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The Clinical Mental Health Experience of Persons with Paraphilic Infantilism and Autonepiophilia.

A phenomenological research study

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By

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Vita

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Abstract

In the field of psychology and psychotherapy, there are numerous articles and chapters in text books devoted to the treatment of various paraphilia and fetishes, especially those that infringe on the rights of others such as pedophilia, exhibitionism, voyeurism, and frotteurism. Very little is written or discussed regarding fetishes that are consenting and non-exclusive in a sexual manner yet cause the individual shame, embarrassment, depression, anxiety and difficulty in interpersonal relationships, especially romantic relationships. The focus of this dissertation will be on a greater understanding of the issues involved so that treatment of individuals presenting with sexually non-exclusive, consenting paraphilic infantilism and autonepiophilia receive more empathetic and compassionate care.

Studies show that few individuals who engage in paraphilic infantilism or autonepiophilia seek psychotherapy to help improve their lives. A review of the literature reveals a lack of peer-reviewed research into this unique area of human sexuality for therapists who see such individuals. While psychology and psychotherapy have made advances, further study is necessary to address the attitudes of the field regarding diaper fetishism.

The purpose of this qualitative phenomenological research is to explore the participant's world view and perspective. It used a social constructivist model and a phenomenological inquiry to describe and understand the sexual lives of individuals who practice these particular fetishes (Creswell, 2014) conducted open-ended and semi-structured interview questions, assessed by mining the data to explore the participants lived experiences and perspectives.

The themes that were discovered by the research represent the values and beliefs of the participants regarding the meaning of their AB/DL desires in their lives. The most critical theme

that emerged from the research was the desire for a mother or mother figure despite the evidence that none of those in this study reported a poor relationship with their mothers.

This study does provide further evidence that psychotherapy can be beneficial to the lives of those who struggle to understand atypical sexual practices that appear at a young age despite no history of trauma or abuse and remain throughout the subjects' lives. This study also shows that further investigation could be useful to help broaden the definition of sexual orientation beyond its current definition of the gender one seeks to have sexual experiences with. There is the possibility that fetishism is a natural expression of human variation that has been pathologized by the definition of deviance (Hawkinson & Zamboni, 2014).

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Chapter 1: Introduction and the problem

In the field of psychology and psychotherapy, there are numerous articles and chapters in text books devoted to the treatment of various paraphilia and fetishes, especially those that infringe on the rights of others such as pedophilia, exhibitionism, voyeurism, and frotteurism. *The Diagnostic and Statistical Manual for Mental Disorders* (DSM-5, American Psychiatric Association, 2013) and the legal system declare these disorders considered to be criminal offenses and problematic for society at large (*Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000, p. 566). The DSM-5 definition of these particular paraphilias states they continue to be included "because of their noxiousness or potential harm to others, are classed as criminal offenses" (American Psychiatric Association [APA], 2013, p. 685). Many of these treatment strategies focus on psychological and pharmacological treatments intended to change or control the individual who exhibits these problematic behaviors. Very little is written or discussed regarding fetishes that are consenting and non-exclusive in a sexual manner yet cause the individual shame, embarrassment, depression, anxiety and difficulty in interpersonal relationships, especially romantic relationships. The focus of this dissertation will be on a greater understanding of the issues involved so that treatment of individuals presenting with sexually non-exclusive, consenting paraphilic infantilism and autonepiophilia receive more empathetic and compassionate care.

While young children might show a passing interest in diapers, the urges of those with paraphilic infantilism and autonepiophilia are generally life-long. It is reported that as many as

52% of individuals with these fetishes may try desperately to change. Few, maybe 0.1%, if any, are successful (Grey, 2011, para. 2). Autonepiophilia, also known as diaper fetishes or diaper lovers, are the easiest to understand. This is a fetish, a sexual attraction to diapers or other infantile objects. The diapers themselves serve as a sexual focus. Their idealized partner would be an erotic lover and if the partner is willing, diapers and other fetish objects would be incorporated into their sexual relationship (Grey, 2011, p. 2).

Paraphilic infantilism, or Adult Baby, is not a fetish (Grey, 2011, p. 2). It focuses on the self-image of the person who has an alternate self-image of a baby. This is similar to a transvestite, except that instead of engaging a female alter-ego every now and then, the paraphilic infantilists engage in an infantile alter-ego (Grey, 2011, p. 2). This may include the use of adult sized diapers, baby clothing, toys, etc. If the person's partner is willing to engage in role-play, she/he will play the role of the parent or caregiver while the adult baby would play the infant, toddler or young child. Sex during the role-play is often thought of as incestuous. The adult baby and partner often have a typical sexual relationship outside of the infantilism role-play (Grey, 2011).

According to clinical research it appears that those who engage in these behaviors fall along a spectrum from only Adult Baby (11%), to mostly Adult Baby but sometimes diaper lover (14%) to mostly diaper lover sometimes Adult Baby (29%) to only diaper lover (18%) with about 19% feeling equal levels of each ("The Basics," 2013, p. 5).

In order to better understand the significance of this topic, it may be best to share a story of an actual event. A less seasoned therapist was asked by a clinical supervisor to assist with a session of group supervision. One of the supervisee's presented a case of a couple where the male half was struggling with a diaper fetish. As the supervisee presented the case, she made it

clear to the group that she found this patient to be freakish and perverted and presented her case in a way to induce the most shock of the group. The therapist, who was assisting in the supervision, was appalled that a professional counselor, even in the privacy of a group supervision setting, would discuss a patient in such disparaging terms. Even more to her disappointment was the fact that the clinical supervisor did not address this lack of professionalism or obvious prejudice by the supervisee or how this bias could affect the level of treatment this couple would receive. The importance of this matter became even clearer a few months later when her first diaper fetish patient entered her office seeking therapy. Over the past few years, additional patients have found their way to her office door so the thoughts about the best practices for treatment of these individuals have been molded through professional experience. Since there is limited data written on the treatment of individuals with autonepiophilia or paraphilic infantilism, as the saying goes: "To quote Indiana Jones, we are making this up as we go along" (Pate & Gabbard, 2003, p. 3).

The Problem

Discussions with sexual therapists, who specialize in patients with alternative means of sexual expression, has brought up the question regarding why more fetish patients with issues of shame, self-esteem building, as well as management of depression and anxiety symptoms do not seek out psychotherapy. The psychotherapy and psychology field have a long and less than stellar history when it comes to the area of understanding and normalizing human sexual behavior (Bullough & Bullough, 1977). In some ways the field continues to remain stuck with judgmental attitudes toward human sexuality despite great advancements in ideology, for example, views regarding homosexuality. While psychology and psychotherapy have made advances, further study is necessary to address the attitudes of the field regarding diaper

fetishism. Specifically, there may be an opportunity for a new respect for those patients who are brave enough to seek therapy for issues relating to fetishes after reading only the abstract of a professional journal article from 2005 called “A case of diaper fetishism.” In the abstract alone, the term “perverted” or “perversion” was used four times to describe the 22 year old patient presented in the article (Oguz & Uygur, 2005, p. 133). With this level of bias in a peer-reviewed journal article, one wonders how the profession of psychotherapy ever expects those from disenfranchised communities such as paraphilic infantilism and autonepiophilia, to trust that they will receive anything other than judgment and ridicule, rather than, empathetic and compassionate care.

Yet positive and compassionate stories of experience with psychotherapists also are found in the literature. As one individual writes, “as I become more aware of my internal needs and wants, I accept them more. Through therapy I am slowly getting to accept this aspect of myself, but it is difficult and a long road” ("Survey #2," 2009, p. 2). Most have a very similar theme when they talk to a therapist who tells them that as long as the person is not causing harm to themselves or others, is able to engage in typical sexual encounters with a partner and it doesn’t interfere with daily activities such as work, that it is OK and there is no reason to stop the behaviors ("Survey #2," 2009).

Much of the understanding regarding fetishism has been documented between 2006 and 2013 by B. Terrance Grey, a self-defined diaper fetishist, in a series of surveys with up to 2000 men and women who identify engaging in this phenomenon. While the psychological community has made little headway with formalized studies into this area of sexology, it appears those within this community have taken it upon themselves to create a wealth of sexological studies worthy of serious attention. Based on the lack of credible peer-reviewed studies in this

unique area of paraphilia, a combination of both academic and infantilism/diaper fetish community resources will be used to create the most accurate portrait of the historic and modern day environment for patients and how the psychotherapeutic community might more effectively engage this population for treatment.

