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Paraphilia And Related Crime: A Neurological Perspective

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Abstract **:**The cardinal objective of this paper is to contrive awareness amidst the public anent paraphilia. It will elucidate the intrinsic causes adhering paraphilia and will give a neurological perspective to it. It agnates criminal activities to multifarious forms of paraphilia and its coping contrivances wielding neuropsychology.The research work was steered using case study method. The theories pertaining to crime and sexual disorders endowed by psychologists abetted further in the inquest. Paraphilia, a psychosexual disorder ultimately perturbs the process of sexual arousal which is a primordial stage of the sexual response cycle. It is premeditated as sexual perversion or a disorder of sexual preference. It was contemplated speculatively via disparate provenances that paraphilia is an impairment of the neurological facet of brain. The research aided in apprising the subsistence of umpteen sorts of paraphilia, esquibus eight were espied to be the most prosaic ones. The scrutiny ascertained the fact that men were more impinged by paraphilia as conferred to women. The dissertation of various literatures and theories led to the denouement that neuropsychology can patronize in the diagnosis as well as the regimen of this sexual malady. It was discerned that nescience to this deviant behaviour led to vehement and erroneous crimes. This paper accentuates the effect of paraphilic individuals on society. It expedites the liaison of sexuality to the neurological facet of human beings ainsique the psychosocial structure of crime. Also this sexual anomaly can breach the eudaemonia of the society. The paper also rivets the effect of Paraphilia on minors that fosters juvenile delinquency. It concludes with the conflicting and accosting mechanisms to abate the risk of such impetuous behaviour and fallacious deeds.

Keywords: Paraphilia, Neuroscience, Neuropsychology, Crime, Juvenile Delinquency.

INTRODUCTION:

Paraphilia is a disorder caused due to the deformities in the nervous system but its affects are seen on the sexual behaviour of an individual. It is defined in various ways in accordance with different literatures. It can be explained as a condition in which a person's sexual arousal and gratification depends on fantasizing about and imagining sexual behaviour that is typical and extreme. Paraphilia can revolve around a particular object (children, animals, undergarments) or around a particular act (inflicting pain, exposing oneself). It is distinguished by preoccupation with the object or behaviour to the point of being independent on that object / behaviour for sexual gratification.

Paraphilia is a medical or behavioural science term for what is also referred to as sexual deviation, sexual anomaly, sexual perversion or a disorder of sexual preference.

Richard Von Krafft – Ebing, a German Psychiatrist credited with formally introducing study of sexology as a psychiatric phenomenon, identified paraphilias first in his **1886*PsychopathiaSexualis* (SexualPsychopathy**). This highly influential psychiatric test laid the foundation for the development of research and treatment in this area.

Paraphilia is recognised as one of the categories of Sexual and Gender Identity Disorders.

Paraphilias is defined in Diagnostic and Statistical Manual of Mental Disorders Fourth Edition text revised (DSM-IV-TR) as the intense, recurring sexual fantasies, sexual urges or behaviours that involve non-human objects, children or non-consenting adults, suffering or humiliation (to self or others). These are sexual feelings or behaviours that may involve sexual partners that are not human, not consenting, or that involve suffering by one or both partners. It can be defined as disorder in which sexual arousal cannot occur without the presence of unusual imagery or acts.

Paraphilic behaviours refer to behaviours that are considered to be outside of the conventional range of sexual behaviour.

After studying and analysing different literatures and texts regarding paraphilia it is understood that the most important phenomenon related the same is **"Sexual Arousal".** Sexual arousal is a natural physiological process which is the initial stage of every sexual act.According to a medical dictionary, sexual arousal can be defined as **"a** state **of** sexualreadinesswhichhas **a** mentalcomponent, increasedcorticalresponsiveness **to** sensorystimulation, physicalcomponent, increasedpenilesensitivity,neuralresponse **to** stimuli,andsense **of** impendingorgasm".

In other words, sexual arousal is the pilot light that has several stages and may not lead to any actual sexual activity, beyond a mental arousal and the physiological changes that accompany it.

This leads to the **"Sexual Response Cycle"** which refers to a series of physical and emotional phases that occur when an individual becomes aroused or engages in sexually stimulating activities. The sexual response cycle has **four phases: excitement, plateau,orgasm, and resolution**. Both men and women experience these phases, although the timing usually is different.

Phase 1: Excitement:

General characteristics of the **excitement phase**, which can **last from a few minutestoseveral hours**, include the following:

- Muscle tension increases.
- Heart rate quickens and breathing is accelerated.
- Skin may become flushed (blotches of redness appear on the chest and back).
- Nipples become hardened or erect.
- Blood flow to the genitals increases, resulting in swelling of the woman's clitoris and labia minora (inner lips), and erection of the man's penis.
- Vaginal lubrication begins.
- The woman's breasts become fuller and the vaginal walls begin to swell.
- The man's testicles swell, his scrotum tightens, and he begins secreting a lubricating liquid.

Phase 2: Plateau:

General characteristics of the **plateau phase**, which **extends to the brink of orgasm**, include the following:

- The changes begun in phase 1 are intensified.
- The vagina continues to swell from increased blood flow, and the vaginal walls turn a dark purple.
- The woman's clitoris becomes highly sensitive (may even be painful to touch) and retracts under the clitoral hood to avoid direct stimulation from the penis.
- The man's testicles are withdrawn up into the scrotum.
- Breathing, heart rate, and blood pressure continue to increase.
- Muscle spasms may begin in the feet, face, and hands.
- Muscle tension increases.

Phase 3: Orgasm:

The orgasm is the **climax of the sexual response cycle.** It is the shortest of the phases and generally lasts **only a few seconds**. General characteristics of this phase include the following:

- Involuntary muscle contractions begin.
- Blood pressure, heart rate, and breathing are at their highest rates, with a rapid intake of oxygen.
- Muscles in the feet spasm.
- There is a sudden, forceful release of sexual tension.
- In women, the muscles of the vagina contract. The uterus also undergoes rhythmic contractions.
- In men, rhythmic contractions of the muscles at the base of the penis result in the ejaculation of semen.
- A rash or **"sex flush"** may appear over the entire body.

Phase 4: Resolution:

During resolution, the **bodyslowly returns to its normal level** of functioning, and swelled and erect body parts return to their previous size and colour. **This phase is marked by a general sense of well-being, enhanced intimacy and, often, fatigue.**

Thus this sexual arousal and sexual response cycle play an important role in an individual's sexual gratification and also in the reproduction process. Sexual functioning is an aspect of human existence that can be a part of a person's life. Sexuality involves such a driving force in human nature, and is such an emotionally charged phenomenon, that is not surprising that there are problems associated with this facet of human behaviour.

Due to some factors some people don't get natural sexual arousal which causes frustration to them and their ego as they lack in achieving sexual gratification. Thus such people develop deviant means to attain it or in other words

they develop different preferences in order to achieve sexual arousal. This can be coined as **paraphilia**.

This deviance in sexual preference or behaviour can be of various types differing from person to person but all share the common feature that people who have these disorders are so psychologically dependent on the target of desire that they are unable to feel sexual gratification unless this target is present in some form. For some, the unusual sexual preferences occur in occasional episodes, such as during the periods in which the individual feels especially stressed. Paraphilias are not fleeting whims or daydreams about unusual sexual practices but are conditions that **last for at least six months**. People with paraphilias find themselves recurrently compelled to think about or carry out their unusual behaviour. Even if they actually don't fulfil their urges or fantasies, they are obsessed with them to the point of experiencing considerable personal distress. Paraphilia can get so strong and compelling that the individual loses sights of any goals other than the achievement of sexual fulfilment. By definition, paraphiliascause intense personal distress or impairment in social, work and other areas of life functioning. Based on this **more than 50 types** of paraphilia are observed out of which nine are the mostly recognised ones. It is not uncommon for an individual to have more than one paraphilia.

DSM-IV-TR lists the following paraphilia:

- ✓ Exhibitionism
- ✓ Fetishism
- ✓ Transvestic fetishism
- ✓ Frotteurism
- ✓ Pedophilia
- ✓ Sexual masochism
- ✓ Sexual sadism
- ✓ Voyeurism

The most uncommon types are:

- ✓ Necrophilia
- ✓ Zoophilia (or bestiality)

These types can be explained as following:

1)EXHIBITIONISM:

Exhibitionism is the exposure of genitals to a**"non-consenting stranger".** In some cases, the individual may also engage in autoeroticism which means getting the arousal and satisfaction of sexual excitement within or by oneself while exposing himself. Generally, no additional contact with the observer is sought; the individual is stimulated sexually by gaining the attention of and startling the observer. The exhibitionist actually doesn't expect a sexual reaction from the other person but finds the sight of shock or fear in the onlooker to be arousing. Some exhibitionists have the fantasy, however, that the onlooker will become sexually aroused. While studying exhibitionistic behaviour, it is important to differentiate this psychological disorder from exhibiting behaviours that associated with a neurological condition in which an individual lacks normal inhibitory capacity. The paraphilia of exhibitionism is also different from socially sanctioned display (Hollender, 1997) as would be found at a nudist beach or strip club. People with this paraphilia feel they cannot control their behaviour or feel driven to this behaviour in order to make an attempt to get attention; the result is emotional torment and significant disruption in life.

Example:

Ernie is in jail for the fourth time in the past 2years for public exposure. As Ernie explained to the court psychologist who interviewed him, he has **"flashed"** much more often than he has been apprehended. In each case, he has chosen as his victim an unsuspecting teenage girl, and he jumps out at her from behind a doorway, a tree, or a car parked at the sidewalk. He has never touched any of these girls, instead fleeing the scene after having exposed himself. On some occasions, he masturbates immediately after the exposure, fantasizing that his victim was swept off her feet by his sexual prowess and pleaded for him to make love to her. This time, seeing that his latest victim responded by calling the police to track him down, Ernie felt crushed and humiliated by an overwhelming sense of his sexual inadequacy.

Diagnostic Features:

- This diagnosis is assigned to people who, for a period lasting at least 6 months, have intense sexually arousing fantasies, sexual urges, or behaviours involving genital exposure to unsuspecting strangers.
- The person has acted on these urges, or the sexual urges or fantasies cause significant distress or impairment.

2) FETISHISM:

A fetish is a strong, recurrent sexual attraction to **a non-living object**. People with the paraphilia of fetishism are preoccupied with an object, and they become dependent on his object for achieving sexual gratification, actually preferring it over sexual intimacy with a partner. It is difficult to estimate how common fetishism is, because fetishists, virtually all of whom are men, are unlikely to seek treatment for their disorder. The most common fetishtic objects are ordinary items of clothing, such as undergarments, stockings, shoes, boots, etc; however, there

are also reports in the psychiatric literature of a wide range of fetishes, including rubber items, leather objects, diapers, safety pins, and even amputated limbs. Some fetishes involve specific attractions – for example, brown boots lined with fur. **Partialism**is another paraphilia, which some experts regard as a variant of fetishism; people with partialism are interested solely in sexual gratification from a specific body part, such as feet. Also, behaviour is not regarded as fetishtic when it involves the use of an object specifically designed for increasing sexual excitation, such as a vibrator.

A fetishist becomes sexually excited by the object. Some fondle or wear thefetishistic object. Some are aroused by smelling the object, rubbing against it, or observing other persons wearing it during sexual encounters. In some cases, the fetishist may not even desire to have intercourse with the partner, preferring instead to masturbate with the fetishistic object. Some men find that they are unable to attain an erection unless the fetishistic object is present. Some fetishists engage in bizarre behaviour, such as sucking it, rolling in it, burning it, or cutting it into pieces.

It is important to keep in mind the difference between what is considered as normal sexual behaviour and what would be considered deviant. Fantasies and behaviours that occasionally enhance a person's sexual excitement are different from the ritualistic preoccupations seen in true fetishism. Fetishism involves a compulsive kind of behaviour that seems beyond the control of the individual, and it can be the source of considerable distress and interpersonal problems. Although some people with fetishes incorporate their fetishistic behaviour into their sexual relationship with a partner who accepts this divergent behaviour, more often the fetishistic behaviour interferes with normal sexual functioning.

Example:

For several years, Tom has been breaking into cars and stealing boots or shoes, and he has come close to being caught on several occasions. Tom takes great pleasure in the excitement he experiences each time he engages in the ritualistic behaviour of procuring a shoe or boot and going to a secret place to fondle it and masturbate. In his home, he has a closet filled with dozens of women's shoes, and he chooses from this selection the particular shoe with which he will masturbate. Sometimes he sits in a shoe store and keeps watch for women trying on shoes. After a woman tries on and rejects a particular pair, Tom scoops the pair of shoes from the floor and takes them to the register, explaining to the clerk that the shoes are a gift for his wife. With great eagerness and anticipation, he rushes home to engage once again in his masturbatory ritual.

