Volume 3, Issue 1, 2025

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

AN EFFECTIVE MANAGEMENT OF PARAPHALIC AND RELATED DISORDERS IN CLINICAL SETTING

Shamsa Batool[*1], Dr. Saima Majeed[2], Maryam Munir[3], Dr. Mahwash Zulfiqar Khan[4]

[*1]*MS Clinical Psychology, Department of Psychology, Forman Christian College Lahore, Pakistan*
[2,3]*Associate Professor, Department of Psychology, Forman Christian College Lahore, Pakistan*
[4] *Head of Department of Physiotherapy, Al-Razi Institute Lahore*

[*1]shamsabatool007@gmail.com, [2]saimamajeed@fccollege.edu.pk, [3]maryammnir@fccollege.edu.pk,,
[4]zulfiqar1991khan@gmail.com

DOI: https://doi.org/10.5281/zenodo.15037725

Keywords
Cognitive Behavior Therapy (CBT), MI, Assessment, Management, Paraphalia disorder, exhibitionistic, Frotteuristic, and fetishistic disorders

Article History
Received on 05 February 2025
Accepted on 05 March 2025
Published on 17 March 2025

Copyright @Author
Corresponding Author: *

Abstract

Paraphilic sexual interests are characterized as unusual and anomalous, yet the true prevalence in nonclinical samples is unknown (J;, J. C. (n.d.). In the last century, the diagnostic criteria of paraphilias/paraphilic disorders have been developed and become more descriptive and specific (Downing L., DSM-V). But no diagnostic system including DSM-5 or any other tool can fully encompass the diverse spectrum of paraphilic pathology (Balon, R. (2016)). In previous research, it was reported that 62.4 % of people are facing at least one paraphilia type. Voyeurism is the most prevalent form of paraphilia and manifests in approximately five percent of men and three percent of women (Gandhi, Dr. V. A., 2022). A similar case of a 20-year-old boy was referred with overtly presenting complaints of insecurity, guilt, sexual thoughts, masturbation, aggression, sadness, irritability, feelings of rejection, and worthlessness with the duration of many years starting from childhood. However, after initiating therapeutic sessions, client reported some other clinical symptoms which helped to understand the underlying issue and aided in developing a management plan. Client reported significant symptoms of uncontrolled obsessive sexual thoughts, masturbation, and roaming around previously encountered females. Without consent touching their private parts, exposing his genital to stranger females, and using their clothes for sexual satisfaction. The formal and informal assessment was done by using structured clinical interview, behavioral observation, and baseline charts. The motivational Interviewing (MI) technique was used frequently in sessions to keep the client motivated for therapy and coming to sessions for purpose of behavior change. In therapeutic sessions relaxation exercises and CBT techniques were used. For the management of the client's sexual thoughts and other related symptoms specifically strengthening of familial support was highly promoted, and strategies were implemented for engaging more in educational activities, ensuring a protective environment, and reducing access to objects or triggers which were the main cause of increasing sexual activities. A total of 14 sessions were conducted with the client and 55% improvement was reported. The provisional diagnosis of the client was Paraphilia disorder, with the subtypes of Exhibitionistic 302.4 (F65.2)

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

Frotteuristic 302.89 (F65.81), and Fetishistic 302.4 (F65.2).

INTRODUCTION

Paraphalic disorder is explored to be very common but reported rarest disorder in clinical settings. According to DSM-5, paraphilic disorders are exhibitionistic disorder (exposing the genitals), frotteuristic disorder (touching or rubbing against a non-consenting individual), and fetishistic disorder (using nonliving objects or having a highly specific focus on non-genital body parts). According to DSM-5, these disorders entail actions for client's satisfaction because of their noxiousness or potential harm to others and are classed as criminal offenses (Gandhi, Dr. V. A., 2022). Previous studies found that the combination of neurobiological, and interpersonal cognitive processes is important for the etiology of paraphilia and paraphilic disorders (Committee on Nomenclature and Statistics American Psychiatric Association, 1952). To assist individuals suffering from paraphilia disorders in controlling sexual arousal or behavior, medication is considered to be important, whereas CBT is most commonly used for the management of paraphilia disorder (Paraphilic disorders | Abnormal psychology. (n.d.).

Case study

The Client was experiencing symptoms of sadness, aggression, feeling of guilts, jealousy, complexity, low self-esteem, lack of confidence, urge of breaking things and hitting/harming others, sexual thoughts (to encounter intercourse with any female by fantasizing or staring at females' figures, such as buttock, breast, and thighs, etc., watching porn movies and become sexually arousal and masturbating by recalling memories of his favorite teachers or cousins, stalking and harassing unknown female, attempt to touch their private parts without consent. Whenever he gets a chance to expose his genitals in front of unfamiliar female/others, use female undergarments for masturbation. The duration of all these behaviors is more than eight years and some behaviors were since his childhood.

The client lived belong to a joint family system and was deeply connected with his grandfather. He described that his father was short-tempered and mostly fought/beat his mother. Client reported that he has not developed a warm relationship with any of his parents since childhood and was mostly disturbed due to the conflicting environment of the house. Client also reported frequent physical and verbal abuse from his parents. The environmental distress and conflicting relationship of parents led the client began to remain alone, sad, irritable, and aggressive in nature.

