

When Desire Becomes a Question About the Relationship

Recognition, bodily experience, sexual meaning, and the clinician's responsibility to leave room for difference

Brian Kennedy, MA, LMFT

A client says that their partner has become more attentive. Difficult conversations are less defensive. Promises are more often kept. They are grateful for the change, and then they add, with some reluctance, that they still do not want sexual contact.

There is a moment in which the therapist can begin working too hard. Perhaps we have understood desire through an attachment injury and expected greater trust to make a difference. Perhaps we have emphasized autonomy and are waiting for self-definition to release an inhibited erotic life. We may find ourselves searching for the missing piece that will allow the client to want the partner whose effort we can now see.

The client's experience may be asking us to loosen the explanation. Increased trust can be important without producing attraction. A respected boundary can bring relief without awakening desire. An improved relationship can remain sexually incompatible. These possibilities do not invalidate attachment or differentiation; they limit what either framework can decide in advance.

The work begins in our capacity to stay interested when a hoped-for outcome does not arrive. We can appreciate change, hear an unmet longing, and permit uncertainty about the future without recruiting the client into confirming that therapy has worked.

The hesitation after the client's statement matters. They may be waiting to learn whether we will be disappointed in them, defend the absent partner, or uncover another reason they ought to feel differently. A simple acknowledgment can leave more room: the relationship has changed in ways they value, and sexual interest has not followed. We can ask what it is like to say both things here. Their response may lead toward grief, relief, confusion, or a practical question. It should also be able to lead away from our interpretation.

An integrative formulation has to account for more than the presence or absence of desire. We are listening for attachment longing, the organization of protection, embodied feeling, a person's capacity to remain themselves with another, and the meanings through which an intimate life becomes their own. Contemporary sexuality research gives these questions needed specificity. The foundational traditions give them developmental, relational and existential depth. Neither can decide the client's experience in advance.

The clinical question beneath the presenting complaint

A report of mismatched desire can refer to several different difficulties. Someone wants more frequent sexual contact. Someone wants to feel approached. Someone experiences sex as unpleasurable, painful, obligatory or organized around another person's satisfaction. Someone wants affection that is not treated as consent to escalation. Someone is distressed by a change in attraction, or by the belief that their preference makes them deficient.

Before formulating the discrepancy, we need to establish whose concern is being described and what each person hopes could become different. Frequency, spontaneous interest, bodily response, satisfaction, distress, relationship meaning, and freedom to decline are distinct dimensions. A low frequency does not tell us which of these is troubling the person.

The ESSM position statement approaches desire discrepancy as a relative, dyadic phenomenon and emphasizes the meanings and distress associated with it. Its clinical value includes moving us away from automatically designating the less interested partner as the patient. The statement also describes limitations in the available literature; it does not establish a single preferred intervention for every mismatch. [1]

In the room, that means allowing two descriptions to remain different. One person may feel unwanted while the other experiences pressure. Both experiences can be real, while the conduct and responsibility involved remain unequal. Describing a reciprocal sequence cannot make coercive behavior one half of a symmetrical misunderstanding.

Assessment becomes more useful when it follows the specific difficulty. Is the change recent or longstanding, generalized or particular to a partner or circumstance? Is the person missing desire they once enjoyed, distressed by how others interpret its absence, or content until a demand arrives? What is pleasurable or welcome now? An asexual identity, a chosen period without sex, and distressing loss of wanted interest call for different conversations. We need the person's account before assigning the clinical task.

