Treating Desire Discrepancy in Couples

Linda E. Savage, Ph.D. AASECT Certified Sex Educator

One of the most common sexual issues we treat is couples reporting that they have a desire discrepancy in long-term relationships. Inhibited desire or desire discrepancy is when one partner feels rejected or unhappy because he or she wants more sexual interaction than the partner and when the stalemate has become chronic, the result will often be a low-sex or no-sex relationship. The perennial question about sex in a committed relationship is what is healthy and what is normal? Yet what is "normal" is not necessarily healthy. Often the sex that is occurring is based on one partner giving in to pressure or coercion and he or she is accommodating with sex that is unwanted or not particularly pleasurable, even when the low desire partner has an orgasm. I think of the issue of good sex in long-term relationship as more of a conundrum, you have an available partner but the motivation isn't very strong.

Masters and Johnson's clinical director estimated one in three couples are affected by low desire. According to Barry and Emily McCarthy in Rekindling Desire, 50 percent of couples will experience significant inhibited desire and desire discrepancy sometime in their marriage. The percentage of couples experiencing this problem may be even higher.

Given all the sexual hype in our culture (Americans are simultaneously the most puritan and the most obsessed sexual culture), most couples feel that others are having way better and more frequent sex. How to rekindle desire in relationships, or make love 365 days a year, or have passionate marriages is the stuff of big business and unrealistic expectations. The books, ads and articles are not talking about new romance and hot single sex, they are written for long-term relationships. And so it is a silent stigma because it evokes our deepest fears that if we are sexually inadequate, we will be abandoned.

According to John Gottman, couples take an average of six years to seek help after they have become aware of a marital problem and it is troubling to think of how long it will take to seek help for a sexual problem. By then the dysfunctional patterns have become chronic and the difficulties in treatment increase. When you have a couple in your office, they will not volunteer the information about their sexual disappointment readily. Couples who come in for marital therapy often withhold information about inhibited desire. They simultaneously want to protect their partner and hide their own sense of shame. Male sexual dysfunction is often an underlying reason for low desire in women, although the couple may not initially admit to it. She may be covertly or even subconsciously saying, in effect, "I do not desire the type of sexual interaction that happens" with her partner because there's no real pleasure in it for her.

You can give the couple this simple true/false test to take home and fill out individually, to report back next time. You can ask that they fill it out for themselves and then project what they think will be their partner's answers. Be sure to ask them to wait to talk about it with each other until they are in your office. No matter how they have answered each question, it is sure to generate some very significant discussion in your office. [from Barry and Emily McCarthy, *Rekindling Sexual Desire*:]

1. Sex is more work than play

2. Touching always leads to intercourse.
3. Intimate touching takes place only in the bedroom
4. I no longer look forward to making love
5. Sex does not give me feelings of connection and sharing
6. I never have sexual thoughts or fantasies about my spouse
7. Sex is limited to a fixed time, such as Saturday night or Sunday morning
8. One of us is always the initiator and the other feels pressure.
9. I look back on premarital sex as the best time
10. Sex has become mechanical and routine.

Couples will come to you with some entrenched notions about what desire is, who has less desire and who is the more "sexual" one in the relationship. Do not automatically accept your client's definition of low desire and their idea of who's got the problem in the relationship. You will need to discuss what desire is and what different factors contribute to low desire. Since it is much more complicated than biological urges, keep in mind that discussing this with couples is a creative dialogue. Our job is to offer some new ways of viewing the problem that will help the couple move beyond their impasse.

The following is information that can be used as psycho-education, intended to remove the blame and shame. Desire may be viewed as the strong erotic pull that is not the same as sexual arousal, which is the purely physical response of lubrication, erections, swelling tissues or sensations in the genitals. Desire is also a positive anticipation or it could be experienced as a longing to feel connected to the partner. It is more a mental and emotional state, complicated by everything that contributes to our individuality.

More often it is the woman who reports low desire, but it can be the opposite. Men with low desire often have a history of functioning problems and shame blocks their desire to attempt intercourse with their partners, but they enjoy an active masturbatory and fantasy life. For some people, the greatest sexual desire they have experienced was in their worst relationships. For many, the strong erotic pull was there in the beginning of the relationship and it has slowly eroded, or was suddenly reduced by events such as the birth of a child, an affair or a serious fight.

Many individuals in long-term relationships lose sexual interest because genitally focused sex in rote patterns purely for physical release becomes boring without additional paths of emotional and spiritual discovery. This is especially true for women. The higher levels of testosterone (10 times as much) in men, creates what I call appetite sex. Testosterone governs the desire for orgasmic release, but not necessarily connected lovemaking with a partner. The partner who is interested in merely appetite sex is often viewed as the "high desire" person, yet this is a distortion of what is really going on. The low sexual desire partner may be very knowledgeable about their sexuality, which is why they are opting out of the type of sex that may be occurring in the relationship. This partner may have experienced some truly connected, ecstatic, high touch or dramatic sex in another relationship and may feel, after many attempts to make changes that their partner's "genital sex for release" approach is not to their taste. That is just one scenario, but it will help us let go of the notion that the high desire person is always the sex lover and the low desire person just doesn't like sex.