Client reported one of the events from his childhood that at the age of 5 years, he was going to a bazaar with his grandmother and at that time he saw a woman sitting on a footpath where she was masturbating. On that very moment client mentioned he started rubbing his genitals which shocked him and made him suffer consequences later. His parents and family members forbade him not to do this behavior again. But in the absence of others mostly he touched his private organs by hiding himself under the bed or curtain.

According to the client if he did not rub or touch his sexual part then he felt irritated and uncomfortable. The client used to masturbate when he was in class six at the age of 11 years, he had his first ejaculation which made him more satisfied. He shifted his school where he learned more about abuse, sex, and porn movies. One of his cousins also had sexual thoughts and they both did masturbation. Mostly they tried to get access to porn movies but did not get any access. He used to note female undergarments through their dresses and become aroused. In his tuition, one of his teachers tried to get his attention by undressing herself but as he had already done masturbation and received pleasure so he did not involve with her. He was not able to concentrate on studies because his attention was to focused on female figures and undergarments which attracted him and became erotic. He intentionally used to observe the undergarments and private parts of females which made him erotic and often did masturbation.

From the age of 14 years to 17 years, he got access to porn movies on a USB device and got erotic and started masturbation with the undergarments of females, via bra, underwear, dupatta, shalwar, jersey, etc. He started to follow females and began to expose himself. At the age of 14th, he used to stalk females which made him erotic and the frequency of

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

following them was 20 to 25 times in a month. At the age of 15 years, he started to expose himself in public places and the frequency of exposure was around 80 times in a month. After the exposure reaction of females made him horny and satisfied. He watched different websites to receive access to sexual/adult content, romance, porn movies, etc.

The client had Facebook and WhatsApp groups related to porn and adult content. He involved in sex chat with one of a female on WhatsApp. At the age of 16 years, his father found out all his secretive things and caught USB, other CDs, or DVDs. Client's father scolded him used abusive language, and compared him with others relative's children. Due to this all happened to him he became more aggressive, bought a new USB and continued this process. At the end of the second year, the intensity, frequency, and duration of all these behaviors were further increased.

Client reported that one day he met a prostitute and had sexual relations with her and also tried to have sexual relations with gays but he missed that chance. Once he paid some money to a beggar on the roadside and spent time with her and got pleasure. He remembered all his behaviors which made him guilty and frustrated. This guilt increased day by day which led to strong suicidal thoughts. At that time, it was his last practical when he started experiencing hallucinations and paranoid delusion due to oppression, obsession with sexual desire, and guilt, so he was admitted to a renowned mental health hospital. With proper medication and psychological treatment, he showed some recovery. For almost seven months he did not face any symptoms related to sexual activity or sexual arousal for about three months. Client reported he managed his excessive masturbation because he thought was weak due to his delusion and treatment and did not produce ejaculation which made him distressed.

Mostly he had thoughts of going to the red-light area but he did not visit there. Two months ago, he had had an emotional attachment with his cousin but she did not feel comfortable talking to him about sex. Around 6 to 7 months, he had sexual thoughts but he controlled them after this duration he started to do these behaviors again. Now the intensity, frequency, and duration of symptoms were increased. For example, he started to expose himself in front of females in local places 10 to 15 times a year and followed females' frequency 20 to 25 times a month. He had thoughts related to female figures, and using female undergarments during masturbation. According to him, "I wanted to do sex oral, anal, and vaginal and touch every part of my partner, that's why I followed female. Whenever I masturbate by using a female dress, I have these thoughts which make me more erotic, happy, and satisfied". Now from the previous two months, his symptoms have increased.

In 2016 when client was preparing for F.Sc final exams, he experienced some symptoms of grandiose delusions (I am a god, I have all the powers, I can do everything, the air is in my control and his girlfriend is in the air and she will come back when the wind blows). He verbally abused and fought with his parents, and also attacked others who tried to stop him. He thought other people were against him (especially children were laughing and talking about him, and food which is given to him is being poisoned). He had aggression symptoms and strong suicidal ideations. His parents brought him to a mental health hospital and doctors admitted him for treatment. He remained in the hospital for 22 days, his symptoms decreased, and was in recovery phase within a few months.

When he was discharged from hospital his parents took him to a village religious healer. Client mentioned he was taking his medicines properly and symptoms decreased gradually within 1.6 years. His symptoms of hallucinations and delusions were displaying less intensity. He did not show any problems, even his sexual thoughts, masturbation, and aggression were also controlled completely for 7 months. After his recovery he again watched some porn movies and started masturbating, he felt guilt every time after this act.

Initially intensity, duration, and frequency were at normal range and no disturbance or impairment was shown in his daily life. Now when he was brought to hospital with the presenting complaints of sexual thoughts, harassment, aggression, and masturbation. The intensity, duration, and frequency of his symptoms were increased which were alarming and caused distress to the client. These symptoms were displayed three months before and currently was masturbating 8 to 10 times per day and some days it

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

was more increased. The time duration was approximately ten minutes, which was increased to half to one hour and sometimes all the day which caused him to remain distressed. Sometimes he used to follow strangers all day and because of this behavior, he became frustrated and aggressive. If any female passes through him or comes in front of him, her body parts make him erotic, only the presence of his mother, little children, and aged female did not make him erotic. There was no psychotic feature e.g., delusion or hallucination was reported.