Purpose of this study

The purpose of this qualitative phenomenological research is to explore the participant's world view and perspective. It will use a social constructivist model and a phenomenological inquiry to describe and understand the sexual lives of individuals who practice these particular fetishes (Creswell, 2014) by conducting open-ended and semi-structured interview questions, assessed by mining the data to explore the participants lived experiences and perspectives. The objective of this research will be to look back at common beliefs about the paraphilic population; to propose some new ideas for building a more effective therapeutic alliance, especially trust, in the psychological profession and treatment ideas that respect the unique flavor of this group of people.

The rationale of this study is to continue upon and add to the discussion of those voices in the field of psychology, psychotherapy and sexology who advocate for more balanced treatment approaches for those patients who would be diagnosed with paraphilias, especially those of a consenting, non-threatening manner. There may be reason to believe that "paraphilias, sexual orientation, and gender identity are not learned, or at least not learned the same way sexual dysfunctions are learned" (Moser, 1992, p. 65) so that we may need to begin to consider broadening our understanding of these definitions. The researcher hopes to discover whether the findings from this research provide significant evidence such that advocacy and resource development may be necessary to reach the underserved members of this community by the

mental health community. It appears that many of these individuals suffer needlessly with treatable symptoms of shame, low self-esteem, depression and anxiety rather than risk how they fear they will be treated should they seek mental health treatment (Speaker, 1986).

Research Questions

As the research regarding this area of sexology was analyzed, a number of questions became apparent as needing to be considered.

1. The research indicates that many individuals who engage in paraphilic infantilism cannot identify a trauma or event that caused their atypical sexual interests. Could these atypical sexual interests be a type of sexual orientation similar to heterosexual, homosexual or bisexual?
2. Is it possible for individuals who desire paraphilic infantilism to engage in these behaviors in a psychologically healthy manner? Is it possible to treat the symptoms with which many in this community suffer (depression, anxiety, low self-esteem, shame and embarrassment) by encouraging the use of their atypical sexual behaviors in a consenting manner?
3. According to the research, only a small percentage (12%) of individuals who engage in paraphilic infantilism will admit to a therapist about their atypical sexual behaviors and seek treatment. Of those, the majority (91%) report the experience as between very helpful to no effect and only 9% report the experience as hurtful or very hurtful. If this is true, what causes so many in the paraphilic infantilism community to be distrustful of the mental health community?
4. Many individuals who engage in paraphilic infantilism suffer with untreated conditions that are easily managed with psychotherapy due to their distrust of the

mental health community. What, if anything, could the mental health community change to improve the level of trust from the paraphilic infantilism community?

Limitations/Delimitations

Limitations: A phenomenological study of only a few individual men has limitations when applied to the larger community of individuals with the same type of paraphilias. The fact that this study had only male participants and no female participants is another obvious limitation. While the majority of individuals with these particular paraphilias are predominately male, there is a larger than average number of female infantilists as the literature shows and the research will discuss later. There was the assumption that the answers given by the participants in the study were honest and forthright, however due to the high levels of shame and embarrassment regarding the atypical behaviors engaged in by members of this fetish community, complete honesty cannot be assured.

Delimitations: This phenomenological study was set up to use individuals from the State of Colorado, in the United States of America. It was limited to individuals between the ages of 25 to 45 years of age, individuals who were actively involved in either age play or diaper fetish, the participants could have had experience with the mental health community or may not have had any, their education level as to be minimally currently enrolled in an undergraduate college program or graduated, their fetish play will be of a consensual nature, and their sexual behavior will be non-exclusive in regards to their fetish.

Definition of Terms

There is a difference between the psychological terms and the terms heard within the communities of individuals who engage in these unique fetishes. For the broadest level of understanding, the variety of terms that may be encountered range from academic, peer-reviewed

journal articles and text books to the Internet web sites that cater to the unique fetish communities as well as the vernacular of patients who present themselves in clinical practice.

Autonepiophilia: Coined by John Money PhD, first in his 1984 article in the *American Journal of Psychotherapy* and later in his 1986 book *Lovemaps*. In his journal article, he defines it simply as "diaperism" (Money, 1984, p. 167). In *Lovemaps*, he expands his definition as follows: "a paraphilia of the stigmatic/eligibilic type in which sexuoerotic arousal and facilitation or attainment of orgasm are responsive to, and dependent upon impersonating a baby in diapers and being treated as one by the partner" (Money, 1986, p. 259).

Infantilism: "Described as a post-pubescent person seeking the emotional experience of returning to childhood or infancy using regression and/or other props, such as diapers, to build an authentic experience. Infantilists do not want to involve children; they want to be a child" (Bent, 2012, p. 13)

Psychosexual Infantilism: A term coined by Wilhelm Stekel to describe a phenomenon he observed in patients who he believed were seeking a source of erotic stimulation as well as sympathy and love from their parents by regressing into a state of childhood. (Stekel, 1952, Chapter 1) Also described as "the erotic return to babyhood" (Speaker, 1986, p. 1)

Paraphilic Infantilism: "A paraphilia characterized by the desire to wear diapers and be treated as an infant or toddler" (http://www.odd-sex.com/adult-baby-play-paraphilic-infantilism.htm)

Sexually Exclusive: "in which only the Paraphilic imagery and behaviors are fantasized during the desire phase, and produce sexual arousal. Other fantasies and behaviors do not elicit erotic arousal. (Granzig, 2012, p. 7)

Sexually Non Exclusive: “in which the individual has both normaphilic and paraphilic sexual desires.” (Granzig, 2012, p. 7)

Normophilia: “a condition of being erotosexually in conformity with the standard as dictated by customary, religious, or legal authority.” (Money, 1986, p. 266)

Paraphilia: “a condition occurring in men and women of being compulsively responsive to and obligatively dependent upon an unusual and personally or socially unacceptable stimulus, perceived or in the imagery of fantasy, for optimal initiation and maintenance of erotosexual arousal and the facilitation or attainment of orgasm.”(Money, 1986, p. 267)

Fetish: “is a narrower field of paraphilia, in which the source of stimulation or arousal is an inanimate article such as high heeled shoes, or a choker, or material such as fur, leather, or rubber.” (Bent, 2012, p. 198) Some authors also include arousal to specific parts of the body such as feet or hair (Bent, 2012, p. 198) while other authors define arousal to specific parts of the living body as partialism (Granzig, 1997, p. 2)

Ego-dystonic: The distress some individuals experience when their sexuoerotic desires are in conflict with their personal sense of right and wrong. (Granzig, 2012, p. 7)

Ego-syntonic: The lack of distress some individuals experience when their Paraphilic desires appear to be acceptable or even highly prized. (Granzig, 2012, p. 7)

Age-play: “Age-play is simply adults who are role-playing being a different age. During age-play, some people will take on the role of children while others take on the role of adult or caregiver roles. Age-play is simply a variation of erotic role-play” (Bent, 2012, p. 197).

Adult baby, Adult infant, Adult Toddler, Adult Pre-schooler: “The generic term ‘Adult baby’ comprises Adult Infants, Adult toddlers and Adult Preschoolers for Littles that identify as ages newborn to five years. Note these ages are at best approximate” (Bent, 2012, p. 197).

Little Ones or Littles: A common term used within the Adult Baby community to describe someone who enjoys infantilism and/or diaper fetishes. The age range can vary from Adult infant to Adult teenager (Bent, 2012, p. 13).

Big: “The regular, adult persona of an adult baby: or one who cares for adult babies” (Barber, 2011, p. 148).

AB/DL: Adult baby/Diaper lover (http://understanding.infantalism.org/)

Diaper lover: “A diaper fetishist who does not necessarily have an interest in infantilism.” (Barber, 2011, p. 148) Often diaper lovers have a strong sexual component to the fetish, however not always.

Regression: “The act of mentally returning to a younger age.” (Barber, 2011, p. 149) “is where the adult reverts to the behaviors and emotions of a younger age – usually infant or toddler” (Bent, 2012, p. 198).

Role play: “A theatrical practice in which people assume a role different from their actual role, in this context during sexual encounters” (Barber, 2011, p. 149).

