Arousal Non-Concordance: When the Body Responds but the Mind Does Not — or the Mind Is Aroused but the Body Does Not Respond as Expected

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Understanding an Important but Often Misunderstood Sexual-Health Phenomenon

One of the most confusing experiences a patient can describe to me is:

"Doctor, my body seems to respond, but mentally I do not feel sexually excited."

Another patient may describe exactly the opposite:

"I feel desire and mental excitement, but my body does not respond properly."

A woman may feel emotionally and mentally aroused but notice very little vaginal lubrication. Another woman may experience genital lubrication or swelling even though she does not subjectively feel sexually interested. A man may mentally desire intimacy but experience difficulty obtaining an erection. Conversely, an erection can sometimes occur automatically even when the person does not consciously feel sexual desire.

This apparent mismatch is commonly described as **arousal non-concordance**, **sexual arousal discordance**, or **subjective-genital arousal desynchrony**.

The first thing I want patients to understand is that **arousal non-concordance itself is not automatically a disease**. It is a descriptive phenomenon explaining that subjective sexual excitement and physical genital response do not always occur at exactly the same time or with the same intensity.

Modern sexual-medicine research strongly supports this distinction. Sexual arousal includes both subjective or cognitive experiences—feeling mentally engaged or "turned on"—and physical genital responses such as erection, vulvovaginal lubrication, genital engorgement and changes in sensitivity. These components can overlap closely, but they can also diverge.

This distinction is particularly important because misunderstanding it can create unnecessary fear, shame, relationship conflict and even serious misconceptions about consent.

What Exactly Is Sexual Arousal?

Sexual arousal is not just one event.

It involves a combination of neurological, psychological, vascular, hormonal and emotional processes.

When the brain interprets sexual or intimate stimulation as relevant, several responses may occur. Attention may become focused on the experience, sexual thoughts may develop, genital blood flow can increase, the heart rate may change and the body may prepare physiologically for sexual activity.

But these responses are not controlled by one single switch.

A person may therefore have a **subjective response**, meaning:

“I feel sexually excited.”

They may also have a **genital response**, meaning that physical changes are occurring in the genitals.

Ideally these responses may occur together, but they do not always do so.

The latest international consensus from the **Fifth International Consultation on Sexual Medicine**, published in 2026, specifically distinguishes female **cognitive arousal** from **genital arousal**. It recognizes that problems with feeling mentally excited and problems with achieving an adequate genital response can occur independently or together.

This modern classification provides strong support for something patients have been describing clinically for many years:

The mind and the genitals can respond differently.

What Does “Arousal Concordance” Mean?

Sexual researchers use the term **concordance** to describe how closely a person's reported mental sexual arousal corresponds with measurable genital response.

High concordance means:

The person feels mentally aroused and their physical genital response closely reflects that experience.

Low concordance or non-concordance means:

The subjective and physical responses do not correspond closely.

An important meta-analysis involving more than 130 laboratory studies found that, on average, the relationship between self-reported and genital sexual arousal was stronger in men than in women. However, substantial individual differences exist, and measurement methods themselves can influence the observed relationship.

This does **not** mean that women are confused about their sexuality or that men are always perfectly concordant.

It means only that genital physiology and conscious sexual experience are partly separate systems.

Two Common Forms of Arousal Non-Concordance

The Body Responds but the Mind Is Not Sexually Engaged

A woman may notice lubrication or genital sensations despite feeling little or no subjective excitement.

A man may develop an erection even though he did not consciously intend to become sexually aroused.

People can find this experience confusing.

They may ask:

“If my body responded, doesn't that mean I wanted it?”

The answer is **no**.

Physical genital responses can occur partly automatically through nervous-system and vascular mechanisms.

Research particularly in women has repeatedly shown that measurable genital response does not always correspond closely with consciously reported sexual interest, preference or arousal.

The same general principle applies to men: physiological components of arousal and subjective experience can sometimes diverge because they are controlled by overlapping but not identical mechanisms.

This concept has very important implications for sexual health and consent.

