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Source / Izvornik: **Sexual Medicine**, 2020, -

Journal article, Published version

Rad u časopisu, Objavljena verzija rada (izdavačev PDF)

<https://doi.org/10.1016/j.esxm.2020.02.008>

Permanent link / Trajna poveznica: <https://urn.nsk.hr/urn:nbn:hr:131:339790>

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Sexual Desire Discrepancy: A Position Statement of the European Society for Sexual Medicine

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ABSTRACT

Introduction: There is a lack of theoretical and empirical knowledge on how sexual desire functions and interacts in a relationship.

Aim: To present an overview of the current conceptualization and operationalization of sexual desire discrepancy (SDD), providing clinical recommendations on behalf of the European Society of Sexual Medicine.

Methods: A comprehensive Pubmed, Web of Science, Medline, and Cochrane search was performed. Consensus was guided by a critical reflection on selected literature on SDD and by interactive discussions between expert psychologists, both clinicians and researchers.

Main Outcome Measure: Several aspects have been investigated including the definition and operationalization of SDD and the conditions under which treatment is required.

Results: Because the literature on SDD is scarce and complicated, it is precocious to make solid statements on SDD. Hence, no recommendations as per the Oxford 2011 Levels of Evidence criteria were possible. However, specific statements on this topic, summarizing the ESSM position, were provided. This resulted in an opinion-based rather than evidence-based position statement. Following suggestions were made on how to treat couples who are distressed by SDD: (i) normalize and depathologize variation in sexual desire; (ii) educate about the natural course of sexual desire; (iii) emphasize the dyadic, age-related, and relative nature of SDD; (iv) challenge the myth of spontaneous sexual desire; (v) promote open sexual communication; (vi) assist in developing joint sexual scripts that are mutually satisfying in addition to search for personal sexual needs; (vii) deal with relationship issues and unmet relationship needs; and (viii) stimulate self-differentiation.

Conclusion: More research is needed on the conceptualization and underlying mechanisms of SDD to develop clinical guidelines to treat couples with SDD. **Marieke D, Joana G, Giovanni C, et al. Sexual Desire Discrepancy: A Position Statement of the European Society for Sexual Medicine. J Sex Med 2020;XX:XXX–XXX.**

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Key Words: Sexual Desire; Sex Therapy; Relationship; Couple

Received December 13, 2019. Accepted February 5, 2020.

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<https://doi.org/10.1016/j.esxm.2020.02.008>

INTRODUCTION

Issues regarding sexual desire are among the most commonly reported complaints among couples.^{1–3} Given that sexual desire problems manifest themselves mainly in the context of a relationship,^{4–7} it is remarkable that low and high sexual desire are typically approached from an individualistic perspective that reduces the problem to the individual desire levels of the partners, thereby disregarding the dyadic interaction in which it develops.⁷ In line with recommendations by Masters and Johnson,⁸ most clinicians involve both partners when treating sexual desire problems. Yet, we still lack theoretical and empirical knowledge on how sexual desire functions and interacts in a relationship. Sexual desire discrepancy (SDD) was first defined by Zilbergeld and Ellison (1980)⁹ to describe when 2 partners in an intimate relationship desire different levels or a different frequency of sexual activity. Although the concept has been introduced decades ago and is likely as prevalent in today's sexual relationships, research on this topic is scarce, and we lack clear clinical guidelines to support couples who are distressed by SDD.

Most of the literature on SDD focuses on conceptualization and how to approach SDD in light of current classification systems of sexual dysfunctions, pointing towards the risk of pathologizing normal variation in sexual desire.^{10,11} There are only a few empirical studies on the effects of SDD, examining mainly relationship and sexual satisfaction as outcome variables.^{11–13} To our knowledge, no clinical intervention studies have been published so far.

The aim of the present study is to perform a critical analysis of the current knowledge on SDD to provide the European Society for Sexual Medicine (ESSM) position on this topic. We will identify theoretical and methodological gaps, set priorities for future research, and make suggestions for therapeutic intervention. Given the lack of systematic evidence on SDD, this position statement is mainly based on expert opinions and focuses on how couples perceive their level of sexual desire within a relationship context.

How to Define Sexual Desire?

