British Journal of Bio-Medical Research Vol.03, Issue 05, Pg.1068 - 1079, September - October 2019

Available Online at http://www.bjbmr.org

BRITISH JOURNAL OF BIO-MEDICAL RESEARCH

Cross Ref DOI: https://doi.org/10.24942/bjbmr.2019.573 Volume 03, Issue 05, Sept - October 2019

ISSN:2456-9739

Research Article

Association Between Paraphilic And Obsessive-Compulsive Symptoms In Women

Arnaldo Barbieri Filho[1], Carmita Helena Najjar Abdo[2]

[1]Department of Psychiatry, Medical School, University of São Paulo. São Paulo, Brazil
Av. Braz Olaia Acosta 727 sala 205. Ribeirão Preto-S.P. Brazil. Zip Code: 14026-040.

[2]Department of Psychiatry, Medical School, University of São Paulo, São Paulo, Brazil.
Rua Pascal, 181, Apto 41. São Paulo-S.P. Brazil. Zip Code: 04616 001.

ARTICLE INFO

Article History:
Received on 17th Sept 2019
Peer Reviewed on 29th Sept 2019
Revised on 14th October 2019
Published on 29th October 2019

Keywords:
Paraphilic Disorders, Obsessive-Compulsive Disorder, Compulsive Personality Disorder, Women

ABSTRACT

Objective: DSM-5 differentiated paraphilias from paraphilic disorders (PD), making the boundaries among paraphilic fantasies, paraphilias and PD more precise. The aim of this study was to evaluate the association between paraphilic and obsessive symptoms using DSM-5 criteria for paraphilias and PD.

Methods: One hundred and ninety female medical students were evaluated using anonymous / self-reporting questionnaires. For symptoms of Obsessive-Compulsive Disorder (OCD), the Yale-Brown scale was used. For symptoms of Obsessive-Compulsive Personality Disorder (OCPD) and paraphilias, scales based on DSM-5 were used.

Results: The most paraphilic fantasies were: Voyeurism (30.2%) and Fetishism (25.4%). The most frequent paraphilias were: Voyeurism (9%) and Fetishism (8.5%). In relation to PD, the most frequent were: Voyeuristic (6.9%), Masochistic (3.7%) and Frotteuristic (3.7%). Subclinical OCD was statistically significant when associated with paraphilic fantasies, while OCD was associated with paraphilia and PD. OCPD was statistically significant when associated with fantasies, paraphilia and PD.

Conclusion: The intensity of OCD symptoms was directly related to the intensity of the paraphilic symptoms and the OCPD was associated with paraphilic fantasies, paraphilias and PD. The results point to trends of association among these clinical conditions, which recommends further research in this direction.

Corresponding Author: *Arnaldo Barbieri Filho, Av. Braz Olaia Acosta, 727/205, Phone: 55-16-3913-4106, Ribeirão Preto-SP. Brazil. Zip Code: 14.026-040.*

INTRODUCTION

The Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) provided a formal distinction between paraphilias and paraphilic disorders (PD). [1] The prevalence of PD is still unknown and is only estimated. [1,2] As most paraphilias are liable to prosecution or cause embarassment, the bearer has difficulty revealing them. [3] Not infrequently, the paraphilic can present multiple paraphilias. [1] Some studies show a higher prevalence of PD in males. [4-7] However, estimates in women seem to be minimized as they can sublimate their pregenital impulses. Thus, they are less likely to externalize their paraphilic behavior. [8-11] The etiology of PD is still little known, but many hypotheses have been formulated. [8] Psychological, environmental, organic, and even physical aspects of individuals have been studied. [12-27]

The prevalence of Obsessive-Compulsive Disorder (OCD) reaches fewer than 2% throughout life, but there are methodological controversies. [28,29] The etiology of OCD is also not known; however, multiple theories have been proposed: genetic influences, [30,31] cerebral abnormalities, [32] psychological and environmental factors. [33,34] The prevalence of OCPD is estimated at 2.1 to 7.9% of the general population and is twice as high in men. [1] Its etiology is supported by psychodynamic, genetic and morphological alterations. [35-38]

The literature reports that Paraphilias are sometimes identified as belonging to the spectrum of OCD. [39-41] Others also consider OCD and paraphilias to be part of the impulsive-compulsive spectrum.[26,42] Common organic factors have been described: response to selective serotonin reuptake inhibitors (SSRIs), [8,43] association with Tourette's syndrome, [44] study of various organic and psychological aspects common to OCD and paraphilia. [45]

The correlation between OCPD and paraphilia has also been investigated. Bogaerts, Daalder, Vanheule, Desmet and Leeuw (2008) [46] showed that among the personality disorders studied, the only one that was significantly associated with the paraphilic abuse of children was the obsessive-compulsive. Hebbar (2014) [47] studied a case of OCD associated with OCPD and paraphilias. Other authors, such as Chan and Beauregard (2016), [48] found an association between paraphilias and several personality disorders, among them OCPD. However, studies on the association between OCPD and paraphilias are rarer than those associated with OCD. The association between obsessive symptoms and paraphilias is a topic that has been discussed since the early days of psychiatry, but without conclusion. [40] Therefore, the objective of this study was to investigate this association.