Background Information

Personal History: Client's mother reported she had two miscarriages due to her weak health and took a one-month course of 30 injections to maintain her pregnancy. She had constipation and motion in the 7th month of her pregnancy and it ended after the 3rd month of the client's birth. The client's birth was normal at home but his first cry was delayed and all milestones were achieved at appropriate ages. The immune system of the client was weak since his childhood and it continued till his adolescence. As client had constipation and motion since his birth to the 4th month of birth. Different antibiotics were used for his stomach ache, abdominal pain, and throat problems.

The childhood of the client was disturbed and was being physically and verbally abused because he remained physically ill so whenever his father came home his illness made him angry and he used to behave aggressively and use abusive words for himself and his mother. He became feared when his father came home due to father's aggressive and abusive language. His father used to compare him with other children of his age and did not spend much time with him. He was a lonely child and did not have friends. He had a small friend circle. He did not have social skills, etiquette (manners), and had low self-esteem. He had an emotionally abusive childhood and his childhood experiences were not satisfactory. He had a friendship with his cousin who also did masturbation and he learned this behavior from him when his cousin told him about doing such activity. The client is introverted by nature. One day when he was sleeping with his mother, he got a sexual urge and that night he attempted to have sex with his mother. But his mother slapped him and made him aware it was a wrong act. He then went to the washroom and after coming back, he slept. The next morning when he got up, he did not remember what happened last night.

Educational History

The client started basic early education at home with his grandparents. He continued schooling at age of six years in a private school. They moved to a nuclear family system from a joint one and because of that client had to change his institute. His behavior with teachers, peers, and other fellows was appropriate. When passing grade 5th enrolled in a new Government school where he got access to information related to abuse, sex, and porn movies. At tuition the undergarments of females attracted him and he observed them and rubbed his genital. One day when saw his teacher's sister she undressed herself and tried to get his attention but because had already masturbated and was satisfied he did not involved with her.

Client was not able to concentrate on his studies and left the tuition center. He did not continue this tuition again because lingering sexual thoughts came whenever he saw female class fellows. His studies were greatly disturbed due to this situation. As a tutor, her mother taught him in six and seven classes. After 8th grade completion, he got admission to another Government school and passed his matriculation. His behavior in school was normal. Friend circle in school was not good because their conversation was related to adult content. Then he enrolled to Govt. college in a pre-engineering group, where he made new friends. It was reported he did not engage in any extracurricular activities and neither had any close friends nor any fights with fellows. Currently, client is enrolled as a 2nd semester student of B.S Honor in English literature. Client is considered as a bright student, but his studies remained disturbed. Along with studies he is teaching in an academy as a teacher. Future plan is to become an English professor after the completion of MPhil English studies.

Family History

The client lived in a joint family system since childhood. He was closer to grandparents, especially with his grandmother. Due to some family conflicts, the grandparents left them when the client was 12 years old and never met again. Presently, client is

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

living in a nuclear family system and has three family members. In his childhood, he remained alone because he was a single child and now his friends' circle consists of a few class fellows and cousins.

The general home environment was strict and strained. There was a strong history of mental disorders from the client's parental aunts. It was reported that one of the aunts was suffering from depression and was not able to settle with her husband. She reported some sexual conflicts with her husband and committed suicide. Another aunt was suffering from Epilepsy disorder.

Client father's paternal aunts had also psychiatric problems. His father and grandfather had aggression issues. His father was around 63 years old. Client's father was educated till matric and is a businessman by profession. He is fond of reading books. His father is an authoritative figure in the family. He is aggressive and authoritarian by nature. The client has a strained relationship with his father due to his behavior. His father did not give him proper time since his childhood. Now his father realized his mistakes and tried to compensate.

The mother of the client was 62 years old, polite, and loving by nature. She got educated till F.A. The client has a congenial relationship with his mother. The client belongs to a middle-class socioeconomic status. His parents' relationships were not satisfactory since he was a child. It was reported, now his father expressed feelings of guilt that he misbehaved with his wife and his son. Now he realized and tried to compensate and gave them time.

Premorbid Personality

Client's mother reported that he was a storyteller child. He used to go outside and play with children of his age. The client was kind-hearted and timid, shy by nature. He has low self-esteem. He was an introverted person. He did not have any close friends just his cousin who used to masturbate. But after knowing this client's mother did not allow client to go outside the home, because of this he stayed at home alone, playing games on a computer, watching TV, and playing with toys. He did not have any physical activity and had no proper checks and balances from his parents. So, he used to watch Indian songs, erotic and porn movies. Client has low self-confidence and low self-esteem. He is fond of poetry and romantic books and stories. He likes painting and drawing. He likes to go out with his friends and hotlink with them.

Diagnosis

As per the DSM-5 criteria, the diagnosis was "Paraphilia Disorder"

Exhibitionistic Disorder (Exposing genital to others)

Frotteuristic Disorder (Follow and inappropriate touch of female private parts)

Fetishistic Disorder (using non-living objects to get arousal and for masturbation.

