Desire Mismatch

When Partners Have Different Levels or Frequencies of Sexual Desire

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Introduction

One of the most common relationship concerns I hear in sexual-health practice sounds very simple:

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

Sometimes the opposite partner tells me:

“I love my spouse, but I don't want sex as frequently as they do.”

The couple may immediately assume that somebody is abnormal.

The higher-desire partner thinks:

“Why doesn't my partner want me anymore?”

The lower-desire partner thinks:

“Why am I never enough? Why am I constantly being asked?”

If this continues, an ordinary difference in desire can gradually become a cycle of rejection, pressure, resentment and avoidance.

This situation is usually called **sexual desire discrepancy**, **desire mismatch**, or **mismatched libido**.

Importantly, desire mismatch is **not automatically a disease**.

The European Society for Sexual Medicine describes sexual desire discrepancy as a relative, couple-based phenomenon rather than a disorder belonging automatically to

whichever partner wants sex less. It specifically emphasizes that differences in sexual desire are common and do not necessarily require treatment unless they are creating meaningful distress.

Current European urological guidance takes a similar approach: sexual desire discrepancy is frequently found between partners and may reflect normal variations in desire across life and relationships. Focusing on the couple rather than automatically labelling the lower-desire partner as the patient can be less stigmatizing and clinically more useful.

That is the starting point I consider most important:

The problem is not automatically that one person wants "too much" sex or the other wants "too little."

The clinical question is:

Why are their levels of desire different, how is the difference affecting the relationship, and can the couple find a mutually respectful way to manage it?

What Is Sexual Desire?

Sexual desire is the motivation or interest to engage in sexual or intimate activity.

But desire is not a fixed quantity stored inside the body.

It can fluctuate according to:

age,

health,

hormones,

sleep,

stress,

relationship quality,

pregnancy and childbirth,

menopause,

medication,

chronic illness,

mental health,

sexual confidence,

and the emotional circumstances surrounding intimacy.

WHO's definition of sexual health specifically recognizes sexuality as including **desires, intimacy, pleasure, relationships, beliefs and values**, influenced by biological, psychological, social, cultural, religious and other factors.

Therefore, when couples ask me:

“Who has the normal libido?”

there is often no single answer.

What Is Desire Mismatch?

Desire mismatch occurs when two partners differ meaningfully in how much, how often or under what circumstances they want sexual intimacy.

One person may want sexual activity several times each week.

The other may prefer it less frequently.

One partner may initiate spontaneously.

The other may rarely think about sex until affectionate contact has already begun.

One may want sexual closeness during times of emotional stress.

The other may lose sexual interest during the same stress.

The difference itself is not necessarily pathological.

The ESSM position statement emphasizes that sexual desire discrepancy is **relative and dyadic**—it exists because two people's levels of desire differ, not because one level is inherently correct.

There Is No Universal “Normal” Frequency of Sex

One of the most damaging assumptions couples make is:

“A healthy married couple should have sex exactly ___ times per week.”

There is no universal medical number.

A frequency that feels satisfying to one couple may feel too frequent or too infrequent to another.

The important questions are:

Are both partners generally comfortable?

Is there significant distress?

Does either partner feel chronically rejected?

Does the other feel chronically pressured?

Is intimacy voluntary?

Has there been a major unexplained change?

Is an underlying sexual or medical condition present?

Trying to measure a relationship against someone else's frequency often creates anxiety rather than solving anything.

Desire Mismatch Is Extremely Common

Perfectly synchronized desire would actually be unusual over the course of a long relationship.

People's bodies and circumstances change.

Work becomes stressful.

Children arrive.

Pregnancy occurs.

Sleep disappears.

Illness develops.

Menopause begins.

A man develops ED.

One partner takes medication.

Another experiences grief.

Relationships themselves move through different phases.

The ESSM therefore describes desire discrepancy as something that can be expected within long-term relationships rather than automatically viewed as evidence of dysfunction.

A 2024 qualitative study of long-term couples likewise described desire discrepancy as one of the common and potentially distressing issues in couples' sexual health, with

participants reporting changes in desire, sexual frequency, barriers to intimacy and coping strategies across their relationships.

Desire Difference Does Not Automatically Mean Loss of Love

This is one of the first misunderstandings I try to correct.

The higher-desire partner may think:

“If my spouse loved me, they would want sex more often.”

But reduced desire may reflect:

fatigue,

poor sleep,

depression,

anxiety,

pain,

medication,

hormonal changes,

work pressure,

childcare,

sexual dysfunction,

or relationship tension.

None automatically means:

“I no longer love you.”

Similarly, the lower-desire partner may assume:

“My spouse only cares about sex.”

That may also be inaccurate.

For the higher-desire partner, sexual intimacy may be one of the main ways they experience affection, closeness or reassurance.

Couples often become less distressed once they stop assigning hostile motives to each other.

Higher Desire Is Not Automatically Healthier

Another common assumption is:

"The person who wants sex more often is normal, and the other person needs treatment."

That is not how contemporary sexual medicine approaches the issue.

The ESSM explicitly cautions against using the higher-desire partner as the standard and pathologizing the lower-desire partner.

Sometimes the lower-desire partner does have a treatable condition.

But sometimes both partners are healthy and simply have different preferred frequencies.

Conversely, unusually high sexual behaviour can also become clinically relevant if it involves loss of control or significant impairment.

Therefore, **higher does not automatically mean healthier, and lower does not automatically mean diseased.**

The Higher-Desire and Lower-Desire Labels Are Relative

A man may be the higher-desire partner in one relationship and the lower-desire partner in another.

That demonstrates why these labels should not become identities.

The terms simply describe the relationship at a particular point:

Partner A currently wants sexual activity more often than Partner B.

That may change later.

Pregnancy, illness, stress, aging or relationship repair can reverse the pattern.

Desire Is Not Always Spontaneous

One important misconception is that genuine sexual desire must appear suddenly and independently:

"If I truly wanted my partner, I would spontaneously feel sexual before anything happened."

Not necessarily.

Some people experience more **spontaneous desire**.

Others experience more **responsive desire**, meaning interest may emerge after affectionate closeness or pleasurable stimulation begins.

The ESSM specifically recommends challenging the assumption that spontaneous desire is the only legitimate form of desire when working with desire discrepancy.

This distinction can be very helpful.

A partner may say:

“I almost never suddenly think, ‘I want sex right now,’ but when we have relaxed time together and there is no pressure, I sometimes become interested.”

That is very different from:

“I experience no desire before, during or after intimacy.”

The two situations should not be treated identically.

Desire Can Change From Day to Day

Newer research increasingly treats sexual desire not merely as a stable personal trait but as something that can fluctuate within a relationship.