Diagnostic Features:

- For a period lasting at least 6 months, people with this condition have recurrent, intense sexually arousing fantasies, sexual urges, or behaviours involving non-involving objects.
- The fantasies, sexual urges, or behaviours cause significant distress or impairment.
- The fetish objects are not limited to female clothing used in cross-dressing or devices used for tactile genital stimulation, such as a vibrator.

3) TRANSVESTIC FETISHISM:

A syndrome found **only in males** is transvestic fetishism, in which a man has an uncontrollable urge to wear a woman's clothes (called **cross-dressing**) as his primary means of achieving **sexual gratification.** This sexual gratification has a compulsive quality, and it consumes a tremendous amount of the individual's emotional energy. Cross-dressing is often accompanied by **masturbation** or fantasies in which the man imagines that other men are attracted to him as a woman. When he is not cross-dressed, he looks like a typical man, and he may be sexually involved with a woman. In fact, the definition of this disorder implies that the man sees himself as a man and is heterosexual in orientation.

Transvestic behaviours vary widely. Some men wear only a single item of women's clothing, such as undergarment, often under men's outerclothing. Others have complete woman's wardrobes and, while alone, put on an entire outfit, possibly including "breasts" made with water-filled balloons or padding, as well as makeup, wigs, shoes, and other accessories. Their experience while wearing these clothes is one of having assumed a different personality. They may also find that cross-dressing while alone relaxes the or, when having sex with a partner, increases their level of excitement. A phenomenon related to transvestic fetishism is **autogynephilia**, in which a man derives sexual excitement from the thought or image of himself as having female anatomy or experiencing such biological functions as menstruation, childbirth, and breast-feeding (**Blanchard, 1993)**.

Homosexual men who make themselves up as women are not transvestic fetishists because they are generally not dressing this way to gain sexual gratification. They don't have the same sense of compulsion that transvestic fetishists have. Rather, cross-dressing for some homosexual men has more to do with their participation in a subculture that they find inviting.

Example:

In the evenings, when his wife leaves the house for her part-time job, Phil often goes to a secret hiding place in his workshop. In a locked cabinet, Phil keeps a small wardrobe of women's undergarments, stockings, high heels, makeup, a wig, and dresses. Closing all the blinds in the house and taking the phone off the hook, Phil dresses in these clothes and fantasizes that he is being pursued by several men. After about 2 hours, he usually masturbates to the point of orgasm, as he imagines that he is being seduced by a sexual partner. Following this ritual, he secretly packs up the women's clothes and puts them away. Though primarily limiting his cross-dressing activities to the evenings, he thinks about it frequently during the day, which causes him to become sexually excited and to wish that he could get away from work, go home, and put on his special clothes. Knowing that he cannot, he wears women's undergarment under his work clothes, and he sneaks off to the men's room to masturbate in response to the sexual stimulation he derives from feeling the silky sensation against his body.

Diagnostic Features:

- For a period lasting at least 6 months, heterosexual men with this condition have recurrent, intense sexually arousing fantasies, sexual urges, or behaviours involving cross-dressing.
- The fantasies, sexual urges, or behaviours cause significant distress or impairment.

4) FROTTEURISM:

The term frotteurism is derived from the French word ***frotter*** (meaning **"to rub"**), and it refers to masturbation that involves rubbing against another person. A frotteur has recurrent, intense sexual urges and sexually arousing fantasies of rubbing against or fondling another person. The target of the frotteur is not a consenting partner but a stranger. The frotteur seeks out crowded places, such as buses or subways, where he can select an unsuspecting victim and then usually rubs up against the person until he ejaculates. While rubbing against or touching the person, the frotteur may fantasize that they are involved in a close, intimate relationship. To avoid detection, he acts quickly and is prepared to run before his victim realizes what is happening. Customarily, it is a very brief encounter and the victim may be unaware of what has just taken place.

Example:

Bruce, who works as a delivery messenger in a large city, rides the subway throughout the day. He thrives on the opportunity to ride crowded subways, where he becomes sexually stimulated by rubbing up against unsuspecting women. Having developed some cagey techniques, Bruce is often able to take advantage of women without their comprehending what he is doing. As the day proceeds, his level of sexual excitation grows, so that by the evening rush hour he targets a particularly attractive woman and only at that point in the day allows himself to reach orgasm.

Diagnostic Features:

- For a period lasting at least 6 months, people with this condition have recurrent, intense sexually arousing fantasies, sexual urges, or behaviours involving touching and rubbing against non-consenting people.
- The person has acted on these urges, or the sexual urges or fantasies cause significant distress or impairment.

5) SEXUAL MASOCHISM & SEXUAL SADISM:

These two types of paraphilia, masochism and sadism are closely interconnected. The term **masochism** comes from the name of a nineteenth century Austrian writer **Leopold Baron von Sacher-Masoch** (1836-1895), known for his novels about men who were sexually humiliated by women. A masochist is someone who seeks pleasure from being subjected to pain. The term *sadism* comes from the name of eighteenth century French author **Marquis de Sade** (1740-1814), who wrote extensively about obtaining sexual pleasure from inflicting cruelty. The psychiatric terms *masochism* and *sadism*were coined by**Krafft-Ebing** (1840-1903), a German physician who pioneered the scholarly approach to understanding the broad range of human sexual behaviour in his book ***PsychopathiaSexualis*** (Krafft-Ebing, 1886/1950).

Sexual masochism is a disorder marked by an attraction to achieving sexual gratification by having **painful stimulation** applied to one's own body, either alone or with a partner. Men and women with this disorder achieve sexual satisfaction by means such as binding with cloth or ropes, injuring the skin with pins or knives, or administering electric shocks. Some sexual masochists don't act on their fantasies, but they feel recurrent urges and many feel distressed by the power of these urges.

Sexual sadism is the converse of sexual masochism in that it involves deriving sexual gratification from activities that harm, or from urges to harm, another person. Seeing or imagining another's pain excites the sadist. In contrast to sexual masochism, which doesn't require a partner, sexual sadism clearly does require a partner to enact sadistic fantasies.

People with these disorders may alternate playing **sadistic** and **masochistic** roles. In some sexual activities, one of the partners acts in a very submissive role and begs to be hurt and humiliated. In other activities, the partners reverse the roles such that the previously submissive person now inflicts the pain and dominates the interaction. The term **sadomasochist** refers to people who derive sexual pleasure from both inflicting and receiving pain.

The specialized nature of their sexual activities and their desire to meet other people with similar preferences lead some sadomasochistic individuals to join organisations designed to cater to their needs, such as the **Till Eulenspiegel Society** in New York City or the **Janus Society** in San Francisco. They may employ the internet to find others who share their interests using chat rooms or e-mail to communicate with people around the world. Obviously, it is difficult to conduct research on people with this disorder. In a rare survey of sadomasochists who were members of such a society, researchers found the most prevalent sadistic sexual interests to be spanking, master-slave relationships, extremely restrictive bondage, humiliation, and restraint. Less common were infliction of pain, whipping, and verbal abuse, less severe bondage, and enemas and other toilet-related activities. Some people act out dramatic scenarios, such as being led around on a collar and leash and ordered to act like a submissive puppy that may be spanked for slight misbehaviours. Interestingly, women and men reported similar levels of interest in most of these behaviours, with somewhat higher percentages of women indicating interest in bondage and verbal abuse (**Breslow, Evans, & Langley,** 1985).

Activities such as cutting, bondage, pricking, and shocking can be dangerous and this danger adds to the excitement sadomasochists feel. Even more extreme, however, is strangling to the point of oxygen deprivation, wearing a mask or plastic bag over the head, placing a noose around the neck, or ingesting a nitrate gas, which causes asphyxiation. This type of activity, which some individuals practice while alone, is usually accompanied by fantasies of near escapes from death; however, such fantasies sometimes become reality when the limits are pushed too far.

Example:

For a number of years, Ray has insisted that his wife, Jeanne, submit him to demeaning and abusive sexual behaviour. In the early years of their relationship, Ray's requests involved relatively innocent pleas that Jeanne pinch him and bite his chest while they were sexually intimate. Over time, however, his requests for pain increased and the nature of the pain changed. At present, they engage in what they call **"special sessions",** during which Jeanne handcuffs Ray to the bed and inflicts various forms of torture. Jeanne goes along with Ray's requests that she surprise him with new ways of inflicting pain, so she has developed a repertoire of behaviours, ranging from burning Ray's skin with matches to cutting him with razor blades. Jeanne and Ray have no sexual intimacy other than that involving pain.

Diagnostic Features of Sexual Sadism:

- For a period lasting at least 6 months, people with this condition have recurrent, intense sexually arousing fantasies, sexual urges, or behaviours involving real or stimulated acts in which they are sexually excited by the psychological or physical suffering or humiliation of another person.
- The person has acted on these sexual urges with a non-consenting person, or the sexual urges or fantasies cause significant distress or impairment.

Diagnostic Features of Sexual Masochism:

- For a period lasting at least 6 months, people with this condition have recurrent, intense sexually arousing fantasies, sexual urges, or behaviours involving real or stimulated acts of being humiliated, beaten, bound, or made to suffer in other ways.
- The fantasies, sexual urges, or behaviours cause significant distress or impairment.

6) PEDOPHILIA:

Pedophilia, a paraphilia in which an adult (16 years or over) has uncontrollable sexual urges toward **sexually immature children**. Adults who engage in **hebephilia**have uncontrollable sexual urges to have sexual relations with adolescents, and those with **ephebophilia** are specifically attracted to male adolescents (**Wolak, Finelhor, Mitchell, Ybarra, 2008).** Another important distinction is between those who molest youth within their own families, which would be considered incest, and those who engage in non-familial exploitation. (**Marshall, 2007).**

Sometimes the stories involving exploitation of children take on gruesome proportions, as when children are submitted to horrifying forms of victimization, such as kidnapping and sexual abuse, that persist for months or even years. Although these extreme cases are rare, the prevalence of child sexual abuse is disturbingly high in United States. Among children about whom reports of maltreatment are made, approximately **10%** involve cases of sexual abuse involving forced fondling, **sodomy**, or penetration with an object (U.S. Department of Health and

Human Services, 2005). In fact, when sexual assault statistics for the entire population are reviewed, the statistics are quite alarming, in that two-thirds of all sexual assault victims are children and adolescents. Among adolescents (12-17), 14 year olds are the most commonly abused; among children (under age 12), 4 year olds are the most common victims. Nearly **two-thirds of the victims are females**, the vast majority of perpetrators are male, and approximately one-third of the offenders are relatives of the victimized children (**Snyder, 2000**).

Although pedophiles are by definition attracted to children, their sexual preferences and behaviour vary a great deal. Some don't act out their impulses but have disturbing fantasies and inclinations to molest children. Those who do act on their pedophilic impulses commit such acts as undressing the child, touching the child's genitals, coercing the child to participate in oral-genital activity, and attempting vaginal or anal intercourse.

Researchers have used various systems to classify pedophiles. A particularly useful one (**Lanyon, 1986**) involves the distinction among situational molesters, preference molesters, and child rapists. Situational molesters have a history of normal sexual development and interests; as adults, they are primarily interested in relationships with other adults. However, in certain contexts, such as during a stressful time, they are overcome by a strong impulse to become sexual with a child. Rather than feeling relieved after the incident, though, situational molesters feel distress. For the preference molester, pedophilic behaviour is ingrained into his personality and lifestyle, and he has a clear preference for children, especially boys. He will marry only out of convenience, to be near children or as a cover for his disorder. The preference molester sees nothing wrong with his behaviour; if anything, he feels that society is too critical of what he regards as simply a variant of sexual expression. The child rapist is a violent child abuser whose behaviour is an expression of hostile sexual drives.

Example:

Shortly following his marriage, Kirk began developing an inappropriately close relationship with Amy, his 8-year-old stepdaughter. It seemed to start out innocently, when he took extra time to give her bubble baths and backrubs. But, after only 2 months of living in the same house, Kirk's behaviour went outside the boundary of common parental physical affection. After his wife left for work early each morning, Kirk invited Amy into his bed on the pretext that she could watch cartoons on the television in his bedroom. Kirk would begin stroking Amy's hair and gradually proceed to more sexually explicit behaviour, encouraging her to touch his genitals, saying that it would be "good" for her to learn about "daddies" are like. Confused and frightened, Amy did as she was told. Kirk reinforced compliance to his demands by threatening Amy that, if she told anyone about their secret, he would deny everything and she would be severely beaten. This behaviour continued for more than 2 years, until one day Kirk's wife returned home unexpectedly and caught him engaging in this behaviour.

Diagnostic Features:

- For a period lasting at least 6 months, people with this disorder have recurrent, intense sexually arousing fantasies, sexual urges, or behaviours involving sexual activity with a prepubescent child or children (generally 13 years old or younger).
- The person has acted on these urges, or the sexual urges or fantasies cause significant distress or impairment.
- The individual with this disorder is at least 16 years old and at least 5 years older than the victimized child or children.
- The individual's pedophilic behaviour may be characterized by sexual attraction to males, females, or both sexes.
- The pedophiliic behaviour is characterized by whether or not it is limited to incest.
- The pedophilic behaviour is characterized by whether or not sexual attraction is exclusive to children.