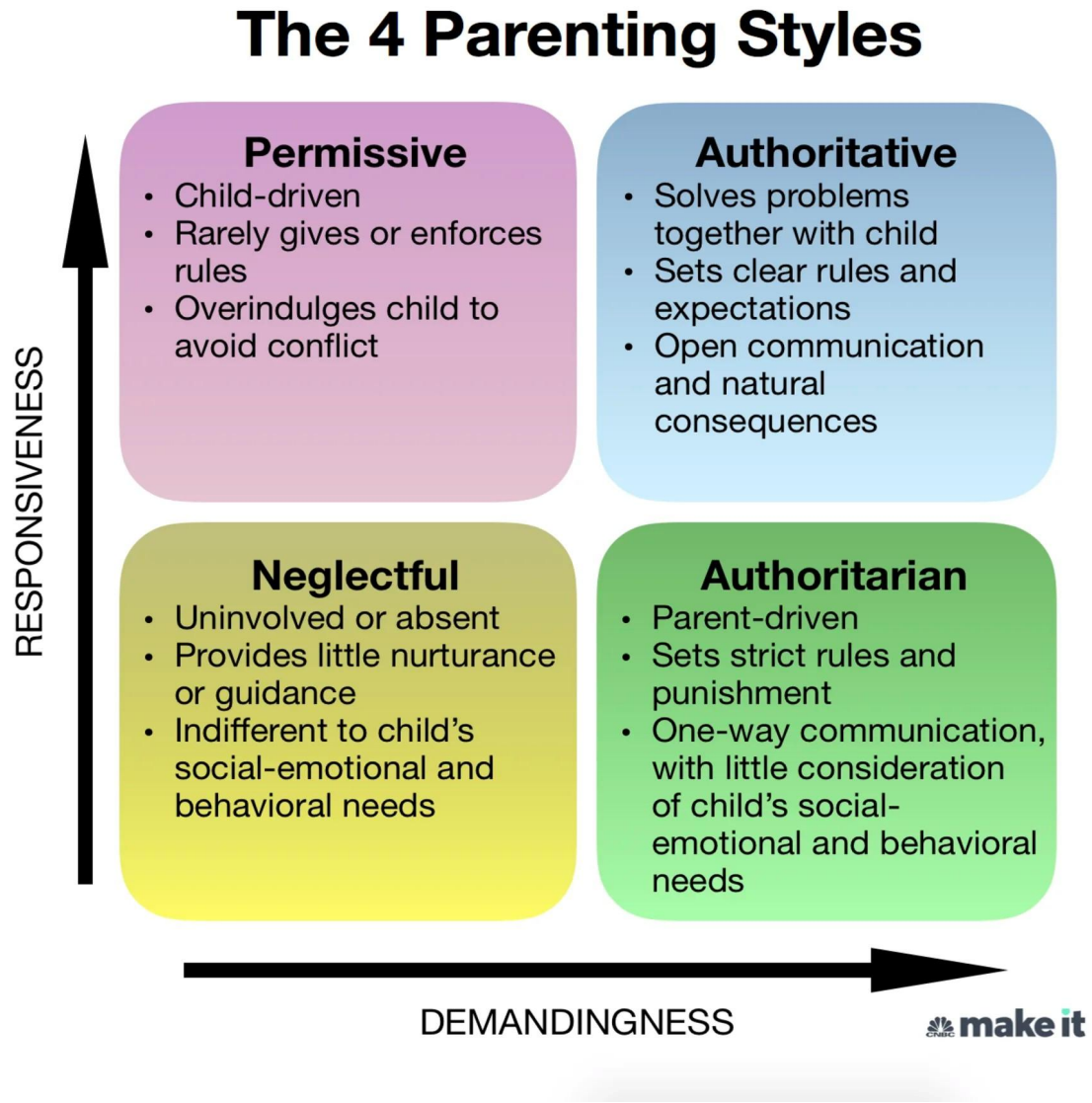
Theoretical framework

According to Bandura's learning theory, client learned all these behaviors from the environment that influenced his personal growth negatively (Paraphillia: A case report. (2001, January).

While Sigmund Freud's psychoanalytical theoretical perspective, client learned sexual behaviors and masturbation activities in his childhood because his childhood had a great impact on his adult life in developing his personality (Bandura A, Grusec JE, Menlove FL., 1986).

According to Diana Baumrind, every parent has different parenting styles that affect differently on their children's behavior and are identified by certain characteristics, as well as degrees of responsiveness and demandingness. It is said that neglectful and uninvolved parents are neither demanding nor responsive; while providing little guidance, support, and attention to fulfill their children's needs/demands. This is why this is associated with negative outcomes for children, including poor academic performance and emotional difficulties similar to this case (Kendra Cherry, Mse. (n.d.). For details please look into diagram:

Frontier in Medical & Health Research
ISSN: (e) 3007-1607 (p) 3007-1593

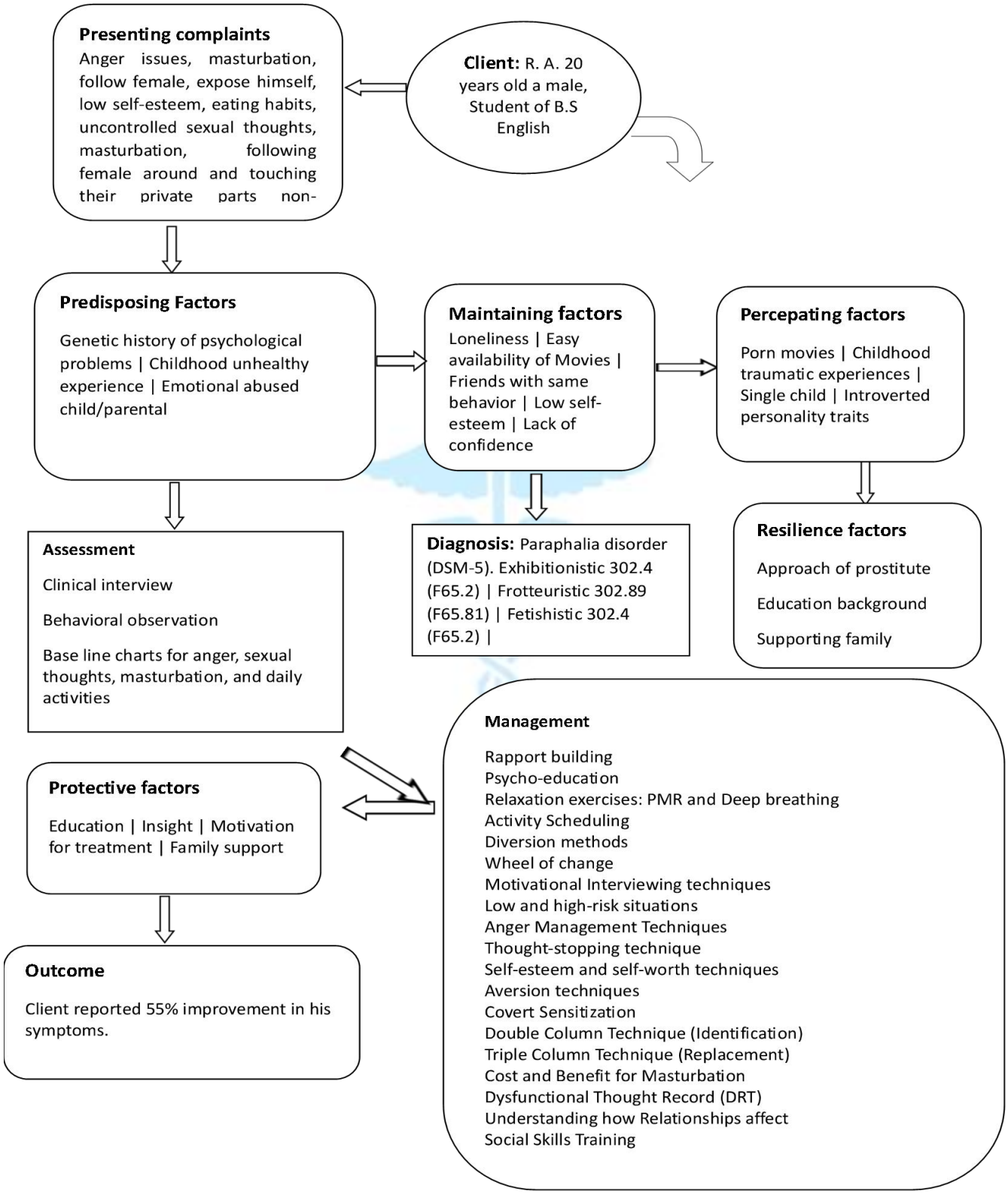


The 4 Parenting Styles Francyne Zeltser, CNBC Make It (3)

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

Figure.1: *Showing Pictorial Summary of Case Formulation*



Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

THERAPEUTIC INTERMISSIONS

Rapport building: To make the client and his parents feel comfortable/relaxed and establish a healthy therapeutic relationship with the client so that they can easily share their problematic behaviors. It was developed through active and effective listening, motivational interviewing, and providing unconditional positive regard that would create a non-threatening environment for the client to enhance the efficiency of treatment.

Psyhco-education:

Parent's psycho-education was given related to the nature of the disorder, duration, and treatment plan was provided to parents and patient as well. It also guided the parents on how to handle the patient at home.

Relaxation techniques: (Progressive Muscle Relaxation & Deep breathing):

The client was introduced to this exercise in the session given by Jacobson (1929), based on reciprocal inhibition and counter-conditioning principles. The patient was given the rationale that tension is usually experienced in a more physical state rather than a mental state. Client was told that he could relax his muscles systematically so that he would feel relaxed/calm as compared to tense or strict. The patient was given the demonstration of how to tense and then relax our muscles and made to practice with feedback to correct any ambiguities. He was told to practice the entire procedure as his therapist instructed. After completing the exercise, a brief imagery was done and feedback was taken which was positive because he was feeling relaxed.

Deep breathing:

Deep breathing was applied as a technique to help cope with stress, helpful as a distraction in stressful conditions, and as a focusing approach, keeping in view the rationale of reciprocal inhibition.