A daily-diary study published in 2025 examined how day-to-day partner interactions were associated with changes in dyadic sexual desire, reflecting the increasing recognition that desire can shift according to relational context rather than remaining fixed.

Clinically this matters because couples often think:

“My partner's libido is simply low.”

But the better question may be:

“Under which circumstances does desire increase or decrease?”

Common Patterns in Desire Mismatch

One of the most common cycles looks like this:

The higher-desire partner initiates.

The lower-desire partner says no.

The higher-desire partner feels rejected.

They initiate more frequently or more urgently because they want reassurance.

The lower-desire partner now feels watched or pressured.

Sex begins feeling like an obligation.

Their desire decreases further.

They avoid affectionate touch because they fear it will automatically lead to a sexual request.

The higher-desire partner experiences less affection and becomes even more insecure.

The cycle repeats.

At this point, the original difference in libido may no longer be the largest problem.

The **relationship pattern created around the difference** has become the problem.

The Pursuer–Withdrawer Sexual Cycle

I sometimes describe this as a sexual pursuer–withdrawer cycle.

One person moves toward intimacy.

The other moves away.

The first person interprets withdrawal as rejection and pursues harder.

The second interprets increased pursuit as pressure and withdraws more.

Research examining demand–withdraw communication during sexual conflict supports the importance of this pattern. A study of 151 couples found that greater demand–withdraw behaviour during sexual conflict was associated with lower sexual and relationship satisfaction and greater sexual distress, with some relationship effects continuing at 12-month follow-up.

The treatment goal should therefore not simply be:

“Make the lower-desire partner have more sex.”

It should include changing the cycle.

How Desire Mismatch Affects the Higher-Desire Partner

The partner wanting more sexual intimacy may experience:

rejection,

loneliness,

self-doubt,

frustration,

reduced sexual confidence,

fear that attraction has disappeared,

or resentment.

They may begin thinking:

“Why am I always the one initiating?”

Eventually, they may stop initiating entirely to protect themselves from rejection.

That withdrawal can then make the relationship even more distant.

These feelings deserve respect.

But emotional pain does not create entitlement to another person's body.

Both realities can be true:

The higher-desire partner can feel genuinely hurt, and the lower-desire partner still has the right to decline sexual activity.

How Desire Mismatch Affects the Lower-Desire Partner

The lower-desire partner can experience a different kind of distress.

They may feel:

constantly evaluated,

guilty,

inadequate,

pressured,

or afraid that any affection will create expectations.

They begin thinking:

“If I hug my spouse, they will assume I want sex.”

So they stop hugging.

The higher-desire partner then experiences even less affection.

Sexual pressure therefore can unintentionally reduce **both sexual and non-sexual intimacy**.

Nobody Should Become "The Problem Partner"

This is central to my clinical approach.

When couples arrive saying:

"Doctor, please fix her libido,"

or

"Please reduce his demands,"

I try to move the conversation from blame to understanding.

The ESSM recommends exactly this dyadic approach—normalizing variation, examining relationship needs and developing mutually satisfactory sexual patterns rather than automatically diagnosing one individual.

The question is not:

"Who is wrong?"

The question is:

"What is happening between you?"

Desire Mismatch and Relationship Satisfaction

Research does show that large or distressing desire discrepancies can be associated with poorer relationship outcomes.

A study of **1,054 married couples** found that greater discrepancy between desired and actual sexual frequency was generally associated with lower relationship satisfaction and stability and greater relationship conflict.

Studies of other couple populations have also linked larger desire discrepancies with lower sexual satisfaction. For example, research involving couples transitioning to parenthood found that greater mismatch was associated with lower sexual satisfaction for both partners.

However, these are associations.

Desire mismatch does not automatically destroy relationships.

How the couple understands and manages the discrepancy appears to matter greatly.

Perceived Mismatch May Matter as Much as the Numerical Difference

Imagine two couples.

Both have sex twice a month.

In Couple A, both partners are comfortable with that frequency.

No problem exists.

In Couple B, one partner wants intimacy three times per week and the other is comfortable with twice a month.

The actual frequency is identical to Couple A.

But the meaning is completely different.

This is why desire discrepancy is not simply a mathematical measurement.

Earlier research has shown that people's subjective perception of mismatch can relate strongly to their sexual and relationship adjustment.

Clinically, I therefore ask not only:

“How often do you have sex?”

but:

“How do both of you feel about that frequency?”

Communication Can Change How Mismatch Is Experienced

Communication is one of the strongest themes in this field.

A meta-analysis of **93 studies involving 38,499 people in relationships** found that better sexual communication was associated with greater relationship satisfaction and greater sexual satisfaction. The **quality** of communication showed stronger associations than simply talking frequently.

A 2023 study focusing specifically on desire discrepancy found that better dyadic sexual communication was associated with lower perceived desire discrepancy through greater sexual satisfaction. Because the study was observational, it does not prove causation, but it supports the clinical importance of communication.

Communication therefore should not be:

“Why don't you ever want sex?”

It should sound more like:

“Can we understand what makes intimacy easier or harder for each of us?”

Communication Is Not Negotiating a Quota

Couples sometimes try to solve desire mismatch by deciding:

“We must have intercourse exactly three times per week.”

For some couples, scheduling can be helpful.

But a rigid quota can also turn intimacy into a duty.

The purpose of communication is not to pressure the lower-desire partner into meeting a numerical target.

It is to understand:

what each partner values,

what interferes with desire,

what forms of intimacy feel meaningful,

and what arrangements both can genuinely accept.

Consent Remains Essential

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

This principle remains true in marriage and long-term relationships.

Desire mismatch does **not** justify:

guilt,

threats,

silent punishment,

financial pressure,

emotional blackmail,

or repeated demands after someone has said no.

A statement such as:

“If you loved me, you would have sex with me”

does not create healthy desire.

It creates pressure.

Compromise Is Not the Same as Coercion

This distinction deserves careful explanation.

Relationships naturally involve generosity.

Partners sometimes choose activities because they value making each other happy.

But sexual activity should remain voluntarily chosen.

Research on sexual motivation helps clarify the difference.

Dyadic studies have found that being motivated to respond to a partner's sexual needs can be associated with better satisfaction when the motivation remains autonomous and mutually caring. By contrast, engaging in sex primarily because of pressure, obligation or fear of disappointing the partner is associated with poorer satisfaction.

So the healthier question is not:

“How can I make my spouse agree?”

It is:

“How can we create circumstances where intimacy remains wanted rather than compulsory?”

The Higher-Desire Partner's Needs Still Matter

Protecting consent does not mean telling the higher-desire partner:

“Your needs do not matter.”