This is only a partial list of the most relevant terms that will be helpful for readers of this particular study. For further study see http://understanding.infantilism.org and look under Glossary A/Z (Grey et al., 2011).

Importance of this study

A little over 40 years ago the American Psychological Association removed homosexuality as a mental disorder from the *Diagnostic and Statistical Manual of Mental Disorders* and as of August 2014, there are now nineteen states and the District of Columbia that have legalized same-sex marriage with the majority of the remaining states in judicial review of their laws ("Same-sex marriage," 2014). For those who have been alive during this time in

history, the enormity of these changes, how it has impacted the mental health treatment approaches for gay and lesbian patients and the importance for the millions of American citizens these changes affect is abundantly clear. According to the literature, attitudes about infantilism and diaper fetishes have begun to change among those born in the past 20 to 25 years causing a trend towards being more well-adjusted within supportive communities and free of the emotional scars that those born prior to this time have experienced. This trend is expected to continue or increase (Grey, 2011). Just as the attitudes about treatment approaches for gay, lesbian and bisexual individuals has changed dramatically in the past 40 years with the changing cultural attitudes, it is time for the mental health profession to catch up with AB/DL community attitudes.

Chapter Two: Review of the Literature

"People seem forever intrigued by what peculiar sexual activities others might perform. Given the apparently high human interest, it might seem plausible that a large army of researchers would be working to further the collective understanding of sexual deviance. It might be surprising then, to learn the reality. Relatively little empirical work has been done regarding unusual sexual activities and preferences, and precious little is known for sure in this area. Perhaps part of the reason for the comparative lack of research attention is the common assumption that sexuality researchers investigate topics of personal relevance, and presumably few researchers want to be thought of as sexual deviants" (Wiederman, 2003, p. 315). In the twenty first century, those who study clinical sexology continue to be viewed differently in the academic world (Wiederman, 2003). Another problem is that sexuality research has had difficulty attracting public funds. According to researchers, from 1972 to 1996 in the USA less than 1% of the research funding from the National Institutes of Health went to sex research (Ng, 2000, p. 275). So it is understandable that sexuality and especially the areas of legal, consenting paraphilias are given even less attention in the multiple peer-reviewed journals, textbooks, and grant-funded studies than those involving such areas as pedophilia, exhibition or voyeurism that have real legal consequences. However this does not make the studies any less important in the scope of the field of sexology and psychotherapy. This chapter will present information from some of the major contributors to the world of psychology throughout recent history, looking at how the psychological world view has changed when it comes to the area of atypical sexual behavior. The research will also look at some recent studies conducted from within the infantilism community, who have performed their own surveys, to increase understanding of this phenomenon. From terminology, to attitudes and treatment approaches, examination of how

beliefs about sexual behavior, the need to control, limit or change it, and hopefully in more recent times, a desire to understand and accept it have emerged.

A Brief History of Attitudes Regarding Atypical Sexual Behaviors

"Whilst it is almost certainly the case that all human societies through history have imposed limits on the types of sexual behavior regarded as acceptable, a degree of variation across cultures has occurred, whilst, within cultural traditions, change in sexual mores may occur over time. Throughout history, it is evident that societies require a concept of sexual deviancy, but that it is subject to changes in social perspective" (Gordon, 2008, p. 79).

"The concept that unconventional sexual interests are mental illnesses or crimes (religious or societal) predates both the DSM and modern psychiatry" (Moser & Kleinplatz, 2006, p. 94). It has not been unusual for many of those in the seats of power to attempt to control the masses by expounding upon the sins against nature for engaging in sexual activity other than for procreation. When religion was not enough to control people the legal system was used. "At first, it was considered a sin to be governed by penitentials and religious courts. Over time, civil laws were used to "control" the unacceptable behavior. In the 19th century the medical model was applied to transform these "sins" or "crimes" into "pathology" (Moser & Kleinplatz, 2006, p. 94). An illustration of how easily discussion of sexuality was suppressed is the case of Dr. Denslow Lewis, a Chicago physician, who wanted to discuss and present a paper for publication with his colleagues at the 1899 meeting of the American Medical Association. Based on the objections of Dr. Howard Kelly, a famous Johns Hopkins University gynecologist on the grounds that the "discussion of the subject is attended with filth and we besmirch ourselves by discussing it in public" the AMA refused to authorize the publication of Dr. Lewis's paper (Bullough & Bullough, 1977, p. 2). Homosexuality was often cited in the legal system as a crime

worthy of punishment and in some Islamic and African countries around the world it remains so today (Reynolds, 2013).

Throughout Europe, the history books are full of criminal codes outlawing homosexuality including King Henry the VIII of England in 1553 declaring that all acts of sodomy were against nature and punishable by death (Heath & White, 2002, p. 22) and the infamous case of Queen Victoria's Criminal Law Amendment Act 1885 in which oral sexual contact between men was outlawed and although lesbian behavior was generally condemned, it was not explicitly recognized in the legislation (Heath & White, 2002, p. 22). Apparently, Her Majesty did not believe that women would ever engage in such behaviors. Yet these conflicting attitudes regarding sexuality in Victorian England were reflected in the growth of pornographic materials as well as a large number of brothels, some with specialties in flagellation and homosexual prostitutes (Bhugra, Popelyuk, & McMullen, 2010, p. 246). In early colonial American times, the court of public opinion was often used, such as Nathaniel Hawthorne's story of the Scarlet Letter, where the heroine was forced to wear a large red A on her chest to show she had been sexual out of wedlock, even though the sex was non-consensual (Hawthorne, 1994).

"Two figures of noble European origin are associated enduringly with the public image of sexual deviance – the Marquis de Sade (1740-1814) and the Baron Leopold von Sacher-Masoch (1835-1895), who have given their names to 'sadism' and 'masochism'. De Sade was confined in a lunatic asylum more than once, and in fact died there, possibly suggesting a contemporaneous association between deviance and mental abnormality" (Gordon, 2008, p. 79).

In the United States during the late nineteenth and early twentieth century the name often cited as a powerful force in the area of sexual repression was Anthony Comstock (1844-1915). During the post-Civil War period the country began to transition from a predominately rural

country to an urban one as many from the younger generation flocked to the larger cities for opportunities. Many from the older generation were shocked by what they considered to be the evils of city life. Comstock became a leader in an effort to return America to its pure, pristine innocence. Due to his campaign he was able to be appointed a special agent by the United States Post Office. Here he was able to confiscate all kinds of materials he deemed pornographic such as birth control information written by physicians (Bullough & Bullough, 1977, p. 2) as well as publications for women encouraging sexual pleasure (Arnold, 2006). During his time in power, Comstock imprisoned over 3,600 people for distributing sexual information. One of which was Ida Craddick, a woman arrested in 1902 who wrote *The wedding night* in order to inform women about their right to sexual pleasure within marriage. She was found guilty and committed suicide before she was imprisoned. Comstock also charged Margaret Sanger, in 1914 for her publication of the Woman Rebel which advocated birth control and sexuality education for women. Sanger was charged yet never convicted because she fled to Europe until such time as the charges were dropped. Margaret Sanger eventually went on to found Planned Parenthood and was instrumental in the development of oral contraceptives in 1960 (Arnold, 2006).

In addition to Comstock, in 1906, John Harvey Kellogg invented the bland breakfast cereal, Corn Flakes, to keep the stomach full, suppressing the stomach and the loins, in order to reduce sexual urges, especially masturbation among young men and women. When this was not enough, he would have the cereal administered by enema, and in the most severe cases blisters applied to the genitals or removal of the clitoris was performed (Arnold, 2006).