CBT: Activity Scheduling:

Daily activity chart was given to keep the client busy an activity schedule was given to client as per the regular tasks that the client does. To overcome his risk behaviors. A daily routine for a patient was planned from morning to night. In activity schedule, the routine of waking, sleeping, exercise, and other tasks were listed/advised for client. This technique proved very helpful for reducing negative symptoms as well as decreasing the intensity of positive symptoms.

Diversion methods:

The client was taught different diversion methods to divert his sexual or disturbing thoughts. The client was asked to apply different diversion methods whenever client felt erotic or sexual thoughts.

Wheel of change:

The core principle of CBT is that one person's thoughts, feelings, and actions are all interconnected and this stage of change model is helpful for conceptualizing the mental states of the patient. In this technique, the client is asked to recognize negative thoughts to change his behavior into healthier alternatives.

Motivational Interviewing techniques:

to increase the self-confidence of the client and to realize his self-worth MI was used to come to know about the level of change of the client. The readiness for change was also checked by it.

Low and high-risk situations:

The client was guided to identify high and low-risk situations to avoid the entire situation that brings him into the danger zone.

Anger Management Techniques:

anger is a complex and confusing emotion that you may experience in response to specific stressors Center for Integrated Health Anger (2013). An action that is intended to cause harm to a person or others so some feelings/emotions are quite different than aggression. To manage clients' problematic behavior, anger management techniques were taught to identify external and internal cues through a model along with the related thoughts and emotions. The client was briefly psycho-educated about the early warning signs of anger and alternative ways to deal with it.

Thought-stopping technique:

To stop sexual thoughts client was taught about thought-stopping techniques.

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

Self-esteem and self-worth techniques:
To enhance client confidence, self-esteem, and self-worth, different self-esteem-building exercises were taught.

Behavioral Interventions:
Aversion techniques:
To reduce the client's craving for erotic feelings and arousal for his target behaviors as well as its attractiveness the aversion techniques were taught to the client (Laws & O'Donohue, 2008).

Covert Sensitization:
To weaken targeted behavior, aversive imagery has been used with some success to treat exhibitionism and fetishism symptoms (Cautela, 1967).

Double Column Technique (Identification):
CBT-based double-column charts were provided to the client for a week. The client was asked to write down the negative automatic thoughts in one column and then identify the cognitive distortions/errors in the other column. This exercise would help the client to gain awareness of his cognitive errors.

Triple Column Technique (Replacement):
Client was given a triple-column CBT-based chart, after double-column chart. It's a step ahead of the double-column chart. There're three columns which first column is about writing the negative automatic thoughts, second is about the identification of cognitive distortion/errors and third is replacement of the negative thoughts with positive ones. Technique aimed to help client restructure his negative unhelpful thought patterns into positive helpful patterns.

Cost & Benefit for Masturbation:
Client was asked to list down 5 to 10 benefits of masturbation, sexual thoughts, following females, exposing himself, watching porn movies, and using female clothes for masturbation. Then he was asked to write about the cost of doing such behaviors and see across both columns and decide which is more suitable and beneficial for him. So, client identified the benefits of not repeating these behaviors because these are most problematic for him.

Dysfunctional Thought Record (DRT):
REBT was applied to record and challenge dysfunctional thoughts, and a DTR worksheet was provided to the client. This exercise encourages clients to identify the involvement of any cognitive biases, which are unhelpful thinking styles that are operating.

Understanding how Relationships affect:
This exercise helps the client to foster a healthy relationship with parents and improve social interaction. One of the reasons for sexual thoughts is when people lack of social interaction and become isolated from others.

Social Skills Training:
Social skills training comprises learning activities utilizing behavioral techniques. It was applied for a client to deal with low self-esteem and lack of confidence to acquire interpersonal management and independent living skills for improved functioning in their communities (5). The client was facilitated with different social skills, such as taking initiative when communicating with others and maintaining accurate eye contact, while talking. Different guidelines were given to the client for social interaction through role-playing and modeling. The client was referred to the gym for physical activities and asked for regular painting practice.

