

# CORRESPONDENCE

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## Question No.1: What is the paradoxical frigidity?

The term “paradoxical frigidity” has been defined as “the association of strong sexual impulses with the absence of orgasm (anorgasmia)”, a context in which the question arises about which structure is responsible for this pathological condition, starting from specific vulvo-vaginal cellular receptors and ending with the brain.

It should be noted that, normally, strong sexual impulses increase libido, and the vaginal copulation with a heterosexual partner or local tactile maneuvers, performed mainly on the clitoris (Fig.1) or the Vaginal Area of Hypererotism, H Area, (Fig. 2), which directly affects the tactile receptors of the two areas, as well as those of the labia minora, vestibular bulbs, introitus or erectile tissue of the surrounding areas, determines all stages of the normal sexual intercourse, including orgasm.

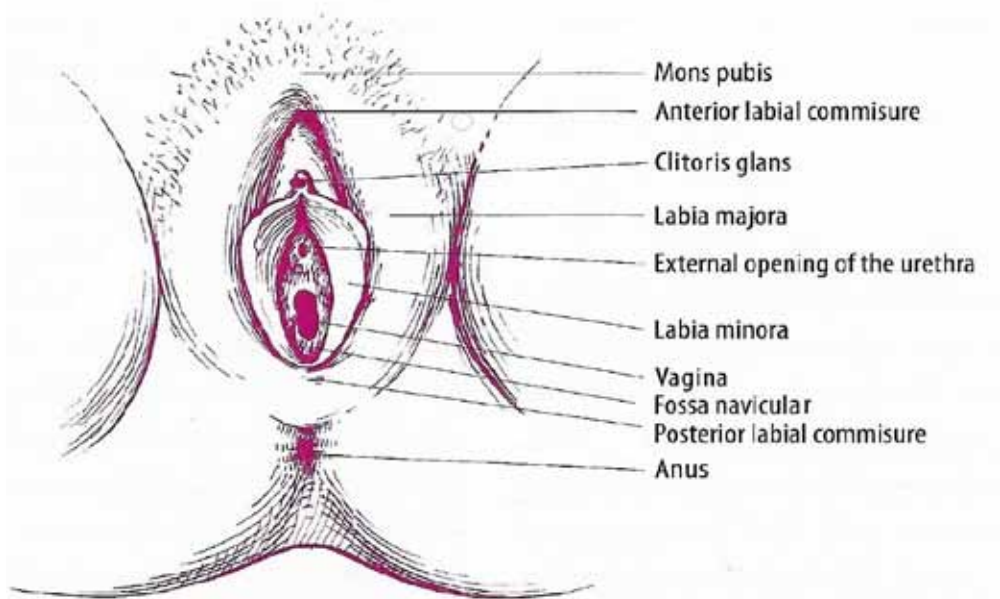


Fig.1 The external Genital Organs (Vulva- image from Treaty of Clinical Sexology)



**Fig.2 The Vaginal Area of Hypereroticism, H Area- image from Treaty of Clinical Sexology)**

### **Regarding anorgasmia:**

Usually, the orgasm does not appear from the first sexual intercourse, but after several months of sexual activity. Thus, it appears gradually, by installing the state of stress relief, of relaxation and peace, while in the frigid woman this state does not occur, maintaining, among other things, the neuro-psychic tension (Vasile Nițescu).

Anorgasmia, according to some authors (Robinson) occurs in 30-40% of sexual contacts, and according to our statistics the incidence is around 3%. Anorgasmia may be total or partial or selective (See Treaty of Clinical Sexology).

Sexual frigidity is the inability to react to psychic (central) and local (vulvo-vaginal organs) sexual impulses in determining orgasm.

In paradoxical frigidity, orgasm does not occur, although the strong sexual impulses triggered by the tactile receptors of the erogenous zones propagate through the nerve fibers to the sacro-lumbar medullary erectile center, then, through ascending medullary pathways, reach the brain, and from here, through the descending medullary pathways could have normally determined the specific erotic changes of the genitals, respectively the periods of sexual intercourse (completed by ejaculation, orgasm and resolution).