MATERIALS AND METHODS

Ethics

This study was approved by the Research Ethics Committee of the Medical School. All the subjects formalized their participation by signing the Free and Informed Consent Terms of the Medical School.

Participants

Three hundred female medical students from a private Brazilian university were recruited. All those over 18 who accepted to participate were included: 190 accepted to respond to the questionnaires in October 2016. Of the 190, none were excluded.

Instruments

All the questionnaires were self-reporting in order to preserve the anonymity of the participants and to make the answers more reliable. In the questionnaires that discuss paraphilias and PD, items 1, 2 and 3 refer to the main paraphilias (exhibitionism, voyeurism, fetishism, frotteurism, pedophilia, sexual masochism, sexual sadism and transvestism) while items 4 and 5 refer to the PD. These instruments were elaborated according to the DSM-5 criteria in the Portuguese version for paraphilia and PD. [1,49] Therefore, criterion A of DSM-5 is divided into sub items 1, 2 and 3 and criterion B into sub-items 4 and 5, respectively. If the participant provided positive answers for criterion A (items 1, 2 and 3) she was considered as having the respective

paraphilia. That is, if the answers were "a few times", "sometimes", "often" or "always" for item 1, "yes" for item 2 and "a", "b" or "c" for item 3. In the case of a positive response also to items 4 or 5 (criterion B), the participant was considered to be the bearer of the respective PD, which corresponds to responding "a few times", "sometimes", "often" or "always" to items 4 or 5. On the other hand, the participant was considered to be the bearer of only her paraphilic fantasy if she answered "few times", "sometimes", "often" or "always" to item 1, but has not met the criteria for paraphilias.

The presence of life-long OCPD was investigated through a questionnaire developed according to the Portuguese version of DSM-5. [49] The instrument was elaborated with eight questions whose answers could be "yes" or "no". If four or more responses were "yes," the diagnosis of OCPD was confirmed, as defined by DSM-5.

Symptoms of lifelong OCD were assessed using the Portuguese version of the Yale-Brown scale (Y-BOCS). [50] A brief explanation of the meanings of obsessions and compulsions was provided by the researcher to the participants prior to the application of the scale. [51,52] The result is obtained by the following total scores: equal to or greater than 16 characterizes OCD; between 8 and 15 means subclinical OCD; less than 8 identifies minimal or absence of symptoms.

The evaluations of the presence of paraphilias / PD and OCPD were developed, according to the DSM-5 criteria, due to the absence of valid scales in Portuguese. Questionnaires were developed (paraphilia / PD and OCPD) adapted to a simplified language in order to improve participants' understanding. A self-reporting questionnaire was also developed for socio-cultural evaluation.

Procedures

Group meetings were organized with the students in order to present the project and clarify possible doubts, preparing them to fill out the questionnaires in a self-reporting manner. All precautions were taken so that no participants had their answers identified. Therefore, for ethical reasons, confidentiality has been prioritized, maintaining privacy and more reliable answers regarding sexual fantasies. Even the researcher would not be able to identify any of the respondents' answers.

Statistical analysis

The sample size calculation was based on the sampling technique for a finite population size (N = 300), adopting a 95% confidence interval and 5% error margin as parameters. Thus, the minimum N would be 169. Three hundred students were recruited, and of these, 190 accepted to answer the questionnaires. The data collected was represented by the descriptive analysis of the sample, containing information such as absolute and relative frequency. The tests of association of OCD and/or OCPD were conducted with each of the paraphilias studied, as well as with PD and paraphilic fantasies. The results were compiled into tables containing the frequency and percentage of each clinical condition (OCD, OCPD, each of the paraphilias, each of the PD and each of the paraphilic fantasies). As the main objective of the present study was to verify the possibility of correlation between OCD and paraphilias, OCD and PD, OCPD and paraphilias, OCPD and PD, these variables were considered as binary ("Yes" or "No"). In order to test the hypothesis of interest, the Fisher exact test or the Chi-square test was applied. In addition to this, simple and multiple logistic regression models were adjusted to determine the factors that characterize a group of individuals with the event of interest relative to those who do not present them. For the statistical analysis, a level of significance of 5% was established and the software Statistical Package for Social Sciences (SPSS 18) was used.

RESULTS AND DISCUSSION

Table 1 shows the sociodemographic data of the 190 students evaluated. The group consisted of mostly healthy, unmarried, caucasian women with incomplete higher education, catholics, heterosexuals and a good socio-economic level. The youngest was 18 years old and the oldest was 32. The median age was 22, the average 22.13 and 3.7% omitted this information.

Table 1: Socio-demographic data (total N = 190).