They do.

Their loneliness and frustration are genuine relationship concerns.

A healthy relationship makes room for discussion of those needs.

But needs should be expressed as information rather than demands.

For example:

“Physical intimacy helps me feel connected to you, and I have been missing that. Can we talk about what intimacy is like for you lately?”

This invites conversation.

It is different from:

“You owe me sex because we are married.”

The Lower-Desire Partner's Needs Matter Equally

The lower-desire partner also needs freedom to explain:

“I am exhausted.”

“Sex has started to feel pressured.”

“I have pain.”

“I am angry about something in our relationship.”

“I need emotional closeness first.”

“My medication has changed my desire.”

These statements contain diagnostic information.

If they are ignored and the focus remains only on increasing frequency, the actual problem may never be treated.

Desire Mismatch Is Often a Symptom, Not the Root Problem

Sometimes desire mismatch is the main relationship issue.

At other times it is a visible symptom of something else.

Possible causes include:

relationship conflict,

erectile dysfunction,

premature ejaculation,

painful intercourse,

vaginal dryness,

depression,

anxiety,

poor sleep,

medication,

hormonal changes,

menopause,

pregnancy,

postpartum recovery,

infertility treatment,

chronic disease,

or unresolved infidelity.

This is why I do not treat desire discrepancy simply by asking:

“How can we increase sex?”

First we need to ask:

“Why has desire changed?”

Male Low Desire

If the man is the lower-desire partner, medical causes deserve consideration.

Current EAU guidance lists contributors to low male desire including:

androgen deficiency,

high prolactin,

depression,

anxiety,

relationship conflict,

antidepressant treatment,

chronic illness,

ED,

aging,

cardiovascular disease,

renal disease,

and other conditions.

Therefore, telling a man simply to:

“Try harder”

may be medically inappropriate.

Female Low Desire

Women also experience desire changes for many reasons.

Relevant factors can include:

pregnancy,

breastfeeding,

menopause,

pain,

vaginal dryness,

relationship strain,

mental health,

medication,

fatigue,

body-image concerns,

and sociocultural expectations.

A 2025 study of 829 women in relationships found that adherence to certain heterosexual sexual scripts—particularly the belief that men inherently have stronger sex drives than women—was associated with women's reported desire. Because the study was observational, it cannot establish causality, but it highlights how social expectations can influence women's sexual experiences.

This reinforces the need to avoid stereotypes such as:

“Men always want more sex.”

Couples vary enormously.

Sometimes the Woman Is the Higher-Desire Partner

This is important because gender stereotypes can create additional shame.

A woman who wants more sex than her husband may think:

“Something must be wrong with me.”

Her husband may think:

“Something must be wrong with my masculinity.”

Neither conclusion is necessary.

Desire discrepancy can occur in either direction.

Research in couples transitioning to parenthood found that the direction of mismatch could influence sexual satisfaction, demonstrating that the relational meaning of discrepancy can matter.

Clinical care should therefore not assume in advance which partner “should” want more sex.

Desire Mismatch After Marriage

Some couples discover a difference soon after marriage.

During courtship, opportunities for intimacy may have been limited.

Both partners imagined that marriage would create a highly active sexual relationship.

After marriage, their actual patterns become visible.

One partner may want sex almost daily.

The other prefers much less frequent intimacy.

This can feel like a major incompatibility.

Before declaring the relationship unsuccessful, I encourage couples to explore:

expectations,

sexual education,

performance anxiety,

pain,

communication,

privacy,

and cultural assumptions.

Early marriage often requires learning—not proof that both partners should already function identically.

Desire Mismatch in Long-Term Relationships

Desire frequently changes over time.

Early relationships often contain novelty and strong anticipation.

Years later, couples may be dealing with:

children,

work,

caregiving,

financial responsibilities,

health problems,

and familiar routines.

This does not mean desire inevitably disappears.

It means the context in which desire occurs has changed.

The ESSM recommends educating couples about the natural course of sexual desire rather than treating any decline from the early relationship as proof of dysfunction.

Parenting Can Change Desire Dramatically

The transition to parenthood is one of the clearest examples.

Sleep is disrupted.

The body changes.

Breastfeeding may influence hormones and vaginal comfort.

Privacy decreases.

Mental workload rises.

A parent may feel physically touched all day by children and want personal space at night.

The partner may interpret lower desire as rejection.

Research involving **255 new-parent couples** found that desire discrepancy was linked with lower sexual satisfaction for both partners.

This does not mean new parents should force themselves to restore pre-child frequency.

The couple may need to renegotiate intimacy for their new life stage.

Desire Mismatch Around Menopause

Menopause can influence sexual desire and comfort through hormonal and physical changes.

Vaginal dryness or pain may turn intercourse into something anticipated with anxiety.

The higher-desire partner may see avoidance.

The woman experiences self-protection.

Treating vaginal or pelvic symptoms can therefore sometimes improve the couple's apparent desire discrepancy.

The mistake would be assuming:

“Her libido is low”

without asking:

“Does sexual activity hurt?”

Erectile Dysfunction and Desire Mismatch

Suppose the husband is avoiding intimacy.

His wife believes he has lost interest.

In reality, he is afraid of erection failure.

He wants sex but avoids situations in which ED may become visible.

The couple presents with desire mismatch, but the primary problem is erectile dysfunction plus performance anxiety.

The ED should be assessed medically.

Once sexual confidence improves, apparent desire may change.

Premature Ejaculation and Desire Mismatch

The same can occur with PE.

A man who repeatedly experiences ejaculation earlier than desired may begin avoiding sex.

His partner thinks:

“He doesn't want me.”

He thinks:

“I don't want another embarrassing experience.”

Treating PE and the associated anxiety may be more useful than attempting to increase libido directly.

Painful Intercourse and Desire Mismatch

A particularly important rule is:

Never diagnose low desire without asking whether sexual activity is painful.

If intercourse hurts, reduced interest may be protective.

The person is not necessarily experiencing a primary desire disorder.

They may be avoiding pain.

Treatment therefore requires investigation of the pain—whether related to vaginal dryness, pelvic-floor dysfunction, vulvodynia, infection, menopause or another cause.

Demanding more intercourse would worsen the problem.

Chronic Disease and Desire Difference

Diabetes, cardiovascular illness, neurological conditions, chronic pain, cancer and other medical conditions can alter sexual desire.

The affected partner may feel exhausted.

The healthier partner may still have their previous level of interest.

Now a desire discrepancy emerges.

The appropriate response is not blame.

Sexual rehabilitation should form part of the broader medical picture.

Medication and Desire Mismatch

Some medicines can change libido or sexual function.

Antidepressants are a common example.