Mark and Lasslo's systematic review synthesized 64 articles about desire in nonclinical long-term relationships through individual, interpersonal and societal factors. That scope supports a formulation extending beyond intrapsychic deficit. It also sets a boundary: a conceptual synthesis of nonclinical research does not establish the cause of a particular client's distress or an intervention's effectiveness. [16]

Attachment longing and the particularity of desire

John Bowlby's 1977 account treats attachment as a significant lifelong bond and distinguishes attachment behavior from sexual behavior. This distinction belongs within our formulation, rather than appearing only as a caution at its edge. The wish for a particular person to remain available can be profound while erotic interest follows a different course. [20]

Sue Johnson's EFT account attends to the protective interaction through which fears about connection become blame, insistence or withdrawal. Her discussion of sexual conversations also makes vulnerability and the ability to describe a preference clinically important. This directs attention to how the bond is being negotiated, without establishing that every sexual difficulty is caused by its insecurity. [21]

Consider what the formulation allows us to hear. A request for sex may also ask whether the person still has a place in the partner's imagination. A refusal may involve protecting an overrun boundary, fear of failing, an unwelcome activity or lack of attraction. Accessing a softer feeling can change the encounter, but it must not become the prerequisite for taking a clearly expressed limit seriously. We keep the longing visible while examining the terms on which a response is being sought.

A body is not a verdict

Basson's model of responsive and spontaneous desire challenges an obligatory desire-first sequence. It can relieve a person who has understood the absence of initial spontaneous interest as proof of dysfunction. Used carelessly, the same idea can become persuasion: begin the activity and desire will follow. A model of possible response must never become a reason to override a person's unwillingness. [2]

The dual control model offers another distinct contribution: response involves excitatory and inhibitory processes rather than a single quantity of drive. It suggests questions about what supports or constrains interest in a particular context. It does not allow us to infer a neural mechanism from a narrative, assign someone a fixed inhibition type, or regard every inhibition as an obstacle to be removed. [3]

A person may be inhibiting a response because the circumstances are unwanted, painful, rushed or unsafe. They may be tired, uninterested, unfamiliar with a sensation, or uncertain about what they are being asked to do. Inquiry should be able to identify a sensible limit as readily as a revisable expectation.

Chivers and colleagues' meta-analysis found that subjective and genital arousal were not interchangeable measures, with variation across studies and groups. Clinically, a physical response should not be treated as privileged evidence of what the person really wanted. Consent requires the person's freely given agreement; it cannot be established from arousal, orgasm, immobility or an interpretation of the body. The empirical distinction and the ethical requirement support different claims and should remain distinct. [4]

The body within an affective relationship

Antonio Damasio and Gil Carvalho's account places feelings within the organism's experience and regulation of bodily life. It supports our interest in the felt quality of an encounter: pleasure, tension, depletion, ease or apprehension. The clinical interpretation still needs checking. An account of embodiment cannot tell us that one sensation reveals the person's authentic desire beneath an inconvenient verbal answer. [23]

Allan Schore's developmental synthesis gives early dyadic affect regulation a central role, including repair after misattunement and the shared amplification of positive affect. Its principal subject is infancy. In adult intimacy work, it offers a developmental lens for attending to nonverbal experience and the conditions for repair; it does not identify a client's childhood or locate their difficulty in one brain hemisphere. [22]

In practice, the therapist might notice that a client's speech becomes faster as their partner leans closer, or that warmth appears when there is more physical space. We describe what we

observe, ask about its meaning and adjust with permission. The change may concern comfort, hearing, pain, expectation or something else entirely. Bodily observation becomes clinically useful through this dialogue. It remains answerable to the person whose experience we are attempting to understand.

Keeping the field of explanation open

A sound formulation includes the body, the relationship, the setting, and the meanings the person brings. It also includes what we do not know. New pain, an abrupt change in function, medication concerns, illness, fatigue and other bodily changes may warrant qualified health assessment. ACOG's information on painful sex is a useful reminder that relational understanding should not substitute for appropriate medical care. We do not prescribe enduring pain as an experiential task. [14]

Cultural and material conditions matter as well. The availability of privacy, accessible positioning, time away from care responsibilities, and the freedom to be honest are not decorative context around an essentially internal problem. They can determine whether a proposed encounter is feasible or wanted.