Within the literature, a more modern notion of sexuality began to shape in the last two decades of the nineteenth century, especially in the works of psychiatrist Richard von Kraft-Ebing (1840-1902) and neurologist Albert Moll (1862-1939). This modernization of sexuality

was closely linked to the recognition of sexual diversity, as it was articulated in the medical-psychiatric understanding of what, at that time, was labeled as perversion (Oosterhuis, 2012, p. 133). By todays beliefs about typical human sexual expression it can be difficult to read their works and see them as advancing the cause of normalizing sexual behavior since their use of the term 'perversion' and thoughts about masturbation and homosexuality, would be considered highly judgmental. However compared with other voices of their era theirs are closer to modern beliefs about sexuality. As an example of the era, in 1872, ovariotomy, the removal of normal ovaries was the fashionable treatment for many female maladies, some of which were nymphomania and masturbation as well as 'all cases of insanity' (Studd, 2006, p. 411). It becomes clear reading the works of Kraft-Ebing, Moll, as well as Freud, Hirschfeld, Stekel, and Ellis that their personal views on normality is based on religion, law and the upper-class level of society in which they interacted affect their opinions yet they are considered by many today to be brilliant thinkers who were far ahead of their time. Not everyone agrees. "Edward Brecher has gone so far as to write that Kraft-Ebing made sex a loathsome disease" (Bullough & Bullough, 1977, p. 207).

In the late nineteenth century, physicians believed that mental and nervous disorders were the result of 'unnatural' behaviors, while psychiatrists began to take a different view, suggesting that such disturbances were actually the cause of sexual deviance. Their assertions were that irregular sexual behavior should not be regarded as sin or crime but rather as symptoms of pathology to be treated rather than punished (Oosterhuis, 2012, p. 134).

The transition of sexual deviancy, being regarded as a medical phenomenon from a social nuisance or crime may well has been with the publication of *Psychopathia Sexualis* (Kraft-Ebing, 1886) (Gordon, 2008, p. 79). Kraft-Ebing does advocate for the understanding of sexual

acts that are other than for procreation. In his words (translated into English in 1965 by Dr. Harry E. Wedeck) “In order to differentiate between disease (perversion) and vice (perversity), one must investigate the whole personality of the individual and the original motive leading to the perverse act. Therein will be found the key to the diagnosis” (Kraft-Ebing, 1965, p. 108). Freud saw the roots of perversion as interplay between physical and social factors (Gordon, 2008, p. 80). While Ellis and Hirschfeld were known for their beliefs on the normalizing of homosexual behavior, with both Kraft-Ebing and Moll having conflicting views about the subject, Kraft-Ebing becoming more lenient as he aged while Moll become more conservative, yet both signed onto Hirschfeld’s petition to abolish Section 175 of the German legal code, which made so-called ‘unnatural vice’ punishable (Oosterhuis, 2012, p. 137). The terms homosexual and heterosexual were introduced in 1869 by Karl Maria Kertbeny, yet did not gain much use until Kraft-Ebing reintroduced them, along with Moll around 1890 (Oosterhuis, 2012, p. 144).

Kraft-Ebing is believed to have coined some of the terms for various paraphilias, such as sadism, masochism and pedophilia, (Oosterhuis, 2012, p. 144) while Stekel is believed to have coined the term paraphilia to replace the more judgmental term perversion which was a standard term in the literature of the time. The exact date of when Stekel coined the term appears to vary in the literature with dates of 1905 (Seligman & Hardenburg, 2000, p. 107), 1908 (Downing, 2010, p. 276), 1912 (Money & Lamacz, 1989, p. 17), 1922 (Granzig, 2002, p. 3), 1924 (Wiederman, 2003, p. 315), and 1925 (Fankhanel, 2006, p. 16). The term was not widely adopted in the professional lexicon until its assimilation into the DSM-III in 1980 and promotion by Money in the 1980’s with his extensive research and naming of many of the various paraphilias (Money, 1986).

The Meaning of Paraphilias:

The meaning of the word deriving from the Greek words *para* defined as other or outside of, and *philia* defined as love or loving (Wiederman, 2003, p. 315). It has also been defined by Dr. Charles Moser, who is less fond of the term, as "interest in perversion or love of the perverse". Moser believes the term should have been coined as *paralagnia* with the root *lagnia,* meaning lust rather than love (Moser, 2001, p. 94). While Stekel may have believed he was improving the lives of those referred to as "perverts" with the creation of a less pejorative term, it appears the medical and psychological community just switched one term for another leaving the basic meaning one of a mental diagnosis needing to be treated or cured.

"The word *fetish* derives from the Portuguese *feitico*. It was apparently first used by 15th Century Portuguese explores to describe West African sacred carvings. In its original (and current anthropological) meaning, fetish refers to a sacred artifact invested with spiritual or talismanic power. The erotic fetish is not merely a symbol of the divine but is itself divine. It possesses a discrete power: It can arouse and, sometimes, induce ecstasy in its devotee. For fetishists, a shoe may be sexier than the foot it adorns; lingerie more enticing than the erotic anatomy it screens; a rubber coat more stimulating than the person it contains" (Brame, Brame, & Jacobs, 1993, p. 358).

DSM: A Look at the Paraphilias

DSM-I

"The APA first published a predecessor of the DSM in 1844, as a statistical classification of institutionalized mental patients. It was designed to improve communication about the types of patients cared for in these hospitals. This forerunner to DSM also was used as a component of the full U.S. census. After World War II, DSM evolved through four major editions into a

diagnostic classification system for psychiatrists, other physicians, and other mental health professionals that described the essential features of the full range of mental disorders" (APA, 2013, p. 6).

In 1952, the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) was published by the American Psychiatric Association as a means of giving psychiatrists a guide to better understand and treat mental disorders. In that edition, the term sexual deviation, as part of the classification for Personality Disorders, was under Sociopathic Personality Disturbances and included in its definition "the type of pathologic behavior, such as homosexuality, transvestism, pedophilia, fetishism and sexual sadism (including rape, sexual assault, mutilation) (*Diagnostic and Statistical Manual of Mental Disorders* (1st; American Psychiatric Association, 1952, p. 38-39). This was not surprising, since at the time homosexuality was aggressively treated by psychiatrists with various forms of olfactory and electro-shock aversion therapy (Smith, Bartlett, & King, 2004) and nymphomania in women was treated with similar practices and even incarceration in an insane asylum (Angel, 2010). Even though it has been over 60 years and we now have the DSM 5 published, there remain those in the psychological community who are quick to pathologize sexual behavior such as Patrick Carnes and the "sex addiction" movement creating a whole industry from support groups such as SAA (Sexoholics Anonymous) (Lipscomb, 2007) to treatment facilities specializing in repressing sexual behavior. To be clear, yes there are those whose sexual lives can become problematic, however the term "sexual addiction" can be and often is used to describe a very broad range of sexual expression that falls outside of what a few individuals deem appropriate (Taverner, 2008, p. 11).

In DSM I, (1952) while the description of 000-x63 Sexual deviation is short, the tone created by language such as “deviant sexuality” and “pathologic behavior” (American Psychiatric Association, 1952, p. 38-39) gives a strong impression that the listed behaviors, homosexuality, transvestism, pedophilia, fetishism and sexual sadism are clearly not to be tolerated and in need of change.

DSM-II

The publication of DSM II in 1968 attempted to expand upon the previous edition and gave clinicians a little more definition of what the intention behind the committee for the American Psychiatric Association had in mind regarding sexual deviation. The new addition re-coded Sexual deviations from 000-x63 to 302 with an additional numeral for the list of deviations of clinical significance. In DSM II, the diagnosis was made when “individuals whose sexual interests are directed primarily toward objects other than people of the opposite sex, toward sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstances” (American Psychiatric Association [APA], 1968, p. 44). The description states that many who engage in these practices find them “distasteful” yet are unable to substitute normal sexual behavior for their deviant ones (APA, 1968, p. 44). The list of the deviations is similar to DSM I with the addition of exhibitionism, voyeurism, masochism, other sexual deviation, and unspecified sexual deviation (APA, 1968, p. 44). There is no definition of either “other sexual deviation” or “unspecified sexual deviation.” It is unclear whether sexual acts such as oral or anal sex and mutual masturbation by opposite sex partners would qualify them for a diagnosis of sexual deviation either with the “other sexual deviation” or “unspecified sexual deviation.” It appears to be an individual clinical judgment whether such acts could be considered as not usually associated with coitus or “bizarre.” Other researchers have criticized

the descriptions of disorders in the various versions of the DSM since even the accusation of interest in specific sexual practices and especially the diagnosis of a sexual deviation could result in death, imprisonment, and/or loss of civil rights (Moser & Kleinplatz, 2006, p. 92).