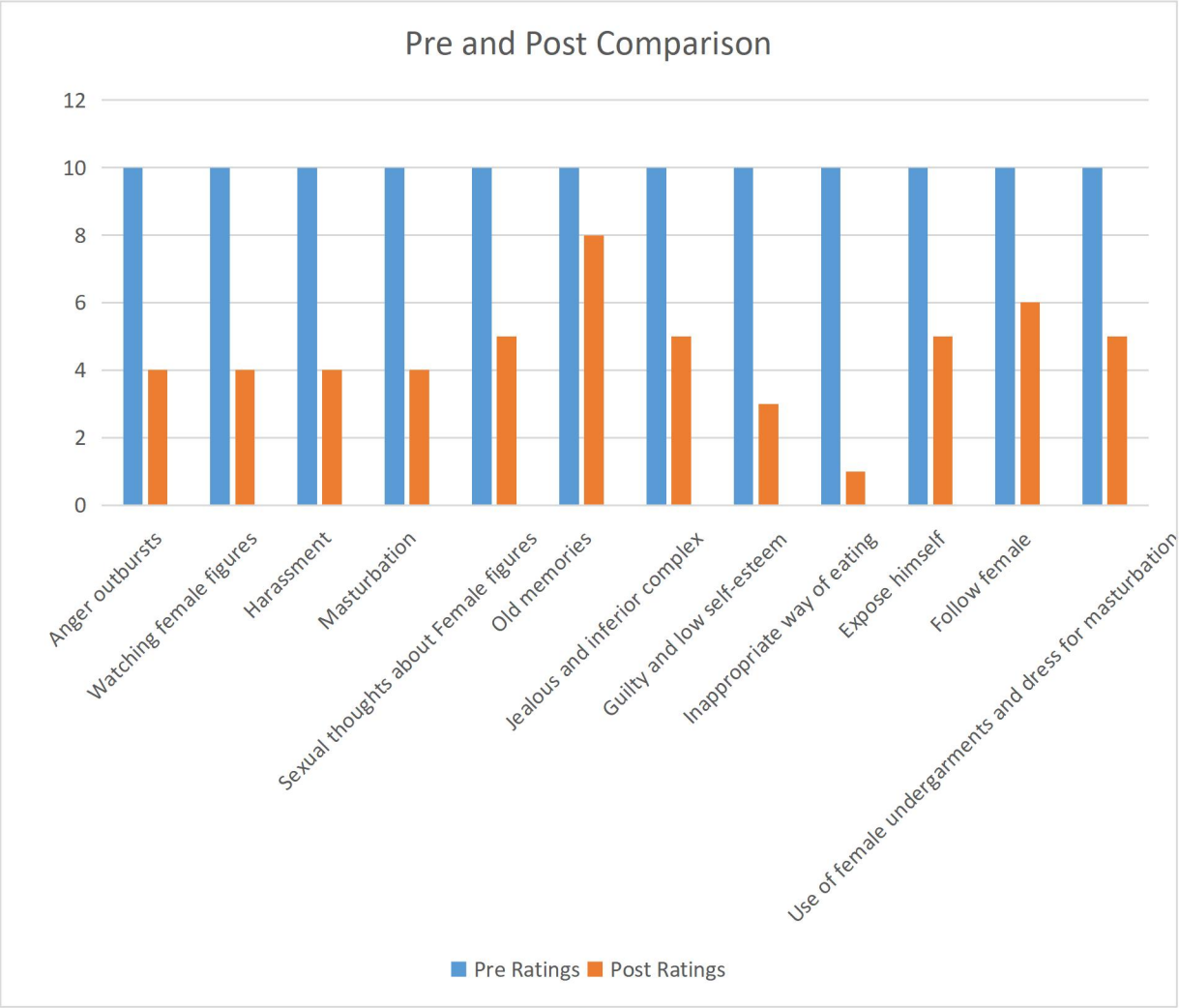
Acceptance and Commitment Therapy (ACT):
Focuses on accepting unwanted thoughts and feelings and committing to behavior change strategies. To reduce guilt feelings ACP was applied (Hayes, Strosahl, & Wilson, 2016).

RESULTS
The results showed that the client improved over his problematic behaviors, such as sexual thoughts, masturbation, following, exposing, and watching porn movies, attacking females, and using female clothes. The total change was 55% after the management.

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

OUTCOMES



Pre and Post Ratings by Therapist

Table Showing the Post Management Subjective Ratings of the Client's Symptoms:

Symptoms	Pre-Ratings	Post Ratings
Anger outbursts	10	4
Watching female figures (Private parts)	10	4
Harassment (following and inappropriate non-consenting touch of female)	10	4
Masturbation (with and without using female undergarments and dress)	10	4
Sexual thoughts about Female figures (private parts)	10	5
Old memories (teachers & cousin)	10	8
Jealous and inferior complex	10	5
Guilty and low self-esteem	10	3
Inappropriate way of eating	10	1
Expose himself	10	5
Follow female	10	6
Use of female undergarments and dress for masturbation	10	5

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

A comparison of the pre and post-ratings of the client's subjective ratings was done to see a difference in the client's symptoms. The average improvement reported by the patient and his parents related to his symptoms and targeted behavior was around 55 % which was satisfactory for the parents and patient as well.

DISCUSSION

From the given case study, several factors were highlighted which identified psychological stress markers among youth group and the factors which influences on their mental health. According to the study, client was being raised by avoidant parents who had less mutual understanding and knowhow of client's physical, social and psychological needs. These unhealthy behaviors and psychological manifestation depicted that the client had traumatic past experiences from his childhood which was needed to be resolved by a mental health practitioner to help him cope from the situation and have alternative adaptions of healthy life styles and to reach to one of the goals from therapy was self-healing and self-forgiveness.