Who can propose an encounter, who anticipates it, and who manages the aftermath? A person may arrive already responsible for protecting the partner from disappointment, arranging privacy and deciding when a conversation is allowed to end. Another may have stopped initiating because they fear becoming intrusive, without their partner knowing why. These arrangements are part of the presenting difficulty. We can examine them without assuming that equal affection requires identical contributions or that caregiving dependence removes a person's sexual authority.

Suzanne Iasenza's narrative relational work integrates psychoanalytic, systemic and sex-therapy perspectives to examine the stories through which sexual experience becomes intelligible. For this pathway, its contribution is a question about a rule or meaning the person recognizes now: what does wanting, declining, initiating, receiving or being seen seem to say about them? This clinical framework is not evidence that a hidden narrative causes every sexual concern. [12]

We can inquire about history without requiring a confessional sexual autobiography. A current sentence may be sufficient: I should not have to ask; a good partner should want what I want; if I disappoint you, I will lose you; my pleasure is embarrassing. The learner or client can decide that the sentence does not fit. Their correction should change what we do next.

A psychodynamic question concerns what becomes difficult to experience in another person's presence. A client might become highly articulate about their partner's needs while losing access to their own interest or boredom. The therapist can notice that shift and ask whether it fits. We have not yet established a defensive organization, much less its developmental origin. We have located a moment in which the client's experience may be disappearing from the conversation.

Their correction may be bracing: they know what they want but have stopped saying it because the answer is repeatedly ignored. What appeared to be exclusion from awareness may be exclusion from influence. In another case, the person may discover a prohibition they do

recognize and want to reconsider. The clinical value of a depth formulation depends partly on its ability to distinguish these situations, rather than making every difficulty evidence of a concealed past.

Richard Schwartz's IFS model gives a specific account of multiplicity and the protective intentions of parts. It offers a way to explore a polarization between reaching toward contact and guarding against what contact may require. Clinically, we can be curious about both concerns without appointing either one as the obstacle to a supposedly more authentic erotic self. Parts language is optional; assigning an exile or recovering a memory is not part of this pathway. [24]

Recognition with room for an answer

Perel and Miller's account of sexual candor makes language for preferences, discomfort and pleasure part of erotic authorship. Its contribution here concerns the clinician's willingness to hear an experience that changes the proposal. A person's candor may identify a wanted possibility, a refusal or a real injury. We should not require disclosure as proof of engagement, or interpret an unwelcome answer as a failure of erotic openness. [10]

Consider an invented clinical scene. Tamsin says that Ewan never initiates. Ewan answers that every conversation about their relationship ends with a question about sex. The therapist first asks what initiating would mean to Tamsin. She says that she wants to feel met with interest before she has explained what she needs.

The therapist reflects the wish and asks Ewan what he has heard. He says he understands the loneliness, but that responding affectionately often leaves him worried that a sexual decision has already been made for him. The clinical task changes. We are not simply helping a distant person become more available. We are helping the pair describe the terms under which availability is being sought and understood.

An intervention might make one distinction speakable: can an invitation to spend time together be answered without settling whether sexual contact will follow? The answer may be yes, no, or uncertain. If a limited agreement is freely wanted, its reliability becomes something to observe. If it is not wanted, further disclosure or physical closeness should not be prescribed to demonstrate commitment.

The therapist asks whether they would like to stay with what has just become clearer. Tamsin says she had imagined that any time together would be better than this distance, but now worries that Ewan would only be keeping an appointment. Ewan answers that he does sometimes want company; he becomes less sure when an ordinary evening must also demonstrate desire. The therapist checks the distinction rather than choosing a winner. Can companionship be wanted and meaningful while leaving the sexual question open?

This is where an attachment formulation needs the counterweight of differentiation. Tamsin's wish to be spontaneously wanted deserves recognition, yet Ewan cannot be assigned to produce that experience. Ewan's reluctance deserves recognition, yet it does not settle how he has responded to her or whether he has left every conversation for her to initiate. The task includes the bond, each person's position within it and their actual participation. Attunement and accountability can become more precise together.