Here is one important way the cultural misunderstanding about the meaning of sex plays out in low desire cases. There is a fundamental disservice to the many varieties of sexual interaction when we adhere to the common meaning of the word ***sex*** as equaling intercourse or penile penetration. Especially in women's life experience and even for a growing number of men, the notion of sex as synonymous with intercourse does not reflect the totality of their sexuality. When we expand our understanding of sex to include many activities, and shift the goal to ***pleasure*** rather than erections and orgasms, there is more possibility of an enjoyable and active sex life with a long term partner. This principle is particularly important for the feminine approach to sexuality.

Here is a helpful definition of "healthy" sexuality in a committed, long term relationship. There are at least three factors to healthy sexuality: that one is able to receive pleasure (feeling good about one's own erotic sensations), that one is able to give pleasure, (enjoying their partner's responses), and one is open to new experiences and sexual possibilities rather than adhering to rigid routines. An erotic encounter is experienced as a pleasurable activity that includes sensual touch, good erotic feelings and possibly (but not necessarily) some orgasms. That's pretty broad intentionally because everything else that defines sex is biased towards some kind of performance, outcome or frequency.

The Pleasure paradigm shifts the perspective enormously. 1) Pleasure rather than orgasm is central to the erotic encounter. 2) Sensual touch is the vehicle rather than genital performance, and 3) Orgasm is perceived as multi-dimensional and energetic. This new paradigm shifts the couple out of very black and white thinking about sexuality and desire into a whole new playing field. In letting go of intercourse as the main event, couples can open themselves up to new creative ways of experiencing pleasure. We can help by separating the performance concept from pleasure.

For years when couples have told me that they want to feel the way they did at the beginning of the relationship, or they want the same passion they had, or that they want to fall in love again, I've had to suggest that long term relationships simply cannot roll back the clock. Now brain imaging shows us that this is neurochemical certitude. Our brains are wired with reward systems that activate in the beginning of relationships that guarantee a strong sexual attraction.

I have found that giving couples information about the new brain research by Helen Fisher on romantic love, helps them disengage from the notion that they should feel the way they did in the beginning of their courtship, or when they were single and having many sexual encounters. The new information helps us understand the chemistry of sex, and what is activated in the process of courting, and attachment. Since our couples are often using their earlier experiences as a kind of "gold standard" for desire, this information is simple and extremely helpful as an intervention. As Pat Love says, understanding can promote change. I have used this information successfully to help one partner disengage from an affair, when he or she desires to renew the marriage. Both partners can more readily make changes when they grasp some of the neurophysiology of sex and emotions.

According to Helen Fisher's fMRI research there are three brain systems involved in the mating game 1) the lust system 2) the romantic attraction system, (which she now views as a basic drive), and 3) the attachment system. Testosterone plays big role in lust for both men and women. It is a craving for sexual gratification, especially

orgasm, which does not even need a particular subject. When we are falling in love, the reward system—dopamine and norepinephrine become activated. This reward system interacts with the lust system to produce what Helen Fisher refers to as the romantic drive: the sense of euphoria, an intense and often obsessive need to be with the love object who is so special that no one else will do. I tell couples "this is your brain on drugs" and it is very compelling. Sexually we are eager to experiment in ways that are outside our ordinary comfort zone and of course we are likely to make love with alarming frequency. The experience of being in love is universally recognized as painful as much as pleasurable, fraught with anxiety and quite literally experienced as "crazy." This is the same reward system, by the way, that is activated by addictive substances.

I tell my couples that it is a trick of nature that we are so compelled to mate in the beginning and then everything that seems to support hot sex fades away, leaving us on our own to figure it out. Interestingly enough, cultures that use falling in love as a prerequisite for making a long-term commitment have the highest divorce rate.

In order to survive the shifts from extreme attraction and obsessive mating to a long term loving sexual relationship, couples will need to embrace the pleasure paradigm outlined above. As the reward system fades, there is a third attachment system that begins to activate as romantic attraction decreases. Oxytocin, the principle hormone associated with attachment (and touching, holding, cuddling) and Vasopressin, sometimes called the monogamy hormone are associated with this system. Dr. Fisher postulates that they make it possible to remain with a partner for an extended period of time.

Since the reward system is by nature time limited, couples will need to build a model for long-term partnership to become an intimate team. We can offer blueprints and some tools with which to build a healthy partnership model. One of the first suggestions I make is: ***blaming and pouting does not make one's partner feel sexy***.

I am a firm believer in behavior change. I don't know any other way to promote really lasting change that creates couple satisfaction, than practicing new skills. Once added to the repertoire, the positive behaviors lead to satisfying interactions with the partner. When treating couples with low desire we can reframe the primary goal increasing the experience of intimacy, pleasure and satisfaction without regard to sexual frequency, intercourse, or performance.