In DSM I both rape and pedophilia were listed as 'sexual deviations' and classified as disorders, yet in DSM II rape was eliminated and pedophilia remained. It is unclear what caused pedophilia to remain a psychopathology and rape was not. The commonalities between rape and pedophilia are quite similar. Both are crimes that involve sex, power, and victimization and adversely affect the survivors subsequent functioning. The inclusion of one criminal behavior and not the other is inconsistent (Moser, 2001, p. 104).

DSM-III

"The publication of the DSM III in 1980 marked a revolution in the history of the DSM. One of the most visible changes was the increase in the number of mental disorders: from 182 disorders in the DSM II of 1968, to 265 disorders in the DSM III" (Singy, 2012, p. 141). The sketchy psychoanalytic models of some disorders described in DSM I and DSM II were abandoned and replaced with more detailed criteria and the atheoretical approach predominated the new DSM III (Zucker, 2010, p. 217). The sexual deviations section within both DSM I and II was contained within a single paragraph. It appears the APA attempted to address some of the perceived weakness of the previous editions with the edition of DSM III (American Psychiatric Association [APA], 1980) which went from a single paragraph to a chapter with 22 pages. "With the publication of DSM III, the focus of the DSM changed from a theoretically based, psychoanalytic model of illness to an evidence-based and descriptive model" (Moser & Kleinplatz, 2006, p. 93). DSM III renamed the sexual section from Sexual Deviations to Psychosexual Disorders (APA, 1980, p. 261) and divided the chapter into four groups; gender

identity disorders, paraphilias, psychosexual disorders and other psychosexual disorders (APA, 1980, p. 261). Despite the APA's decision to remove homosexuality from its list of mental disorders in 1973, the "other psychosexual disorders" group continued to list "Ego-dystonic Homosexuality" as a diagnosis (APA, 1980, p. 281).

In DSM III, the use of the term paraphilia is seen for the first time replacing the more pejorative term, sexual deviation. The advisory committee explains their rationale for the change by stating it was "preferable because it correctly emphasizes that the deviation (para) is in that to which the individual is attracted (philia) (APA, 1980, p. 267). The influence of John Money, who is listed as part of the psychosexual disorders advisory committee at the beginning of DSM III, is likely the reason for the change in terminology. His journal article about paraphilia and his book, *Lovemaps*, which helped to popularize the term paraphilia, were both published shortly after DSM III's release (Money, 1984) (Money, 1986).

Paraphilia's in DSM III were characterized as "arousal in response to sexual objects or situations that are not part of normative arousal-activity patterns and that in varying degrees may interfere with the capacity for reciprocal affectionate sexual activity" (APA, 1980, p. 261). DSM III continued with some of the judgmental language of the previous versions when discussing paraphilia. It states that an essential feature was "unusual or bizarre imagery or acts necessary for sexual excitement" (APA, 1980, p. 266). The three areas used to diagnose a paraphilia included 1) preference for use of a nonhuman object for sexual arousal, 2) real or simulated suffering or humiliation, or 3) sexual activity with non-consenting partners. It goes on to further explain that associated features of paraphilia have individuals admitting to "guilt, shame, and depression at having to engage in an unusual sexual activity that is socially unacceptable" (APA, 1980, p. 266-267).

The paraphilia listed in the DSM III are 302.81 Fetishism, 302.30 Transvestism, 302.10 Zoophilia, 302.20 Pedophilia, 302.40 Exhibitionism, 302.82 Voyeurism, 302.83 Sexual masochism, 302.84 Sexual sadism, and 302.90 Atypical paraphilia for individuals with paraphilias that cannot be classified in any other categories (APA, 1980, p. 268-275). For the first time the DSM further expanded upon the definitions of the various paraphilia as well as listed categories such as age at onset, differential diagnosis, course, and in some cases, predisposing factors (APA, 1980, p. 268-275).

The diagnostic criteria for fetishism involved A) "use of nonliving objects (fetishes) is a repeatedly preferred or exclusive method of achieving sexual excitement" and B) "fetishes are not limited to articles of female clothing used in cross-dressing (transvestism) or to objects designed to be used for the purpose of sexual stimulation (e.g., vibrator)" (APA, 1980, p. 269).

The essential feature was the use of nonliving objects as a preferred or exclusive means of achieving sexual excitement. It was not considered a fetish if the nonliving objects were limited to female clothing used for cross-dressing as that was considered transvestism, a separate category. The differential diagnosis was allowed for "nonpathological sexual experimentation" when the use of the object for stimulation was neither preferred nor required (APA, 1980, p. 268).

DSM-III-R

In 1987, the DSM was revised with the publication of DSM III-R (American Psychiatric Association [APA], 1987) and in this revision the category name changed once again from Psychosexual Disorders to simply Sexual Disorders and dropped from four to two main groups; Paraphilias and Sexual Dysfunctions, as well as a residual class referred to as Other Sexual

Disorders (APA, 1987, p. 279). The revision kept the basic essential features of the disorder the same with the addition to children to non-consenting partners in number three.

DSM III-R did for the first time begin to allude to the possibility that Paraphilic behavior was not always diagnosable. When discussing the imagery in a paraphilia it gave the example that "being humiliated by one's partner may be relatively harmless and acted out with a consenting partner" and also stated that many men are sexually excited by female undergarments, however this did not mean they would quality for a diagnosis of transvestism (APA, 1987, p. 279). DSM III-R was the first edition to finally drop the judgmental and non-clinical language of "unusual and bizarre images or acts" when describing paraphilias and fetishes specifically. These shifts began to show an appreciation for a broader range of sexual expression without being pathological or diagnosable. DSM III-R also finally dropped all mention of homosexuality as any type of mental disorder. While officially the DSM would drop homosexuality from its editions as a mental disorder, the controversy surrounding the issue would fail to so easily be extinguished. Well into the twenty first century, while same-sex marriage would become legal in 25% of the states, organizations such as NARTH (National Association for Research and Therapy of Homosexuality) would continue to advocate for therapies such as Reparative Therapy designed to change a person's sexual orientation (The NARTH Perspective, n.d.).

The specific paraphilia described in DSM III-R was similar to DSM III with the exclusion of zoophilia, the addition of frotteurism, and the revision of "Atypical Paraphilia" to "Paraphilia Not Otherwise Specified" (APA, 1987, p. 280). There was also the additional criterion for severity of manifestation of a paraphilia ranging from mild, (distressed about urges,

yet has not acted upon them), moderate, (has occasionally acted upon the paraphilic urge), to severe (has repeatedly acted upon the paraphilic urge) (APA, 1987, p. 281).

The 1987 revision changed the essential feature of fetishism describing it as "recurrent, intense, sexual urges and sexually arousing fantasies, of at least six months' duration, involving the use of nonliving objects" (APA, 1987, p. 282). The diagnostic criteria were expanded from two to three criteria. Criteria A, added the measure of time with "over a period of at least six months" as well as "recurrent intense sexual urges and sexually arousing fantasies" (APA, 1987, p. 283). A 'Note' was also added to A. criteria stating that at times the nonliving object may be used with a sexual partner (APA, 1987, p. 283). Criteria B from DSM III became Criteria C in DSM III-R and the new criteria B became "the person has acted on these urges, or is markedly distressed by them" (APA, 1987, p. 283).

This new diagnostic criteria has brought questions from critics of the Paraphilias in the DSM. The questions of "why 6 months?, what does recurrent mean?, what does intense mean?, and is it meaningful to discuss sexual urges independent of sexual fantasies?" abound in the literature (Fedoroff, 2008, p. 638).

In DSM III-R was the first mention of the term "infantilism" as part of the Sexual Masochism disorder. There is one sentence about the issue which states "The term *infantilism* is sometimes used to describe a desire to be treated as a helpless infant and clothed in diapers" (APA, 1987, p. 286). The implication is that infantilism is part of the aspect of humiliation discussed within the diagnosis for sexual masochism and gives no indication of how to work with a patient for whom this is a desired, self-inflicted activity rather than one where they were forced and is done for humiliation. "If the infantile role playing does not involve feelings of

humiliation and suffering, then the diagnosis of sexual masochism would not be appropriate and a diagnosis as paraphilia NOS is warranted" (Milner, Dopke, & Crouch, 2008, p. 407).

