sexual-health assessment.

But medicine alone cannot create communication.

A healthy intimate relationship requires both partners to be able to say:

“This is what I desire.”

“This is what I am comfortable with.”

“This is what I am struggling with.”

and

“I want to understand your experience as well.”

That conversation is often where meaningful improvement begins.

About the Author

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At Saira Health Care, the clinical focus includes confidential and individualized assessment of sexual-health concerns, sexual dysfunction, relationship-related sexual difficulties and infertility, with an integrative approach that respects Unani principles while incorporating contemporary medical and psychological understanding.

Medical Disclaimer

This article is intended for **public education and general sexual-health information**. It does not replace individual medical, psychological or relationship assessment.

Sexual desire discrepancy is not automatically a disease, and one partner should not be pressured into medical treatment solely to satisfy the other's preferred sexual frequency.

Persistent or sudden changes in sexual desire may sometimes be associated with physical illness, hormonal problems, medication effects, pain, depression, anxiety, erectile dysfunction or other sexual-health conditions and should be professionally assessed when appropriate.

Unani or herbal medicines should be used under qualified professional supervision and should never be used as a substitute for consent, communication or appropriate medical and psychological care.