Here are some basic principles that will apply.

1. Educate, educate, educate
2. Develop each partner's entitlement to his and her own feelings, own brand of sexuality, own pleasure
3. Reduce rigid routines of touch and position that feel mechanical to one partner.
4. Develop breathing and relaxation during pleasuring.
5. Assign homework for each partner to list their conditions for good sex. After each makes a list of what they find personally seductive, in your office the couple will brainstorm seductive conditions they can both enjoy.

All couples can become much better at partnership. Since the 1960s and 70s women began to turn to their partners for face to face intimacy and emotional support and have raised the bar for what is expected from long-term relationships. We seem to be in a double bind in long-term relationships, trying to reconcile security with novelty, since the

latter often stimulates erotic energy. You will find that couples will fall somewhere along a continuum of inadequate differentiation at the one end and lack of a secure bond at the other. Sometime our interventions will lean towards increasing differentiation or towards enhancing security depending on what is needed. Some theorists believe family incest taboos overpower sexual desire after several years as the sense of family becomes ingrained. Thus, one begins to unconsciously recoil from having sex with a mate who is now perceived as family. Sometimes sexual desire can emerge from enhancing differences rather than increasing comfort.

Since the chemically driven intense attraction fades, I find that it is important to help couples realize that now they must work on the edge of their comfort zone. I offer them a definition of intimacy that allows a deeper understanding of what is involved in long-term love. The definition of intimacy I prefer is "the desire to know and be known by another." When there are two people involved in a long-term relationship there are infinite permutations of negotiations with the partner. This formula helps them realize that they must use a team approach.

You		Your Partner		Relationship
Win	+	Lose	=	Lose
Lose	+	Win	=	Lose
Win	+	Win	=	Win

No longer is it easy to do the things that promote romance, and they will have to practice behavior that they may not be inclined to do but it will be well negotiated so that both feel it is a win/win. Initially they will be practicing new directives from the therapist. All of the great communication skills and other methods that you teach couples will be useful. The task is defined as developing a team approach in order to develop seductive conditions and continue creating new ways to turn towards each other: inside and outside the bedroom.

1) Sexual desire can be defined as:
    a. Always accompanied by physiological arousal
    b. A mental and emotional experience
    c. Positive anticipation, erotic pull and longing to be connected
    d. Both b and c

2) The high desire partner in a long term relationship
    a. Is usually more experienced with sex
    b. Wants more connection
    c. Has high levels of dopamine and norepinephrine
    d. None of the above

3) Healthy Sexuality is:
    a. The ability to receive pleasure and to feel good about one's own erotic responses
    b. The ability to give pleasure and to enjoy the partner's responses
    c. The ability to be open to new sexual possibilities rather than rigid routines
    d. All of the above

4) The Pleasure model of sex includes
    a. Great orgasms each time
    b. Sensual touch and good erotic feelings
    c. Frequent intercourse

d. Long sessions of erotic lovemaking

TRUE/FALSE

The frequency of intercourse is a good measure of high desire and healthy sexuality.

Bio: Linda E. Savage, Ph.D. is a licensed psychologist, marriage and family therapist, and sex therapist in practice since 1984. She is an AASECT certified sex educator and the author of *Reclaiming Goddess Sexuality,* a blend of ancient wisdom with current clinical knowledge.

Bibliography

Castleman, Michael, *Great Sex: A Man's Guide to The Secret Principles of Total Body Sex*. (Rodale, 2004)

Ellison, Carol Rinkleib, Ph.D., *Women's Sexualities.* (New Harbinger Publications, 2000)

Fisher, Helen, *Why We Love*. (Henry Holt & Co., 2004)

Kerner, Ian, *She Comes First: the Thinking Man's Guide to Pleasuring a Wom*an, (HarperCollins, 2004)

Kleinplatz, Peggy, Editor. *New Directions in Sex Therapy: Innovation and Alternatives*, (Brunner-Routledge, 2001)

Leiblum, Sandra R & Raymond C. Rosen. *Principles and Practices of Sex Therapy*, (Guilford Press, 3rd ed. 2000)

McCarthy, Barry W. & Emily J. McCarthy. *Rekindling Desire: A Step by Step Program to Help Low S*ex *And No Sex Marriages*, (Brunner-Routledge, 2003)

Metz, M.E. & McCarthy, B.W. *Coping with Premature Ejaculation: Overcome PE, Please Your Partner and Have Great Sex,* (New Harbinger Publications, 2003)

Pert, Candace, *Molecules of Emotion*: *Why You Feel the Way You Feel*. (Scribner, 2003)

Savage, Linda E., *Reclaiming Goddess Sexuality: The Power of the Feminine Way*. (Hay House, 1999)

Schnarch, David & Jamies Maddock. *Resurrecting Sex: Resolving Sexual Problems and Rejuvenating Your Relationship*, (Harper Collins, 2002)