Physical Arousal Is Not Consent

I consider this one of the most important educational points in this entire article.

An erection, vaginal lubrication, genital swelling or another involuntary physical response does not prove desire, enjoyment, preference or consent.

Consent is a conscious, voluntary decision.

The body can respond automatically to stimulation even when the person's emotional experience is neutral, uncomfortable or unwanted.

Therefore:

Physical response should never be interpreted as permission for sexual activity.

The World Health Organization emphasizes that sexual health requires sexual experiences that are safe, respectful and free from coercion, discrimination and violence.

This distinction can also be profoundly reassuring for people who have experienced unwanted sexual situations and subsequently feel confused or guilty because their body produced an involuntary physical response.

A physiological response does not determine what the person wanted.

When the Mind Is Aroused but the Body Does Not Respond

The opposite form of non-concordance is equally important.

A person may think:

“I genuinely want intimacy and feel sexually excited, but my body is not responding.”

A woman may feel desire but have little vaginal lubrication.

A man may feel mentally aroused but have difficulty obtaining or maintaining an erection.

Neither situation necessarily means attraction is absent.

Physical genital response depends upon:

blood circulation,

nervous-system function,

hormonal environment,

medication,

genital tissue health,

adequate stimulation,

comfort,

and general physical health.

For example, a postmenopausal woman may be mentally interested in sex yet experience significant vaginal dryness because lower estrogen levels have altered the tissues of the vulva and vagina. ACOG explains that reduced estrogen around menopause can make vaginal tissue thinner, dryer and less elastic and can reduce natural lubrication.

Similarly, a man with diabetes or vascular disease may have normal sexual interest but impaired erectile response because adequate penile blood flow or nerve signaling has been affected.

The brain may therefore be saying:

“Yes.”

while the body's physical response is saying:

“I need more time, different stimulation or medical attention.”

Desire, Arousal and Genital Response Are Different

Patients often use the words **desire**, **arousal**, **erection**, **lubrication** and **libido** as though they all mean exactly the same thing.

They do not.

Desire is the motivation or interest in sexual activity.

Subjective or cognitive arousal is the feeling of becoming mentally sexually excited.

Genital arousal is the physical response of genital tissue.

Orgasm is another separate component of the sexual-response process.

These processes interact, but one can be affected while others remain intact.

This distinction has become increasingly important in modern sexual medicine. The latest 2026 international consensus continues to recognize separate female cognitive and genital arousal disorders rather than assuming that every arousal difficulty represents the same problem.

Female Cognitive Arousal Versus Female Genital Arousal

The International Consultation on Sexual Medicine defines **Female Cognitive Arousal Disorder** as a distressing difficulty or inability to become or remain mentally excited during sexual activity for at least six months.

By contrast, **Female Genital Arousal Disorder** refers to a persistent and distressing difficulty achieving or maintaining an adequate genital response, such as vulvovaginal lubrication, genital engorgement or genital sensitivity.

These problems can occur separately.

For example:

A woman may have normal lubrication but feel emotionally disconnected and not mentally aroused.

Another woman may feel strong mental excitement while experiencing insufficient lubrication or genital sensitivity.

Understanding which component is affected is extremely important because the treatments are different.

Arousal Non-Concordance Is Not Automatically Female Sexual Dysfunction

Another important distinction is between **variation** and **disorder**.

ACOG explains that a person may experience only mental excitement or only physical excitement during sexual activity.

Therefore, occasional non-concordance should not automatically be medicalized.

Clinical concern becomes more appropriate when the problem is:

persistent,

distressing,

new or markedly different from the patient's previous sexual experience,

interfering with relationships,

associated with sexual pain,

or connected with another medical condition.

The 2026 international consensus similarly places emphasis on **distress and persistence** when defining female cognitive or genital arousal disorders.

A normal variation does not require medication simply because it differs from what television, films or popular culture portray.

Why Can the Body Respond Without Mental Desire?

Human physiology contains automatic responses.

The genital nervous system can react to touch, pressure or sexual cues before—or without—the person consciously interpreting the experience as desirable.