Tamsin grows quiet. The therapist asks whether something was missed. She says, 'I hear that I can have an evening with him. I am sad that I still have to wonder whether he wants me.' The sadness should not be translated immediately into a demand. Nor should its tenderness become evidence that sexual attraction has returned between them. There is a loss she can now describe more precisely. Ewan can hear it without being asked to correct it through physical contact.

He says he had understood every mention of loneliness as the beginning of a negotiation he would eventually lose. Hearing this particular sadness feels different, though he remains wary. The therapist asks what made the difference and what would help the conversation remain answerable. Both identify a change in the task: they are describing an experience before deciding what to do. That account is tentative. If pressure returns, the therapist needs to acknowledge it rather than preserve the scene as a therapeutic success.

They choose one short conversation later in the week, with permission for either to stop and a specific time to return if necessary. At the next session, they report that the conversation was easier to begin but ended in familiar defensiveness. The therapist asks where the terms changed, what each did, and whether either felt free to stop. A partial result gives us more information than a global rating of closeness. We can retain a useful beginning while revising the agreement that did not hold.

Stan Tatkin's principle of attending to self and partner together places responsibility in the handling of this encounter. Applied here, secure functioning concerns whether both remain able to speak, whether a pause is honored, and whether the promised return occurs. We can examine those actions even while wishes remain different. The principle does not require agreement about sex or the removal of all disappointment before a conversation ends. [26]

This is experiential work at an ordinary scale. We meet the first reaction, slow enough to describe it, offer a provisional understanding, receive a correction, and choose a manageable next action. The important evidence is what each person actually experiences and does. A tender moment is welcome; it is not a clinical instruction to proceed to a more demanding one.

Fosha and Thoma describe metatherapeutic processing as attending to the experience of therapeutic change itself. Their 2020 paper is a clinical primer illustrated through three cases, rather than a controlled trial of an intimacy intervention. It gives a theoretical basis for pausing with a small difference instead of rushing toward another task. [18]

In this scene, we might explore how it was to hear sadness without an immediate obligation to resolve it, or to speak a limit while remaining in conversation. The experience may include warmth and suspicion together. Consolidation concerns what actually became available and under which conditions. Neither tears nor calm can establish that a new relational expectation has been learned; the pair's later conduct remains consequential.

The meaning of care and the freedom to disappoint

Attachment research makes responsiveness a relevant consideration without making it an erotic guarantee. Birnbaum and colleagues found that perceived partner responsiveness could support desire under the conditions studied. Such results do not establish that greater responsiveness will generate desire in a particular relationship. Nor should care become a transaction in which one partner earns access to the other's body. [8]

The Bowen Center's account of differentiation supports a clinical focus on the capacity to retain a considered position while receiving another person's experience. A person may hear that their partner is deeply sad and remain clear that they do not want sexual contact. The partner may respect that limit and remain clear that a sexually inactive relationship is painful for them. Neither position automatically decides what the relationship should become. This is a systems formulation, not a measure of sexual maturity or a promise that separateness will restore attraction. [19]

An integrative therapist needs to tolerate the tension between these traditions. An attachment emphasis can help us recognize a bid for contact that has become hard to hear. A differentiation emphasis can help us see when a bid has become a requirement that another person feel the right thing. A protective position may need softening; it may also need to become more definite. We decide which question to pursue by examining the encounter and the clients' responses, rather than arranging the theories into an automatic sequence.