Hormonal treatments, some pain medicines and other therapies can also contribute depending on the patient.

When desire changes after starting or changing medication, tell the prescribing clinician.

Do not stop treatment abruptly.

The relationship issue may have a pharmacological contributor.

Mental Health and Desire

Depression can markedly reduce interest in pleasure, including sexuality.

Anxiety can replace erotic attention with worry.

Trauma may make vulnerability feel unsafe.

Body-image concerns may prevent relaxation.

In these circumstances, sex therapy alone may not be enough.

The psychological condition itself may need treatment.

Stress and the "Mental Load"

Desire requires more than functioning reproductive organs.

A person whose mind is occupied continuously by:

children,

deadlines,

household work,

finances,

caregiving,

or family conflict

may have little mental space available for sexual interest.

This can affect men and women.

Couples sometimes interpret this as:

“You have lost desire for me.”

But the more accurate explanation may be:

“Your nervous system has almost no opportunity to shift from responsibility into intimacy.”

Practical relationship changes can therefore sometimes be relevant to sexual treatment.

Desire and Relationship Resentment

Sexual desire rarely thrives in untreated resentment.

A partner may say:

“I have low libido.”

But when we talk further, the person says:

“I feel angry and unheard.”

Intimacy may then feel emotionally dishonest.

A sexual tonic cannot resolve resentment.

The couple needs to address the unresolved relationship issue.

Infidelity and Desire Mismatch

After infidelity, either partner's desire may change dramatically.

The betrayed partner may avoid sexual intimacy because trust has been damaged.

Alternatively, some couples temporarily experience increased sexual intensity following disclosure.

The pattern varies.

Sexual frequency should not be used as the only measure of healing.

Trust, emotional security and consent remain essential.

Infertility and Desire Mismatch

Infertility is especially important in my practice.

When couples are trying to conceive, intercourse can become scheduled around ovulation.

One partner may still want spontaneous intimacy.

The other begins associating sex with medical responsibility.

The man may feel:

“I have to perform tonight.”

The woman may feel:

“We cannot waste this fertile window.”

Pleasure becomes secondary.

Eventually one partner's desire decreases.

This does not necessarily mean the relationship has lost attraction.

It may mean that sex has become a fertility procedure.

Separating Some Intimacy From Fertility Treatment

Where practical, couples undergoing infertility treatment may benefit from maintaining some affectionate or sexual closeness that is not always focused on pregnancy.

That does not replace timed intercourse when medically indicated.

It simply protects the relationship from allowing every intimate experience to become a conception attempt.

A couple can simultaneously pursue pregnancy and preserve intimacy as a relationship experience.

Desire Mismatch and Sexual Confidence

The higher-desire partner may begin thinking:

“I am undesirable.”

The lower-desire partner may think:

“I am sexually defective.”

Both lose confidence.

This is why desire mismatch should not be framed as:

normal partner versus defective partner.

The problem belongs to the interaction.

Desire Mismatch and Sexual Shame

The lower-desire partner may feel guilty for saying no.

The higher-desire partner may feel ashamed of wanting more.

Neither emotion helps.

Wanting sexual intimacy is not inherently selfish.

Wanting less sexual activity is not inherently cold.

The couple must find a way to respect both experiences.

What Research Says About How Couples Cope

A 2024 study involving **300 adults** experiencing sexual or affectionate desire discrepancies identified several strategies people used, including communication, alternative forms of affection or sexual expression, continuing activities despite differences, doing nothing, and allowing one partner more control over initiation. The study does not establish which method is universally best, but it shows that real couples use multiple strategies rather than one solution.

A separate 2024 qualitative study of long-term couples similarly found coping with desire differences to be an ongoing relational process rather than a problem solved once and permanently.

This reflects what I tell patients:

Desire mismatch is often something couples learn to manage, not something they permanently eliminate.

Communication Should Be an Ongoing Conversation

The 2024 research described the process well in its title:

“It's an ongoing discussion about desire.”

That is realistic.

A couple may reach a good balance.

Then pregnancy occurs.

The balance changes.

Later, children grow older.

It changes again.

Menopause occurs.

A medical illness develops.

The relationship changes again.

Sexual agreements may therefore need periodic renegotiation.

Helpful Questions for Couples

Instead of arguing about numbers, I often encourage couples to explore questions such as:

When do you feel most open to intimacy?

What tends to reduce your desire?

What makes initiation feel loving rather than pressuring?

How do you prefer to decline sexual activity without the other partner feeling rejected?

What kinds of affection feel good even when sex is not desired?

Is pain, ED, PE, fatigue or anxiety influencing the situation?

What does sex mean emotionally to each of you?

These questions produce more information than:

“How many times per week should we do it?”

Non-Sexual Affection Matters

Couples experiencing desire discrepancy sometimes lose ordinary affection.

The lower-desire partner avoids:

hugs,

kisses,

cuddling,

or touching

because these actions are interpreted as automatically initiating sex.

That is unfortunate.

Couples can explicitly create space where affection does **not** carry an automatic obligation to progress further.

This can help restore physical closeness without making every touch feel like a negotiation.

Do Not Weaponize Affection

There is also an important responsibility for the higher-desire partner.

If every kiss becomes an attempt to obtain sex, the lower-desire partner may eventually stop kissing.

If every cuddle becomes pressure for intercourse, cuddling disappears.

Restoring non-demand affection can therefore help preserve emotional and physical connection.

Scheduling Intimacy: Helpful or Unromantic?

Some couples resist scheduling because they think:

“Real desire should be spontaneous.”

But long-term relationships involve responsibilities.

Scheduling private time can sometimes create the conditions in which responsive desire has an opportunity to emerge.

However, scheduling should mean:

“We create protected time for connection.”

It should not mean:

“At 9 p.m. you are contractually obligated to have intercourse.”

Consent remains present at the scheduled time.

Expanding the Meaning of Intimacy

Another mistake is defining sex and intimacy only as penetrative intercourse.

Couples may have different levels of desire for intercourse but still share desire for:

affection,

kissing,

touch,

emotional closeness,

or other mutually comfortable sexual intimacy.

Broadening the couple's repertoire can sometimes reduce the all-or-nothing pattern:

intercourse or nothing.

This should remain consensual and adapted to the couple's values.

Is "Meeting in the Middle" Always the Answer?

Not literally.

If one partner wants sex seven times per week and the other wants once, mathematical compromise would suggest four.

Human sexuality does not work like that.

The lower-desire partner may still feel pressured at four.

The higher-desire partner may still feel deprived.

Instead, treatment explores what each person means by intimacy and what each can voluntarily sustain.