Researchers have proposed several theories to explain why genital responses, particularly in women, may not always match consciously reported arousal.

One hypothesis suggests that some genital responses may function partly as automatic physiological preparation for potential sexual activity rather than as a direct signal of desire. Research reviewing this “preparation hypothesis” found some supportive evidence but also emphasized that it remains incomplete and requires further research.

For patients, the practical message is simpler:

Do not interpret an automatic genital response as a complete psychological statement.

The body responding does not necessarily mean:

“I want this.”

It does not necessarily mean:

“I like this.”

And it certainly does not automatically mean:

“I consent to this.”

Why Can the Mind Feel Aroused While the Genitals Respond Poorly?

Several factors may interfere with the physical component of arousal even when emotional desire is intact.

Hormonal Changes

Hormonal changes are particularly important in women.

Estrogen helps support vaginal lubrication, tissue thickness, elasticity and blood flow.

During perimenopause and menopause, declining estrogen can produce the **genitourinary syndrome of menopause**, which may include dryness, irritation and pain during intercourse.

A woman can therefore be very emotionally attracted to her partner but still experience limited lubrication.

Similar hormonal changes can occur during breastfeeding and after childbirth.

Diabetes and Metabolic Disease

Diabetes can damage nerves and blood vessels.

Because genital arousal depends heavily on both neurological signaling and vascular response, poorly controlled diabetes can contribute to erectile problems in men and altered genital sensation or arousal in women.

Patients may still experience mental desire.

The physical system simply may not respond as effectively.

This is why treating the underlying metabolic condition is more important than immediately assuming that the problem is psychological.

Cardiovascular and Vascular Factors

Sexual arousal depends upon increased genital blood flow.

Conditions affecting circulation can therefore reduce genital response.

In men, vascular dysfunction is an important cause of erectile dysfunction.

In women, vascular dysfunction may contribute to reduced engorgement and genital sensitivity, although female sexual arousal is complex and should not be reduced to circulation alone.

The 2026 ICSM consensus specifically identifies vascular and neurological dysfunction among potential causes of female genital arousal disorder.

Neurological Causes

The nervous system connects the brain with the genital organs.

Spinal injury, pelvic nerve injury, neurological diseases, pelvic surgery and certain other conditions can disturb these signals.

A patient may still think about and desire intimacy while experiencing reduced genital sensation or physical arousal.

This is another example in which mental and physical arousal can diverge without either experience being “imaginary.”

Medicines Can Affect Arousal

Some medicines can interfere with different parts of sexual functioning.

Certain antidepressants, hormonal treatments and other medicines may affect:

desire,

lubrication,

erection,

orgasm,

or genital sensation.

A medication history is therefore essential.

Patients should **never stop antidepressants, psychiatric medication, blood-pressure treatment, hormonal treatment or other prescribed medicines without consulting the prescribing doctor**.

Sometimes changing the medicine or adjusting treatment is possible.

Sometimes maintaining the medicine is medically necessary and the sexual side effect needs separate management.

Stress, Anxiety and Mental Distraction

Arousal requires attention.

Imagine trying to engage sexually while thinking about:

work,

money,

children,

family responsibilities,

infertility treatment,

pregnancy concerns,

illness,

or an argument with your partner.

The body and mind are being asked to perform two different tasks.

Anxiety can be particularly disruptive.

A man who repeatedly thinks:

“Will I get an erection?”

may become so focused on monitoring his erection that normal sexual engagement decreases.

A woman may similarly become preoccupied with:

“Will intercourse hurt?”

or

“Am I lubricated enough?”

This constant self-monitoring can interfere with subjective arousal.

ACOG lists stress, anxiety, depression and insufficient sleep among factors that can influence sexual response.

Sexual Pain Can Disconnect Mind and Body

Pain deserves particular attention.

A person who expects sex to hurt cannot reasonably be expected to remain fully relaxed and emotionally engaged.