Variable	Categories	n (%) (n=190)
Race	Caucasian	172 (90.5 %)
	Indian (South American)	11 (5.8 %)
	Asian (Japanese, Chinese and others)	3 (1.6 %)
	Omitted	4 (2.1 %)
	Total	**186 (97.9 %)**
Socioeconomic status	Average financial conditions	57 (30 %)
	Good financial conditions	128 (67.4 %)
	Omitted	5 (2.6 %)
	Total	**185 (97.4 %)**
Physical Health	Good	163 (85.8 %)
	Minor issues	23 (12.1 %)
	Omitted	4 (2.1 %)
	Total	**186 (97.9 %)**
Schooling	Complete primary education	1 (0.5 %)
	Incomplete secondary education	2 (1.1 %)
	Complete secondary education	24 (12.6 %)
	Incomplete higher education	138 (72.6 %)
	Complete higher education	19 (10 %)
	Omitted	6 (3.2 %)
	Total	**184 (96.8 %)**
Marital status	Single	177 (93.2 %)
	Stable union	6 (3.2 %)
	Married	2 (1.1 %)
	Omitted	5 (2.6 %)
	Total	**185 (97.4 %)**
Sexual orientation	Heterosexual	179 (94.2 %)
	Homosexual	4 (2.1 %)
	Bisexual	2 (1.1 %)
	Omitted	5 (2.6 %)
	Total	**185 (97.4 %)**
Religion	Other	6 (3.2 %)
	Not present	14 (7.4 %)
	None and catholic	1 (0.5 %)
	Catholic	123 (64.7 %)
	Catholic and Spiritualist	2 (1.1 %)
	Christian	21 (11.1 %)
	Spiritualist	23 (12.1 %)
	Total	**190 (100 %)**

The most observed paraphilic fantasies were: at least one paraphilia (53.2%), voyeurism (30.2%) and fetishism (25.4%). The most commonly reported paraphilias were at least one paraphilia (24.5%), voyeurism (9%) and fetishism (8.5%), while the most common PD were at least one PD (13.8%), voyeuristic (6.9%), masochism 3.7%) and frotteuristic (3.7%). The frequency of paraphilic fantasies, paraphilias, PD, subclinical OCD, OCD and OCPD are presented in Table 2.

Table 2: *Frequencies of each clinical condition (total N = 190). Those participants who provided either incompatible or no answers to a certain diagnosis were excluded from the corresponding clinical condition, Among the 189 who answered about Fetishism, 48 presented fantasies, but only 3 presented PD.*

Categories	Fantasy		Paraphilia		Paraphilic Disorder (PD)		Results		
	Total	n (%)	Total	n (%)	Total	n (%)	Category	Total	n (%)
Voyeurism	179	54 (30.2 %)	189	17 (9.0 %)	189	13 (6.9 %)	OCD	183	24 (13.1 %)
Exhibitionism	186	30 (16.1 %)	188	7 (3.7 %)	190	5 (2.6 %)	Sub-clinical OCD	180	45 (25.0 %)
Frotteurism	188	33 (17.6 %)	190	12 (6.3 %)	190	7 (3.7 %)	OCPD	190	43 (22.6 %)
Masochism	190	26 (13.7 %)	190	12 (6.3 %)	189	7 (3.7 %)			
Sadism	189	11 (5.8 %)	189	3 (1.6 %)	190	2 (1.1 %)			
Pedophilia	190	3 (1.6 %)	190	2 (1.1 %)	190	2 (1.1 %)			
Fetishism	189	48 (25.4 %)	189	16 (8.5 %)	190	3 (1.6 %)			
Transvestism	190	1 (0.5 %)	190	1 (0.5 %)	190	0 (0.0 %)			
At least one	186	99 (53.2 %)	188	46 (24.5 %)	188	26 (13.8 %)			

OCD had p≤0.05 when associated with paraphilia and PD (voyeurism, exhibitionism, frotteurism, and at least one), sadism paraphilia and fetishistic PD. Subclinical OCD had p≤0.05, when associated with fantasies (exhibitionism, fetishism and at least one) and fetishism paraphilia. OCPD had p≤0.05 when associated with fantasies (voyeurism, fetishism and at least one), paraphilias (exhibitionism, fetishism and at least one) and PD (exhibitionist, masochism, fetishist and at least one) (Table 3).

Table 3: *Association between paraphilic conditions and OCD, sub-clinical OCD, and OCPD. Among the 46 female students that presented at least one of the paraphilias, 13 had OCD and 54.2 % of those with OCD presented at least one paraphilia.*