7) VOYEURISM:

The word ***voyeur*** comes from the French word ***voir*****("to see").** Voyeurism is a sexual disorder in which the individual has a compulsion to derive sexual gratification from observing the nudity or sexual activity of others who are unaware of being watched. The disorder is more common in men. The colloquial term **"Peeping Tom"** is often used to refer to a voyeur. This is a reference to the character Tom the Tailor, who was the only one in town to violate Lady Godiva's request for privacy when she rode nude on horseback through town.

Unlike people who become sexually aroused when watching a sexual partner undress or a performer in a sexually explicit movie, the voyeur has the recurrent and intense desire to observe unsuspecting people. The voyeur is sexually frustrated and feels incapable of establishing a regular sexual relationship with the person he observes. He prefers to masturbate either during or soon after the voyeuristic activity. Peeping provides him with a substitute form of sexual gratification.

Example:

Edward is a university senior who lives in a crowded dormitory complex. On most evenings, he sneaks around in the bushes, looking for a good vantage point from which to gaze into the windows of women students. Using binoculars, he is able to find at least one room in which a woman is undressing. The thrill of watching this unsuspecting victim brings Edward to the peak of excitement as he masturbates. Edward has been engaging in this behaviour for the past 3 years, dating back to an incident when he walked past a window and inadvertently saw a naked woman. This event aroused him to such a degree that he became increasingly compelled to seek out the same excitement again and again.

Diagnostic Features:

- For a period lasting at least 6 months, people with this condition have recurrent, intense sexually arousing fantasies, sexual urges, or behaviours involving the act of observing unsuspecting people who are naked, in the process of undressing, or engaging in sexual activity.
- The person has acted on these sexual urges, or the sexual urges or fantasies cause significant distress or impairment.

Other than these commonly observed types, there are two most uncommon types of paraphilias which are observed in rare case. These are as follows:

1)NECROPHILIA:

Necrophilia can best be described as sexual arousal stimulated by a **dead body**. The stimulation can be either in the form of **fantasies** or **actual physical sexual contact** with the corpse.

Legends with necrophilic themes are common throughout history and the concept of sexual interference with the dead has been known and abhorred since the ancient Egyptians, as noted by **Herodotus** (484 BCE -425 BC approx.):

"When the wife of a distinguished man dies, or any woman who happens to be beautiful or well known, her body is not given to the embalmers immediately, but only after the lapse of three or four days. This is a precautionary measure to prevent the embalmers from violating her corpse, a thing which is actually said to have happened in the case of a woman who had just died." (DeSelincourt, translation, 1972, p.161)

The DSM-IV-TR criteria for necrophilia are the presence, over a period of at least six months, of recurrent and intense urges and sexually arousing fantasies involving corpses which are either acted upon or have been markedly distressing.

There is a broad spectrum of necrophilic behaviours, ranging from fantasies alone to murder for the sake of procuring a dead body. Experts have subcategorized the paraphilia according to where it falls on that spectrum.

"Necrophilic fantasies" of corpses, never acted upon, still fall within the scope of necrophilia and some authors have categorized this as a **"neurotic equivalent"** to necrophilia.

"Pseudonecrophilia" describes isolated incidents where the sexual contact with the corpse may happen without pre-existing fantasies or desire to have sexual contact with the body.

Even in its truest form, necrophilia can be quite varied, ranging from simply being in the presence of a corpse to kissing, fondling or performing sexual intercourse or cunnilingus on the body.

The presence of other paraphilias or personality disorders, however, can manifest in more grotesque or sadistic elements such as mutilation of the corpse, drinking the blood or urine, or homicide **("necrophilic homicide" or "necrosadism").** The latter is the most disturbing end of the spectrum.

Although the act of murder itself may generate the subsequent sexual frenzy, research has determined an alarming rate of homicide in order to obtain a body for subsequent sexual violation**. Rosman and Resnick (1988)** found that **42%** of their study sample of necrophiles had murdered in order to obtain a body. Researchers have determined, however, that sadism itself is not usually an intrinsic characteristic of true necrophilia. (Rosman&Resnick, 1988)

In all cases, there is undoubtedly sexual preference for a corpse rather than a living woman. When no other act of cruelty - cutting into pieces etc., - is practiced on the corpse, it is probable that the lifeless condition itself forms the stimulus for the perverse individual. It is possible that the corpse - a human form absolutely without will - satisfies an abnormal desire, in that the object of desire is seen to be capable of absolute subjugation, without possibility of resistance. (Kraft-Ebing, 1886)

Although assumed rare, many have argued that necrophilia may be more prevalent than statistics imply, given that the act would be carried out in secret with a victim unable to complain and given the length of time which the paraphilia has been recognized.

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An important study in the area in 1988 by Rosman and Resnick compiled 122 cases of necrophilia, both from the literature and previously unreported cases referred to the investigators by colleagues. The large number of cases in that study is noteworthy.

As with most sexual anomalies, the cases reported in the literature have actually involved males between the **ages of 20 and 50** with occupations that provide ready access to corpses: gravediggers, mortuary attendants, orderlies, etc. Most individuals have been reported to be **heterosexual**.

2) ZOOPHILIA (BESTIALITY):

Zoophilia is sexual attraction of a human towards an **animal**, which may involve the experience of sexual fantasies about the animal or the pursuit of real sexual contact with it (i.e., bestiality). Bestiality is a term that describes sexual feelings or behaviours involving animals that is termed zoophilia by *DSM-IV*. The disorder does not specify an animal or category of animals; the person with zoophilia may focus sexual feelings on domesticated animals, such as dogs, or farm animals, such as sheep or goats. In 1894, the well -known psychiatrist Krafft-Ebing described cases of sexual contacts with animals in his ***PsychopathiaSexualis***(Schmidt, 1969). He defined all non-pathological sexual acts with animals as "bestiality", while he referred to cases that were comparable to an animal fetishism as **"zoophilia erotica"-** thus he became one of the first to use term "zoophilia".

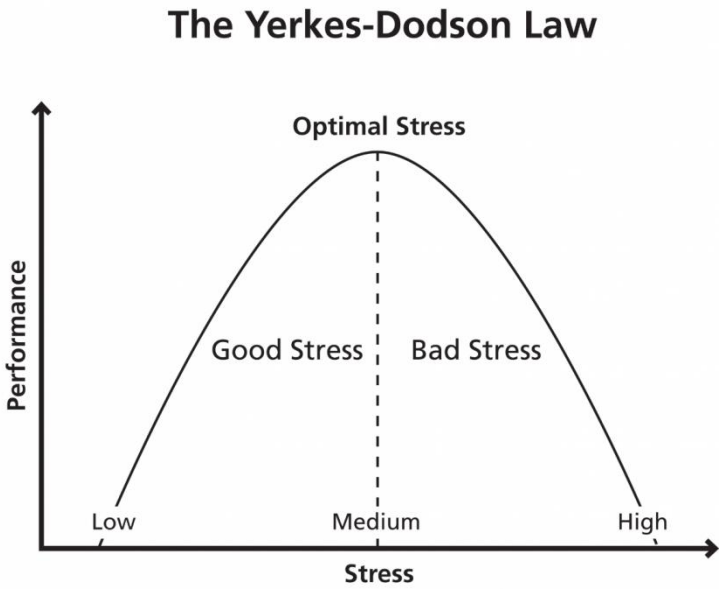
THEORIES:

1) AROUSAL THEORY:

It is also termed as **Yerkes-Dodson law**. The law suggests that there is a relationship between performance and arousal. Increased arousal can help improve performance, but only up to a certain point. At the point when arousal becomes excessive, performance diminishes.

The law was first described in 1908 by psychologists **Robert Yerkes and John DillinghamDodson**. They discovered that mild electrical shocks could be used to motivate rats to complete a maze, but when the electrical shocks became too strong, the rats would scurry around in random directions to escape.

Thus, on the basis of this arousal theory it can be said that due to excessive stress or arousal the performance of the individual will diminish as a result a deviant sexual behaviour can be established which can be some or the other kind of paraphilia.



2) MULTIPLE PATHWAYS THEORY (Ward &Siegart, 2002):

This theory gives a complex and comprehensive understanding of sexually harmful behaviour towards children. It is maintained that early life experience, biological factors and cultural influences may lead to vulnerability, which can lead to

- deviant sexual preferences
- intimacy deficits
- inappropriate emotions
- cognitive distortions

These four issues can be dismantled into smaller components which are organised into pathways that lead to the abusive behaviour of a child. It's probably the most influential model of sexually harmful behaviour in research and practice today.

3) VICTIM-TO-ABUSER CYCLE THEORY:

Most paraphilias have their roots in childhood experiences, and they emerge during adolescent years as sexual forces within the body intensify. Some researchers have described as "victim-to-abuser cycle" (**Bagley, Wood, & Young, 1994; Haywood et al., 1996)**, which leads childhood victims to perpetrate similar acts of sexual abuse when they reach adulthood. Establishing such a connection would provide some greater insight into the minds of those who commit disturbing crimes.

4) THEORY OF DISTORTED LOVEMAPS (Money &Ehrhardt, 1973/1996):

According to Money, a lovemap is the representation of an individual's sexual fantasies and preferred practices. Lovemaps are formed early in life, during what Money considers to be a critical period of development: the late childhood years, when an individual first begins to discover and test ideas regarding sexuality. **"Misprints"** in this process can result in the establishment of sexual habits and practices that deviate from the norm. A paraphilia, according to this view, is due to a lovemap gone awry. The individual is, in a sense, programmed to act out fantasies that are socially unacceptable and potentially harmful.

STATISTICS OF PARAPHILIA:

For a disorder to be classified in DSM-IV-TR, **three clear elements** must be observed (**First**&**Halon**, 2008):

(i) there must be a clearly **deviantmode** of sexual gratification (i.e., arousing thoughts, fantasies, urges, or behaviours involving **atypical activities** involving non-human objects, the suffering of others such as children, or non-consenting individuals);

(ii) there must be evidence of a **pattern of arousal** (sexual urges and sexual arousing fantasies) in response to this deviant mode of gratification that is recurrent and intense for at least six months;

(iii) such thoughts, feelings, and behaviours must have caused a **significant amount of distress** and impairment in social/occupational functioning, or other areas of functioning for the individual in question.

It is of note that all three criteria are essential for diagnosis no matter how uncommon or unusual the paraphilia. Therefore, the diagnosis of a paraphilia should not be made on the basis of criminal sexual activity without evidence of these behaviours being causally related to a paraphilic sexual arousal pattern. As for the demographic characteristics of those diagnosed with a DSM paraphilia, typically such interests begin in adolescence, and are more **common in males**. This former observation is unsurprising given that sexual arousal/interests normally emerge around the age of puberty. All ethnic and socioeconomic groups are represented across the range of paraphilias, suggesting that these are not social constructions. It is also of note that those involved in one illegal DSM paraphilic activity will commonly also engage in others. However, studies reporting information regarding paraphilic activities are typically based on small samples, or are selected from one geographical area, making some findings difficult to generalize.

It is difficult to establish demographic characteristics for all of those diagnosed with DSM paraphilias. A review of pedophilia and fetishism reported that these paraphilias are more common in males, all races and socio-economic groups are represented, and that the interest usually begins by adolescence. However, studies tend to report relatively small samples, or are selected from one geographical area, making findings difficult to generalize. However, one **large scale study (N= 561)** found that the majority were relatively young, moderately well educated, came from all socioeconomic level, and ethnicity was representative of the general population. This study also demonstrated that those involved in one paraphilic activity commonly also engaged in other. We will now discuss specific **demographiccharacteristics** for paraphilias, where available.

Exhibitionism, a type of paraphilia which is legally defined in the United Kingdom as indecent exposure, onset generally begins in the **mid-teens**. Many exhibitionists have been found to be involved in other forms of paraphilicbehaviour. **Fetishism usually begins byadolescence**; however, the fetish object may have been endowed with special significance since early childhood (APA, 2000). Fetishists are most commonly males. All races and socioeconomic groups are typically well represented. Approximately **30%** of the general population has committed an act that would qualify as **frotteuristic**. Masochists typically do not necessarily seek professional help, making it difficult to identify this paraphilia. Studies have demonstrated that higher education levels, income, and occupational status are found in this group, compared to the general population. On an average, individuals start engaging in sadomasochistic practices in their early 20's. **Pedophiles are most commonly males**, although it is seen in a small number of females. There is a large degree of heterogeneity of pedophiles in terms of education, socioeconomic status and ethnicity**. Abel and Rouleau** reported in their sample of 561 sexual offenders, **50% of pedophiles with male victims** had developed their sexual interest by **age15 years**, while **40% of those with unrelated femalevictims** had developed their sexual interest by **age 18 years**. Limited information about sexual sadism suggests that this paraphilia is most often found in males. Abel and Rouleau reported that **50%of voyeurs** in their sample reported that their paraphilia had developed by the **age of 15 years**. Offenses are typically committed by men. However, there are some rare cases of females who meet the diagnostic criteria for voyeurism.