Pain during intercourse may result from:

vaginal dryness,

vulvodynia,

pelvic-floor dysfunction,

infection,

endometriosis,

menopausal changes,

skin disease,

or other gynecological and pelvic conditions.

ACOG recommends clinical assessment when sexual pain is persistent or severe and notes that lubricants, treatment of the underlying condition and sometimes pelvic-health or specialist therapies can be useful.

The treatment should focus on **why the activity hurts**, rather than simply instructing the patient to increase sexual desire.

Menopause and Arousal Non-Concordance

Menopause provides one of the clearest examples of mental-genital non-concordance.

A woman may tell me:

“Doctor, mentally I still want intimacy with my husband, but my body is not cooperating.”

This description can be medically accurate.

The woman's emotional interest may remain strong, while reduced estrogen causes:

less lubrication,

vaginal dryness,

reduced tissue elasticity,

irritation,

or discomfort.

ACOG recommends vaginal moisturizers and lubricants as non-hormonal options for dryness. When medically appropriate, local vaginal estrogen and other treatments may also be considered.

An important principle follows:

Lack of lubrication does not automatically mean lack of attraction.

Pregnancy, Childbirth and Breastfeeding

The postpartum period can similarly alter the relationship between desire and physical response.

Women may experience:

reduced estrogen during breastfeeding,

vaginal dryness,

sleep deprivation,

healing after childbirth,

pain,

fatigue,

and changes in body image.

ACOG specifically recognizes vaginal dryness after childbirth, particularly during breastfeeding, and notes that lubricants or appropriate local treatment can be helpful.

A couple should therefore avoid interpreting postpartum physical changes as evidence that affection or attraction has disappeared.

Men Can Experience Arousal Non-Concordance Too

Although much of the laboratory research has focused on women, men can also experience a mismatch between subjective and physical arousal.

A man might feel:

strong desire,

attraction,

mental excitement,

and emotional connection

yet have difficulty developing or maintaining an erection.

Possible causes include:

diabetes,

vascular disease,

neurological disease,

medication,

anxiety,

previous pelvic or prostate treatment,

alcohol,

fatigue,

or erectile dysfunction.

Conversely, an erection can occur reflexively without deliberate sexual desire.

A scientific review of male sexual arousal emphasizes that sexual arousal involves central, peripheral and behavioral components and that discordance between these components demonstrates that different mechanisms can control them.

Therefore:

An erection is neither a perfect measure of desire nor a complete measure of sexual satisfaction.

Erection and Desire Are Not the Same Thing

This distinction is particularly important in male sexual-health practice.

A patient may say:

“If I really wanted my wife, surely my erection would be automatic.”

That conclusion is medically incorrect.

Desire originates largely from motivational, emotional and neuroendocrine processes.

An erection requires a successful vascular and neurological response.

A man can therefore:

want sex but have erectile dysfunction,

or have an erection without actively wanting sex.

Understanding this removes unnecessary guilt and relationship misunderstanding.

Relationship Problems Created by Non-Concordance

Arousal non-concordance can easily be misinterpreted between partners.

A husband may say:

“If you were attracted to me, your body would respond.”

A wife may think:

“If he loved me, he wouldn't lose his erection.”

Both statements can be wrong.

A better conversation would be:

“Our sexual responses are not perfectly synchronized. What might be influencing them, and what would help us feel more comfortable and connected?”

That change—from accusation to curiosity—is often therapeutic by itself.

Communication Is Part of Treatment

Couples benefit from speaking about:

what type of stimulation feels comfortable,

how much time is needed,

whether there is pain,

whether pressure is developing,

which situations increase anxiety,

whether privacy is adequate,

and whether emotional closeness has changed.

ACOG recommends communication, increased time for stimulation, adequate sleep, reduced stress and learning more about one's own sexual responses when addressing sexual concerns.

Sexual treatment is often much more successful when both partners understand what is happening.

Arousal Non-Concordance and Infertility

This subject has particular relevance in infertility practice.

Couples trying repeatedly for pregnancy may begin scheduling intercourse according to ovulation.

At first this is manageable.