Variable	OCD		P value
	No	Yes	
Voyeuristic paraphilia	11 (7 %)	6 (25 %)	**0.013**
Voyeuristic PD	8 (5.1 %)	5 (20.8 %)	**0.016**
Exhibitionistic paraphilia	4 (2.5 %)	3 (12.5 %)	**0.05**
Exhibitionistic PD	2 (1.3 %)	3 (12.5 %)	**0.017**
Frotteuristic paraphilia	7 (4.4 %)	5 (20.8 %)	**0.011**
Frotteuristic PD	3 (1.9 %)	4 (16.7 %)	**0.006**
Sadistic paraphilia	1 (0.6 %)	2 (8.3 %)	**0.046**
Fetishistic PD	1 (0.6 %)	2 (8.3 %)	**0.046**
At least one paraphilia	33 (21 %)	13 (54.2 %)	**0.002**
At least one PD	17 (10.8 %)	9 (37.5 %)	**0.002**
	Sub-clinical OCD		
	No	**Yes**	
Exhibitionistic fantasy	17 (12.7 %)	13 (31 %)	**0.012**
Fetishistic fantasy	29 (21.6 %)	18 (40 %)	**0.026**
Fetishistic paraphilia	8 (6 %)	8 (17.8 %)	**0.03**
At least one paraphilic fantasy	62 (47 %)	32 (72.7 %)	**0.005**
	OCPD		
	No	**Yes**	
Voyeuristic fantasy	35 (25.4 %)	19 (46.3 %)	**0.018**
Exhibitionistic paraphilia	1 (0.7 %)	6 (14.3 %)	**0.001**
Exhibitionistic PD	1 (0.7 %)	4 (9.3 %)	**0.01**
Sexual masochistic PD	3 (2 %)	4 (9.5 %)	**0.045**
Fetishistic fantasy	31 (21.2 %)	17 (39.5 %)	**0.026**

Fetishistic paraphilia	7 (4.8 %)	9 (20.9 %)	**0.002**
Fetishistic PD	0 (0 %)	3 (7 %)	**0.011**
At least one paraphilic fantasy	68 (47.6 %)	31 (72.1 %)	**0.005**
At least one paraphilia	27 (18.6 %)	19 (44.2 %)	**0.001**
At least one PD	14 (9.6 %)	12 (28.6 %)	**0.004**

The logistic regression model showed that in relation to the fantasies, none were sufficient in explaining OCD, only the voyeurism fantasy was significant in explaining OCPD (OR = 2.154, but p = 0.05) and only the exhibitionism fantasy was significant in explaining sub-clinical OCD (OR = 3.296). The paraphilias that were significant in explaining OCD were "at least one paraphilia" (OR = 6.448) and sadism paraphilia (OR = 54,759, however with a large confidence interval due to the small number of students with OCD and sadism). The significant paraphilias in explaining OCPD were: exhibitionism (OR = 15.221) and fetishism (OR = 4.097). No paraphilia was enough in explaining sub-clinical OCD. In relation to PD: the frotteristic PD was important in explaining OCD (OR = 14,109); the exhibitionist PD (OR = 10,713) and sexual masochism (OR = 5,423) were significant in explaining OCPD. No PD was significant in explaining sub-clinical OCD (Table 4).

Table 4: Logistic regression model

Result	Variable	Estimate	Standard error	p value	*Odds ratio* (OR)	CI (95 %) for OR	
						Lower	Upper
OCDC	Voyeuristic fantasy (Yes)	0.767	0.392	**0.05**	2.154	1	4.644
	Exhibitionistic paraphilia (Yes)	2.723	1.124	0.015	15.221	1.682	137.759
	Fetishistic paraphilia(Yes)	1.41	0.574	0.014	4.097	1.329	12.63
	Exhibitionistic PD (Yes)	2.371	1.167	0.042	10.713	1.087	105.549
	Sexual Masochistic PD (Yes)	1.691	0.799	0.034	5.423	1.133	25.962
Sub-clinical OCD	Exhibitionistic fantasy (Yes)	1.193	0.442	0.007	3.296	1.386	7.837
OCD	Sadism paraphilia (Yes)	4.003	1.761	0.023	54.759	1.734	1729.164
	At least one paraphilia (Yes)	1.864	0.559	0.001	6.448	2.157	19.274
	Frotteuristic PD (Yes)	2.647	0.837	0.002	14.109	2.734	72.803

In this study, paraphilic fantasies were differentiated from paraphilias and PD according to DSM-5 criteria in a female population, which was not found in studies prior to the fifth DSM version.

Paraphilic individuals with exhibitionistic, frotteuristic, voyeuristic, and pedophilic behavior are considered PD because, by definition, they are consummate impulses with someone who has not consented or is unable to consent. In contrast, sadistic behavior can be performed with consenting individuals and therefore is not classified as PD, if there is consent and there is no suffering. [1] The "DSM-5 Criterion A" for Pedophilic Disorder states: "Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger) ". [1] Therefore, the word "behavior" of this "criterion A" could have been suppressed in the exhibitionist, frotteurist, voyeurist, and pedophilic scenario, as these behaviors are always PD.

Pedophilia and transvestism were scarce in this study, and pedophilic clinical conditions were more frequent in other studies). [53-55] As pedophilia is a crime, the application of face-to-

face questionnaires could inhibit the trustworthiness of the responses. Another hypothesis would be that these clinical conditions are even rarer in women, at least with these sociodemographic characteristics. Another possibility is the fact that women sublimate their pedophilic impulses, resulting in less frequency. [8,10,56]

Similar to the studies by Frías et al. (2017), [9] masochism PD was also very frequent, just behind the voyeuristic PD. The masochism paraphilia was more recurrent than the exhibitionism paraphilia, contrary to what happened with the respective fantasies. This suggests that exhibitionistic fantasies are more common than masochistic ones, but not as intense and persistent for at least six months as the latter.