A full understanding of SDD requires a definition of sexual desire. We forgo a detailed analysis of different theories on sexual desire and focus mainly on how sexual desire is conceptualized in the SDD literature. Although sexual desire has clear biological underpinnings (involving cortical, limbic, and endocrine structures)^{14–16} that drive patterns of initiation and receptivity, the literature on SDD makes little notice of these biological forces. Definitions of sexual desire in the SDD literature emphasize the motivation and wish to behave sexually and how these are shaped or blocked by individual characteristics, partner behavior, interpersonal dynamics, and/or sociocultural standards.^{15,17} This corresponds with current views indicating that sexual desire is an emotional-motivational response that emerges from beginning arousal in response to stimulation that signals reward.¹⁸ Accordingly, sexual desire should not be regarded as an inner drive or bodily tension that pops up spontaneously, urging to be released. Often, sexual desire is experienced as responsive to sexual and,

more broadly, intimacy-related cues, and it results from beginning arousal.¹⁹ Without denying the important role of hormones, neurotransmitters, physiological, and psychological changes that unfold within the individual and may be experienced as “spontaneous,” the SDD literature emphasizes the subjective experience of desire and points towards the boundaries of our current knowledge on sexual desire because it stems mainly from research on individual responses and puts too much emphasis on quantifying sexual desire levels.²⁰ The way sexual desire is defined on an individual level is likely different from how it functions in a relationship. Hence, desire-related problems do not arise from the (level of) sexual desire as such but from discrepant meanings and/or levels of sexual desire, which develop as a function of the relationship.⁷ This will be the central focus of this study.

Research Methods

A comprehensive Pubmed, Web of Science, Medline, and Cochrane search was performed including the following words: sexual desire discrepancy, sexual desire and dyadic, sexual desire and interpersonal, sexual desire and relationship, and sexual desire and agreement/disagreement. Publications up to July 1, 2018, were included. We screened the abstracts and included only articles that explicitly mentioned SSD, or discussed the role of sexual desire in a relationship, or measured sexual desire within a couple. The final selection of articles was based on the clinical and research expertise of 5 expert clinical psychologists, composing the ESSM sexology subcommittee. Note that we did not aim to provide a comprehensive, systematic analysis of all available literature on (hypoactive) sexual desire and SDD but focused on defining the concept and deducing suggestions for assessment, counseling, and treatment.

Owing to limited evidence on clinical implications of SDD and a lack of good study quality, no recommendations as per the Oxford 2011 Levels of Evidence criteria were possible [all level 4 evidence, <https://www.cebm.net/2009/06/oxford-centre-evidence-based-medicine-levels-evidence-march-2009/>]. ESSM statements on this topic will be provided in which we summarize current knowledge on SDD, give our opinion about the conceptualization of and treatment approach to SDD, and provide first suggestions to develop a coherent treatment protocol.

SDD as a Sexual Problem

Statement 1: SDD is a relative and dyadic concept, rather than the outcome of individual characteristics or traits

Statement 2: SDD does not necessarily cause distress or require treatment

Evidence

SDD is not a clinical condition and is assigned no official diagnosis as per the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases. Although the most recent International Classification of

Diseases—11 does include relationship and partner issues as descriptors of low desire, different levels of sexual desire between partners are still described in terms of hypoactive sexual interest disorders (HSDDs), identifying the partner with the lowest desire as the patient.⁷ Such individual diagnosis stems from a health model in which desire serves only to initiate sexual function, thereby placing more emphasis on quantity rather than quality.^{5,21} Quantifying individual desire levels on a continuum between low and high implies that the focus of intervention lies on increasing sexual frequency instead of targeting the meaning of sexual desire within the couple. More recently, it has been proposed that sexual desire in a relationship should be conceptualized, studied, and treated as a relative and dyadic concept, rather than an individual characteristic or trait.^{2,4,5,13,22} Instead of pathologizing the low-desire partner and using the high-desire partner as a benchmark, it has been proposed to reframe sexual desire problems as a mismatch in desire.⁷ Although we lack systematic studies on clinicians' beliefs and treatment approaches to SDD, we acknowledge that most clinicians nowadays evaluate the context and the partner before ever diagnosing an individual with HSDD. Forcing a diagnosis onto one of the partners may contradict the observation that a decline in sexual desire is common over the course of a relationship.^{23–25} Given that any 2 individuals likely differ in their level of sexual desire, which fluctuates over contexts and time, discrepancies in desire have been described as an inevitable feature of long-term sexual relationships [refer to [Table 1](#)].^{2,26,27}