After several months, however, sex can begin feeling like a medical task:

“Ovulation is tonight—we have to perform.”

The man's mental pressure can interfere with erection.

The woman's anxiety can interfere with subjective arousal.

Either partner may become focused primarily on achieving pregnancy rather than experiencing intimacy.

This does not mean the couple has lost affection.

It may mean that **performance pressure has disrupted normal sexual response**.

Because Saira Health Care works extensively with infertility as well as sexual disorders, I consider these overlapping issues very important.

Treating infertility without discussing the sexual relationship can sometimes leave an important part of the problem untreated.

Arousal Non-Concordance Is Different From Persistent Genital Arousal Disorder

These terms should not be confused.

Ordinary arousal non-concordance means mental and physical arousal do not correspond perfectly during particular situations.

Persistent Genital Arousal Disorder/Genito-Pelvic Dysesthesia (PGAD/GPD) is a different and potentially severe condition involving persistent, unwanted and distressing genital sensations that occur without sexual desire or stimulation and may last for hours, days or longer.

The latest 2026 International Consultation on Sexual Medicine describes PGAD/GPD as a sensory hyperactivity condition that can affect people of different genders and may originate from several neurological or genito-pelvic regions.

Someone experiencing persistent unwanted genital tingling, throbbing, burning, pulsation or orgasmic sensations unrelated to sexual interest should seek specialist evaluation rather than assuming this is ordinary non-concordance.

How I Assess Arousal Non-Concordance at Saira Health Care

When patients consult me with a mind-body mismatch, I first try to identify **which part of the sexual response is affected**.

I do not begin with the assumption that they need an aphrodisiac.

I ask:

Is sexual desire present?

Is mental arousal present?

Is genital arousal present?

Is erection adequate?

Is lubrication adequate?

Is genital sensation normal?

Is sexual activity pleasurable?

Is there pain?

Is orgasm possible?

Is the difficulty lifelong or new?

Does it happen in every situation or only with a particular partner or circumstance?

Did it begin after a medication, illness, childbirth, menopause, surgery or major emotional event?

How is sleep?

How is the relationship?

Is infertility creating pressure?

Is anxiety present?

These questions help differentiate normal variation from genuine sexual dysfunction.

Medical Evaluation

Not every patient requires extensive laboratory testing.

Testing should follow the history.

Depending on the clinical situation, appropriate assessment may include:

general medical examination,

blood pressure and metabolic health,

diabetes assessment,

thyroid testing,

reproductive or sex hormones when clinically indicated,

medication review,

gynecological examination,

assessment for vulvovaginal conditions,

urological assessment,

neurological evaluation,

or pelvic-floor assessment.

The newest international sexual-medicine consensus similarly emphasizes differentiating genital arousal disorder from inadequate stimulation, vulvovaginal disease, pain conditions and cognitive arousal problems.

Treatment Begins With Education

For many patients, simply understanding non-concordance provides immediate relief.

A woman realizes:

“My lubrication is not a perfect measurement of how attracted I am.”

A man realizes:

“My erection is not a perfect measurement of my desire.”

A partner realizes:

“Physical response does not tell me everything about what the other person is feeling.”

Reducing these misconceptions can lower performance anxiety.

Sexual-health education is therefore a genuine therapeutic intervention.

Give Arousal Enough Time

Human sexual responses are not machines.

Some people require:

longer stimulation,

greater emotional engagement,

different types of touch,

more privacy,

or more time before the body and mind begin working together.

ACOG specifically recommends allowing additional time for stimulation or foreplay when arousal is difficult.

There should be no requirement that either partner respond immediately.

Lubricants and Vaginal Moisturizers

When mental arousal is present but lubrication is insufficient, appropriate lubrication can sometimes make an enormous difference.

ACOG recommends water- or silicone-based lubricants to decrease friction and improve comfort. Vaginal moisturizers can also help persistent dryness.

For menopause-related dryness or genitourinary syndrome, prescription therapies including local estrogen may be appropriate for selected women after medical assessment.