Masochism was more frequent than sadism in the three intensities, according to Levitt, Moser and Jamison (1994) [57] in the female population. Some authors report much higher frequencies of sadomasochism, at least in relation to fantasies. All these studies used an online sample, rather than face-to-face respondents, such as this study, [5,58] which may explain the lower frequency observed here.

In this study, fetishism was the second fantasy and the second most frequent paraphilia. However, there was a low rate of PD, which suggests that having fetishistic fantasies does not usually lead to suffering. The frequency of fetishistic fantasy corroborated the findings of Scorolli et al. (2007). [59] Oliveira Júnior and Abdo (2010) [6] also found the highest frequencies in fetishism and voyeurism.The comparison of this research with other data in the literature was made difficult because the other studies did not perform the distinction among fantasy, paraphilia and PD, as the new DSM-5 criteria was only published more recently.In relation to OCD, a frequency of 13.1-percent was observed, which is much higher than that described in the literature (2%). As the answers to this research were self-reporting, it is worth remembering that in the Yale-Brown scale, some authors found a valid convergence between the face-to-face interview (non self-reporting) and the self-reporting interview, with a higher score for the latter interview.[60] The frequency of OCPD was found to be 22.6%, while the estimated value for the general population is between 2.1 and 7.9% (APA, 2013). However, higher frequencies are referred to in self-reporting surveys. [61]

Some authors have described associations between OCD and paraphlias. [8,18,26,39-41,47,62-65] However, such research was based on case studies, literature reviews, theories, letters to the editor, and even non-paraphilic compulsive sexual behaviors.Paraphilic fantasies and obsessions are intrusive thoughts and OCD rituals are similar to compulsive masturbation or other paraphilic sexual behaviors. Both OCD and paraphilias have comorbidity with the spectrum of anxiety and with some degree of depression. [43] Abdo et al. (2001) [18] studied two cases of association between OCD and Transvestism. In paraphilias, intrusive thoughts (fantasies) are pleasurable, while in OCD they are unpleasant.The findings of the present study confirm that subclinical OCD is more associated with paraphilic fantasies, whereas OCD is associated with paraphilia and PD. Therefore, the more intense the paraphilic symptoms, the greater the possibility of OCD symptoms.Southern (2008) [68] demonstrated an association between compulsive virtual sex and sexual disorders, such as courtship disorders. In the present study, the paraphilic symptoms of courtship (voyeurism, exhibitionism and frotteurism), fetishism and sadism were those associated with OCD, and the differential of this research is the division of the cadres into paraphilic fantasies, paraphilias and PD (according to the criteria of DSM-5) and their association with OCD, demonstrating that the greater the intensity of paraphilic symptoms, the greater the intensity of OCD symptoms.As for the association between OCPD and paraphilias, the studies are much scarcer than those with OCD. [46-48,67] In the present sample, OCPD was associated with fantasies (voyeurism, fetishism and at least one paraphilic fantasy), paraphilias (exhibitionism,

masochism, fetishism and at least one paraphilia) and PD (exhibitionist, sexual masochism, fetishist and at least one PD). Therefore, although several studies (including this research) show an association of OCPD with cases of paraphilias, no substantial results were obtained to conclude that there is an association of OCPD with one or other paraphilic condition. Hence, the need for a standardized methodology for both cadres.The development of PD questionnaires based on the DSM-5 criteria helps to define to what extent the individual only has a paraphilic fantasy or a paraphilia and when the PD really begins.

It is important that the instruments (for PD, OCD and OCPD) are self-reporting and validated. Studies with larger samples may also be useful, as well as with different sociodemographic characteristics. Neuroimaging assessments may also demonstrate common pathophysiological mechanisms. Regarding the mode of application, studies can compare online/telephone interviews with face-to-face interviews. Joyal and Carpentier (2017) [11] found a higher frequency of paraphilias in online interviews than by telephone. Associations of the various types of OCD (aggressive, sexual, contamination, etc.) with symptoms of paraphilias could be investigated. For example, a sadist who causes symmetrical lesions and counts the number of lashes he has inflicted on a masochist, would his condition be associated with symmetry or counting OCD?Another important point is to differentiate when PD is characterized by consumating the act with an individual who did not consent or is unable to consent (item 4), or when the individual presents suffering or psychosocial problems due to the paraphillia in question (item 5).If there is an association between paraphilic and obsessive symptoms, it is important to investigate paraphilias in obsessives and vice versa. The use of SSRIs can treat OCD and a possible associated PD, as serotonergic action inhibits libido. [26] Therefore, the earlier the diagnosis of both cases, the earlier the appropriate treatment can be established.

CONCLUSION

The presence of PD and paraphilia in female medical students was frequently reported on a self-reporting scale. The more frequent the paraphilic symptoms, the more frequent the symptoms of OCD. Similarly, the more frequent the paraphilic symptoms, the more frequent the symptoms of OCPD.