Libido, respectively the sexual desire, is triggered by the stimulation of the vulvo-vaginal genitals, but also of the neighboring formations, especially perianal, respectively anal.

Erectile tissue is controlled by parasympathetic fibers, which, through the pelvic nerves of the sacral plexus, reach the external genitalia. The impulses of parasympathetic fibers, through their terminations, release nitric oxide, acetylcholine and VIP (Vasoactive Intestinal Polypeptide), substances that dilate the arteries of vulvo-vaginal tissue (cavernous tissue turgidity), enlarging the vulva, increasing the sensitivity of local cellular receptors.

The information from the sensitive receptors of the erectile tissue no longer reaches the central nervous structures of the brain, the hypothalamus, a context in which the woman's erection and completion of sexual intercourse, the orgasm, no longer occur. Hence the name "paradoxical frigidity".

Also, the parasympathetic impulse no longer determines the appearance of transparent secretion at the vulvo-vaginal introitus, with the disappearance of the sensation of pleasure triggered by peno-vaginal maneuvers, respectively the lack of orgasm, which no longer exists due to psychic (cerebral) factor.

Due to the lack of orgasm, the perineal muscles no longer contract rhythmically through spinal reflexes, as well as the uterus and uterine tubes, due to the lack of oxytocin. Under these conditions, the sperm are no longer aspirated from the vagina, through the external orifice of the cervix, increasing the woman's infertility.

In the absence of orgasm, intense sexual sensations are no longer transmitted to the brain, there is no general muscle tone (Guyton), and the lack of uterine contractility no longer gives the pleasure of sexual intercourse essential to procreation.

According to current authors, "frigidity is a woman's inability to respond to sexual stimuli, a context in which she cannot achieve orgasm" (Patrick C. 2021). In reality, as it has been shown, normal sexual intercourse depends on many factors, with neuroendocrine ones in the first place, and orgasm, when it exists, is the peak of erotic tension.

Anorgasmia may be caused by malformations of the genitals, genital infantilism, perineal ruptures, inflammatory vulvo-vaginal and pelvic diseases, hypothalamic pathology, by altered gonadoliberin secretion (GnRH), by the genital structure misadjustment of the two sexual partners, by vaginal keloid scars, sexual misconduct, obesity, cardiovascular disease, diabetes mellitus, chronic tobacco and alcohol intoxication, anxiety, ovarian failure, chronic pituitary and adrenal pathology, severe hyperthyroidism, acromegaly, schizophrenia, depression, cerebro-medullary neurological lesions, neuro-psychic diseases, lues.

Sometimes, at the classic gynecological examination, no local pathology or functional disorder was found.

Not least, as variants of frigidity were also described: permanent frigidity, facultative frigidity (alternating anorgasmia with obtaining vaginal orgasm, usually with some partners), pseudo-frigidity, incomplete frigidity, frigidity with exaggerated sexual desire, clitoral orgasm obtained only by manual maneuver and vaginal anesthesia (Coja N.), the explanation given being the teleclitoridia hypothesis, respectively the anatomy topography of the clitoris at a distance greater than 3 cm from the orifice of the urinary meatus (Fig.3).



**Fig.3 The distance between the clitoris glans and the urethral meatus: 8 cm and 6 cm - images from Treaty of Clinical sexology**

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**Question No.2:**

**What is the most effective season for accomplishing the act of human procreation?**

The low temperature amplifies the pituitary secretion of TSH, which stimulates the prolactin secretion, which is responsible for reducing dopamine synthesis (Treaty of Clinical Sexology page 104), the final result being a decrease in the intensity of sexual activity.

On the other hand, heat acts stimulatively on gonadal function, increasing libido and sexual activity, including fertility. See Journal of Clinical Sexology – Vol.2, Joint Number No.3 & 4: July – December 2019

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2.Journal of Clinical Sexology – Vol.2, Joint Number No.3 & 4: July – December 2019