Although DSM-IV bases sub classification of paraphilia on the stimulus/activities found to be sexually arousing, some research suggests many paraphilic individuals engage in multiple forms of deviant sexual behaviour: Abel, Becker, Cunningham-Rathner, Mittelman, &Rouleau (1988) reported that less than **10%** of their patients had a single paraphilia, approximately **20%** had two paraphilic

diagnoses, **32%** had three or four diagnoses, and **38%** had engaged in five or more concomitant paraphilicbehaviours; other investigators have reported high rates of multiple paraphilias. In a non–sexual offender study conducted in Sweden, 2450 people were surveyed, and researchers found prevalence rates of **voyeurism of7.7%; exhibitionism, 3.1%; and transvestic fetishism, 2.8%.** DSM-IV criteria, however, were not used in this study, and a diagnosis was given if the respondent reported one or more incidents of the respective behaviour. Furthermore, the sexual thoughts or behaviours were not required to occur over at least a 6-month period or cause clinically significant distress in functioning.

In total, more than 50 types of paraphilias have been described; most of them being far more common in men **(about 99% in Europe)** than in women, but the percentage of women are increasing in the US. Except for sexual masochism, which is about 20 times less likely to affect men than women, paraphilias are **quite unlikely to be diagnosed in women.**Paraphiliacs often have more than one type of deviant sexual behaviour (e.g., one-third of pedophiles are also exhibitionists), **50 – 70% of pedophiles have more than one paraphilia.The onset of paraphiliac sexual interest usually occurs before the age of 18.**

In a population of 193 students, **21%** of subjects had pedophilic fantasies. **15 – 20%** of their population of male students and **2%** of females would like to have a sexual relationship with a child if that would be allowed, **40%** of males reported sexual fantasies of women's rapes.

NEUROSCIENCE:

Neuroscience is defined as a branch (as neurophysiology) of science that deals with the anatomy, physiology, biochemistry, or molecular biology of nerves and nervous tissue and especially their relation to behaviour and learning.

Neuroscience is the study of the brain and nervous system, including molecular neuroscience, cellular neuroscience, cognitive neuroscience, psychophysics, computational modelling and diseases of the nervous system.

It is the scientific study of nerves and especially of how nerves affect learning behaviour.

Neuroscience comprises the study of neuroanatomy, neurophysiology, and brain functions and related psychological and computer based models. For years, investigations on a neuronal level were completely separated from those on a cognitive or psychological level. The thinking process is so vast and complex that there are too many conceivable solutions to the problem of how cognitive operation could be accomplished. Neurobiological data provide physical evidence for a theoretical approach to the investigation of cognition. Therefore it narrows the research area and makes it much more exact. The correlation between brain pathology and behaviour supports scientists in their research. It has been known for a long time that different types of brain damage, traumas, lesions, and tumors affect behaviour and cause changes in some mental functions. The rise of new technologies allows us to see and investigate brain structures and processes never seen before. This provides us with a lot of information and material to build simulation models which help us to understand processes in our mind.

As neuroscience is not able to explain all the observations made in the laboratories, neurobiologists turn towards**Neuropsychology** in order to find the models of brain and behaviour on an interdisciplinary level. This **'inter-science'** acts as a bridge that connects and integrates the two most important domains and their methods of research of the human mind.

Neuropsychology is defined as the study of the relationship between behaviours, emotion and cognition on one hand and brain function on the other.

Neuropsychology is a science concerned with the integration of psychological observations on behaviour and the mind with neurological observations on the brain and nervous system.

Sexual desire is the culmination of several different neural mechanisms; each is controlled in different areas of the brain and is activated at different times of the sexual experience. The euphoric and pleasurable experience of sex stems primarily from the limbic system. The colloquial term for areas including the amygdala, hippocampus and limbic lobe (dentate and cingulate gyrus). This area is common to all mammals and is considered one of the oldest areas of the brain. It regulates emotion and encourages the avoidance of painful of aversive stimuli and the repetition of pleasurable experiences.

Thus, sexual arousal is clearly a result of biological processes. Sexual arousal for both men and women is partially reflexive. Nerve impulses from the receptor site travels to the spinal cord, which responds by sending messages to the target organs or glands. The spinal cord responds to the stroking (of genitals) messages by telling the valves in the genital arteries to relax. When these valves relax, blood is allowed to flow into the area; this increased blood volume produces erection of the penis in the male and an engorged clitoris and tissues in the female

The Autonomic Nervous System (ANS) is intricately involved in emotional and sexual responses. The ANS is divided into sympathetic and parasympathetic nerves, in which the **parasympathetic nerves are dominant during sexual arousal.**

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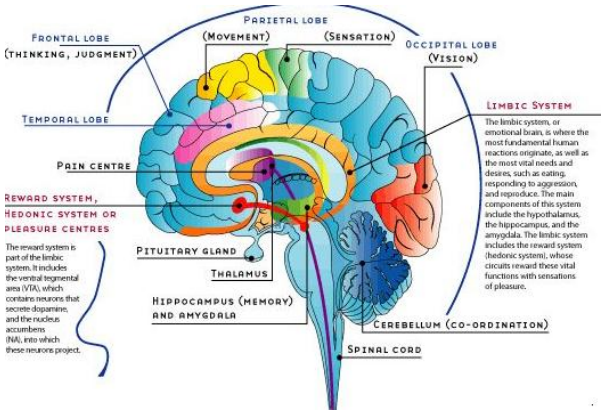

The different areas of the brain that play an important role in the process of sexual arousal are:

Limbic System:

The limbic system (the word means "**marginal**" and these structures are in the inner margin of the upper brain) includes the thalamus, hypothalamus, hippocampus and amygdala. The limbic system is a convenient way of describing several functionally and anatomically interconnected nuclei and cortical structures that are located in the telencephalon and diencephalon. In general, the limbic system is involved in **emotions, motivation and learning**. These nuclei serve several functions; however most have to do with control of functions necessary for self-preservation and species preservation. They regulate autonomic and endocrine function, particularly in response to emotional stimuli. They set the level of arousal and are involved in motivation and reinforcing behaviours.

The limbic system has been conceptualized as the "**feeling and reacting brain**" that is interposed between the "**thinking brain**" and the **"output mechanisms"** of the nervous system. In this construct, the limbic system is usually under control of the "thinking brain" but obviously can react on its own. Additionally, the limbic system has its input and processing side (the limbic cortex, amygdala and hippocampus) and an output side (the septal nuclei and hypothalamus).

Amygdala and hippocampus:

The amygdala is an important structure located in the anterior temporal lobe within the uncus (the innermost part of the temporal lobe). The amygdala is a critical centre for coordinating behavioural, autonomic and endocrine responses to environmental stimuli, especially those with emotional content. It is important to the coordinated responses to stress and integrates many behavioural reactions involved in the survival of the individual or of the species. Prior to the physical stimulation, comes sexual desire. Largely mediated by emotion through the limbic system, activation of the amygdala can trigger penile erection, sexual feelings, **(Georgiadis and Holstege, 2005)** sensations of extreme pleasure (**Olds and Milner, 1954**), memories of sexual intercourse (**Gloor, 1986**), as well as ovulation, uterine contractions, and orgasm. The role of the amygdala in the processing of emotional stimuli. It has been proposed that the amygdala regulates the attachment of appropriate emotional significance to sensory stimuli and determines reinforcing or discriminative properties of stimuli. A larger amygdala may function better in its role as a processor of emotional stimuli, specifically social/sexual cues, and in the attachment of significance to such stimuli. This would increase the likelihood of sexual response, resulting in a sexual increase. Irrespective of the mechanism, this finding points to an important role of the amygdala in regulating human sexual behaviour, specifically sex drive.

The amygdala is sexually differentiated; males on average have a 16% larger cortico-medial area which is the area responsible for steroid uptake, specifically the male and female sex hormones testosterone and oestrogen. These are known to produce sex specific behaviours (Rhawn J, 2004). **Males more than femaleswere found to have greater amygdala activation** when presented with a sexually pleasing, visual stimuli (Hamann et al., 2004). Several case studies of subjects with lesions or tumors in areas proximal to the amygdala illustrated aggressive tendencies, became sexually preoccupied.

The role of hippocampal system in memory remains elusive. Nevertheless, there is an increasing convergence of evidence indicating that the hippocampus represents and relates specific experiences into a network of memories that supports our capacity for declarative memory (refers to memories that can be consciously recalled such as facts and verbal knowledge).

Hypothalamus:

The hypothalamus is a very small but extremely powerful part of the brain. The hypothalamus regulates body temperature, thirst, hunger, sleeping and waking, sexual activity and emotions.

The hypothalamus, located in the brain directly above the hypophysis, is known to exert control over it by means of neural connections and hormone-like substances that are called releasing factors, the means by which the nervous system controls sexual behaviour via the endocrine system.

Sexual behaviour is influenced by the hypothalamus. It controls and stimulates the pituitary gland to release the sex hormones. When levels of those hormones fall, so does sexual desire.

The hypothalamus secretes the appropriate releasing factor into the blood, which reaches the pituitary and stimulates it to secrete gonadotrophic hormone. In the female the target gland of the gonadotrophic hormone is the ovary. The ovary has two functions, the first one is to produce eggs, and the other is to secrete hormones (estrogen and progesterone). The ovarian hormones make feedback loops to the hypophysis and develop sexual characteristics that distinguish females from males.

Role of human hormones in sexual arousal:

A **hormone** is a chemical substance of an endocrinegland. A hormone is a chemical substance produced in the body that controls and regulates the activity of certain cells or organs. Endocrine glands, which are also called ductless glands, deposits the hormones into the blood stream. The blood, on its turn, carries the hormones to every part of the body. Hormones are essential for every activity of life, including the processes of digestion, metabolism, growth, reproduction, and mood control. Many hormones, such as neurotransmitters, are active in more than one physical process.

Hormone levels are also involved in sexual activity. In males, testosterone levels remain generally above the threshold required for sexual interest and activity. Thus increases testosterone above this threshold is believed to have additional influences on sexual interest or behaviour. Interestingly, estrogen (the "female hormone") seems to have little impact on sexual desire on either males or females. Estrogen deficient women, however, can cause a decrease genital lubrication caused by the thinning of the vaginal epithelium. All factors can impair both the physiological and psychological aspects of sexual arousal.

The sex hormones are **estrogen**and **testosterone**. Like all hormones, they are chemical messengers, substances produced in one part of the body that go on to tell other parts what to do. Both women and men produce both estrogen and testosterone, though in different quantities, and both sexes produce less as they age. These hormones seem to affect arousability by altering the threshold for **erotic stimulation.**
They act:

Centrally - by determining the amount of change in arousal produced by a given stimulus.

Peripherally - by determining the amount of receptor response to a stimulus.

In most animal species the brain controls and regulates sexual behaviour primarily by means of hormones. Man and other primates are exceptions to this role because he depends on personal experience and cultural aspects than it does on hormones. However, hormones seem to affect arousability by altering the threshold for erotic stimulation, regardless of whether the threshold in question is one of peripheral tissue sensitivity.

Testosterone and Estrogen:

Sexual desire is initially modulated by the release of sex hormones, for males' testosterone and for females'estrogen; our levels of these hormones are understood to affect our behaviour. Recent studies how found that male testosterone levels increase by approximately 7.8% in males even though they do not consider her attractive. Testosterone, a member of the androgen family of steroids, is secreted in the testes of males and the ovaries of females as well as small amounts from adrenal glands. Arousal causes the cerebral cortex to signal the hypothalamus to stimulate the production of testosterone, the production is regulated by a complex chain of events known as the **hypothalamic-pituitary-gonadal axis**; **Gonadotropin-releasing hormone (GnRH)** is secreted by the hypothalamus, via the hypophyseal portal system, it travels to the anterior pituitary which then releases luteinizing hormone (LH) in order to stimulate the production of testosterone in the testes. Production levels are controlled by negative feedback.

Luteinizing hormones also stimulate the production of estrogen in the ovaries; some estrogens are also produced in other tissues such as the liver and adrenal glands. In females, estrogen synthesis begins in cells in the ovaries by the synthesis of androstenedione, this compound then travels into the surrounding granulosa cells of the basal membrane where it is converted to oestrone or oestradiol, testosterone is also converted to oestradiol at this point.

Other hormonal influences in sexual function include oxytocin, cortisol, pheromones, and prolactin. There is some evidence showing that **oxytocin (produced by dopamine) levels increase during sexual arousal and orgasm in both men and women**.Also the combination of oxytocin and female hormones like estrogen in women, encourage an emotional attachment with a partner. In men, the bonding effect is muted, due to the male's higher testosterone levels. As a result, men form emotional ties slower, and are more likely to regard initial sexual contact as just sex. Studies of men and women with elevated levels of prolactin report decreased sexual interest, arousal, orgasm as well as mood disturbances such as anxiety and depression. Dysfunction in remaining erect has been described in men with both abnormally low and abnormally high prolactin levels. In women, high prolactin has been associated with infertility and decreased sexual activity. Animal studies also suggest that prolactin has an inhibitory influence on both male and female sexual behaviour, although short-term prolactin elevations may play a role in some elements of sexual behaviour in male rats.