REFERENCES

1. American Psychiatric Association (APA). Diagnostic and statistical manual of mental disorders-DSM-5. Arlignton; American Psychiatric Association: 2013.
2. Oliveira Júnior WM. Impacto da psicoterapia sobre a escolha dos parceiros sexuais de parafílicos em tratamento medicamentoso. Tese (Doutorado). Faculdade de Medicina da Universidade de São Paulo. São Paulo, 2015.
3. Sharma BR. Disorders of sexual preference and medicolegal issues thereof. Am J Forensic Med Pathol. 2003;24(3):277-282.
4. Dawson SJ, Bannerman BA, Lalumière ML. Paraphilic interests: an examination of sex differences in a nonclinical sample. Sex Abuse, 2016;28(1):20-45.
5. Holvoet L, Huys W, Coppens V, Seeuws J, Goethals K, Morrens M. Fifty shades of Belgian gray: the prevalence of BDSM-related fantasies and activities in the general population. J Sex Med, 2017;14(9):1152-1159.
6. Oliveira Júnior WM1, Abdo CH. Unconventional sexual behaviors and their associations with physical mental and sexual health parameters: a study in 18 large Brazilian cities. Braz J Psychiatry, 2010;32(3):264-274.
7. Wéry A, Vogelaere K, Challet-Bouju G, Poudat FX, Caillon J, Lever D, et al. Characteristics of self-identified sexual addicts in a behavioral addiction outpatient clinic. J Behav Addict, 2016;5(4):623-630.
8. Abdo CHN. Sexualidade humana e seus transtornos. (4th ed). São Paulo; Casa Leitura Médica: 2012.

9. Frías Á, González L, Palma C, Farriols N. Is There a Relationship Between Borderline Personality Disorder and Sexual Masochism in Women? Arch Sex Behav, 2017;46(3):747-754.
10. Gillespie WH. The general theory of sexual perversion. Int J Psychoanal, 1956;37(4-5):396-403.
11. Joyal CC, Carpentier J. The prevalence of paraphilic interests and behaviors in the general population: a provincial survey. J Sex Res, 2017;54(2):161-171.
12. Antinucci G. Beating phantasies: Mourned and unmourned. Int J Psychoanal, 2016;97(3):615-639.
13. Bailey JM, Bernhard PA, Hsu KJ. An Internet study of men sexually attracted to children: Correlates of sexual offending against children. J Abnorm Psychol, 2016;125(7):989-1000.
14. Baltieri DA, Andrade AG. Comparing serial and non-serial sexual offenders: alcohol and street drug consumption, impulsiveness and history of sexual abuse. Rev Bras Psiquiatr, 2008;30(1):25-31.
15. Berryessa CM. Potential implications of research on genetic or heritable contributions to pedophilia for the objectives of criminal law. Recent Adv DNA Gene Seq, 2014;8(2):65-77.
16. Clemente J, Pillon SC, Mari JJ, da Silva CJ, Santana PRH, Diehl A. Paraphilic thoughts, behaviors and sex addiction in a sample of persons who use drugs: a cross-sectional study. J Addict Med. 2017;11(5):377-385.
17. Fazio RL, Dyshniku F, Lykins AD, Cantor JM. Leg length versus torso length in pedophilia: further evidence of atypical physical development early in life. Sex Abuse, 2017;29(5):500-514.
18. Fisher AD, Castellini G, Casale H, Fanni E, Bandini E, Campone B et al. Hypersexuality, Paraphilic Behaviors, and Gender Dysphoria in Individuals with Klinefelter's Syndrome. J Sex Med, 2015;12(12):2413-2424.
19. Jakubczyk A, Krasowska A, Bugaj M, Kopera M, Klimkiewicz A, Łoczewska A et al. Paraphilic sexual offenders do not differ from control subjects with respect to dopamine- and serotonin-related genetic polymorphisms. J Sex Med, 2017;14(1):125-133.
20. Kamping S, Andoh J, Bomba IC, Diers M, Diesch E, Flor H. Contextual modulation of pain in masochists: involvement of the parietal operculum and insula. Pain, 2016;157(2):445-455.
21. Klein M. El psicanalisis de ninõs. Buenos Aires; Hormé: 1964.
22. Knafo D. For the love of death: somnophilic and necrophilic acts and fantasies. J Am Psychoanal Assoc, 2015;63(5):857-86.
23. Łucka I, Dziemian, A. Pedophilia--a review of literature, casuistics, doubts. Psychiatr Pol, 2014;48(1):121-134.
24. Poeppl TB, Eickhoff SB, Fox PT, Laird AR, Rupprecht R, Langguth B et al. Connectivity and functional profiling of abnormal brain structures in pedophilia. Hum Brain Mapp, 2015;36(6):2374-86.
25. Reininghaus E, Lackner N. Relationship satisfaction and sexuality in Huntington's disease. Handb Clin Neurol, 2015;130:325-34.
26. Stahl SM. Stahl's essential psychopharmacology: neuroscientific basis and practical applications. (4ª ed). New York; Cambridge University Press: 2013.
27. von Franqué F, Briken P, Klein V. Paraphilic Disorders and Sexual variations. In: Kirana, P. S., Tripodi, F., Reisman, Y. & Porst, H. (eds.). The EFS and ESSM syllabus of clinical sexology. (1ª ed.). Amsterdam; Medix: 2013, pp. 1128-1143.
28. Fontenelle LF, Mendlowicz MV, Versiani M. The descriptive epidemiology of obsessive-compulsive disorder. Prog Neuropsychopharmacol Biol Psychiatry, 2006;30(3):327-337.
29. Torres AR, Lima MC. Epidemiology of obsessive-compulsive disorder: a review. Rev Bras Psiquiatr, 2005;27(3):237-242.
30. Shavitt RG, Valério C, Fossaluza V, da Silva EM, Cordeiro Q, Diniz JB et al. The impact of trauma and post-traumatic stress