This demonstrates an important principle:

The solution to low lubrication is not always "try harder to become aroused."

Sometimes tissue health itself needs treatment.

Treat Erectile Dysfunction Properly

A mentally aroused man with persistent erectile difficulty should receive proper evaluation rather than being told he simply lacks desire.

Depending on the cause, management may involve:

lifestyle and cardiovascular risk management,

diabetes treatment,

medication review,

psychological support,

appropriate ED medication,

or further urological evaluation.

The treatment should address the cause rather than create more pressure.

Treat Anxiety and Performance Monitoring

Performance anxiety often creates a cycle.

The person begins monitoring:

"Am I aroused yet?"

"Am I lubricated enough?"

"Is my erection hard enough?"

"Will I reach orgasm?"

The more attention moves toward evaluation, the less attention remains available for pleasurable experience.

Psychological approaches such as cognitive-behavioral therapy, sex therapy and mindfulness-based therapy have evidence in the broader treatment of sexual desire and arousal difficulties. The 2025/2026 International Consultation on Sexual Medicine recommends a biopsychosocial approach and recognizes psychological treatments including sex therapy, CBT and mindfulness-based interventions in relevant sexual-desire disorders.

Reduce Goal-Oriented Sexual Pressure

Another useful principle is to stop treating every intimate interaction as a test.

Sexual contact does not always have to progress through:

arousal → penetration → orgasm.

A couple may benefit from periods of affectionate contact in which neither partner is required to demonstrate a particular genital response.

This removes the idea:

"If the body doesn't respond correctly, the encounter has failed."

That reduction in pressure can sometimes improve arousal naturally.

The Role of Unani Medicine in Arousal Non-Concordance

As a Unani physician, I find the holistic philosophy of Unani medicine particularly valuable in conditions where physical health, psychological state, sleep, lifestyle and sexual functioning overlap.

However, it is important to be scientifically precise:

There is currently insufficient high-quality clinical evidence showing that a specific Unani medicine directly "cures arousal non-concordance."

Arousal non-concordance is not itself one single disease requiring one particular herbal prescription.

The greatest contribution of Unani medicine in this area is therefore through an **individualized supportive and whole-person approach**.

The Unani Concept of Sexual Health

Classical Unani literature discusses conditions broadly described as **Zu'f-i-Bah**, or sexual debility, in which sexual desire or sexual capability may be reduced.

Official CCRUM Unani treatment guidelines recognize that such problems may include **psychological factors** and include addressing psychological contributors among the principles of management.

This is particularly relevant to arousal non-concordance.

It shows that traditional Unani physicians did not necessarily view every sexual problem purely as weakness of the genital organs.

Mental and physical factors were both considered.

Asbab-e-Sitta Zarooriya: The Six Essential Factors

Unani medicine places major importance on maintaining balance in the essential conditions of life.

For a patient with sexual-response problems, I consider areas such as:

sleep and wakefulness,

physical activity and rest,

food and drink,

mental and emotional states,

general health,

and daily routine.

CCRUM describes **Ilaj-bil-Tadbir**, or regimental therapy, as involving modification of these essential lifestyle factors and recognizes adequate sleep, physical activity and stress management as important components of health maintenance.

These principles complement modern understanding remarkably well when patients are experiencing stress-related or fatigue-related sexual difficulties.

Ilaj-bil-Tadbir — Regimental Therapy

In suitable patients, Unani supportive care may emphasize:

appropriate physical activity,

regular sleep,

restoration of daily routine,

stress management,

and correction of lifestyle imbalance.

CCRUM formally recognizes **Ilaj-bil-Tadbir, Ilaj-bil-Ghiza, Ilaj-bil-Dawa and Ilaj-bil-Yad** as therapeutic approaches within Unani medicine.

When sexual response is being affected by exhaustion, obesity, metabolic problems or psychological stress, lifestyle correction can be clinically valuable.

Ilaj-bil-Ghiza — Dietotherapy

Diet should support general health rather than promise an instant increase in sexual arousal.