Daniel Siegel's account of relational integration links differentiated persons through empathic communication. Its contribution is to keep distinctness within our understanding of connection. Clinically, we can ask whether this conversation increases the capacity to know and respond to one another while each retains a recognizable position. That is a conceptual frame, not evidence of measured neural integration or a substitute for the couple's own judgment about what changed. [25]

Accommodation also needs careful language. Impett and colleagues' work on general relationship sacrifice distinguishes approach and avoidance motives and their associations with well-being. It reminds us to examine how a choice is made, rather than treating all generosity as self-erasure or all agreement as freely chosen. These findings are not a consent instrument, and they do not establish a prescription for sexual participation. [15]

More directly relevant sexual-motivation research by Shoikhedbrod and colleagues distinguishes responsiveness that includes one's own needs from responsiveness organized around neglecting them. Across cross-sectional and longitudinal dyadic studies, autonomous reasons for participation were associated with more favorable satisfaction and desire, while pressure-based motives were associated with poorer outcomes. Self-report, observational design and predominantly White, cisgender, mixed-gender samples limit causal and general claims. This is evidence for examining motivation, not a test that can certify a particular encounter as freely chosen. [17]

Clinically, we can ask what makes a yes available and what would happen if the answer changed. A person can freely value their partner's enjoyment. They may also describe pleasure alongside obligation, or recognize pressure only afterward. Ambivalence needs enough room to be understood. A polished statement of consent in the session cannot substitute for the ability

to decline in daily life. The partner's conduct when disappointed is part of what we need to know.

Our responsibility includes noticing the difference between a person choosing something for shared enjoyment and a person managing the cost of refusal. Retaliation, repeated pressure, threats or fear change what can appropriately be explored together. The WHO sexual-health framework places freedom from coercion and discrimination within the conditions of well-being; joint learning cannot manufacture those conditions by assuming them. [13]

Attention, pleasure, and the limits of extrapolation

Brotto and colleagues randomized 148 women with diagnosed sexual interest/arousal disorder to mindfulness-based cognitive therapy or supportive sex education and therapy. Both structured group conditions showed improvement, with retention of gains reported at follow-up. This is meaningful clinical evidence for the studied interventions and population. It does not validate a short written mindfulness invitation, identify the active ingredient in this pathway, or establish effectiveness across all genders and sexual concerns. [5]

BKL uses a smaller educational invitation: notice whether a proposed form of attention makes the current experience more knowable, more pressured, or less manageable. External attention, practical support and stopping remain available. The instruction is not to attend closely enough that desire must return.

Kleinplatz and colleagues' preliminary group intervention examined the quality of erotic intimacy in 14 heterosexual couples. Improvements in reported satisfaction are of interest, while the small sample and design limits prevent broad causal claims. Its contribution here is a question about the quality of an encounter that people would choose, rather than frequency alone. The answer may include nonparticipation or seeking different help. [7]

Vowels and Mark's mixed-method study identified varied ways people responded to desire differences. Reported strategies were associated with satisfaction but not with sexual desire in the same way; the observational findings do not tell us that a particular strategy caused improvement. BKL should not turn a reported behavior into a recommended practice, especially when it could normalize unwanted sexual activity. [6]

We also need room for the occasions when wanting does become available. Imagine a client describing an encounter that included pleasure, an awkward interruption and laughter. They are moved that they could ask for a change and remain welcome. The therapist can inquire about the experience at its own scale: what did they enjoy, what made the request possible, and what did the partner actually do? We need not make the moment exemplary to take its significance seriously.

There may be shyness in acknowledging enjoyment, especially when the relationship has become organized around what is wrong. A welcome experience can become another thing to monitor or reproduce. We can help the client appreciate it while retaining curiosity about the next encounter. The quality worth carrying forward might be the ability to speak during contact, the freedom to laugh, or a preference that finally had an interested listener. These particulars give pleasure a place within the clinical account, alongside distress and the differences that remain.

The therapist's preferred ending

Sexuality can recruit our own values quickly. We may identify with the person who feels rejected, the person protecting bodily autonomy, the couple preserving a family, or the individual who longs for an un-lived part of life. These identifications can deepen recognition when they remain available to reflection. They can narrow inquiry when they become the destination.

A therapist who values emotional openness may interpret continuing low desire as resistance to vulnerability. A therapist who values self-definition may interpret accommodation as loss of self before discovering what the person freely chooses. A therapist who prizes erotic vitality may regard a contented low-sex relationship as a problem its members do not have.