disorder on the treatment response of patients with obsessive-compulsive disorder. Eur Arch Psychiatry Clin Neurosci, 2010;260(2):91-99.
31. Shavitt RG, Torres AR, Hounie AG. Transtorno Obsessivo-compulsivo. In: Miguel, E. C., Gentil, V, Gattaz, W. F. (eds.). Clínica Psiquiátrica. Barueri; Editora Manole Ltda: 2011, pp. 848-862.
32. Lopes AC, Greenberg BD, Norén G, Canteras MM, Busatto GF, de Mathis ME et al. Treatment of resistant obsessive-compulsive disorder with ventral capsular/ventral striatal gamma capsulotomy: a pilot prospective study. J Neuropsychiatry Clin Neurosci, 2009;21(4):381-392.
33. Cordioli AV. Vencendo o transtorno obsessivo-compulsivo. Porto Alegre; Artmed, 2008.
34. Miguel EC, Leckman JF, Rauch S, do Rosario-Campos MC, Hounie AG, Mercadante MT et al. Obsessive-compulsive disorder phenotypes: implications for genetic studies. Molecular Psychiatry, Mol Psychiatry, 2005;10(3):258-75.
35. D'Andrea FF. Desenvolvimento da personalidade. (6ª Ed). São Paulo; Difel: 1984.
36. Erickson EH. Childhood and society. (2ª ed.). New York; Norton: 1963.
37. Gunderson JG, Phillips KA. Transtornos de Personalidade. In: Kaplan HL, Sadock BJ. Tratado de psiquiatria. Vol. 2. Tradução de Dayse Batista, Ireneo CS Ortiz, Maria Rita Hofmeister, Sandra de Camargo Costa. 6ª ed. Porto Alegre; Editora Artes Médicas Sul Ltda: 1999, pp.1542-1582.
38. Tavares H, Ferraz, R. B. Transtornos de Personalidade. In: Miguel, E. C., Gentil, V. & Gattaz, W. F. (eds.). Clínica Psiquiátrica - FMUSP - Miguel. (1ª Ed). Barueri; Editora Manole Ltda: 2011, pp. 1051-1064.
39. Abdo CH, Hounie A, de Tubino Scanavino M, Miguel EC. OCD and transvestism: is there a relationship? Acta Psychiatr Scand, 2001 Jun;103(6):471-473; discussion 473.
40. Steinberg H. Introduction and transformation of the psychiatric term "anancasm": From Gyula (Julius) Donáth via Kurt Schneider to ICD-10. Nervenarzt, 2014;85(9):1171-1174.
41. Anupama M, Gangadhar KH, Shetty VB, Dip PB. Transvestism as a symptom: a case series. Indian J Psychol Med, 2016;38(1):78-80.
42. Raymond NC, Coleman E, Miner MH. Psychiatric comorbidity and compulsive/impulsive traits in compulsive sexual behavior. Compr Psychiatry, 2003;44(5):370-380.
43. Bradford JM. The neurobiology, neuropharmacology, and pharmacological treatment of the paraphilias and compulsive sexual behaviour. Can J Psychiatry, 2001;46(1):26-34.
44. Comings DE. Tourette syndrome: a hereditary neuropsychiatric spectrum disorder. Ann Clin Psychiatry, 1994;6(4):235-247.
45. Krueger RB, Kaplan MS. The paraphilic and hypersexual disorders: an overview. J Psychiatr Pract, 2001;7(6):391-403.
46. Bogaerts S, Daalder A, Vanheule S, Desmet M, Leeuw F. Personality disorders in a sample of paraphilic and nonparaphilic child molesters: a comparative study. Int J Offender Ther Comp Criminol, 2008;52(1):21-30.
47. Hebbar S. Doing Psychiatry Right: A case of severe avoidant personality disorder with obsessive-compulsive personality disorder, obsessive-compulsive disorder, intermittent explosive disorder and sexual paraphilias. Indian J Psychol Med, 2014;36(3):326-8.
48. Chan HC, Beauregard, E. Non-homicidal and homicidal sexual offenders: prevalence of maladaptive personality traits and paraphilic behaviors. J Interpers Violence, 2016;31(13):2259-2290.
49. American Psychiatric Association (APA). Manual Diagnóstico e Estatístico de Doenças Mentais. (5th Ed.). Tradução: Maria Inês Corrêa Nascimento et al.; revisão

técnica: Aristides Volpato Cordioli et al. Porto Alegre; Artmed: 2014.