SDD is not necessarily a clinical condition that causes distress and requires treatment.⁷ It is thus crucial to determine the level of distress evoked by the SDD, distinguishing between personal — because one of the partners is missing something (that has been there before) — and relational distress because the SDD strains the relationship. Note that we should be careful not to approach every case of low sexual desire as a relational problem, thereby forgoing an individual diagnosis of HSDD or ignoring the individual distress caused by low levels of sexual desire. There are also situations in which one partner does indeed qualify for a clinical diagnosis of HSDD, which can still lead to SDD.

SDD as a Clinical Problem

Statement 3: SDD becomes a clinically relevant problem when both or one of both partners are distressed by it and request consultation

Evidence

[Table 2](#) summarizes the most important factors to be considered when dealing with SSD. In some cases, SDD may elicit considerable levels of distress and dissatisfaction in one or both partners, when, for example, the mismatch in desire persists or grows over time.^{10,12,28} Conversely, when both partners' level of sexual desire declines at a similar rate or when the couple accepts the ebbs and flows in sexual desire over the course of the

relationship, SDD may be less distressing.²⁹ To better understand the clinical implications of SDD, it is important to investigate under what conditions SDD is experienced as a problem and what enables some couples to maintain satisfaction despite their discrepant desire levels. Whether or not SDD will elicit distress may depend on social norms and myths about sexuality and relationships, and individual psychopathology and also on the personal experience of missing a sense of desire that has been there before.² Gender specificity represents another issue to be evaluated.^{13,30} Because gender stereotypes tend to portray male sexual desire as an active, internally driven force that spontaneously unfolds, it has been suggested that SDD will be experienced as more distressing and evoke more negative outcomes when men are the low-desire partner.^{25,31}

Remarks

At present, there are no data available on how large or distressing a SSD must be to be reported as clinically significant.¹¹ An important question here is whether we actually need objective criteria for a clinical decision, as SDD relies on the subjective experience of both partners.^{7,32} If we argue that the impact of SDD becomes clinically relevant only when both partners are distressed and request consultation, this might raise the problem whether SDD is clinically relevant when only one partner is distressed by the discrepancy. In the latter case, it may become a relational problem, bearing on other aspects of relational life. It also important to consider that a clinical diagnosis of SDD would imply the loss of sexual desire is persistent and generalized and not a temporally or context-dependent condition. The issue of distressing SDD needs further study to identify clinical needs of affected couples and develop tailored interventions.

Current Research on SDD: Conceptual and Methodological Issues

Several conceptual and methodological issues complicate the interpretation of findings on SDD.

Conceptual Issues

Statement 4: Actual and perceived level of sexual desire should be compared during the clinical evaluation of SDD.

Statement 5: The focus on actual versus desired sexual frequency represents one of the most important conceptual problems in evaluating SDD.

Evidence

In many studies, SDD is defined as a difference between both partners' scores on sexual desire and is often referred to as the "actual desire discrepancy."^{11–13,33} Other studies have focused on "perceived desire discrepancy" by asking each partner to estimate how discrepant their sexual desire is.^{11,28} Actual and perceived SDD reflect different perspectives and thus yield different results. A systematic comparison between actual and

Table 1. Brief characterization of sexual desire discrepancies (SDD)

Individual approach (not recommended)	Dyadic approach (recommended)
Clinical targets	
Quantity: Frequency/level of sexual desire	Quality: Sexual pleasure and emotional intimacy
Distress associated with low desire	Distress associated with SDD
Main focus	
Focus on the low desire partner	Focus on the (relational) meaning of SDD, preferences and motives
Focus on diagnostic criteria for hypoactive desire	Focus on the mismatch between partners

perceived levels of sexual desire is useful because partners tend to show biased perceptions of each others' sexual desire, which often results in misinterpretations and unnecessary distress.³⁴