DSM-IV

In 1994 the DSM IV was published and again the name of the chapter relating to sexual issues changed from Sexual Disorders to Sexual and Gender Identity Disorders and lists four major categories, Sexual Dysfunctions, Paraphilias, Gender Identity Disorders, and Sexual Disorder Not Otherwise Specified (American Psychiatric Association [APA], 1994, p. 493). Much of the description and tone of the Paraphilia section of DSM IV is similar to DSM III-R with a few notable exceptions. Under the heading of Associated Features there was the addition of Specific Culture and Gender Features which mentions the issue of the difficulty diagnosing paraphilia across cultures and religions since what is considered deviant in one cultural setting may be acceptable in another (APA, 1994, p. 524). The Course section expounded upon what had been briefly mentioned in previous editions regarding age of onset, childhood to adolescence, and that the disorders tend to be chronic. However here it expanded upon the chronic and lifelong to add that the fantasies and behaviors often diminish as adults advance in age (APA, 1994, p. 524-525).

In DSM IV the diagnostic criteria was altered slightly. Criteria A remained the same, with the removal of the Note relating to the use of the fetish object with a sexual partner. Criteria B were expanded to "the fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning" (APA, 1994, p. 526). Here the DSM changes its approach by describing the issue of "clinically" significant distress or impairment in areas of a patient's life functioning leaving behind terminology that

could not be empirically measured such as “unusual or bizarre” and aiming for a more scientific approach to understanding human sexual behavior.

In another shift from previous editions, DSM IV added a ‘Differential Diagnosis’ section which stated that “a Paraphilia must be distinguished from the nonpathological use of sexual fantasies, behaviors, or objects as stimulus for sexual excitement in individuals without a Paraphilia” (APA, 1994, p. 525). Paraphilias are only diagnosed when fantasies, behaviors, or objects lead to clinically significant distress or impairment (APA, 1994, p. 525). Some found this to be a significant step forward in the DSM’s position on atypical sexual behavior. Moser stated that this section of the DSM IV was becoming more liberal and less pathological (Moser, 1999, p. 83).

DSM-IV-TR

In 2000, the DSM IV-TR was published with a few minor revisions from the previous edition. For the first time in several editions, the section name, Sexual and Gender Identity Disorders, remained the same as well as the essential features of paraphilia and the diagnostic criteria for fetishism. Under the heading of Associated Features and Disorders, the subsection of ‘Associated general medical conditions’ was added specifically mentioning that “frequent, unprotected sex may result in infection with, or transmission of, a sexually transmitted disease” (APA, 2000, p. 567). This disclaimer warning clinicians to look for unprotected sex among those with paraphilias was missing from the same ‘Associated general medical conditions’ section under the Sexual Dysfunctions and the Gender Identity Disorders sections (APA, 2000, p. 560, 579). Apparently the belief by the committee was that those engaging in paraphilias were more sexually active and careless about their sexual encounters than the remaining populations despite evidence to the contrary.

Before the publication of DSM 5 in 2013, as with many previous editions of the DSM, there was much controversy about potential changes to be made within the chapter on sexual diagnoses. Voices both within and outside of the psychological community were vocal regarding their thoughts about the previous editions, as well as potential changes for the upcoming edition. In 2006, Charles Moser, PhD, MD, and Peggy Kleinplatz, PhD published an article in the *Journal of Psychology and Human Sexuality* advocating the removal of paraphilias from the DSM. According to their research findings, the concept of paraphilia as psychopathology does not meet the DSM's own definition of a mental disorder and therefore the category should be removed (Moser & Kleinplatz, 2006, p. 91). They argue that "empirically based, scientific definitions of healthy and pathological sexual behavior continue to elude us" and that the paraphilia section is severely flawed (Moser & Kleinplatz, 2006, p. 92). DSM IV-TR states it is to be neutral with respect to theories of etiology (APA, 2000, p. xxvi) and based on objective observation, and able to support its statements with empirical research (Moser & Kleinplatz, 2006, p. 93). Since little empirical research is conducted on many of the paraphilias and there is little opportunity for objective observation, the argument that Moser and Kleinplatz made is a sound one.

Moser and Kleinplatz are not the only ones advocating for the removal of the paraphilias from the DSM. Baumeister and Butler in 1997, and Hucker in 2008, stated that many of the paraphilias were not pathological and addressed a call to remove the paraphilias from the DSM (Krueger, 2010, p. 349). Many in the field of psychology feel that the DSM when evaluated according to the empirical scientific criteria of validity and reliability is found to be fundamentally flawed, unable to account for the complexity of human subjectivity and on both clinical and ethical grounds fails as a valid diagnostic instrument (Bradford, 2010, p. 335, 348).

Prior to the publication of DSM 5, Hinderliter proposed the committee consider making a distinction between paraphilias and paraphilic disorders. He stated that the use of the term paraphilia had been used to label certain sexual interests as mental disorders and that creating a non-pathologizing term for non-normative sexual interests would be a better choice (Hinderliter, 2011). He went on further to state "the DSM does not seem to be an appropriate place for classifying what are acknowledged to be nonpathological variations in human sexuality" (Hinderliter, 2011, p. 20).

DSM-5

DSM 5 divided the sexual disorders into three separate chapters under Section II, Diagnostic Criteria and Codes. Those chapters were Sexual Dysfunctions, Gender Dysphoria, and Paraphilic Disorders. Included under Paraphilic Disorders were voyeuristic disorder, exhibitionistic disorder, frotteuristic disorder, sexual masochism disorder, sexual sadism disorder, pedophilic disorder, fetishistic disorder, and transvestic disorder. The various disorders were divided into two groups. The first group of disorders were based on *anomalous activity preferences* and then subdivided into *courtship disorders,* which relate to distorted components of human courtship behavior (voyeuristic disorder, exhibitionistic disorder and frotteuristic disorder) and *algolagnic disorders* which involve pain and suffering (sexual masochistic disorder and sexual sadism disorder). The second group of disorders was based on *anomalous target preferences* which include one directed at other humans (pedophilic disorder) and two directed elsewhere (fetishistic disorder and transvestic disorder) (American Psychiatric Association [APA], 2013, p. 685).

The definition in DSM 5 changed for paraphilias to "any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with

phenotypically normal, physically mature, consenting human partners" (APA, 2013, p. 685). It was also said to be defined as "any sexual interest greater than or equal to normaphilic sexual interests" (APA, 2013, p. 685).

In a shift from previous DSM editions, the DSM 5 states that while having a paraphilia is necessary to diagnose a paraphilic disorder, a paraphilia alone does not necessarily justify or require clinical intervention. The diagnostic criteria for a paraphilic disorder consists of Criteria A) the qualitative nature of the paraphilia and Criteria B) the negative consequences of the paraphilia. In order to diagnose a paraphilic disorder, both Criteria A and B must be met. In the case where one criterion is met, yet the other is not, then the individual may have a paraphilia and not a paraphilic disorder (APA, 2013, p. 686).

The DSM 5 goes on to add that assessing the strength of a paraphilia should be evaluated in relation to their normaphilic sexual interests and behaviors. This can be done with clinical interviews and or self-administered questionnaires examining whether their paraphilic sexual fantasies, urges, or behaviors are weaker than, equal to, or stronger than their normaphilic sexual interests and behaviors (APA, 2013, p. 686).

The Diagnostic Criteria for Fetishistic Disorder remained relatively the same as DSM IV-TR with the addition of some specifiers. After the A) B) and C) criteria there is the addition to specify: body part(s), nonliving object(s), or other, as well as specify if: in a controlled environment (such as institutional settings) or in full remission (no distress or impairment in social, occupational, or other areas of functioning for at least 5 years) (APA, 2013, p. 700).

Under Diagnostic Features it states that since it is not uncommon for fetishes to include both inanimate objects and human body parts that the definition of fetishistic disorder would re-

incorporate *partialism* (which was defined as an exclusive focus on a living body part) into the boundaries (APA, 2013, p. 701).

News of this shift after publication of the DSM 5 spread quickly through channels of the fetish communities. NCSF, the National Coalition for Sexual Freedom, a national organization designed to protect the rights of alternative sexual expression, released a press release the month following DSM 5's publication. The title of their release was "The DSM-5 Says Kink is OK!" (NCSF, personal communication, June 22, 2013). It goes on to say, "The APA has made it clear that being kinky is not a mental disorder, says Susan Wright, Spokesperson for NCSF. That means people no longer have to fear being diagnosed as mentally ill just because they belong to a BDSM group. We've already seen the impact- NCSF immediately saw a sharp rise in the success rate of child custody cases for kinky parents after the proposed DSM-5 criteria was released three years ago" (NCSF, personal communication, June 22, 2013).