50. Asbahr R, Lotufo Neto F, Turecki GX, Del Porto JA, Rodríguez LR, Baruzzi M et al. Escalas de avaliação de transtorno obsessivo-compulsivo em adultos. In: Gorenstein C, Andrade LH, Zuardi AW. (Orgs.). Escalas de avaliação clínica em psiquiatria e psicofarmacologia. São Paulo; Lemos-Editorial: 2000, pp. 174-179.
51. Goodman WK, Price LH, Rasmussen SA, Mazure C, Fleischmann RL, Hill CL et al. The Yale-Brown Obsessive Compulsive Scale. I. Development, use, and reliability. Arch Gen Psychiatry, 1989a;46(11):1006-1011.
52. Goodman WK, Price LH, Rasmussen SA, Mazure C, Delgado P, Heninger GR et al. The Yale-Brown Obsessive Compulsive Scale. II. Validity. Arch Gen Psychiatry, 1989b;46(11):1012-1016.
53. Ahlers CJ, Schaefer GA, Mundt IA, Roll S, Englert H, Willich SN et al. How unusual are the contents of paraphilias? Paraphilia-associated sexual arousal patterns in a community-based sample of men. J Sex Med, 2011;8(5):1362-1370.
54. Wurtele SK, Simons DA, Moreno T. Sexual interest in children among an online sample of men and women: prevalence and correlates. Sex Abuse, 2014;26(6):546-568.
55. Xu W, Zheng L, Zheng Y. Prevalence of non-contact and contact childhood sexual abuse: An Internet-based sample of men who have sex with men in China. PLoS One, 2017;12(4):e0175444.
56. Raphling DL. Fetishism in a woman. J Am Psychoanal Ass, 1989;37(2), 465-491.
57. Levitt EE, Moser C, Jamison KV.. The prevalence and some attributes of females in the sadomasochistic subculture: a second report. Arch Sex Behav, 1994;23(4):465-473.
58. Dean J. Non-intercourse sexual behaviors, differing sexual preferences and paraphilias. In: ESSM Educational Committee. The ESSM manual of sexual medicine. 2nd. ed. Amsterdam; Medix: 2015, pp. 1026-1033.
59. Scorolli C, Ghirlanda S, Enquist M, Zattoni S, Jannini EA. Relative prevalence of different fetishes. Int J Impot Res, 2007;19(4):432-7.
60. Steketee G, Frost R, Bogart K.. The Yale-Brown Obsessive Compulsive Scale: interview versus self-report. Behaviour Behav Res The, 1996;34(8):675-84.
61. Calvo N, Nasillo V, Ferrer M, Valero S, Perez-Conill Rde S, Rovira-Machordom M et al. Study of prevalence of Personality Disorders in inmate men sample with substance use disorders using of PDQ-4+ self-report. Actas Esp Psiquiatr, 2016;44(5):178-182.
62. Baltieri DA, Boer DP. Two clusters of child molesters based on impulsiveness. Braz J Psychiatry, 2015;37(2):139-145.
63. Ingves MV, Lau T, Fedoroff JP, Levine S. A man with urethral polyembolokoilamania successfully treated with electroconvulsive therapy. Arch Sex Behav, 2014;43(6):1203-1207.
64. Patra, A. P., Bharadwaj, B., Shaha, K. K., Das, S., Rayamane, A. P. & Tripathi, CS. (2013). Impulsive frotteurism: a case report. Med Sci Law, 2013;53(4):235-238.
65. Torres AR, Fontenelle LF, Shavitt RG, Ferrão YA, do Rosário MC, Storch EA et al. Comorbidity variation in patients with obsessive-compulsive disorder according to symptom dimensions: Results from a large multicentre clinical sample. J Affect Disord. 2016;190:508-516.
66. Southern S. Treatment of compulsive cybersex behavior. Psychiatr Clin North Am, 2008;31(4):697-712.
67. Chan HC, Beauregard E, Myers WC. Single-victim and serial sexual homicide offenders: differences in crime, paraphilias and personality traits. Crim Behav Ment Health, 2015;25(1):66-78.

How to cite this article:
Arnaldo Barbieri Filho, Carmita Helena Najjar Abdo. *Association Between Paraphilic And Obsessive-Compulsive Symptoms In Women.* Br J Bio Med Res , Vol.03, Issue 05, Pg.1068 - 1079, September - October 2019. ISSN:2456-9739 Cross Ref DOI : https://doi.org/10.24942/bjbmr.2019.573

Source of Support: Nil **Conflict of Interest:** None declared.