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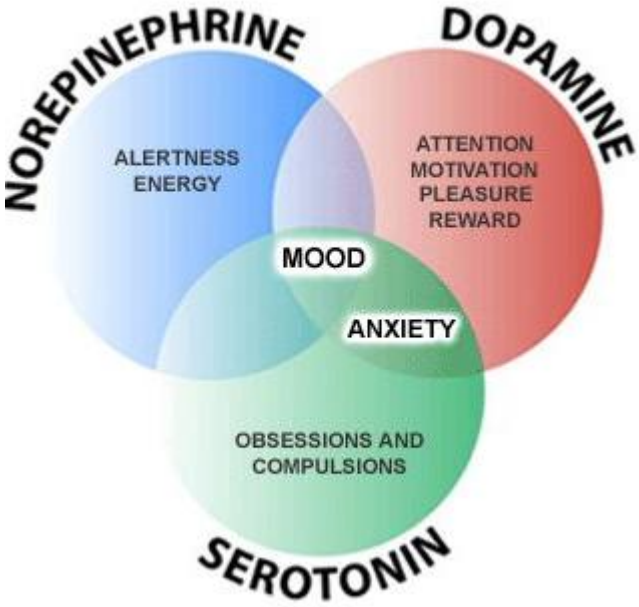
Clearly, this molecule plays many roles in humans but the exact role is uncertain. It is known that prolactin shares a close connection with dopamine in the brain, particularly in the tubero-infundibular tract, which runs along the base of the hypothalamus and releases dopamine into the portal veins of the pituitary gland. Dopamine acts to inhibit the release of prolactin. This, in turn, affects dopamine release. Blockade of dopamine receptors in the tuberoinfundibular tract releases prolactin from the tonic inhibitor control of dopamine, allowing prolactin levels to rise. This self-regulation is critical to prolactin homeostasis, since any disturbance in the connection between the hypothalamus and the pituitary may lead to **hyperprolactinemia** (high prolactin levels).

Neurotransmitters:



Neurotransmittersare types of hormones in the brain that transmit information from one neuron to another. They are made by amino acids. Neurotransmitters control major body functions including movement, emotional response, and the physical ability to experience pleasure and pain. The most familiar neurotransmitters which are thought to play a role in mood regulation are serotonin, norepinephrine, dopamine, acetylcholine, and GABA.

Serotonin:

As a neurotransmitter, serotonin relays signals between nerve cells (neurons), regulating their intensity. Serotonin is regarded by some researchers as a chemical that is responsible for maintaining mood balance, and that a deficit of serotonin leads to depression. Serotonin can affect mood and social behaviour, appetite and digestion, sleep, memory and sexual desire and function. Low serotonin levels in the intoxicated state are thought to contribute to the associated increase in libido, while those taking medication that increase serotonin levels are seen to have a reduction in libido and sexual function.

Dopamine:

Dopamine is a neurotransmitter, one of those chemicals that is responsible for transmitting signals in between the nerve cells (neurons) of the brain. Dopamine is the chemical that mediates pleasure in the brain. It is released during pleasurable situations and stimulates one to seek out the pleasurable activity or occupation. This means food, sex, and several drugs of abuse are also stimulants of dopamine release in the brain, particularly in areas such as the nucleus accumbens and prefrontal cortex. Dopamine is the main neuroendocrine inhibitor of the secretion of prolactin from the anterior pituitary gland.

Epinephrine:

Epinephrine, also known as adrenaline, is a hormone secreted by the medulla (inner part) of the adrenal glands, located on the kidneys. The adrenal glands are one of the body's endocrine glands (glands producing substances that are distributed by way of the bloodstream). The release of epinephrine is exhilarating and creates a surge in energy. Adrenaline causes an increase in heart rate, blood pressure, and works by causing less important blood vessels to constrict and increasing blood flow to larger muscles.

Norepinephrine:

In men, blood plasma NE levels were positively correlated with arousal and erection during masturbation and sexual activity, increased up to 12-fold at orgasm and declined to baseline levels within 2 minutes of reaching orgasm. Studies suggest that norepinephrine is also active during the sexual response cycle of women. Blood plasma levels of norepinephrine increased during masturbation, peaked at orgasm, and slowly declined following orgasm in normally functioning women.

Different lobes of the brain:

The cortex (rind or outer covering) is divided into two sections called the cerebral hemisphere, which are connected by a thick, tough band of neural bodies called the corpus callosum (literally meaning “hard bodies”). Each hemisphere can be roughly divided into four sections by looking at the deeper wrinkles, or fissures, in its surface.

Occipital lobe:

At the base of the cortex, toward the back of the brain is an area called the occipital lobe (the term occipital refers to the rear of the head). This area processes visual information from the eyes in the primary visual cortex. The visual association cortex, also in this lobe, is the part of the brain that helps identify and make sense of the visual information from the eyes. The famous neurologist Oliver Sacks once had a patient who had a tumor in his right occipital lobe area. He could still see objects perfectly well and even describe them in physical terms, but he could not identify them by sight alone. If the occipital lobe is impaired, then the person would not be able to process visual signals, thus it would result in visual confusion.

Parietal lobes:

The parietal lobes are at the top and back of the brain. This area contains the somatosensory cortex, an area of neurons running down the front of the parietal lobes on either side of the brain. This area processes information from the skin and internal body receptors for touch, temperature and body position.

Sexual seizures arising from the parietal cortex have certain distinguishable features. They may involve heightened sexual arousal or sensations in the genitalia or other erogenous areas. The individual is typically conscious and alert during the episodes and can recognize their sexual nature without necessarily finding them pleasurable or eroticism. The "ego alien" quality of some parietal sexual seizures has been highlighted by several case studies which noted that focal genital sensations may be described by patients as irritating, painful or frightening.

Temporal lobes:

The temporal lobes are found just behind the temples of the head. These lobes contain the primary auditory cortex and the auditory association area. The area of the limbic system most frequently implicated in the mediation of human sexual behaviour is the temporal lobes. Accumulating evidence of changes in sexual behaviour following temporal lobe dysfunction has led to the phrase the **"libidinous temporal lobe"** (libidinous meaning 'driven by excessive sexual drive')

Frontal lobes:

The frontal lobes located at the front of the brain help in all the higher mental functions of the brain- planning, personality, memory storage, complex decision making. The frontal lobe also helps in controlling emotions by means of its connection to the limbic system. Activation of numerous frontal regions, including the right prefrontal cortex, anterior cingulate cortex and gyrus (situated in the medial aspect of the cerebral cortex) and orbitofrontal region has been observed during sexual arousal involving masturbation induced orgasm. Orbitofrontal activation has been interpreted as being related to the representation of pleasant bodily sensations,while dorsal anterior cingulate activation has been attributed to the modulation of skeletomotor activities that characterize sexual arousal and the perceived urge to act. Ferretti and colleagues found that during the initial phase of erection anterior cingulate activation peaked and was then maintained while the erection was sustained. They suggested that the activation may reflect the continual correspondence between the affective value of the stimulus and the sexual response. These studies complement those of lesion studies in identifying a critical role of the frontal lobes in human sexual response.

PARAPHILIA AND NEUROSCIENCE:

Neuroscience research is an excellent approach to understand basic brain difference between those with and without compulsive sexual behaviours, though it has rarely been applied to this population. There is an increasing evidence of link between abnormal brain states (fronto-temporal pathology) and sexually deviant behaviour. An abnormal brain state involving fronto-temporal pathology may underlie their Paraphilia. EEG studies using computerized techniques have pointed to important finding of brain- behaviour relationships in the paraphilias.

Hypersexual behaviours have been reported in patients with frontal lobe lesion, tumors and in those with neurological conditions that involve temporal lobes and midbrain areas such as dementia.

A **frontal lobe brain injury** refers to a **traumatic brain injury** that affects the front area of your brain. This is the brain's largest lobe. The frontal lobe damage may trigger the expression and could also explain the increased sexual activity along with decreased control. Orbital frontal damage can introduce abnormal sexual behaviour, while dorsolateral lesions may reduce sexual interest (Walker and Blummer, 1975). Also, temporal and extra temporal lesions were significantly more common in patients with sexual disorders. Also, an association between temporal lobe abnormalities and pedophilia has been reported by Mendez and colleagues.

A **brain lesion** is an area of injury or disease within the brain. It may be caused by injury, infection, exposure to certain chemicals, problems with the immune system, etc.

A **brain tumor** is a collection (or masses) of abnormal cells in the brain. The skull is a very rigid and the brain is enclosed, so any growth inside such a restricted space can cause problems.

Kolarsky et al proposed that some paraphilicbehaviour may be **causedby early lesions orsimilar abnormalities of the left temporal lobe**. Patients with lesions in the left

temporal lobe were more likely to exhibit paraphilicbehaviours than those patients who were not brain damaged or whose lesions were in different areas of brain. Also, if the lesions occurred early in life, the patient was more likely to exhibit paraphilias.

Hyper sexuality and fetishism were found in patients with multiple sclerosis showing frontal and temporal lesions. Joyal et al concluded that this basal fronto- temporal profile was not the characteristic of just sexual deviance, but also that of delinquency and crime in general. It was concluded b many authors that frontal and temporal lobes are in some way involved in inhibitory control of sexual behaviour, and when their functioning is compromised it may lead to paraphilicbehaviours and sexual offences. EEG abnormalities have been found in paraphiliacs, pointing to brain pathology.

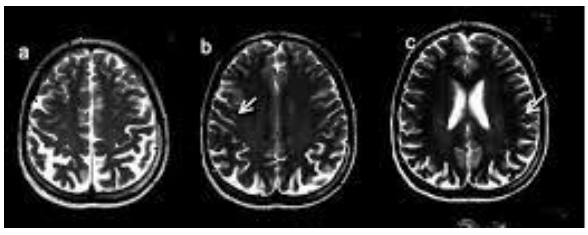
Neurotransmitter studies have focused on monoamines such as serotonin, dopamine, and norepinephrine. These central monoamines are synthesized and released by relatively a small number of neurons whose cell bodies lie in the brain stem, but whose projections extend throughout the brain.

1. An increase in norepinephrine activity enhances sexual behaviours.

2. A decrease in dopamine decreases male sexual appetitive behaviour whereas pharmacological enhancement of dopamine can augment male sexual behaviour.

3. A decrease in brain serotonin is associated with the increase in appetitive sexual behaviour and vice versa.

It is known that sensations such as pain and violence and emotions such as sex and love are associated with the release of epinephrine (adrenaline) which in turn leads to the release of neurotransmitters. The brain interprets the increase in monoamine transmitters, according to what is present in the environment. If the circumstances are favourable, the increase could be perceived as feelings of love and sex. In certain circumstances which are not well understood the brain may make mistakes, and may perceive a painful stimulus as sexual as happens in masochism.



Above shown are the MRI scans of brain that represent various lesions caused in the different lobes in the brain that may further lead to disorders such as paraphilia.

In the above images (A-C) denote atrophy in the parietal and frontal lobes as well as sub-cortical lesions in the frontal white matter (denoted by arrows in B, C). These are the MRI scans of an individual with **"sleeping beauty paraphilia"** (a deviant sexual behaviour in which the person gets aroused by seeing a **sleeping woman**).

CRIME:

A crime can also be defined as a wrongful conduct defined by law as being punishable by imprisonment, a fine or other penalty.

Crime is defined as an act of commission or omission which constitutes an offence and is punishable by law. There are many different types of crimes, but generally crimes can be divided into four major categories:

1. **Personal crimes**: ***"Offenses against the Person".*** These are crimes that result in physical or mental harm to another person. Personal crimes are those that result in physical or mental harm to another person. They can be divided into two main categories, forms of homicide and other violentcrimes. Where the physical harm to another individual is so severe that it causes death, a defendant may be charged with any one of several types of homicide, including, for example, first degree murder, voluntary manslaughter, or vehicular homicide. Personal crimes include:

- Assault
- Battery
- False Imprisonment
- Kidnapping
- Homicide – crimes such as first and second degree, murder, and involuntary manslaughter, and vehicular homicide
- Rape, statutory rape, sexual assault and other offenses of a sexual nature

2. **Property crimes**: Property crimes typically involve interference with the property of another. Although they may involve physical or mental harm to another, they primarily result in the deprivation of the use or enjoyment of property. Many property crimes are theft crimes, including burglary, larceny, robbery, auto theft, and shoplifting. The object of the theft-type offenses is the taking of money or property, but there is no force or threat of force against the victims.