One area where the DSM 5 appears to be behind the empirical evidence in the area of Fetishistic Disorder was the category of Gender-Related Diagnostic Issues. The DSM 5 states "fetishistic disorder has not been systematically reported to occur in females. In clinical samples, fetishistic disorder is nearly exclusively reported in males" (APA, 2013, p. 701). However this contradicts the data discovered by B. Terrance Grey in 2008. He found that approximately 8% of his survey populations were female and that women are actually more common in Paraphilic infantilism and diaper fetishes than other paraphilias (Grey, 2008).

Other researchers have also found higher numbers of women with fetish interests. In the book, Different Loving: The world of sexual dominance & submission, the authors state they have interviewed a larger number of women than expected who volunteered that they were

fetishists. They state that there are extensive case studies of female fetishists in the early psychological literature, however do not list it (Brame, Brame, & Jacobs, 1993, p. 360).

Darcangelo also questioned the belief that the number of female fetishists are as low as the DSM 5 committee would want therapists to believe. According to them fetishism is considered to be more common in males than females yet due to the lack of sound epidemiological evidence the extent of this difference is actually unknown (Darcangelo, 2008, p. 110). She quoted an article by Wilson investigating the sexual fantasies of 1,862 male and 2,905 female readers of a national newspaper. The analysis revealed that 18% of the men reported fetishistic elements to their fantasies while 7% of women included fetishistic elements (Darcangelo, 2008, p. 110).

In 2012, Bent wrote that up until recently it was considered that almost all Adult Babies were male. We now know this is fundamentally inaccurate. While men appear to be in the majority, it is approximately a 60/40 split favoring men. One of the big changes in the AB/DL world over the past decade has been the discovery that women can be just as regressive as men (Bent, 2012, p. 24).

In the previous three editions, (DSM III-R, DSM IV, and DSM IV-TR) infantilism was listed briefly as part of Sexual Masochism. In DSM 5 this was eliminated, however under the area of ‘Comorbidity’ it states that disorders are possible to comorbidly occur with sexual masochism disorder and typically include Paraphilic disorders (APA, 2013, p. 695). Infantilism is not specifically mentioned, however, it does imply that infantilism could comorbidly occur with sexual masochism disorder.

Throughout the seven editions of the DSM, sexuality in general and the paraphilias specifically, indicate that the normative definitions of health have reflected a theoretical and

perhaps biased construct of mental illness on the dominant values and biases of western culture. It has been argued that the DSM reflect the interests and assumptions of the elite psychologists who are involved in its development and shifts the power to determine normality from the individual to the mental health professional whose sexist and heterosexist assumptions dominate their diagnoses (Cermele, Daniels, & Anderson, 2001). In the DSM's defense, over the last several editions, the section on sexual disorders has become more liberal. In the words of Dr. Charles Moser, "it is not the last word on the subject" (Moser, 1999, p. 83).

Modern Era Peer-reviewed Literature

Much of this review of the psychological literature has focused broadly on the historical view of human sexuality and behaviors, the terminology for atypical sexual behaviors, as well as a look at psychology's ultimate definition of disorders and dysfunction, the DSM. The remainder of the review of the literature will focus specifically on what has been written about the phenomenon of paraphilic infantilism and autonepiophilia within the past sixty years. "In the clinical literature the description of the psychosexual infantilist portrays a severely dysfunctional individual. He is likely to have come to the attention of law enforcement or other authorities and been required to receive treatment" (Speaker, 1986, Chapter 1). Three journal articles, published by the *American Journal of Psychiatry* in the mid 1960's exemplify this portrait.

The first article written in 1964, described a man who was arrested and charged with sexually molesting his daughters and after his arrest, admitted to authorities that his wife had urged him to seek psychiatric treatment when she learned he was wearing diapers and rubber pants (Tuchman & Lachman, 1964, p. 1198). The next case, published two years later, involved a twenty year old college student who had been caught stealing diapers from people's homes and leaving his soiled ones behind for them to find (Malitz, 1966). The following year another article

was published in the same journal about a seventeen year old male, brought to psychiatric treatment by his family when they learned he was wearing diapers under his clothing, drinking from a baby bottle and eating baby food (Dinello, 1967). Each of these cases involved a psychoanalytic therapeutic approach that was designed to change their sexual behaviors to typical, heterosexual sexual functioning. It was unclear from these articles whether there was continued use of diapers by these patients once they were in consenting sexual relationships with a partner or if this was only a temporary behavior. Since most of the literature defines these fetishes as life-long and chronic, it is unlikely that the behaviors were extinguished by the therapies described as the articles would have us believe.

There was a gap in the academic literature until 1980 with the publication of a little known master's thesis by Thomas Speaker called *Sexual infantilism in adults: Causes and treatment*. In his case study he had self-proclaimed infantilists complete his survey after he discovered his first subject in a personal ad in The Fetish Times, a monthly publication for fetishes of various varieties. From these personal ads, he compiled his research from the surveys of twelve individuals, eleven men and one woman, ranging in age from 24 to 50 years, who completed his self-administered questionnaire for the case study (Speaker, 1980). He used an ecological model to relate a number of causal factors: biology, stress (psychoanalytic view), faulty learning (behavioral view), blocked or distorted personal growth (humanistic or existential view), unsatisfactory interpersonal relationships and/or pathological social conditions (Speaker, 1980, p. 64). He concluded that, "infantilism is just as much a coping mechanism as it is a fetish. They are not fixated at a certain level, but rather behave as 'time-travelers', alternating between functioning at an adult level (managing careers, families, relationships, etc.) and functioning at an infantile level (wearing diapers, wetting, drinking from a baby bottle, etc.). Sexual infantilism

behavior is compartmentalized, being a behavior that is engaged in only in certain times and situations when it seems "appropriate". There is a conscious decision as to whether to have an infantile experience or not, whether the motivation is for sexual pleasure or as a coping behavior. They use regression as a defense mechanism in times of stress to gather strength for coping or as a method of using illusion to maintain momentum in the face of a difficult reality" (Speaker, 1980, p. 72). He found that none of the models (behavioral, psychoanalytic, humanistic, etc.) fully supported the primary causal relationship yet stated the behavioral model justified the strongest support (Speaker, 1980, p. 73).

When he addressed the area of therapy, he strongly recommended that "assessment and therapy should be individually tailored to the needs of the client." If not severely maladaptive or socially disruptive there appears to be little to no desire for extinction in the subjects. So long as the behavior is self-managed through discretion and does not involve criminal behavior, uninvited intervention could be argued to be an unethical violation of individual rights (Speaker, 1980, p. 74).

Six years later, Speaker completed his doctoral dissertation continuing his earlier research on the subject of infantilism. In, *Psychosexual Infantilism in Adults: The eroticization of regression*, he was able to expand his case studies, using 7 of the original 12 cases and examining their infantilistic behavior during the 5 year period since his previous study. He added an additional 20 respondents to his new study for a total of 27; 26 male and 1 female. The one female participant had been in his original study. He created an infantilism survey as well as a fantasy questionnaire that he used with his participants to then eventually create an 'average' profile from his survey group. Unlike Stekel and other previous researchers who found most infantilists involve a "retreat from reality" (Speaker, 1986, p. 2) be rather pathetic individuals

and lead a completely dysfunctional lifestyle, (Stekel, 1952) Speaker's participants portrayed a different vision. Speaker found the average infantilist to be male, mid-30s, college educated in a professional career. Most were in committed relationships and were not sexually exclusive with their fetish. He did report that most of his participants reported a later than average age of achieving bladder control and voluntarily returned to diapers in adolescence as part of their sexual practices (Speaker, 1986).

While he found that few participants had sought out psychotherapy he stated that "psychotherapy can be helpful in minimizing the possible harmful 'side-effects' of engaging in infantilism" (Speaker, 1986, Chapter 6). In both studies he found the goal of psychotherapy was to open options for patients from which to choose, remove blocks from conventional scripts, increase control over sexual behaviors that may have become out of control and heal emotional side-effects such as guilt, anxiety, and depression. Additional goals were to help patients improve communication skills within romantic relationships so that participation with a partner was not from a place of coercion but rather understanding and negotiation (Speaker, 1986).