Probably the most common conceptualization of SDD focuses on the discrepancy between actual and desired sexual frequency among partners.³⁵ Behavior is, however, not a good indicator of desire because people have sex for different reasons and thus often engage in sexual activity without experiencing sexual desire.^{36,37} This type of consensual, but initially undesired, sex is common among couples and can be driven by different motives such as wanting to please the partner, wanting to feel sexually attractive, stress relief, sense of obligation, and routine.^{38–40} Another problem with the focus on sexual frequency is that sex may mean different things for different people.^{37,41} When sexual desire is defined as a motivational state that can be fulfilled by other needs than sexual activity, SDD may actually reflect a lack of motivation for particular sexual acts with a particular partner.⁴⁰ This implies that problems between partners may arise not only from different levels of sexual desire but rather from differences in the understanding of sexual desire, the object of desire (ie, sexual preferences), and the motives of sexual desire and sexual activity.⁴⁰ Overall, the distress evoked by SDD resides mainly in the actual or perceived difference in desire, timing, activities, and communication about intimacy and sexual behavior rather than one partner having a disorder.

Table 2. Recommendations for assessment of sexual desire discrepancies (SDD)

Consider the dyad rather than the low desire partner
Focus on mismatch (discrepancy) rather than absolute levels of desire
Consider actual versus perceived SDD
Consider levels of distress associated with SDD (distinguish individual versus relational distress)
Learn about the ebb and flow of sexual desire and SDD in the couple's past (identify critical events)
Explore the mechanisms that promote or hinder sexual adaptation to SDD
Explore the function of SDD and examine whether SDD reflects an underlying relationship problem

Remarks

Closely related to the concept of SDD is the literature on the sexual interdependence dilemma, which describes how people make sexual decisions when their own sexual needs are not aligned with their partner's needs.^{40,42} SDD can be considered as the most common sexual interdependence dilemma. Several data have shown that being responsive to one's partner leads to more sexual and relationship satisfaction than deciding not to engage in sex because of lower sexual desire.³⁸ Another related concept is sexual compliance versus sexual restraint, which refers to a partner engaging in sex with low sexual desire versus a partner having little sex despite high sexual desire, respectively.⁴³ Although sexual restraint is psychologically and physiologically demanding for partners, engaging in sex for avoidance reasons has detrimental effects as well, as it may lead to lower relationships quality and higher physiological and emotional stress.⁴⁴ A final related concept is sexual compatibility, which implies that partners desire and enjoy similar things sexually, and this is believed to be beneficial to the relationship.² Although largely hailed and promoted, sexual compatibility may not be realistic or desirable to strive to. When taking into account individual variability in sexual desire responding, it seems unlikely that 2 individuals will desire the same, at the same moment, and in the same way.

Methodological Issues

Statement 6: The lack of uniformly accepted definition of SDD and the heterogeneity of its assessment make the results difficult to compare.

Evidence

The lack of uniform definition of SDD makes it difficult to make direct comparisons between the results of different studies.³³ Furthermore, it has been argued that existing measures of sexual desire and SSD have an inconsistent structure and lack systematic validation studies.^{32,45}

Another methodological difficulty is the variability in sampling strategies. These range from recruiting perimenopausal and postmenopausal women with low sexual desire, couples transitioning to parenthood, and couples with sexual problems to adolescents and college students.^{30,41,46–48} Only a few empirical studies have relied on community samples and most of them are

convenience based.^{35,39,48} Furthermore, most studies have been carried out among heterosexual individuals or couples. It is generally assumed that discrepancies in sexual desire are larger and more distressing in a heterosexual context because women are assumed to show a stronger decline in sexual desire than men.^{23–25} However, there are no reasons to expect that SDD is exclusive to heterosexual couples and would not occur or cause distress in gay or lesbian relationships.^{28,49} Future research on SDD needs to include non-heterosexual couples and different relationship types (eg, consensual non-monogamy). Lack of cross-cultural findings is another limitation of the available literature on SDD. Most studies so far have been carried out in Western European and North American heterosexual samples.

Remarks

Reaching consensus on how to define SDD remains an important task. A standard definition would bring more operational clarity and methodological cohesion, which could stimulate research and ultimately advance our knowledge on SDD. When measuring SDD, we recommend taking a dyadic approach in which SDD is indicated by (i) the degree of discrepancy between partners' actual sexual desire, (ii) the degree of (dis) concordance between partners' assessment of SDD in their relationship, (iii) the level of partners' distress over SDD, and (iv) partners' evaluation of the duration of (distressing) SDD. Given that the clinical value of SDD may depend on both partners' level of distress, we need specific psychometric tools that can capture couple distress in addition to individual discomfort. Building a consensus on how SDD should be defined and measured will also benefit the development of treatment protocols that tap into the core themes of SDD but leave enough room for tailoring the interventions as per the duration, source, underlying reasons, and distress level of SDD.