The answer may include:

changes in initiation,

non-sexual closeness,

scheduled private time,

treatment of an underlying condition,

or couple counselling.

There is no universal arithmetic formula.

Sexual Generosity Without Self-Abandonment

Research sometimes uses the term **sexual communal strength** for the motivation to be responsive to a partner's sexual needs.

Studies have associated this form of caring responsiveness with higher desire and relationship or sexual satisfaction.

But research also distinguishes it from **unmitigated sexual communion**—prioritizing the partner's sexual needs while neglecting one's own. The latter is associated with less favourable outcomes.

In simple terms:

Caring about your partner's needs can be healthy. Erasing your own boundaries is not.

Having Sex Only to Avoid Conflict Can Be Harmful

A person may agree to sex because:

“Otherwise my spouse will be angry.”

“I do not want another argument.”

“They will think I do not love them.”

Research on sexual motivation has found poorer outcomes when sexual activity is driven primarily by avoidance goals such as preventing conflict or disappointment compared with approach goals such as seeking closeness or shared pleasure.

This is why simply increasing sexual frequency is not always treatment.

The **motivation and emotional context** matter.

When Desire Mismatch Requires Professional Help

Not every difference needs a therapist.

Couples often manage ordinary differences themselves.

Professional assessment becomes particularly useful when mismatch is producing chronic arguments, persistent rejection or pressure, sexual avoidance, resentment, relationship instability, or significant personal distress.

It is also important when there may be an underlying:

sexual dysfunction,

hormonal disorder,

medical illness,

pain condition,

depression,

anxiety disorder,

trauma history,

medication effect,

or infertility-related problem.

Medical Evaluation of the Lower-Desire Partner

When one partner has experienced a clear reduction from their previous level of desire, the medical history matters.

For men, current EAU guidance recommends considering medical and sexual history, depression, relationship problems and appropriate endocrine investigation where indicated.

For women, assessment may need to consider hormonal stage, pregnancy, postpartum status, menopause, pain, medication and psychological or relationship factors.

The principle is simple:

Do not label a relationship problem until you have considered whether a medical problem is contributing.

Medical Evaluation of the Higher-Desire Partner

The higher-desire partner usually does not need medical treatment simply for wanting sex more often.

But assessment can occasionally be relevant when there has been a dramatic change, sexual behaviour feels uncontrollable, there are manic symptoms, medication effects or significant impairment.

The goal is not to suppress healthy desire.

It is to identify clinically important changes when they occur.

Couple and Sex Therapy

Sex therapy or couple therapy can be useful when the mismatch has become emotionally charged.

The therapist may help the couple:

remove blame,

identify the pursuit–withdrawal cycle,

understand spontaneous and responsive desire,

improve communication,

identify barriers,

develop mutually acceptable intimacy,

and address relationship resentment.

The ESSM specifically recommends normalizing desire variability, promoting sexual communication, examining unmet emotional needs and helping couples develop mutually satisfying sexual patterns.

What Is the Latest Evidence on Treatment?

The evidence base specifically for **treating sexual desire discrepancy as a couple problem** remains much smaller than the evidence base for broader sexual dysfunction or couple therapy.

That limitation is important.

A 2025 qualitative study of 46 sex therapists found considerable variation in how professionals conceptualize and treat desire discrepancy; psychological and behavioural approaches were used more commonly than attempts to medically alter one partner's desire.

More importantly, a **2025 pilot study** tested an eight-session online sex-education and therapy intervention adapted specifically for couples experiencing sexual desire discrepancy. Twenty couples completed the programme. Participants reported high acceptability and improvements in several clinical outcomes, but the authors explicitly stated that the work was a feasibility study and that a larger randomized controlled trial with longer follow-up is still needed.

As of September 2026, this means couple-focused treatment is developing in a promising direction, but it would be premature to claim that one specific therapy has been proven as the universal treatment for desire mismatch.

Psychological Treatment Should Not Aim to "Convert" One Partner

The goal of treatment should not be:

"Make the lower-desire person want as much sex as the higher-desire person."

Nor should it automatically be:

"Make the higher-desire person stop wanting sex."

A more appropriate goal is:

help the couple understand the discrepancy and create a sexual relationship that respects both partners' autonomy and needs.

Sometimes desire itself increases as pressure decreases.

Sometimes the mismatch remains but becomes manageable.

Both can represent successful treatment.

Why Pressure Often Reduces Desire

Desire generally becomes more difficult when sex feels compulsory.

A person starts thinking:

"I need to want sex."

That thought itself creates pressure.

The body is expected to produce desire on demand.

This is particularly problematic for people whose desire is more responsive than spontaneous.

Creating emotional safety, privacy and pleasurable connection may work better than constant monitoring:

"Do you want sex yet?"

Sexual Desire Cannot Be Ordered

Partners sometimes become frustrated and say:

"Just try to want it."

But desire is not a voluntary muscle.

A person can choose whether to participate in an activity.

They cannot simply command themselves to experience desire instantly.

Treatment therefore focuses on **conditions that influence desire** rather than demanding the feeling itself.

The Importance of Relationship Context

A recent 2025 daily-diary study highlights an increasingly important idea: sexual desire can be influenced by daily interactions between partners.

This helps explain why desire may improve during holidays, after emotionally meaningful conversations or during periods of reduced stress.

The sexual organs did not necessarily change.

The relational environment changed.

Smartphones, Distraction and Modern Intimacy

Contemporary relationships also face newer environmental pressures.

A June 2026 study abstract in *The Journal of Sexual Medicine* examined smartphone use in relation to relationship satisfaction, emotion regulation and sexual desire discrepancy, reflecting increasing research interest in how everyday technology can influence couple intimacy.

Because this is emerging evidence, we should not conclude that smartphones "cause" mismatched desire.

But clinically it is reasonable to ask whether constant digital distraction is reducing protected time for emotional and physical connection.

How I Assess Desire Mismatch at Saira Health Care

When a couple tells me:

"Our sex drives do not match,"

I do not immediately decide which person needs treatment.

I begin by understanding the pattern.

I want to know:

When did the difference begin?

Was the couple always different?

Did one person's desire change?

Is the discrepancy generalized or only within this relationship?

Is sex painful?

Is there ED?

Is there PE?

Is there infertility pressure?

Are medications involved?

How is sleep?

Is pregnancy, childbirth or menopause relevant?

Is there unresolved conflict?

Has there been infidelity?

Does one partner feel pressured?

Does the other feel chronically rejected?

What does intimacy mean to each partner?

These questions reveal whether the mismatch is primarily relational or whether another condition is creating it.

I Assess the Couple Without Ignoring the Individual

A dyadic approach does not mean individual health no longer matters.