3. **Inchoate crimes**: Inchoate crimes refer to those crimes that were initiated but not completed, and acts that assist in the commission of another crime. Inchoate crimes require more than a person simply intending or hoping to commit a crime. Rather, the individual must take a "substantial step"

towards the completion of the crime in order to be found guilty. Inchoate crimes include abetting, attempt, and conspiracy. In some cases, inchoate crimes can be punished to the same degree that the underlying crime would be punished, while in other cases, the punishment might be less severe.

4. **Statutory crimes**: Statutory crimes include those crimes which are prescribed by the statute. Three significant types of statutory crimes are alcohol related crimes, drug crimes, traffic offenses, and financial/white collar crimes. These crimes are specifically prohibited by statute because society hopes to deter individuals from engaging in them. It includes crimes such as drug offence, traffic offence, etc.

PARAPHILIA AND CRIME:

Violent crimes include crimes where intentional harm is inflicted against another individual during the commission of the crime. Additionally, violent crimes can include the threat of intentional harm. The infliction of the harm can include the use of weapons, poison, bodily contact, and more. Most violent crimes are felony crimes. These are considered the most serious crimes and carry a sentence of one year or more in prison. Violent crimes include sexual assaults as well.

The link between sexual disorders and crime has been widely discussed from a range of perspectives, especially when it comes to paraphilias. Therefore, certain paraphilias or paraphilic fantasies can involve illegal acts. Assuming that a person who commits a sex crime must be diagnosed with a paraphilia reflects the wrong idea that the disorder by itself is sufficient to engage in criminal conduct.

Paraphilia can lead to violent sexual crimes. However, simply having Paraphilia is, obviously, not illegal. Acting in response to paraphilic urges, however, may be illegal and in some cases subjects the person with paraphilia to severe sanctions. The distinguishing phenomenological characteristic of paraphilias is an intense craving or urges to fantasize or engage in some form of sexual expression that most people would not find erotic. Most people simply do not experience such cravings. These urges are often difficult and, in some cases, may even be impossible to control. It is this putative lack of impulse control that underlies the insanity defence in trials alleging sexually criminal behaviour. Such defences are based on **impaired mental capacity** and are sometimes, although infrequently, successful.

JUVENILE DELINQUENCY:

One of the serious problems in the society today is juvenile delinquency. It has been the national concern since 1940s though it is too often seen as something 'new'. Government has found it necessary to give attention to the issue of crime by juveniles just as it has to deal with other forms of crime and violence, which generally disrupts the peace of society. A juvenile is a child or young person between **7-17 years** of age. The dictionary defines juvenile as young individuals no longer babies but not yet fully grown.

Delinquency on the other hand, is defined as the quality or the state of being delinquent; a tendency towards behaviour that is not in accordance with accepted social standard or with the law; having a tendency to exhibit socially unacceptable behaviour. Juvenile delinquency therefore is an antisocial misdeed in violation of the law by a minor that is punishable. In other words, **it is a conduct by juvenile characterized by antisocial behaviour beyond parental control and therefore subject to legal action**. The law also defines delinquent juvenile as a young person who has violated the criminal code.

Delinquency itself is socially inadequate adjustment on the part of the individual to difficult situations. The factors which go to make up these difficult situations, together with the mental and physical conditions which influence an individual's capacity to adjust, constitute the causes of delinquency. Each juvenile offense is the outcome of a complexity of causes, some of whose origins date back years before the committal of the offense and others whose origins are more obviously and immediately connected with the act of delinquency. It has been shown that a different set of causes is involved in each individual case. It is impossible therefore to state the group of causes which will invariably result in any particular offense. The factors which operate to turn a child's behaviour in one direction rather than another may be very obscure, many as yet are beyond the detection of expert sociologists, psychologists, physiologists and others.

There are various offenses committed by juveniles. Many of these are sexual offenses but offenses related paraphilias are not noted as such amongst the juveniles.

One of the major reasons behind the paraphilic offences committed by juveniles is the inappropriate relationships with their family. Alexander (1992) suggested that parents' insecure patterns of attachment, their disturbed style of relating, and their sexually abusive behaviour become models for child who later goes on to be sexually abusive himself. Children or juveniles learn most of the things by "**Observational learning**" (**Albert Bandura, 1961)**, which is learning from the visuals seen practically through their eyes or observed their elders practicing such a behaviour.

"Happy families are all alike; every unhappy family is unhappy in its own way."
– Leo Tolstoy, Anna Karenina

The concept that "**attachment**"—the notion that high-quality, close family relationships characteristic of happy families constitutes a strong protective factor against delinquency—has been posited by a number of prominent criminologists. Most notably, **Hirschi** (1969) held that attachment, in conjunction with commitment, involvement, and belief, is critical and "**foundational**" **(Mutchnick, Martin, & Austin, 2009)** to creating and maintaining the social bond. Although all facets of the social bond are important, Hirschi stressed that attachment is the most critical element in the creation and maintenance of a positive parent-child relationship.

Within the concept of attachment, which includes relations with peers, siblings, teachers, and parents, the link to parents is the most critical aspect of attachment itself **(Hirschi, 1969;Nye, 1958).**Young people who are unable, by dint of disposition or circumstance, to attach to parents will presumably have an impaired ability to attach to significant others outside the immediate parental orbit and may find that involvement in conventional activities, commitment to conventional goals, and belief in the validity and relevance of the greater social system is also impaired.Hirschi stated:

"The more the child is accustomed to sharing his mental life with his parents, the more he is accustomed to seeking or getting their opinion about his activities, the more likely he is to perceive them as part of his social and psychological field, and the less likely he would be to neglect their opinion when considering an act contrary to law—which is, after all, a potential source of embarrassment and/or inconvenience to them." (Hirschi, 1969, p. 90).

Attachment to parents has a strong indirect influence that deters the child from deviant acts. "The stronger this bond, the more likely the person is to take it into account when and if he contemplates a criminal act" (Hirschi, 1969, p. 82) and would then, presumably, desist. Thus, in a high-quality relationship between child and parent, the parent is a truly significant other whose opinion and regard are taken seriously; the notion of attachment, therefore, binds the parent and child in the bonds of a mutual filial-parental love. One of the paraphiliccase amongst juveniles is **"The Lust Killer"** case of Jerome Henry "Jerry" Brudos (1939–2006) of America (explained in detail in the case study section).

STATISTICS:

A high percentage of sex offenders and sexually motivated murderers are paraphiliacs. Completed paraphilic episodes were highest for exhibitionism, frottage, non-incestuous pedophiliacs and voyeurism. The range of paraphilia included sexual deviant behaviour such as sadism, fetishism and public masturbation.

G.Abel and colleagues found a high rate of multiple paraphiliacs among paraphiliacs. Nearly one-fourth of the paraphiliacs committed offenses against family, members and non-family victims, 20% of them committed offenses against both the sexes. More than half the paraphiliacs had at least one sexually deviant interest before the age of 18. It was found that 80% of the paraphiliacs, who had committed at least four victimizations, had perpetrated their first act before the age of 20.

In a study conducted for a group of about 561 individuals the cumulative age of onset of the first paraphilia of all the adult subjects were calculated. Accordingly, fifty percent (50%) of voyeurs had interest in that deviant behaviour prior to age 15; 50% of male non-incest pedophiles by age 16; 50% of frotteurs by age 17; 50% of exhibitionists by age 18. More than 40% of female non-incest pedophiles had acquired that interest by age 18; 40% of male incest pedophiles, 30% of rapists, and 25% of female incest pedophiles had acquired their interests prior to age 18.

Of the 53.6% of adult offenders reporting the onset of deviant sex interest prior to age 18, each reported two different paraphilias and an average commission of 380.2 sex offenses by the time he reached adulthood. Similar information from adolescent sex offenders (**younger than 18**) revealed that each adolescent with **child molestation or rape represented by 54.1% of his deviant sex acts.**

These data reveal that the majority of sexual assaulters developed deviant sexual interest prior to age 18. Ample evidence, however, confirms that sex offenders with chronic careers do develop that interest at a very early age. **Assessment- treatment programs must therefore be established to accommodate these young sex offenders**.

Histories from offenders clearly indicate that one individual can have multiple paraphilic interests throughout his lifetime. As an initial paraphilia fades, a second paraphilia begins, accelerates in frequency, and may overtake the initial paraphilia as the most common deviant sexual behaviour, in this fashion; some sex offenders have as many as 10 categories of paraphilic interests throughout their lifetime. Further study was also conducted to know whether individuals who had committed assaultive crimes (rape, child molestation, and frottage) also committed non-assaultive paraphilicbehaviours (public masturbation, voyeurism). This led to the result that **59% participated in assaultive deviant behaviour** only, while **14.9% participated in non-assaultive behaviour** only. However **26% usedboth touching and non-touching behaviours** when offending against their victims.

It is commonly assumed that paraphiliacs involved within their family will not offend against a nonfamily victim. In this sample**, 315 men (56.1%) participated in non-incestuous deviant behaviour only, and 68 (12%) participated in incestuous behaviour only. Nonetheless, 131 individuals (23.3%) offended against both family**

and nonfamily victims, irrespective of familial relationship. Also it was found that paraphilic members in any one specific category were concurrently involved, or had been involved, in other specific categories of paraphilicbehaviour. These data contradict the conventional literature that paraphiliacs have one and only one specific category of deviant sexual behaviour. These results reflect that the majority of paraphiliacs have or have had multiple, specific categories of paraphilic interest.

Although in some cases the age of the preferred victims remains in a distinctive age range, a large percentage of offenders perpetrate sex crimes against the very young, adolescents, and adults. Furthermore, although a large percentage of offenders perpetrate crimes against one gender, a significant proportion perpetrate crimes against victims irrespective of gender. Although over half of this sample's offenders perpetrated only assaultive sexual behaviours, while a minority perpetrated only non-assaultive sexual behaviours, a surprisingly high percentage perpetrated only non-incestuous sex crimes, incestuous sex crimes, or both, it was found that a significant proportion perpetrated sex crimes both outside and within the family.

Since many offenders assault victims of various ages, various genders, with both assaultive and non-assaultive behaviour, and both outside and within their families, one can only conclude that sex offenders have a general deficit that assaults may use a diagnosis of paraphilic rape as a means to escape the criminal justice system. In practice, this has not been the case. To be identified as a paraphiliac, a rapist must have a recurrent, compulsive urge and need to repetitively carry out psychologically driven rape. These features permit rape's incorporation into the category paraphilia. Such a categorization raises the issue of the offender's need for psychiatric and psychological treatment before he can gain control over his sexual assaultiveness. In our culture, this has meant that not only must the individual so categorized serve his time for his illegal act of sexual assault, but he must also serve time receiving psychiatric and psychological treatment for his paraphilia.

According to a survey conducted on the pedophiliacs, the mean number of victims for one pedophile is around 20. The survey reported a median number of 11 unknown victims for those who are attracted to males and of 1.5 for those attracted to females. In case of **intrafamilialpedophilias**, the median number was **4.5 for those attracted to females** and **5 for those attracted to males**. Moreover, in an anonymous survey conducted among 377 **extra-familial pedophilic subjects**, the mean number of victims reported by **pedophilesattracted to females was 20 as compared with 150 among those attracted to males**; in the case of intrafamilialpedophilia the rates dropped, respectively, to 1.8 and 1.7.

Although not in the current DSM listed criteria, paraphilic activities that involve sexual predation are likely to affect a wide range of individuals from the general population, through to the individuals' families, and most importantly have significant impacts upon the victims of their abuse. For the general population, the effects of sexual abuse may produce a possible fear of crime related to sexual offending. For the families of sexual abusers, the public stigma of having a family member arrested for their sexual behaviour may be difficult.

VICTIMOLOGY:

A victim is an individual who experiences loss, injury, or hardship as a result of an illegal act. A direct/ primary victim is the one who experiences criminal act and its consequences first hand whereas an indirect/ secondary victim is the family and those who suffer emotionally or financially but are not immediately involved or physically injured.

Victimology can be defined as the scientific study of physical, emotional, and financial harm people suffers because of illegal activities. Included in this definition is the victimization occurring for victims within the criminal justice system.

Victimization: **Victimization can be defined as the unwarranted singling out of an individual or group for subjection to crime, exploitation, tort, unfair treatment, or other wrong.**

For the victim of contact sexual offenses, there are a number of physical and psychological effects of sexual victimization, including physical injuries, secondary victimization, and psychological trauma. Physical injuries can include non-genital physical injuries, vaginal and/or anal lacerations, bleeding, and pain. Secondary victimization can occur through post-assault medical investigations, such as injury detection, forensic medical examination, evidence collection, and screening and treatment for sexually transmitted infections and pregnancy. As for psychological trauma symptoms, these can include increased risk of Post-Traumatic Stress Disorder, depression, substance abuse, suicidality, and panic attacks. The lifetime prevalence for major depression is three to five times more common in women that have been abused, compared to the non-abused population. As for sexual abuse effects upon child victims, this has been related to a number of negative behavioural outcomes, such as: fear, nightmares, regressive/withdrawn behaviour, cruelty towards others, delinquency, running away, poor self-esteem, general behaviour problems, and sexually inappropriate behaviours. Children reporting sexual abuse involving intercourse, compared with non-abused children, had an increased incidence of major depression and suicide attempts. A variety of adult psychiatric conditions arising from child sexual abuse have also been reported including anxiety and acute stress disorders. While, sexual offenses are mainly carried out against females, male victims may

experience many of the same symptoms that are observed in women. Men also experience additional problems with reconciling their sexual identity with their victim experience.