LIMITATIONS

For this case an "Ethical Concern" could be seen and was widely used related to confidentiality and privacy. The targeted behavior of the client, for instance, following an inappropriate non-consenting touch and exposing his genital to females, watching porn movies and masturbating. The client's parents were not aware of all those activities. The client was not willing to share information to his parents about all psychological issues and sufferings. So, there was no any co-therapist who could report his progress. The therapist relied on the subjective rating of the client's described symptoms and closely observed client's details with symptoms of change. Client was willing to work on his behavior change after motivational interviewing which was conducted in many sessions for building rapport and motivation for change in behavior. As the therapeutic session time period was short and needed much time to work with client. There is more likely client will experience relapse because one of previous research has suggested that 2-3 years are considered warning for the client where the chances of relapses are higher. Lastly, the therapist had a little chance to work with the family and changing the home environment was seem less likely due to rigid attitudes of parents with understanding client's situation. To resolve family conflicts, it was most important to initiate/conduct more focused family therapy sessions. The client was a single child which affected therapy outcomes favorably less than expected as he had to stay alone at home.

SUGGESTIONS

Previous researches showed the role of medication is very important and the role of therapy is rare. So, no significant or specific therapy can be used for paraphilia disorder. The ratings would be more valid if any co-therapists would observe and report the client's actual behavior. The main role of this therapeutic management was the client's parents who were responsible for influencing the client's mental health in the form of paraphilia disorder, including Exhibitionistic, Frotteuristic, and Fetishistic. So, parents must receive family therapy and marriage counseling to better cope in spouse relationships and adopt healthy parenting styles which would aid in the client's mental health treatment.

FUTURE IMPLICATIONS

The current study will help to understand the importance of paraphilia disorder, such as parenting styles that contribute to adolescent development and wellness in mental health. It highlights the importance of basic education about biological, emotional, and physical changes from childhood to adolescence. Mostly it happens that children are being ignored in terms of seeking psychological services for resolving their personal and psychological issues. It is said that unresolved conflicts later converted into alarming clinical manifestations. If we guide our children properly, build/nurture positive relationships, and promote a healthy home environment then most of the paraphilia problems can be minimized. Parents identify the early warning signs/triggers and the inner issues from which adolescents are suffering so the best option is to consult with psychologists, psychiatrists, or mental health practitioners to deal with raising issues before and not making it worse.

THERAPEUTIC BLUEPRINT

After the termination session, the client was given a therapeutic blueprint, in which the therapist discussed

Frontier in Medical & Health Research

ISSN: (e) 3007-1607 (p) 3007-1593

the symptoms of the client, the assessment, and therapeutic techniques for the management of the client's problematic behavior. The client was satisfied with the therapy and felt confident in managing his problematic issues.

REFERENCES

C., J. J. (n.d.). The prevalence of paraphilic interests and behaviors in the general population: A provincial survey. *Journal of Sex Research*. Retrieved from https://pubmed.ncbi.nlm.nih.gov/26941021/

Downing, L. (2015). Heteronormality and repronormality in sexological "perversion theory" and the DSM-5's "paraphilic disorder" diagnoses. *Archives of Sexual Behavior, 44*, 1139–1145.

Balon, R. (2016). *Practical guide to paraphilia and paraphilic disorders*. Springer.

Gandhi, V. A. (2022, September 16). What are the psychological implications of paraphilia? Retrieved from https://www.icliniq.com/articles/sexual-health/paraphilia-and-its-psychological-implications#:~:text=Studies%20show%20that%2062.4%20%25%20of,and%20three%20percent%20of%20women

Committee on Nomenclature and Statistics, American Psychiatric Association. (1952). *Mental disorders: Diagnostic and statistical manual*.

Paraphilic disorders. (n.d.). Lumen Learning – Simple Book Production. Retrieved from https://courses.lumenlearning.com/wm-abnormalpsych/chapter/paraphilic-disorders/

Paraphilia: A case report. (2001, January). *PubMed Central (PMC)*. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2955939/

Bandura, A., Grusec, J. E., & Menlove, F. L. (1966). Observational learning as a function of symbolization and incentive set. *Child Development, 37*(3), 499–506.

Cherry, K. (n.d.). Sigmund Freud's psychoanalytic theories in psychology. *Verywell Mind*. Retrieved from https://www.verywellmind.com/freudian-theory-2795845#:~:text=In%20simple%20terms%2C%20Sigmund%20Freud's,operates%20in%20the%20conscious%20mind

Zeltser, F., & Contributor. (n.d.). A psychologist shares the 4 styles of parenting—and the type that researchers say is the most successful. *CNBC*. Retrieved from https://www.cnbc.com/2021/06/29/child-psychologist-explains-4-types-of-parenting-and-how-to-tell-which-is-right-for-you.html

Jacobson, E. (1929). Progressive relaxation: A physiological and clinical investigation of muscular states and their significance in psychology and medical practice. *Physical Therapy, 18*(6), 334–344.

Spiegler, M. D., & Guevremont, D. C. (1998). *Contemporary behavior therapy* (3rd ed.).

Linley, A. P., Joseph, S., Harrington, S., & Wood, A. M. (2006). Positive psychology: Past, present, and (possible) future. *The Journal of Positive Psychology, 1*(1), 3–16.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2016). *Acceptance and commitment therapy: The process and practice of mindful change* (2nd ed.). Guilford Press.

Laws, D. R., & O'Donohue, W. T. (2008). *Sexual deviance: Theory, assessment, and treatment* (2nd ed.). Guilford Press.

Cautela, J. R. (1967). Covert sensitization. *Psychological Reports, 20*(2), 459–468. https://doi.org/10.2466/pr0.1967.20.2.459