Current Research on the Outcomes of SDD

Statement 7: More research is needed on the predictors, correlates, and underlying factors that promote or hinder a couple's adaptation to SDD.

Statement 8: Because sexual desire naturally fluctuates, it is difficult to make uniform conclusions on the positive or negative impact of SDD or to consider any impact of SDD to be gender specific.

Evidence

Research on the outcomes of SDD yields conflicting findings, which is probably related to the diversity in conceptualization and measurement of SDD. Some studies report positive outcomes of SDD on the (sexual) relationship,^{35,50} whereas others show negative effects.^{11,13,27,51} Most often, the outcome variables are broadly defined in terms of relationship and sexual satisfaction,^{11–13,29,32,48,51,50} leaving unexplored how SDD may affect other parts of individual functioning (eg, mood, coping), relationship functioning (eg, communication, support, partner

responsiveness), and well-being. In addition, we currently lack a clear understanding of what it means for partners to experience different levels of sexual desire and why some couples handle differences in sexual desire better than the other.^{29,52} Finally, current knowledge on the underlying processes and moderators of SDD is mainly based on clinical impressions and not supported by systematic research. For example, SDD is often described as a symptom of an underlying relationship problem.^{47,50,53} Because the agreement of both partners is needed to enter sexual activity, refusing sex may act as a strategic tool to regain or balance power in the relationship.⁵⁰ SDD could also be regarded as a passive and relatively safe or non-challenging way to express dissatisfaction with sexual and/or non-sexual parts of the relationship.^{54,55} Although desire discrepancy can present itself for a variety of reasons and may serve many different relationship functions, it may also originate from biological factors such as menopause, medical treatment, and disease or from simple practical issues such as lifestyle patterns, preferred times for sleeping, parenting, or work-related stress.^{56–58}

Gender Differences in (the Impact of) SDD

As gender is the most common moderator variable in sex research, it is not surprising that most research on the outcomes of SDD has focused on gender differences in whether or not SDD will elicit distress. Given the evidence that women have a lower or more context-sensitive sexual desire than men,^{25,27} it has been assumed that women are more likely to be the low-desire partner in SDD couples than men. There is, however, no solid evidence to support this claim. Moreover, when women are diagnosed with hypoactive sexual desire, it is often not the low desire in itself that causes distress but rather the relational impact of the couple's discrepancy in sexual desire.^{5,59}

Whether or not SDD will be experienced as distressing depends on how important sexual desire is for both partners. It has been suggested that women value the emotional quality of sex more than its quantity and are driven less towards sexual activity.^{5,26,51,55,59,60} Accordingly, women may experience discrepancies in sexual desire levels or desired sexual frequency as less important than differences in how sexual desire is embedded in the relationship and which emotional needs are linked to desire.³⁹ It is plausible that women use feelings of closeness and commitment as an indicator of sexual desire, whereas for men, it is the sexual desire itself that generates the motivation to become intimate with their partner.^{39,60} On the other hand, there are also indications that women's sexual desire is important to both her own and her partner's sexual satisfaction.^{12,61}

Another relevant gender difference that may explain differences in the impact of SDD on (sexual) satisfaction is that women place less value on who initiates sexual activity, whereas men pursue a balance between partners to take sexual initiative.⁶² Studies have shown that holding the belief that men should always initiate sexual interactions lowers sexual satisfaction in both partners, whereas sexual initiation in both genders would increase

sexual satisfaction.^{62,63} Although balancing sexual initiative would benefit the relationship climate, it has been found that men report more satisfaction when the woman takes the initiative to have sex because among other things, this contradicts social norms and expectations about sexually initiating men, which would then increase a men's sense of sexual desirability.⁶⁴

These differences in the meaning and function of SDD could possibly explain the finding that lower levels of SDD leads to better outcomes in men. When confronted with a partner with higher sexual desire, men often adopt the role of the suffering one, whereas women tend to self-sacrifice.⁶ Women tend to take a leading responsibility for maintaining the relationship and are thus more prone to prioritize relationship needs over personal needs.⁶⁵ As a result, women may hide their lack of sexual desire, so that their partners are not even aware of the discrepancy.¹³