Good nutritional management can contribute to:

healthy body weight,

diabetes control,

cardiovascular health,

energy,

and metabolic balance.

These factors can indirectly influence genital vascular and neurological functioning.

I do not believe it is medically responsible to tell patients that one food, dry fruit, spice or herb will automatically synchronize the mind and body's sexual response.

Sexual physiology is more complex than that.

Psychological Balance in Unani Medicine

One of the most useful aspects of traditional holistic thinking is recognition of the influence of emotional state upon physical health.

CCRUM's recent geriatric-care teaching material describes **Quwwat-e-Nafsaniyya**, psychological health, *Asbab-e-Sitta Daruriyya*, and **Ilaj-e-Nafsani** or psychological approaches as components of Unani medical thinking.

This becomes particularly relevant when arousal is being interrupted by:

anxiety,

performance pressure,

relationship problems,

mental fatigue,

or excessive worry.

In these situations, emotional management is not separate from sexual treatment.

It is part of the treatment.

Unani Pharmacotherapy

Classical Unani medicine contains formulations historically classified as **Muqawwi-i-Bah**, or sexual-strengthening/aphrodisiac medicines, and CCRUM publications document traditional use of such medicines in conditions described as sexual debility.

However, arousal non-concordance should not automatically be treated as sexual debility.

If the patient has normal physical genital response but lacks mental engagement, giving an aphrodisiac may completely miss the problem.

If the patient is mentally aroused but physically dry because of menopause, appropriate treatment of vaginal tissue may be more important.

If the patient has erectile dysfunction caused by diabetes, metabolic and vascular care may be required.

Therefore, when I use Unani medicines, they are considered only after the patient's **actual diagnosis, health condition, medications and individual constitution** have been assessed.

Dr. Nizamuddin Qasmi's Integrative Approach at Saira Health Care

At Saira Health Care, I prefer to manage arousal-related problems through an integrative sequence.

First, I identify whether the main difficulty is:

desire,

cognitive arousal,

genital arousal,

erection,

lubrication,

pain,

orgasm,

or relationship-related anxiety.

Then I determine whether the problem represents normal variation or genuine dysfunction.

Next, I look for potentially reversible causes including:

medication,

diabetes,

menopause,

postpartum changes,

sleep disturbance,

stress,

chronic illness,

erectile dysfunction,

sexual pain,

and relationship difficulties.

After that, treatment is individualized.

Modern diagnostic and medical treatment is combined, where appropriate, with Unani principles of:

diet,

sleep,

exercise,

emotional balance,

stress management,

and supportive individualized care.

Where specialist care is necessary, referral to gynecology, urology, endocrinology, psychiatry, pelvic-floor therapy or qualified psychosexual counseling should not be delayed.

This is what I understand by responsible integrative medicine.

Contribution of Saira Health Care in Sexual Disorders and Infertility

At **Saira Health Care**, our work in sexual disorders and infertility often involves problems that patients find difficult to discuss openly.

Patients may come with:

low desire,

erectile dysfunction,

premature ejaculation,

painful intercourse,

vaginal dryness,

sexual performance anxiety,

infertility-related sexual stress,

or simply a feeling that their “mind and body are not working together.”

These symptoms often overlap.

For example, infertility pressure may create anxiety.

Anxiety may reduce cognitive arousal.

Reduced arousal may contribute to erectile difficulty.

Erectile difficulty increases anxiety.

Soon a physical problem and a psychological problem have become one cycle.

Our contribution is therefore not simply prescribing a medicine.

It is helping identify where the cycle began and what needs to change.

About Dr. Nizamuddin Qasmi

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Professional Qualifications and Training

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My clinical approach is based on combining my background in Unani medicine with contemporary knowledge of sexual and reproductive health.

When a patient presents with arousal non-concordance, my goal is not to label the patient as sexually weak.

My goal is to answer a more useful question:

Which part of the sexual-response system is not synchronizing, and why?

When Should You Seek Medical Advice?