We should notice how those allegiances shape timing. Do we soften a client's anger sooner when we identify with the partner who feels accused? Do we ask the person with less desire to explain themselves in greater detail? Do we mistake the disappointed partner's articulate sadness for greater emotional maturity? Our own experiences of rejection, obligation, invisibility or being needed can make one account feel more immediately convincing. Supervision is useful when it helps us identify an observable effect on our listening and change it.

A repair might involve saying that we have been treating the partner's effort as a reason the client should feel differently. We can acknowledge that assumption and ask what it has been like to work within it. The client may feel relieved, angry, or doubtful that the shift will last. Our responsibility is to alter the work, including the questions we ask next, without needing reassurance that the acknowledgment was enough.

The counterweight is not neutrality about conduct. We remain clear about consent, coercion, harm, responsibility and the limits of our competence. We also remain capable of asking what would show our favored explanation to be incomplete. Does the person want the proposed outcome? What happens when a limit is respected? What has changed in actual life, and what has not?

There is emotional depth in allowing a client to recognize that something may remain unavailable. We can accompany the grief without hurried reassurance that desire will return. We can also avoid turning a period of uncertainty into evidence that the relationship is over. Staying with what is known, wanted and still open is sometimes the most demanding part of the work.

A remaining difference can unsettle the therapist's sense of usefulness. We may feel we have brought two people to a painful truth without having made it easier to live with. Accompaniment then requires more than patient silence. We help them consider actual choices, obligations, resources, consequences and the time available for deciding. We can recognize the cost of staying and the cost of leaving without making either choice the measure of courage. Grief may need witnesses before it can inform a decision; a decision may also need practical assistance that grief work cannot provide.

In 'Self Portrait,' David Whyte asks about living 'with the consequence of love.' The phrase gives the clinician an existential question alongside the therapeutic one. Loving may enlarge a life

and expose it to a sorrow that cannot be removed by becoming more skillful. The poem's intensity belongs to poetry; we should not convert it into a demand for brave endurance. Its place here is to keep the cost of a real attachment in view when a case formulation starts to sound more resolved than the lives it describes. [29]

Our task then includes bearing witness to an unfinished choice while remaining practically useful. Can we help a person speak about the future they hoped for, appreciate what has actually changed and consider the life available now? The answer may include renewed erotic connection, a different agreement, further clinical help, grief or separation. The depth of the work lies partly in accompanying that discernment without requiring the person to make our preferred theory come true.

Using the pathway alongside therapy

The client companion, *When Closeness Holds More Than One Wish*, begins with lived experience and postpones module directions until the reader has been emotionally and conceptually met. The five modules make specific capacities practicable: distinguishing a wish from a verdict; observing desire and conditions; speaking without pressure; making a freely wanted arrangement; and reviewing what can be built or needs further attention.

The reflective assessment is an optional educational aid. It does not diagnose dysfunction, infer an attachment category, compare partners, determine compatibility, or measure nervous-system regulation. A person's chosen concern can suggest an entry point. Their account and circumstances remain more important than a proposed route.

For clinical use, ask whether the person wants to bring one observation or question to therapy. A workbook should not become an obligation to disclose sexual details or a source of information a partner is entitled to inspect. Independent use, fiction and private rehearsal can preserve learning when joint participation is unwelcome or inappropriate.

Each module retains a full encounter, provisional explanation, correction, experiment, actual-result review and revised account. The results distinguish helped, unchanged, harder, mixed, explanation did not fit and not tried. A skipped exercise is not resistance coded as data. A respected no is not counted as a failed intimacy trial.

The most useful closing question may be simple: what has become more possible to know, say, choose or receive? An answer might concern a more accurate request, a health need finally taken seriously, a reliable agreement, less pressure, or a difference that can now be faced. We consolidate what actually emerged, with enough humility to leave the person's intimate life larger than our explanation.