Gender differences in the impact of SDD on the relationship may also vary as a function of relationship duration. Although a couple may experience similar levels of sexual desire early in the relationship, the sexual desire of both partners may diverge as the relationship develops. Accordingly, it has been suggested that SDD would be more prevalent and more problematic in long-term compared with short-term relationships.^{2,29} It is also important to note that SDD may not necessarily be caused by gender differences in the level of sexual desire and motivation but rather by differences in the definition of sexual desire and the type of sexual acts they desire.^{39,40,51,66} Sexual preferences may change in the course of the relationship. Hence, a sexual script that elicited arousal in the beginning of the relationship may become less exciting over the years.

Remarks

It is important to note that the observed gender differences in how men and women experience SDD should not be regarded as absolute differences. We need to be careful not to put too much weight on gender differences, because there may be as much variation within each gender as there is between genders. Differences in the impact of SDD could be more strongly related to differences in age and cultural or societal influences than to gender differences.⁶⁷

Suggestions for the Treatment of Distressing SDD

Statement 9: The main focus of the treatment should be directed towards decreasing the distress associated with SDD and assisting partners in better coping with discrepant levels of desire.

Statement 10: Treatment should focus on the dyadic interaction and function of SDD within the relationship, rather than individual levels of sexual desire. This implies exploring the meaning for each partner of having or not having sex within the relationship.

Statement 11: Treatment options are psychoeducation, improving communication to broaden the couple's understanding of sex and their sexual repertoire, homework assignments that

teach partners to schedule intimacy, making efforts to generate sexual desire, and systemic explorations of the relational function of SDD.

Evidence

Table 3 summarizes the most important aspects to consider during SDD treatment. Although SDD is not necessarily a sexual problem, we do need an evidence-based treatment to help subjects who are distressed by SDD.⁶⁸ Currently, no evidence-based treatment for SDD exists. Only a few studies on SDD have used clinical samples^{69,70} and, so far, no comprehensive treatment program has yet been described. Several therapeutic recommendations have been made to treat low sexual desire, but these cannot simply be transferred to a couple-focused treatment of SDD.⁷¹ Most treatments of sexual desire problems take an individual approach and focus on increasing and expanding the sexual desire of the low desire partner.⁶⁸ Partners are then instructed to find a compromise in their level and type of sexual activity, which ignores the fact that SDD often results from partners' interaction and is an important part of their conflict management.⁵⁰

Although some articles on SDD and sexually related constructs discuss clinical implications,^{12,13,33} none of these suggestions are research-informed and evidence-based. The following treatment suggestions are thus only speculative and based mainly on clinical rather than research experiences. Furthermore, most of these treatment suggestions are already standard practices in sex and couple therapy.

Psychoeducation and Normalization

Most often, a couple will not consult for SDD but will present the problem as one partner suffering from hypoactive sexual desire.³⁹ Instead of taking part in this allocation of blame, a clinician may try to reframe the complaint as a couple problem in which both partners are involved.^{6,43} It is also important to normalize SDD as a common experience in long-term sexual

Table 3. Recommendations for intervention (expert opinion)

<i>Psychoeducation</i>
Build non-pathologizing/normalizing narratives
Target social norms and myths; adjust sexual expectations
<i>Break sexual routine (create opportunities to generate sexual desire)</i>
Broaden sexual repertoire (find non-sexual strategies)
Increase open communication (tune sexual responses and compromise to sexual opportunities and types of sexual stimulation)
Strive towards a satisfying sexual script for both partners
Actively search for adequate sexual stimulation
<i>Emotional needs</i>
Explore emotional and intimacy needs (decide whether relationship therapy fits the couple's interest best)

relationships.^{2,6,25} The main focus of treatment should not be on reducing SDD but on decreasing distress and helping partners to better cope with discrepant levels of desire.²⁶