FORENSIC CONSIDERATIONS:

Simply having paraphilia is, obviously, not illegal. Acting in response to paraphilic urges, however, may be illegal and in some cases subjects the person with paraphilia to severe sanctions. The distinguishing phenomenological characteristics of paraphilias are an intense craving or urge to fantasize or engage in some form of sexual expression that most people would not find erotic. Most people simply do not experience such cravings. These urges are often difficult and, in some cases, may even be impossible to control. It is this putative lack of impulse control that underlies the insanity defence in trials alleging sexually criminal behaviour. Such defences are based on impaired mental capacity and are sometime, although infrequently, successful.

The importance of these distinctions, particularly the phenomenology of paraphilias, cannot be overemphasized: **all sex offenders are not necessarily persons with paraphilia and vice versa.** Forensic considerations aside, it is quite possible to be a person with paraphilia on the proverbial desert island without becoming a sex offender.

It is also crucial to recognize the differences between working in the forensic arena and more conventional treatment settings. Treatment providers who are not comfortable with the adversarial nature of forensic psychiatry and the milieu of the courtroom may be reluctant to treat patients with paraphilia who are also sex offenders.

TREATMENT:

The various paraphilic disorders affect a wide variety of people. The level of severity, distress, and impairment (up to and including criminal behaviour) resulting from these disorders also are highly variable. Consequently, treatment options vary and must take into account the specific needs of each individual case.

Treatment options may include psychotherapy, individual psychotherapy, group therapy, marital therapy, and family therapy, as well as pharmacotherapy or even surgical interventions, as indicated.

Inpatient treatment is indicated for patients who are suicidal, homicidal, or disabled to the point where they cannot take care of themselves. Suicide risk is high if they feel exposed or confronted. If patients are charged with a crime or have been arrested, they may be incarcerated.It must be taken into consideration that not every therapist treats people with paraphilias. There may be a need for consultations with other professionals, such as a neurologist (if neurologic signs are present), an attorney, or even a member of the clergy.

A. Psychotherapeutic Interventions:

I. Cognitive-behavioural therapy:

Cognitive-behavioural therapy (CBT) involves applying behavioural therapy techniques to modify sexual deviations by altering patients' distorted thinking patterns and making them cognizant of the irrational justifications that lead to their undesirable sexual behaviours. It may be employed in accordance with a 7-step approach, as follows:

1. **Aversive conditioning** (involves negative stimulus to reduce or eliminate a behaviour) with ammonia or (masturbatory) satiation.
2. Confrontation of cognitive distortions (especially effective in groups)
3. Victim empathy (showing videos of victims and the consequences they experience from the patient's act)
4. Assertiveness training (including social skills training, time management, and structuring)
5. Relapse prevention (identifying antecedents to the behaviour [high-risk situations] and ways of disrupting these antecedents)
6. Surveillance systems (family associates who help monitor patient behaviour)
7. Lifelong maintenance

The incorporation of relapse prevention techniques helps the patient control the undesirable behaviours by avoiding situations that may generate initial desires. The commonly employed technique of **covert sensitization** (entails the patient relaxing, visualizing scenes of deviant behaviour) pairs a patient's harmful sexual variation with an unpleasant stimulus in order to discourage repetition of the act. This approach has proved effective in many cases of pedophilia and sadism.

II. Orgasmic reconditioning:

In orgasmic reconditioning, a patient is reconditioned to a more appropriate sexual stimulus. First, the patient is instructed to masturbate to his or her typical, less socially acceptable stimulus. Then, just before orgasm, the patient is told to concentrate on a more acceptable fantasy. This process is repeated at progressively earlier points before orgasm until, eventually, the patient begins his or her masturbation fantasies with an appropriate stimulus.

III. Social skills training:

Because of the widespread view that paraphilic disorders develop in patients who lack the ability to develop relationships, many therapists and physicians use social skills training to treat patients with these types of disorders. They may work on such issues as developing intimacy, carrying on conversations with others, and assertive skills training. Many social skills training groups also teach basic sexual education, which is very helpful to this patient population.

IV. Twelve-step programs:

Many physicians and therapists refer patients with paraphilias to 12-step programs designed for sexual addicts. Like Alcoholics Anonymous, these programs are designed to give control to group members, who lead most of the sessions. To increase awareness of the problem, the programs incorporate cognitive restructuring with social support. The group also focuses on the sense of a "higher power" and each individual's reliance upon his or her spirituality.

V. Group therapy:

Group therapy in this setting is designed to help paraphilic individuals break through the denial they so commonly exhibit by surrounding them with other patients who share their condition. Once these individuals begin to admit that they have a sexual divergence, the therapist can begin to address individual issues (e.g., past sexual abuse) that may have led to the sexual disorder.

When these individual issues have been identified, initiation of gestalt-type therapy (with the victim, if any) may be desirable to help patients get past the guilt and shame associated with their particular paraphilia. The goal of this type of therapy is to lead the patient to a "healthy remorse." These patients require lifetime therapy to reduce the likelihood of relapse.

VI. Individual expressive-supportive psychotherapy:

Individual expressive-supportive therapy requires a psychologically minded patient who is willing to focus on the paraphilia. The therapist should not set unrealistically high goals but must break through the denial. Patient countertransference and avoidance can be particular problems with this form of therapy. If the therapy enables the patient to break through the denial, he or she can then work on the unconscious meaning behind the particular paraphilia.

B. Pharmacologic Therapy:

Pharmacologic interventions may be used to suppress sexual behaviour. These treatments may offer genuine help to a variety of patients with paraphilic disorders; however, numerous adverse effects have been reported. Additionally, ethical, medical, and legal questions have been raised regarding issues of informed consent, especially in hospital and prison settings.

Medications that may be considered in the treatment of paraphilic disorders include the following:

- A class of drugs called **antiandrogens** are used. These drugs drastically lower the testosterone levels temporarily. It also lowers the sex drive in males and reduces the frequency of mental imagery of sexually arousing scenes.
- **Medroxyprogesterone acetate (Depo-Provera)** and **Cyproterone acetate**: These hormones decrease the level of circulating testosterone thus reducing sex drive and aggression. These hormones result in reduction of erections, sexual fantasies and initiations of sexual behaviours including masturbation and coitus.
- **Antidepressants** such as fluoxetine (Prozac) have also decreased the sex drive but have not effectively targeted sexual fantasies.

C. Surgical Interventions:

Psychosurgery using **stereotactictractotomy** (production of lesion in fibres of caudate nucleus in brain, used as a surgical technique to relieve intractable depression, anxiety or obsessional states) and **limbicleucotomy** (a psychosurgical technique. Also determines lesion sites and lesion symmetry in brain) may be performed. This is an invasive, irreversible procedure that was used on a small number of subjects, primarily in Germany. Some success has been reported in the treatment of pedophilia, hypersexuality, and exhibitionism. Given its emotional, physical, and intellectual adverse effects, as well as the availability of suitable pharmacologic interventions, this procedure is not likely to be widely used.

Bilateral orchidectomy, meaning surgical castration that is removal of testes (**Weinberger, Sreenivasan, Garrick, &Osran, 2005)** has been used since the 19th century in Europe and America, though not in Western Europe since the 1970s. Given the adverse effects of the procedure (e.g., weight disturbance, gynecomastia, hot flashes, osteoporosis and bone pain in elderly patients, depression), it also is not likely to be widely used; pharmacologic interventions provide a reversible alternative.

Considerations for particular paraphilic disorders:

For adults with exhibitionistic disorder (sociopaths excluded), **group therapy** has been effective in improving social skills and providing support against additional offenses. Group therapy has been effective with shy inhibited adolescents but not with compulsive instinct-ridden adolescents. Individual psychotherapy has been helpful with many exhibitionists. Unfortunately, exhibitionism has one of the highest recidivist rates of all sexual offenses. Fetishistic disorder often begins in adolescence and usually persists. Treatment of the specific fetish rather than the primary underlying dynamic has not been very promising. **Behavioural techniques** show some promise, particularly when aided by adequate follow-up. Many individuals with paedophilic disorder have had sexual fantasies about children for a long time. Consequently, change can be very difficult. Thephysician can try to reduce the intensity of the fantasies and help the abuser develop coping strategies. The abuser must be (but often is not) willing to acknowledge the problem and to participate in treatment. **Dynamic psychotherapy, behavioural techniques, chemical approaches, and surgical interventions yield mixed results**. Lifelong maintenance may be the most pragmatic and realistic approach.

Unfortunately, individuals with sexual masochism or sadism disorder rarely present for treatment until someone becomes an unwilling partner or is injured. The seriousness and intensity of these behaviours often increase over time. Prognosis varies, depending on the depth of the underlying dynamics (which are especially poor when sociopathy is involved) and the patient's level of motivation.

SOCIETY'S VIEWPOINT ON PARAPHILIA AND ITS TREATMENT:

"No mass disorder…afflicting humankind has ever been brought under control by attempts to treat afflicted individuals." -George Albee Ph.D.

The understanding of non-procreative sexual behaviour has always been the toughest riddle in sexual science, and there are still more questions than answers. Social scientists, anthropologists and historians have argued that everything depends on the structure of the society - its norms, values, concepts, scripts, etc. Even the concept of sexuality itself is an arbitrary construct, which is only about 120 years old and does not have the same meaning in other cultures as in our own. It has been shown by etiologists that non-procreative sexual behaviour is common among non-human primates. Behaviours such as "homosexuality" and "pedophilia" are functional among apes, and probably among humans as well. When such behaviours occur among humans they may violate moral norms, but not biological laws.

The therapeutic methods were also criticized and considered to be ineffective as well as dangerous. Throughout the history of sexology numerous therapists have claimed their ability to cure paraphilias, but later investigations have always shown that the therapies were ineffective, and not infrequently the patients have fooled the therapists in order to escape further treatment. Also, the **aversion therapy may be regarded as torture**. When prolonged physical punishment is used to suppress a non-dangerous behaviour such as fetishism, it was said that the ends do not justify the means. The physical pain may be severe, yet bearable, but the psychological pain is worse. The rationale behind cognitive therapy is that the world view of the therapist is believed to be right and when the world view of the patient is different he is said to suffer from cognitive distortion. It is a basic doctrine in philosophy that there are no objective standards of truth. The patient may have a better knowledge of his own situation than the therapist, and the latter has no justification for saying that his perception is truer than that of the patient.

Sexual Offenders are often stereotyped and regarded with a special hostility by the general public and there is often reluctance to have treatment facilities in the community. Also, risk of recidivism has to be considered. **Recidivism** is one of the most fundamental concepts in criminal justice**. It refers to a person's relapse into criminal behaviour, often after the person receives sanctions or undergoes intervention for a previous crime.** Recidivism is measured by criminal acts that resulted in re-arrest, reconviction or return to prison with or without a new sentence during a three-year period following the prisoner's release.

Despite a spate of studies suggesting statistically acceptable low recidivism rates for sex offenders who have undergone treatment, the public is very wary of whether sex offenders can benefit from treatment. It has been difficult to change public attitudes towards the treatment of paraphilics. Indeed, despite a number of studies highlighting the effectiveness of specialized treatment, the public perception is that it does not work. Most clinicians treating individuals aspire for an 80% rehabilitation (not cure) rate, yet the findings of an average rate of 86% for offenders is not accepted as high enough because there is zero tolerance among the public for any form of relapse.

A postal survey was conducted in the United Kingdom (Brown, 1999). This investigated stereotypes about sex offenders and attitudes towards their treatment. Generally it was felt that the treatment of sex offenders was undesirable.

- 51% of the public felt treatment of sex offenders was a good idea.
- 35% could not determine.
- 13% said that sex offenders should never be given therapy.

- Generally a mixture of custodial sentence together with treatment was seen as acceptable; therapy alone was unacceptable to the public.

LITERATURE REVIEW:

A deep and detailed study regarding paraphilia and its related disorders and crime has been undertaken by various psychologists across the globe. The effects of this on the society as a whole and the individual have also been considered in these studies. These studies have helped us in the construction and framework of this paper.

Richard Freiherr von Krafft-Ebing was the first scientist to undertake a major study of sexual perversity in its varied forms. The term 'Paraphilia' was coined by him in his book ***"PsychopathiaSexualis"*** in 1886. Krafft-Ebing found that among many manifestations of psychopathia, sexual deviance was routinely unexplored and merely dismissed as insanity. He launched a lifelong endeavour to demystify this form of mental illness by approaching the topic objectively and without shrinking from its more distasteful forms. Beyond Krafft-Ebing's careful categorization and discussion of various forms of sexual perversity, he also studied 45 case histories.