If the lower-desire partner has depression, treat depression.

If the man has testosterone deficiency, address it appropriately.

If the woman has painful intercourse, investigate the pain.

If the higher-desire partner has severe anxiety about rejection, that emotional issue deserves attention.

The couple is the context.

Each person's health still matters.

The Unani Perspective on Desire Mismatch

The Unani system of medicine traditionally approaches health through an integrated relationship between body, psychological state, lifestyle, environment and individual constitution.

The Ministry of AYUSH describes Unani medicine as giving central importance to the six essential factors—**Asbab-e-Sitta Zarooriya**—including food and drink, sleep and wakefulness, physical activity and rest, retention and excretion, environmental influences and mental well-being. AYUSH also describes **Nafsiyati Tadbeer**, or psychological measures, within the traditional system.

This holistic perspective can be valuable when desire discrepancy is being influenced by:

stress,

fatigue,

poor sleep,

metabolic illness,

low general health,

anxiety,

or a separately diagnosed sexual-health condition.

WHO's current benchmarks for Unani practice emphasize safety, quality, appropriate practitioner standards and responsible clinical practice.

Why the Unani Approach Can Be Useful

In desire mismatch, one of the most useful Unani principles is that sexual health should not be separated from the person's broader state of health.

A man may have:

poor sleep,

obesity,

diabetes,

fatigue,

low libido,

and ED.

His reduced desire cannot be understood independently from those factors.

A woman may be exhausted, stressed and emotionally disconnected.

Again, increasing libido pharmacologically without addressing the wider picture may accomplish little.

Unani lifestyle principles can therefore be incorporated into an individualized supportive plan.

Ilaj bil Ghiza – Dietotherapy

Diet does not directly cure desire mismatch.

However, nutrition affects:

body weight,

metabolic health,

energy,

diabetes,

cardiovascular health,

and overall well-being.

If one partner's sexual desire has fallen because of poor metabolic or general health, individualized dietary treatment may form part of the wider plan.

This is where **Ilaj bil Ghiza**, or dietotherapy, can provide supportive value.

But food cannot resolve resentment or incompatible expectations by itself.

Sleep and Wakefulness

The Unani emphasis on balanced sleep and wakefulness is particularly relevant.

Consider a couple with young children.

One partner is chronically sleep-deprived.

The other interprets low desire as rejection.

Before diagnosing a libido disorder, we should recognize exhaustion.

Improving sleep will not automatically make the couple's desire identical.

But it may remove an important barrier.

Physical Activity and Rest

Appropriate movement and rest can support cardiovascular, metabolic and psychological health.

This matters because chronic illness and poor general health can indirectly affect sexual desire.

Unani **Ilaj bil Tadbir**, or regimenal care, can therefore contribute to general health when appropriately individualized.

Again, its role should be supportive—not presented as a proven direct cure for relational desire discrepancy.

Mental and Emotional Balance

This is perhaps the most relevant Unani concept for this subject.

Stress, anger, anxiety and relationship tension can alter sexual interest.

Traditional Unani care recognizes psychological well-being as part of health maintenance, while modern sexual medicine independently recognizes depression, anxiety, shame and relationship conflict as contributors to low desire.

This makes psychological care a natural point of integration.

Nafsiyati Tadbeer and Modern Counselling

Traditional Unani recognition of psychological measures can complement modern psychosexual counselling.

A couple may benefit from:

education about normal desire variability,

discussion of responsive desire,

communication training,

reduction of pressure,

and addressing relationship resentment.

Where formal couple therapy, CBT, sex therapy or mental-health treatment is indicated, it should be provided by appropriately trained professionals.

Integrative care means using the right treatment for the right problem.

Can Unani Medicine Cure Desire Mismatch?

The scientifically responsible answer is:

There is no established Unani herbal formulation that can directly "cure" a difference in sexual desire between two otherwise healthy partners.

Desire mismatch is relational.

A medicine cannot make two individuals naturally want exactly the same frequency of sex.

However, if one partner has a separately diagnosed condition contributing to reduced desire—such as poor general health, fatigue or another sexual complaint—individualized Unani treatment may be considered within the practitioner's scope.

But the relationship component still requires communication and mutual adjustment.

Herbal Medicines Should Not Replace Diagnosis

Suppose the husband has low libido because of depression.

A sexual tonic alone is not adequate.

Suppose the wife has low desire because intercourse is painful.

A tonic is not the correct primary treatment.

Suppose one partner simply has a naturally lower level of desire.

There may be no medical disease to treat.

This is why I do not believe desire mismatch should automatically lead to medication.

The Special Clinical Approach of Dr. Nizamuddin Qasmi

At **Saira Health Care**, my approach is to determine whether the couple is experiencing:

normal desire difference,

one partner's clinical low desire,

sexual dysfunction,

medical illness,

psychological distress,

relationship conflict,

infertility-related pressure,

or a combination.

If a physical sexual disorder exists, it is assessed.

If infertility is contributing, reproductive care is incorporated.

If psychological pressure is maintaining the problem, counselling may be needed.

If relationship communication has broken down, couple-based work may be appropriate.

Where individualized Unani lifestyle or supportive management is clinically suitable, it can be integrated.

This prevents the mistake of giving the same sexual medicine to every couple.

Dr. Nizamuddin Qasmi's Professional Focus

My professional work is focused particularly 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

Saira Health Care's current published professional profile lists the same clinical focus and training credentials.

This combination of sexual-health, infertility and Unani training informs my approach to couples in whom physical, psychological, reproductive and relationship concerns often overlap.

Saira Health Care's Contribution to Sexual Disorders & Infertility

Couples often suffer unnecessarily because neither partner knows how to discuss sexual differences.

They may search online for:

“medicine to increase wife libido,”

“how to decrease husband's sex drive,”

or

“how often married couples should have sex.”

These searches already frame the problem incorrectly.

At **Saira Health Care**, our aim is to create a clinical environment where couples can discuss sexual desire without humiliation.

The contribution of a sexual-health clinic should include:

medical assessment where needed,

education,

sexual-function evaluation,

fertility assessment,

responsible Unani supportive care,

relationship and psychosexual guidance,

and appropriate specialist referral.

The goal should be better health and intimacy—not simply a higher number of sexual encounters.

A Practical Framework I Use With Couples

When working with desire mismatch, I encourage couples to move through several stages.

First: Stop Deciding Who Is Wrong

Do not call one partner frigid and the other obsessed.

Different desire levels are common.

Second: Identify What Changed

Was the discrepancy always present, or is it new?

A new change may provide diagnostic clues.

Third: Look for Physical Barriers

Pain, ED, PE, vaginal dryness, menopause, medication and chronic disease must be considered.