Aligning with a stepped care approach to sexual problems,⁶¹ psychoeducation about the course, function, and context dependency of sexual desire should be a first-line strategy. Giving permission to talk about SDD and providing information to normalize the discrepancy may in some cases already be sufficient to reduce distress and lower the urgency of the complaint.⁷² A focus on pursuing positive and realistic expectations about how to integrate sex in daily life may be helpful. This fits with the Good-Enough Sex Model that has been proposed as a key factor in maintaining sexual satisfaction in long-term relationships.⁷³ A potential way to prevent disappointment and distress is to make couples realize that the desire for and quality of sex may vary from day to day, that it is normal to have mediocre and less satisfying sex once in a while, and that efforts are needed to keep the sparkle alive, especially in the face of daily stress and life changes.⁷³

Specific Advice to Break the Routine, Broaden the Sexual Repertoire, and Tune Sexual Responses

An important challenge in treating SDD is finding non-sexual strategies to balance the discrepancy and diminish the distress associated with it. Specific advice can be provided to break the routine, activate both partners erotically, broaden their definition of sex, and help them tune their sexual desire levels. Open communication in which both partners can willingly express their sexual wishes and communicate their sexual concerns is an important skill that may help couples to deal with SDD.^{74–76} Communication skill training may facilitate the discussion on how each partner defines sex and whether they agree on this conceptualization.^{77,78} This may eventually help to clarify if the lower sexual desire is linked with reduced arousability (which may be due to a range of biological or psychosocial factors), dissatisfaction, or specific preferences and practices. Couples are often too much focused on intercourse and a narrowly defined “sex.”^{39,78} To help the couple broaden their sexual repertoire and develop a joint sexual script that is satisfying to both, therapeutic interventions should be directed at stimulating mutual agreement on sexual acts and pleasurable interactions instead of increasing sexual frequency.^{77,78,79}

Once the couple has developed shared and realistic expectations, it is beneficial to make explicit what type of sexual stimulation each partner wants and to compromise on when and how to get it.⁷⁷ It is also important to explore whether the partner with the lowest desire actually wants to expand his or her desire. Several strategies such as making a list of desired sexual acts to be discussed among the partners or sensate focus exercises to discover what type of sexual stimulation each partner likes can be used. This gradual approach towards reintroducing and expanding sexual touch may help to improve communication about sexuality, minimize pressure and expectations, rebuild

physical intimacy, and increase awareness that sex is a mutual responsibility.⁸ One of the benefits of giving homework assignments is that partners learn to schedule occasions for sexual intimacy.⁸⁰ Instructing them to pursue sexual desire by creating opportunities for sex (eg, date nights) goes against the popular belief that partners should just go with the flow and wait for spontaneous sexual desire to emerge.^{18,81} Sexual desire does not pop up “out of the blue” but is triggered by a stimulus that predicts reward. Although sexual desire may feel as spontaneous, it is always initiated in response to a sexual or even non-sexual cue (eg, relational intimacy). Hence, partners need to actively search for adequate sexual stimulation, which often includes flirting and seduction.⁷³ Eventually, the couple gets a more realistic view on long-term sexual relationships and learns that sexual desire requires effort, intentionality, intimacy, and planning.

Compliance and Positive Rejection

In addition to working together on developing the couple's sexual script, therapeutic advice can also be directed at normalizing and depathologizing having sex without direct, initial desire.^{34,36,38,40,42,43,52} The desire may grow over the course of the sexual act as a result of (physiological) sexual arousal responses.¹⁸ Yet, having sex without sufficient sexual arousal is clearly not indicated. Research has also shown that positive rejection yields better relationship outcomes compared with having sex for avoidance goals.^{42,43} Drawing on a systemic perspective on SDD, partners should learn to understand each other's need to have sex but also the need not to have sex. Both partners' motives need to be acknowledged. This implies that the low-desire partner is not the only one modifying or justifying his/her sexual desire. It works better when both partners try to meet halfway.^{2,7,26,32,33} In this context, it is important to empower mutual consent and assertiveness between partners in order to manage discrepant levels of sexual desire.^{26,38}