Gene Abel and Osborne conducted a survey on 561 paraphilia affected individuals. The assessment technique for paraphilia given by Abel called the **Abel Assessment** has also gained importance. Osborne conducted the evaluation and treatment of the full range of sexual disorders with individuals, couples and groups, with particular interest in the paraphilias and non-paraphilic sexual compulsivity; research in sexual behaviour; contributing to medical education in human sexuality.

Martin Paul Kafka (1947) is an American psychiatrist best known for his work on sex offenders, paraphilia and paraphilia-related disorders such as sex addiction and hyper sexuality. Kafka proposed the use of drugs for the treatment of paraphilia as these drugs regulate monoamines such as dopamine and norepinephrine, but especially serotonin. He states that "sexual deviance is linked to an as-yet-unidentified dysregulation affecting the serotonin system."

John Money (1921-2006) proposed and developed several theories and related terminology, including genderidentity, genderrole, gender-identity/role, and lovemap. He also changed the word "perversions" to "paraphilias", striving towards less judgmental descriptions, and the word "sexual preference" to "sexual orientation", arguing that our attractions are not necessarily matters of free will. Money studied pedophilia, in particular, and he identified a distinction between love-based attraction to children and sadistic pedophilia.

Ray Blanchard (1945) is known for his research studies and views on pedophilia, transsexualism, and sexual orientation. He published research studies on phallometry and several paraphilias, including transvestism and autoeroticasphyxia. He has coined the term autogynephilia which means the tendency of a man to be sexually aroused at the mere thought of him as a woman. Blanchard now wants to include autogynephilia in the DSM and make everyone understand that one can either be a mild fetishists or suffering from a paraphilic disorder.

CASE STUDIES:

A case study is an account of an activity, event or problem that contains a real or hypothetical situation and includes the complexities you would encounter in the workplace. Case studies are used to help you see how the complexities of real life influence decisions.The case study is not itself a research method, but researchers select methods of data collection and analysis that will generate material suitable for case studies. Case studies are widely used in psychology and amongst the best known were the ones carried out bySigmund Freud. He conducted very detailed investigations into the private lives of his patients in an attempt to both understand and help them overcome their illnesses.

Strengths of Case Studies

- Provides detailed (rich qualitative) information.
- Provides insight for further research.
- Permitting investigation of otherwise impractical (or unethical) situations.

Case 1

Karen Greenlee (Necrophilia):

Karen Greenlee(1956–) is one of the very few—and surely the most widely known—female necrophiles. She was employed at Sacramento Memorial Lawn mortuary as an apprentice embalmer. She came to public attention when in 1979 she stole the dead body of John Mercure, a 33-year-old man, apparently for necrophilic activities. She was to deliver his body to a cemetery for a funeral. Instead, she drove off in the hearse and kept the dead body for herself. She was discovered in the hearse with the dead man 2 days later in an adjacent county overdosed on codeine. As California at that time had no law related to necrophilia, she was charged only with stealing a hearse and interfering with a funeral. She received 11 days in jail, a $255 fine, 2 years' probation, and a recommendation for medical treatment. Mercure's mother, on her part, sued for severe emotional stress and received

$117,000.33. It was not the first time Greenlee had felt such a sexual attraction to the dead. She had put a four-and-a-half page letter in Mercure's casket that detailed her earlier necrophilic episodes with between 20 and 40 male corpses. In the letter, she called herself a morgue rat. She wrote, "Why do I do it? Why? Why? Fear of love, relationships. No romance ever hurt like this . . . It's the pits. I'm a morgue rat. This is my rathole, perhaps my grave." On interrogation, she revealed that she did not understand why she felt so compelled to touch dead bodies; it was an addiction she could not seem to break.

Interpretation:

Karen Greenlee, an employee of Sacramento Memorial Lawn Mortuary in California was accused for stealing dead bodies from the mortuary. It was Greenlee's strong sexual attraction towards dead which compelled her to steal the corpses from the morgue. This deviant nature of Greenlee was discovered when she had put a four and a half page letter in her last victim's casket where she described her necrophilic behaviour. It was interpreted later from her letter that she had a fear of getting hurt through her relationships which led her to develop her this disorder and she was also guilty for her acts. She called herself a "morgue rat".

Case 2

Jerome Henry (Multiple paraphilia):

Jerome Henry "Jerry" Brudos (1939–2006) was an American necrophile who suffered from a number of additional paraphilias—most notably fetishism and transvestism. He is more often known for his foot and shoe fetishism and for this reason is often known as "The Shoe Fetish Slayer." He is also sometimes referred to as "The Lust Killer." Brudos developed a particular fetish for women's shoes, especially black, spike-heeled shoes, from the age of 5, after having played with spike-heeled shoes at a local junkyard. This unique fixation with shoes persisted for life. Toward the end of his life, while incarcerated, Brudos had piles of women's shoe catalogues in his cell. He even wrote to major shoe companies asking for catalogs, and claimed they were his substitute for pornography. At age 17, he abducted and beat a young woman, threatening to stab her if she did not follow his sexual demands. These included disrobing her and taking pictures of her in the nude. For this crime, he was institutionalized in a psychiatric ward at Oregon State Hospital for 9 months. There it was found his sexual fantasies revolved around his hatred and revenge against his mother and women in general. He told therapists there that one recurrent fantasy he used to have involved putting women into freezers so that he could arrange their stiffened bodies into pornographic poses.

Interpretation:

This is a case of Brudos who was suffering from multiple paraphilias, specifically noted, fetishism and transvestism. Brudos had a particular fetish for women's spike heeled black shoes. An assumed reason behind this particular fetish can be predicted that he used to play with such shoes in his childhood since he was 5 years old. Due to this he was commonly called "The shoe fetish slayer" and "The lust killer". At the teenage he threatened and forced a women to fulfil his sexual demands. Instead of a court sentence, he was admitted in a psychiatric ward for treatment. During the treatment it was discovered that Brudos rage and hatred for his mother was the cause behind his current behaviour. At the same time his necrophilic behaviour also came into light when he confessed about his antisocial fantasies of freezing women in order to use them for his sexual gratification.

Case 3

The Nithari Case (Necrophilia):

This necrophile came to world attention in 2006. Several children had disappeared mysteriously in the village of Nithari, a small hamlet on the outskirts of Noida City, in Uttar Pradesh, near New Delhi since 2005. The prime suspects were Moninder Singh Pandher, a rich and politically connected businessman and his cook and aide, SurendraKoli. The situation became unmanageable after May 7, 2006, when a 19 year-old girl, Payal visited Pandher's residence at D5, Sector 31, Noida and never returned. Because of public outcry and media blitz, the police had to arrest Pandher on December 26, 2006 and his aide the next day. On March 2, 2007, Koli confessed reportedly to unburden his conscience, at a Delhi court and admitted raping, killing and having sex with the dead bodies of children and women. According to the CBI, Koli was also suffering from Necrophagia, a disorder in which the person eats human flesh.

Interpretation:

In the above case, the accused, SurendraKoli cannot be considered to be completely paraphilic as he has also confessed to having raped the victims even before killing them. The accused seems to have done the crime intentionally and not under the influence of his paraphilic urges. However, the offender seems to regret his actions which indicate that he might be paraphilic. The offender, SurendraKoli is also believed to be suffering from

Necrophagia as he ate human flesh. He can thus be considered to be a person suffering from severe psychological disorders.

Case 4

Dr. Martin McDonald (Frotteurism):

People with frotteurism may hold a vast number of jobs, specifically however in 2002; a Doctor named Martin McDonald began a small crime spree. He was practicing medicine in Poplar Bluff, MO with 2010 population of 17,023.In 2002, he was formally charged and placed on a seven-year probationary period for providing 4,000 Xanax tablets to his office manager for extracurricular use.In 2005, he was given an additional 10 years of probation for improper relations with a patient for performing unnecessary and inappropriate breast exams.The St. Louis Post-Dispatch found that McDonald told the State Board of Registration for Healing Arts that he was a diagnosed frotteur.Shockingly, the Board didn't suspend his license but just extended his probation until 2017 and made a mandatory suggestion that he seeks mental health assistance from a certified health care practitioner.Following this lack of action by the Board, McDonald was released to fondle 6 more women in 2 different Missouri counties.

Interpretation:

Dr. McDonald was diagnosed with frotteurism. He himself confessed his deviant behaviour in front of the State Board of Registration for Healing Arts. Earlier before his confession he was given a probation for unauthorized provision of medicines to his manager and later addition 10 years of probation was given to him for improper breast examination of a patient. In spite of his inappropriate behaviour, he was not punished more than a probation nor was his license cancelled though he was subjected to treatment for the same. This leniency of the authorities enhanced his criminal activities.

Case 5

Max Mosley (Sadomasochism):

Max Mosley, the son of the fascist leader Sir Oswald, father of two, husband to Jean of 48 years and Formula 1 eminence grise was over a story about his sadomasochistic orgy. He was accused of indulging in a "sick orgy" with five prostitutes that featured them dressing up as, allegedly as concentration camp figures.At the High Court Mr. Mosley, 68 admitted the article in a tabloid newspaper had "devastated" not only his own life but that of his wife of 48 years and their sons.They had had no knowledge of his unusual preferences until the News of the World published the results of their sting operation in March.However, James Price QC, appearing for Mr. Mosley, said he had indulged in "S & M" - meaning sadomasochistic - role play for many years."Bottom spanking, whip fantasy and role play scenarios are an interest he accepts he has had since quite a young age," said Mr. Price.The court heard that the session took place in a rented flat in Chelsea paid for by Mr. Mosley for the purpose of meeting the women, whom he paid £500 each.Covert recording equipment captured Mr. Mosley, son of 1930s Fascist leader Sir Oswald Mosley, being spanked by one of the women with a whip, as well as using a strap to spank a woman. He also talked to one of the women in German.

Interpretation:

Max Mosley was a 68 year old married man with two children. He was a normal husband at home but outside, he was accused of being a sadomasochist. He used to perform such violent acts in a rented flat along with the paid prostitutes. His disorder was unveiled when it was highlighted in World news after a sting operation was carried out upon him. Till then even his family was unaware of his such a deviant and devastating behaviour.

Case 6

Earl Bradley (Pedophilia):

Delaware paediatrician Earl Bradley — indicted for abusing 103 of his young patients in his office — is being called the worst pedophile in U.S. history. Horrified parents and medical professionals across the country are demanding to know how Bradley, who videotaped his sexual abuses, got away with his alleged crimes for at least a decade, despite a number of red flags that went unheeded. Bradley's initial arrest in December involved nine child patients. That count has risen to 103 victims — a figure authorities expect could go higher yet — as authorities uncovered more evidence and more victims stepped forward. The acts took place between 1998 and 2009, but the "vast majority" took place since 2007.The victims ranged from babies of just six months to 13-year-olds. All but one was female.Bradley was reported to the police in 2005 for "inappropriately kissing a 3-year-old patient." Dr. Bradley's office manager, his sister Linda Barnes,claims she passed on other patient complaints to the Medical Society of Delaware in 2005. Then, in 2008, three parents complained to the police of "inappropriate vaginal exams."

Interpretation:

A paediatrician is a doctor specialized in treatment of children but Earl Bradley proved to be a demon to the kids. He was discovered to be a pedophile when he was caught kissing a 3 year old patient wrongly. But still no as such

legal action was taken against him as a result of which he continued his evil deeds but at last after three years past the kissing incident, he was accused for a suspicious and inappropriate examination of the private parts of his patients.

SCOPE OF THE PAPER:

Paraphilia, a psychosexual disorder disturbs the process of sexual arousal which is the initial stage of sexual response cycle. It is often referred to as a disorder of sexual preferences. The individuals affected with this disorder show strong, persistent, sexual behaviours or urges regarding either non-human objects or towards non-consenting people. These urges lead to a significant distress in the social, occupational and other areas of normal everyday life of the affected individual and the society as a whole.

One of the recognised causes of paraphilia is lesion in the temporal or frontal lobe causing hormonal imbalance. This further affects the sexual impulsivity of the individual. These overwhelming impulses make the individual prone to criminal activities.

On reviewing various literatures, it was understood that evocations and treatment of paraphilia include both psychological as well as biological factors. The study conducted also brought into focus the breaching effects of paraphilic individuals on the well-being and general norms of the society.

A very large number of offenders in the society commit crime driven by the persistent urges and this also makes them regret for the same, later.

The increasing number of paraphilics in the society in turn affects the younger generation; making them more vulnerable to various sexual offences and thisleads to juvenile delinquency. The society however looks upon these paraphilic individuals with a feeling of contempt, rage and fear. Some forms of paraphilia destroy the lives of both the offender as well as the victim to a great extent. It was discovered that paraphilia being difficult to treat, could however be reduced to some extent by using a combination of pharmacological and cognitiveassets. Although treatments are rendered to these offenders, the society prefers treatment along with a custodial sentence.

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