Fourth: Look at Psychological Barriers

Depression, anxiety, sexual shame, body-image concerns and performance anxiety can all affect desire.

Fifth: Examine the Relationship

Is there resentment, criticism, betrayal or emotional distance?

Sixth: Discuss Desire Rather Than Counting Sex

Explore what increases and decreases interest.

Seventh: Protect Consent

Neither partner should feel forced.

Eighth: Protect the Higher-Desire Partner From Chronic Silence

Their need for intimacy deserves respectful discussion even though it does not create entitlement.

Ninth: Maintain Non-Demand Affection

Touch should sometimes be allowed to remain simply affectionate.

Tenth: Seek Professional Help When the Cycle Remains Stuck

Sometimes couples need help learning a different way of communicating.

How to Talk About Desire Without Blame

Compare these two conversations.

Conversation That Increases Conflict

“You never want sex.”

“That is all you care about.”

“Why did I marry you?”

“Then stop asking me.”

Now compare:

A More Constructive Conversation

“I've been missing physical closeness with you.”

“I know. I have been feeling pressured and exhausted.”

“I don't want you to feel forced. Can you help me understand what has been making intimacy difficult?”

“I need more affection that doesn't automatically become sexual, and I also want to talk about the pain I have been experiencing.”

The second conversation contains information.

Information gives us something to treat.

Rejection Should Not Become Humiliation

The higher-desire partner needs to learn that:

“No tonight”

does not automatically mean:

“I do not love you.”

But the lower-desire partner can also communicate refusal compassionately.

Instead of:

“Leave me alone.”

when circumstances allow, they might say:

“I am exhausted tonight and don't want sex, but I still want to be close to you.”

This does not create an obligation to provide affection every time.

It simply helps couples distinguish refusal of a particular sexual encounter from rejection of the relationship.

Initiation Should Not Carry a Guarantee

Some couples become anxious because initiation itself feels dangerous.

The higher-desire partner thinks:

“If I initiate and get rejected, I will be hurt.”

The lower-desire partner thinks:

“If I respond to affection, I will be expected to continue.”

Couples can agree that initiation is an **invitation**, not a contract.

Either partner can say yes, no or not now.

That understanding can make initiation less threatening.

Desire Can Be Cultivated, but Not Forced

Couples sometimes ask:

“Can desire be increased?”

Sometimes, yes.

Removing barriers such as:

pain,

fatigue,

resentment,

poor sleep,

medication effects,

performance anxiety,

and lack of privacy

may increase desire.

Novelty, emotional connection and protected couple time may also help some people.

But desire cannot be guaranteed on command.

The goal is creating favourable conditions, not forcing a response.

Do Date Nights Fix Desire Mismatch?

Not automatically.

A date night may help if the couple has lost protected time together.

It will not cure low testosterone.

It will not treat vaginismus.

It will not resolve major betrayal.

It will not remove an antidepressant side effect.

This is why relationship advice should not replace diagnosis.

Does Having More Sex Increase Desire?

Sometimes positive sexual experiences can support future desire.

But simply increasing frequency through pressure may have the opposite effect.

Motivation matters.

Research suggests that sexual activity pursued for closeness and positive connection is associated with better satisfaction than sexual activity primarily undertaken to avoid anger, guilt or disappointment.

Therefore:

More sex is not automatically better treatment. Better sexual experiences may matter more.

Can the Higher-Desire Partner Use Masturbation?

This is ultimately a personal and values-based question.

Different individuals and religious or cultural traditions have different views.

Medicine should not dictate a moral position where none is medically necessary.

Clinically, the broader principle is that one partner's higher desire should not be managed by coercing the other.

Any individual strategy should be considered within the couple's personal values and relationship agreements.

Should Couples Schedule Sex?

It can be useful for some couples.

Scheduled private time can reduce logistical barriers and allow anticipation.

But scheduling should not eliminate consent.

It may be better framed as:

“This is protected intimacy time.”

rather than:

“Intercourse must occur at 9 p.m.”

That distinction protects both connection and autonomy.

Should the Lower-Desire Partner Just Have Sex Anyway?

There is no universal answer because motivation matters.

Sometimes a person voluntarily chooses intimacy without beginning with strong spontaneous desire and subsequently develops responsive desire.

That can be a positive experience.

But participating because of fear, guilt, threat or ongoing pressure is different.

The research on autonomous versus controlled sexual motivation supports this distinction.

No partner should be taught to ignore their own boundaries simply to maintain a sexual quota.

What if One Partner Almost Never Wants Sex?

This deserves proper assessment.

Ask:

Was desire always low?

Has it recently changed?

Is there distress?

Is there pain?

Are hormones relevant?

Is there medication?

Is there depression?

Is the relationship safe?

Does responsive desire ever emerge?

A very low frequency alone cannot tell us the diagnosis.

What if One Partner Wants Sex Very Frequently?

Again, the number alone does not diagnose disease.

The important questions are whether the desire is experienced as manageable, whether consent and boundaries are respected, and whether the behaviour is interfering significantly with work, relationships or daily life.

High desire and compulsive sexual behaviour are not the same thing.

What if the Couple Never Reaches the Same Level?

They may not need to.

The realistic goal is not perfect synchronization.

It is a mutually workable relationship.

Successful treatment may therefore mean:

the discrepancy remains,

but pressure decreases;

communication improves;

both partners feel respected;

affection returns;

and sexual experiences become more satisfying.

That can be a very successful clinical outcome.

Frequently Asked Questions

Is desire mismatch a disease?

No. Sexual desire discrepancy is a relational difference rather than an official disease diagnosis. Expert sexual-medicine guidance specifically recommends normalizing and depathologizing ordinary differences in desire unless they are creating significant distress.

Is the lower-desire partner always the patient?

No. Current European guidance specifically supports treating distressing desire mismatch as a couple-level issue rather than automatically pathologizing the lower-desire person.

Does lower desire mean my partner no longer loves me?

Not necessarily. Desire can decrease because of health, fatigue, stress, depression, medication, pain, hormonal changes or relationship context.

Can desire change over time?

Yes. Desire can fluctuate substantially throughout relationships and across different life stages. Current research increasingly treats sexual desire as dynamic and influenced by day-to-day relational experiences.

Is responsive desire normal?

For many people, desire may sometimes develop after affectionate or pleasurable contact has begun rather than occurring spontaneously beforehand. Expert guidance advises clinicians not to treat spontaneous desire as the only valid form of sexual desire.

How often should married couples have sex?

There is no universal medically required frequency. The meaningful question is whether the pattern is comfortable and consensual for both partners or producing persistent distress.

Can poor communication make the mismatch worse?