Continue exploring

Sexuality, Touch, Desire, and Intimacy · pathway and optional reflection

When Closeness Holds More Than One Wish

Sources and reading

Research findings, clinical frameworks and literary perspectives serve different purposes. Their inclusion does not establish the effectiveness of this educational pathway.

[1] Dewitte, M., Carvalho, J., Corona, G., Limoncin, E., Pascoal, P., Reisman, Y., & Štulhofer, A. (2020). Sexual Desire Discrepancy: A Position Statement of the European Society for Sexual Medicine. Clinical consensus / literature synthesis. Source

Position statement is not a BKL trial. Full publisher page intermittently inaccessible; no unverified detailed treatment recommendation imported.

[2] Basson, R. (2001). Human sex-response cycles. Clinical conceptual model. Source

A model developed in a gendered clinical literature is not a universal sequence or permission to override reluctance.

[3] Janssen, E., & Bancroft, J. (2023). The Dual Control Model of Sexual Response: A Scoping Review, 2009–2022. Research review / model. Source

Not an individual diagnostic test; BKL does not identify a person's brain mechanism from a self-report.

[4] Chivers, M. L., Seto, M. C., Lalumière, M. L., Laan, E., & Grimbos, T. (2010). Agreement of self-reported and genital measures of sexual arousal in men and women: A meta-analysis. Meta-analysis. Source

Laboratory aggregate findings do not establish anyone's consent or predict an individual response. Consent principles are normative, not an inference established by this meta-analysis.

[5] Brotto, L. A., Zdaniuk, B., Chivers, M. L., Jabs, F., Grabovac, A., Lalumière, M. L., Weinberg, J., Schonert-Reichl, K. A., & Basson, R. (2021). A randomized trial comparing group mindfulness-based cognitive therapy with group supportive sex education and therapy for the treatment of female sexual interest/arousal disorder. Randomized clinical trial. Source

148 women with diagnosed SIAD; both active conditions improved. No efficacy transfer to BKL, a brief exercise, other populations, or all sexual concerns.

[6] Vowels, L. M., & Mark, K. P. (2020). Strategies for Mitigating Sexual Desire Discrepancy in Relationships. Mixed-method observational study. Source

229 participants, not an experiment demonstrating causal effects. Reported 'have sex anyway' is not adopted as an educational recommendation.

[7] Kleinplatz, P. J., et al. (2018). From Sexual Desire Discrepancies to Desirable Sex: Creating the Optimal Connection. Small intervention study / clinical research. Source

14 heterosexual couples; no randomized control described in inspected abstract. Findings are preliminary and do not establish BKL outcomes.

[8] Birnbaum, G. E., Reis, H. T., Mizrahi, M., Kanat-Maymon, Y., Sass, O., & Granovski-Milner, C. (2016). Intimately connected: The importance of partner responsiveness for experiencing sexual desire. Three empirical studies. Source

Results are conditional and sample-bound; receiving good care never incurs a sexual obligation or guarantees attraction.

[10] Perel, E., & Miller, M. A. (2024). Letters from Esther #61: The Art of Erotic Communication. Clinical / popular essay. Source

Not every criticism conceals a wish; a clear no, actual injury or incompatibility is not to be reformulated away. Original couch scene and exercises not reused.

[12] Iasenza, S. (2016). Transforming Sexual Narratives: From Dysfunction to Discovery. Clinical / psychoanalytic-systemic formulation. Source

Clinical account is not a controlled outcome study. Do not import an inevitable decline of desire, required history disclosure, or assured revival.

[13] World Health Organization (n.d.). Sexual health. Public-health definition / normative framework. Source

Definition is not an individual assessment instrument or outcome standard requiring sex.

[14] American College of Obstetricians and Gynecologists (n.d.). When Sex Is Painful. Clinical patient guidance. Source

No individualized diagnosis, medication recommendation, pelvic exercise or pain treatment provided.