Meaning of SDD in the Relationship

When SDD serves important relationship functions such as controlling and balancing power and/or dissatisfaction, the couple may benefit from prioritizing relationship therapy. When being more satisfied with the relationship, partners may feel less distressed by SDD, even if it does exist, or they may feel more motivated (to make efforts) for sexual contact.⁵² Taking the relationship as a starting point for treatment and exploring the underlying meaning of SDD fits with the basic principles of emotionally focused therapy (EFT), which has recently been proposed as a possible therapeutic model in the context of SDD.⁵³ EFT uses emotional intimacy as a catalyst to sexual desire, redefines sexual desire in terms of unmet attachment needs, and tries to identify negative sexual cycles in which one partner desires intimacy as precursor for sex, whereas the other partner uses sex to feel emotionally close. By focusing on

relationship closeness, the EFT approach has a potential to decrease SDD-related distress.⁶⁹ Some clinicians have challenged the notion of emotional intimacy as a mediator of sexual desire, promoting the concept of differentiation and prioritizing unpredictability and novelty over safety and stability.^{82–85} They direct their interventions towards balancing togetherness and personal autonomy and valuing the perception of otherness and self-differentiation.⁸⁶ Within this perspective, SDD may actually open up possibilities for each partner's self-differentiation and personal growth.

Remarks

Clinical endpoints and treatment success are often defined in terms of increased sexual frequency and decreased sexual distress. This contradicts our proposal that couples who suffer from SDD need to explore their preconditions to experience sexual desire and learn to pursue sexual pleasure, both individually and together with the partner. The essence of sexuality is to experience sexual intimacy and pleasure and not penetration. Another issue that needs further attention is the lack of information on treatment modalities. We strongly encourage working with the couple as a unit of the treatment. However, in case only one partner is available for therapy, it is recommended to take an individual systemic approach and to integrate the partner's responses into therapy by asking circular questions (eg, How would your partner react to this? What are your partner thoughts and feelings about this? How could you communicate this to your partner?). It is also important to provide written instructions of the homework assignments to ensure an accurate understanding and cooperation of the partner not present in therapy. Although it is most evident to treat the couple as a unit and not as 2 individuals,^{11–13,87} it is also worth exploring if other modalities such as group therapy would lead to similar or even better outcomes. The value of group therapy is not only indicated by its cost-effectiveness, treating couples in a group setting allows them to share experiences, which may help to normalize their SDD. In addition, interactive online platforms, including e-health information-based services, and virtual psychotherapy, may prove useful.

CONCLUSIONS

Research on SDD is characterized by conceptual and methodological difficulties, which may explain the lack of empirical and clinical data on how to define, measure, and treat SDD. To develop effective treatment protocols, we need a better understanding of the function, determinants, and underlying mechanisms of SDD and more insight into the sources of distress associated with SDD (see also [table 4](#)). Given that many couples appear to cope well with sexual disagreements and accept differences in sexual desire without feeling threatened or distressed, SDD is not a uniform clinical phenomenon that always requires an intervention. More research is needed to understand the moderators and conditions under which SDD yields positive or

Table 4. Directions for future research on Sexual Desire Discrepancies (SDD)

Building consensus over how to define SDD
Explore dominant gendered norms and beliefs about SDD
Select diary methods and prospective designs to explore variability over time and across different contexts
Construct and validate measures focusing on the dyadic experience of SDD and the related distress
Build measures focusing on relational distress and dyadic experience of desire
Focus on the predictors, functions, and mechanisms underlying SDD

negative outcomes. Furthermore, research on SDD would benefit from new measurement tools that align with a dyadic perspective and tap into the dynamical interaction between partner's sexual (desire) responses. Instead of questionnaires that provide only a snapshot of sexual responding, diary methods, for example, may be better suited to capture fluctuations in sexual desire within the context of the daily relationship. In addition, prospective designs are much needed to explore how SDD develops and evolves in relationships.

Although no systematic and evidence-based treatment protocols are available, we make the following tentative suggestions for treatment, which are based on standard sex therapeutic interventions. A treatment for SDD should (i) normalize and depathologize the between- and within-individual variation in sexual desire; (ii) educate about the natural course of sexual desire; (iii) emphasize the dyadic, age-related, and relative nature of SDD; (iv) challenge the myth of spontaneous sexual desire; (v) promote open sexual communication; (vi) assist in developing joint sexual scripts that are mutually satisfying in addition to searching for personal sexual needs; (vii) deal with relationship issues and unmet emotional needs; and (viii) promote self-differentiation. The ultimate goal of non-clinical and clinical research is to develop a treatment for SDD that effectively and efficiently increases sexual pleasure and well-being, as well as sexual and relationship satisfaction.

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Conflict of Interest: The authors report no conflicts of interest.

Funding: None.

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