Yes. A meta-analysis of 93 studies and 38,499 people found better sexual communication associated with greater sexual and relationship satisfaction.

Can medical problems cause desire mismatch?

Yes. If one partner develops low desire because of hormonal disease, depression, ED, pain, medication, chronic illness or another condition, a previously matched couple may develop a discrepancy.

Can infertility cause mismatched desire?

Yes. Timed intercourse, fertility testing, disappointment and performance pressure can change how each partner experiences sexuality.

Does the lower-desire partner need a libido medicine?

Not automatically. The first step is determining whether there is an actual medical low-desire condition, another sexual dysfunction, medication effect, psychological problem or simply a normal difference between partners.

Can couple therapy help?

It may help couples address communication, pressure, resentment and sexual expectations. The evidence specifically for desire-discrepancy treatment remains

developing, but contemporary expert recommendations support couple-focused psychosexual approaches.

Is there a specific proven therapy for desire mismatch?

The evidence is still emerging. A 2025 pilot involving 20 couples found an eight-session online intervention feasible and associated with encouraging improvements, but larger randomized studies and longer follow-up are still needed.

Can Unani medicine help?

Unani medicine can provide useful **supportive and individualized care** through its traditional attention to mental well-being, sleep, activity, rest, diet and general health.

However, no herbal medicine can directly make two healthy partners have identical sexual desire. Underlying medical or sexual problems should be treated individually, while the relationship discrepancy requires communication and appropriate counselling.

A Message From Dr. Nizamuddin Qasmi

When a couple tells me:

“Doctor, our desires don't match. Who has the problem?”

my answer is:

“First, we need to stop deciding that one of you is the problem.”

Perhaps neither person has a disease.

Perhaps you simply experience desire differently.

Or perhaps something important has changed.

Maybe one partner is exhausted.

Maybe intercourse hurts.

Maybe a man's erections have become unreliable.

Maybe infertility has transformed intimacy into scheduled work.

Maybe depression or medication has reduced libido.

Maybe years of unresolved conflict have reduced emotional closeness.

Maybe one partner experiences spontaneous desire while the other usually experiences responsive desire.

Each possibility requires a different solution.

I Do Not Measure a Relationship Only by Sexual Frequency

A couple can have frequent intercourse and still feel emotionally disconnected.

Another couple may have less frequent sex but feel satisfied and close.

The correct clinical question is therefore not simply:

“How many times?”

It is:

“What is the quality and meaning of your intimacy, and are both of you comfortable with the pattern?”

This is much closer to the WHO understanding of sexual health as physical, emotional, mental and social well-being.

I Do Not Want the Lower-Desire Partner to Feel Defective

If a medical condition is present, we treat it.

But if the person is healthy and naturally wants less frequent intimacy, the goal is not automatically to transform them into the higher-desire partner.

Repeated pressure can create:

fear,

resentment,

and further loss of desire.

That is the opposite of what treatment should achieve.

I Do Not Want the Higher-Desire Partner to Feel Unimportant Either

Their distress is also real.

They may deeply miss physical connection.

They may feel lonely.

Their needs deserve conversation.

The solution is not silence.

It is learning to communicate desire **without converting desire into entitlement**.

That distinction can save relationships from considerable unnecessary conflict.

What I Consider a Successful Outcome

A successful treatment does not necessarily make two people want sex at exactly the same time and frequency.

Success may mean:

They understand why their desires differ.

Medical problems have been identified.

Sex is no longer painful.

Pressure has decreased.

The higher-desire partner feels heard.

The lower-desire partner feels respected.

Affection has returned.

They can talk about sex without starting an argument.

And they have developed a mutually acceptable pattern of intimacy.

That is far more realistic than promising perfectly matched libido.

Final Perspective

Desire mismatch is one of the most common challenges in intimate relationships, but it is not automatically a disease and it is not automatically one partner's fault.

The European Society for Sexual Medicine recommends viewing sexual desire discrepancy as a **relative and dyadic phenomenon**, normalizing natural variation, educating couples about how desire changes over time, challenging the assumption that desire must always be spontaneous, improving sexual communication and addressing relationship needs.

Research also demonstrates why the issue matters. Desire discrepancies have been associated with lower sexual or relationship satisfaction in several couple populations, while high-quality sexual communication is consistently associated with better sexual and relationship outcomes.

More recent work reinforces the idea that desire discrepancy should be understood as an ongoing couple process. Qualitative studies published in 2024 show that couples use many different strategies to manage differences in sexual and affectionate desire, while 2025 research into clinical practice shows considerable variation in how sex therapists approach the problem.

Treatment research is also beginning to develop. A 2025 pilot study of an eight-session couple-focused programme reported promising feasibility and early clinical improvements, but the sample was small and a larger randomized controlled trial is still required.

The **Unani system of medicine** can contribute a valuable supportive framework because it considers mental well-being, sleep, activity and rest, diet and general health as interconnected components of health. The Ministry of AYUSH describes these principles within **Asbab-e-Sitta Zarooriya** and also recognizes psychological measures such as **Nafsiyati Tadbeer** in Unani care.

But responsible integrative medicine must recognize that **no herbal formulation can directly solve a relationship-level desire difference by itself**.

If one partner has hormonal deficiency, investigate it.

If intercourse is painful, treat the pain.

If depression is reducing libido, address depression.

If ED or PE is causing avoidance, treat the sexual dysfunction.

If infertility has placed the relationship under pressure, care for both fertility and intimacy.

If the couple is trapped in pressure, rejection and resentment, improve communication and consider psychosexual or couple therapy.

At **Saira Health Care**, my approach is therefore not to ask:

“Which partner should change?”

I prefer to ask:

“What does each partner need, what is influencing desire, and how can we create a relationship in which both people feel heard, respected and sexually safe?”

My message to couples is simple:

You do not need identical desire to have a healthy relationship.

You need enough understanding to discuss the difference.

You need enough respect to protect consent.

You need enough medical awareness to recognize when a health problem is contributing.

And you need enough flexibility to remember that intimacy can change across life without the relationship itself being a failure.

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Medical Disclaimer

This article is intended for general sexual-health education and does not replace individualized medical, psychological or relationship assessment. Desire mismatch by itself is not necessarily a disease. A substantial change in sexual desire can sometimes be associated with hormonal disorders, depression, medication effects, chronic illness, erectile dysfunction, painful intercourse, menopause, infertility-related stress or relationship problems. Sexual activity should remain voluntary and consensual; treatment of desire discrepancy should never involve coercing either partner into sexual activity. Unani or herbal medicines should be used only under appropriate professional guidance and should not replace necessary endocrine, urological, gynecological, reproductive or psychological care.