[15] Impett, E. A., Gable, S. L., & Peplau, L. A. (2005). Giving up and giving in: The costs and benefits of daily sacrifice in intimate relationships. Two observational relationship studies. [Source](#)

Dating/college samples and general sacrifice, not a consent test or direct prescription for sexual behavior.

[16] Mark, K. P., & Lasslo, J. A. (2018). Maintaining Sexual Desire in Long-Term Relationships: A Systematic Review and Conceptual Model. Systematic review / conceptual synthesis. [Source](#)

Nonclinical long-term relationships; abstract-level reading. Does not identify an individual cause or establish BKL efficacy.

[17] Shoikhedbrod, A., Rosen, N. O., Corsini-Munt, S., Harasymchuk, C., Impett, E. A., & Muise, A. (2023). Being Responsive and Self-Determined When it Comes to Sex: How and Why Sexual Motivation is Associated with Satisfaction and Desire in Romantic Relationships. Cross-sectional and longitudinal dyadic observational studies. [Source](#)

Self-report and predominantly White, cisgender, mixed-gender samples. No causal, consent-certification or BKL outcome claim. Sample sizes are not used; inspected advance-online paper and later author thesis differ on the longitudinal number.

[18] Fosha, D., & Thoma, N. C. (2020). Metatherapeutic processing supports the emergence of flourishing in psychotherapy. Clinical process / theoretical paper with case illustrations. [Source](#)

Abstract and official bibliography, not the full paper or its transcripts. Three illustrative cases are described in the abstract; no controlled intimacy-treatment effect or BKL efficacy inferred.

[19] Bowen Center for the Study of the Family (n.d.). Differentiation of Self. Family-systems clinical theory. [Source](#)

Not a diagnostic scale, sexual-maturity hierarchy or evidence that differentiation restores desire. Site's fictional family narrative is not reused.

[20] Bowlby, J. (1977). The making and breaking of affectional bonds. I. Aetiology and psychopathology in the light of attachment theory. Foundational attachment theory / clinical synthesis. [Source](#)

Theoretical synthesis; not an individual causal account or an intimacy-intervention trial.

[21] Johnson, S. M., interviewed by T. Ferriss (2021). Iconic Therapist Dr. Sue Johnson — How to Improve Sex and Crack the Code of Love (#529). Founder's clinical account of EFT / original interview. [Source](#)

Clinical interview, not a treatment trial. Broad male/female neurobiological claims and guaranteed restoration of desire are not imported.

[22] Schore, A. N. (2001). Effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. Developmental affect-regulation / interdisciplinary theoretical synthesis. [Source](#)

Infant-focused synthesis; adult application is clinical interpretation. No individual history, exclusive hemisphere localization or neural treatment change inferred.

[23] Damasio, A., & Carvalho, G. B. (2013). The nature of feelings: Evolutionary and neurobiological origins. Neuroscientific review / theoretical synthesis. [Source](#)

Abstract-level reading; bodily experience does not establish its personal meaning, consent or a diagnosis.

[24] IFS Institute / model developed by Richard C. Schwartz (n.d.). The Internal Family Systems Model Outline. Foundational parts-oriented clinical model. [Source](#)

Model-specific constructs, optional language; no anatomical claim, required trauma history, memory recovery or efficacy transfer.

[25] Siegel, D. J. (n.d.). Interpersonal Neurobiology. Interpersonal-neurobiology conceptual framework. [Source](#)

Conceptual synthesis, not a measured neural outcome or a trial of these practices.

[26] Tatkin, S. (2018). Secure-Functioning Essentials: Taking Care of Yourself and Your Partner at the Same Time. PACT clinical framework / original clinical essay. [Source](#)

Clinical principle, not outcome evidence. Fixed timing, universal threat-neurobiology, mandatory eye contact and ending without unhappiness are not adopted.

[29] Whyte, D. (1992). Self Portrait. Poetry / existential reflection. [Source](#)

Selected poem, not full collection. Literary reflection, not an instruction to endure harm or prove courage.