Professional evaluation is particularly advisable when mind-body arousal mismatch is persistent, causes significant distress, begins suddenly without explanation, is accompanied by erection difficulties, occurs with persistent vaginal dryness or painful intercourse, follows pelvic or prostate surgery, begins after a new medicine, develops after menopause or childbirth with troublesome symptoms, is associated with diabetes or neurological disease, significantly affects a relationship, or involves persistent unwanted genital sensations unrelated to sexual desire.

Persistent, intrusive and distressing genital sensations without sexual desire deserve particular assessment for conditions such as PGAD/GPD rather than being dismissed as ordinary arousal variation.

Frequently Asked Questions

If a woman lubricates, does that mean she wants sex?

No.

Lubrication is a physiological genital response. It does not independently establish desire, enjoyment or consent. Research demonstrates that genital and subjective arousal do not always correspond closely, particularly in women.

If a man has an erection, does it always mean he wants sexual activity?

No.

An erection is a physiological response influenced by neurological and vascular mechanisms. It can sometimes occur reflexively and is not a substitute for verbal or behavioral consent.

Can a woman want sex but remain dry?

Yes.

Mental desire can be present despite limited lubrication. Menopause, breastfeeding, medication and other physical factors may contribute.

Can a man be sexually attracted to his partner but not get an erection?

Yes.

Erectile response and sexual desire are related but distinct processes. Vascular disease, diabetes, neurological factors, medication or performance anxiety may interfere with erections even when mental desire remains strong.

Is arousal non-concordance a psychiatric disorder?

No—not by itself.

Occasional mismatch between physical and subjective arousal can occur normally. Assessment becomes important when the problem is persistent, distressing or associated with another medical or sexual disorder.

Does non-concordance mean that a relationship is failing?

No.

It can occur even in loving and satisfying relationships.

Misunderstanding the phenomenon, however, can create relationship problems if partners interpret a physical response as proof of attraction or lack of response as proof of rejection.

Can stress cause the mind and body to become less synchronized?

Yes.

Anxiety, distraction, fatigue and performance pressure can interfere particularly with subjective arousal and genital response.

Can Unani medicine help?

Unani medicine can be valuable as part of a broader individualized approach, particularly through lifestyle regulation, sleep, diet, physical activity, stress management and addressing general health. Classical Unani literature also recognizes psychological factors in sexual debility. However, no specific Unani medicine has been established by high-quality modern evidence as a universal cure for arousal non-concordance.

My Final Message to Patients

If your body reacts but your mind is not sexually engaged, please do not assume that your physical response defines your feelings.

And if your mind is sexually interested but your body does not respond exactly as expected, please do not assume that your attraction has disappeared.

Mind and body usually work together, but they are not identical systems.

Sometimes they synchronize beautifully.

Sometimes they require more time.

Sometimes stress interferes.

Sometimes hormones change.

Sometimes medication affects response.

Sometimes there is an underlying vascular, neurological or genital condition.

Sometimes the difference is simply part of normal human sexual variation.

The correct medical approach is therefore not to judge the patient and not to immediately prescribe a sexual tonic.

It is to understand:

What is the mind experiencing?

What is the body doing?

What does the patient actually want?

Is the experience comfortable and consensual?

Is there a medical condition that needs treatment?

At Saira Health Care, I believe sexual medicine should respect both physiology and emotion.

We combine appropriate modern assessment with supportive principles of Unani medicine, particularly attention to general health, sleep, diet, activity and psychological well-being.

Above all, patients and couples should understand one principle:

Physical sexual response is information from the body—not a complete statement of desire, attraction, enjoyment or consent.

Recognizing that distinction can remove shame, improve communication and allow sexual-health problems to be treated more intelligently and compassionately.

Medical Disclaimer

This article is intended for general education and does not replace individual medical, gynecological, urological, psychological or sexual-health consultation. Arousal non-concordance itself can be a normal phenomenon, but persistent cognitive or genital arousal difficulties, sexual pain, erectile dysfunction, unexplained genital sensations, neurological symptoms or significant distress should be professionally assessed. Sexual activity must always be voluntary and consensual regardless of any involuntary physical response.