Speaker's research was some of the first within the academic community that looked at paraphilic infantilism and diaper fetishism through a far less judgmental lens than others before him. His research showed that many people who engaged in these unique sexual behaviors were also able to function successfully within the world and were not completely disabled by their fetishes.

In 2003, Pate and Gabbard published an article in the *American Journal of Psychiatry* titled Adult Baby Syndrome. It described a case of a 35 year old male who presented for treatment stating he wanted to "be a baby." The patient presented for treatment dressed in baby clothes and wearing diapers, talking in a child-like manner and often lying on the couch drinking

from a baby bottle. He reported that there was a sexual nature to his condition and that he only masturbated while in diapers. He stated his fetish greatly affected his ability to engage in interpersonal and especially romantic relationships yet he was able to maintain a career in law enforcement where he said he "did not feel like a baby" (Pate & Gabbard, 2003). Despite his social isolation, he appeared to terminate therapy when the clinician theorized that he could not establish a perfect parent/child relationship in which no demands would be placed on him for adult behavior (Pate & Gabbard, 2003).

Three additional articles were published regarding adult baby syndrome in the *Archives of Sexual Behavior* in 2006, 2007, and 2011. Two referred to the Pate and Gabbard article and all three referred to the term 'Adult baby syndrome' despite the term not yet becoming part of any official psychiatric classification system (Evcimen & Gratz, 2006, p. 115). It appears the term 'adult baby syndrome' has begun to take on acceptance in the academic literature despite the lack of official classification.

Two cases involved male patients in psychiatric care for additional more serious psychiatric diagnoses such as hallucinations and delusions, and neither case reported any sexual gratification from their diaper wearing related to thoughts or behaviors. One case did have the additional component of gender identity disorder as the patient presented as a female baby, and when in his baby persona preferred to be referred to using female pronouns (Kise & Nguyen, 2011, p. 857). The authors appeared uncertain whether these particular cases were related to true infantilism or some form of obsessive-compulsive disorder, a paraphilia or an additional psychiatric disorder (Evcimen & Gratz, 2006) (Kise & Nguyen, 2011).

In 2007, Dickey described a case of a 25 year old male who presented for treatment stating a desire to be a 10 year old girl. This patient reported he achieved sexual arousal

associated with the fantasy of having the physical characteristics and social role or a prepubescent girl yet denied any actual interest in prepubescent girls. He categorized the patient as "autohebepedophilic dysphoria" (Dickey, 2007, p. 131).

Most journal articles relate cases of individuals who either self-present for treatment or are part of in-patient psychiatric care. In a rare case in 2008, Caldwell presented a case of a couple where a 48 year old male and his wife of 26 years presented for couples therapy. She had been in psychiatric hospitalization on several occasions and on one occasion expressed relationship difficulty due to her husband's voluntary use of diapers. He had struggled with his use of the diapers since he was a teenager and found the diapers to be part of not only his sexual fantasies, but also as a means to reduce stress as various points in his life (Caldwell, 2008, p. 158). Caldwell did acknowledge that despite the 'maladaptive coping strategy' related to diaper wearing and the effects on the relationship, there was no evidence of cognitive impairment, psychosis, or affective disorder (Caldwell, 2008).

The most recent academic survey as of the publication of this study, was an internet-based study conducted by Hawkinson and Zamboni published online in the *Archives of Sexual Behavior* (Hawkinson & Zamboni, 2014). The study had 1,795 male and 139 female subjects who were members of an online AB/DL web site and participated in an anonymous survey. The research focused on discerning two possible subgroups, those who focused on role play behavior and those who were primarily interested in sexual arousal in their AB/DL behavior (Hawkinson & Zamboni, 2014). The purpose of the study was to provide descriptive information on individuals who engage in AB/DL behaviors as well as focus on whether AB/DL behaviors were associated with negative mood states (Hawkinson & Zamboni, 2014).

One of the opinions asked by the researchers related to participants opinion about where their AB/DL interests originated. Using a 7 point Likert-type scale, they were asked whether they believed A. one is born with AB/DL sexual interests, B. one learns AB/DL sexual interests, C. AB/DL interests are related to something in childhood, or D. AB/DL interests are related to toilet training (Hawkinson & Zamboni, 2014). The results showed that in most participants believed their AB/DL interests related to something in childhood, followed by they learned their sexual interests in AB/DL, then they were born with the sexual interests with the least believing their AB/DL interests were related to their toilet training (Hawkinson & Zamboni, 2014).

The results also showed little support for the idea that AB/DL behavior functions to reduce negative mood states and most participants reported few problems in their lives due to their AB/DL behavior (Hawkinson & Zamboni, 2014). The researchers concluded that due to the diversity of the AB/DL community it is difficult to make any clear assumptions about persons involved in AB/DL behaviors. It appears the behaviors are not designed to cope with negative mood states; most participants in online communities have become comfortable with their sexual behaviors and have managed to make it work in their relationships (Hawkinson & Zamboni, 2014).

Several of the articles in the twenty first century referred to the growing Internet-based community of adult babies and diaper lovers and their frustration over the lack of scientifically based resources related to treatment of individuals when they present with such conditions. For that reason the review will now turn to some of the more credible sources of information as well as surveys done by members of the AB/DL community.

Modern Era AB/DL Resources and Studies

An Internet search for information on adult babies or diaper lovers will produce a large number of books, articles and magazines regarding the subject from more of an erotic, story-telling type of perspective rather than books or websites designed to educate and inform people about the phenomenon. Two of the books that differ from the rest are written by two women who come from the AB/DL community with the desire to inform more than titillate. In 2011, Penny Barber, (a pseudonym) published *The age play and diaper fetish handbook: The ultimate guide to the world of AB/DL* (Barber, 2011) to better inform the public about this phenomenon as well as tell her own story as a diaper fetishist. In 2012, Rosalie Bent published *There's a baby in my bed! Learning to live happily with the Adult Baby in your relationship* (Bent, 2012). The focus of her book was for romantic partners and family of those who identify as an adult baby. Neither book was written with the standards of academic texts, yet each has valuable information to be gained towards a better understanding of this unique fetish.

In her introduction, Barber explains that she began her interest in diapers at the age of eighteen when she began dating a closeted diaper fetishist. She states that "I like to think that my interest comes from a healthy, bright place, my history correlating with my sexuality, but not causing it" (Barber, 2011, p. 3). Barber goes on to define both age play and diaper fetishes, explaining the various terms used in the community as well as how for many it can be a part of the larger fetish and BDSM (bondage and discipline, dominance and submission, sado/masochism) community.

Barber discusses the difficulty and the distrust that many within the AB/DL community have with the mental health community. She states that the mental health field view paraphilic infantilism as a mental disorder, yet claims the average age play or diaper fetishist is no more

maladjusted than any average person with completely commonplace sexual interests. She states the term "paraphilia" is derogatory, especially when considering the other socially unacceptable sexual practices (sadism, masochism, and pedophilia) are all grouped under a single heading (Barber, 2011, p. 9).

Bent, who like Barber is part of the AB/DL world, comes at the subject from a different perspective. She describes herself as a post-graduate level trainer and communicator who has been happily married to a regressive Adult Baby for almost 40 years. With tertiary training in mathematics and psychology she has learned to understand the inner workings of the Adult Baby's mind and wrote the book to help spouses and families who are dealing with these unique issues (Bent, 2012, p. 203).

Early in the book she makes a point to discuss the concept of difference between a coercive and non-coercive paraphilia. She states that paraphilic infantilism at its core is a non-coercive paraphilia. A coercive paraphilia is one in which the individual needs to involve an unwilling participant to become aroused. Examples of coercive paraphilias would be pedophilia, necrophilia, exhibitionism, zoophilia, voyeurism and frotteurism. However, paraphilic infantilism can become coercive when the Adult Baby wears baby clothes, engages in loud baby talk or crawls in public, thereby bringing others into their orbit without their permission or consent. If a biological child is involved it is considered 'highly coercive' (Bent, 2012, p. 19-20).

The main focus of her book is about regressive age play and the "Parent/Child Relationship". "There is a very special kind of relationship that can exist between a loving couple, where one of them is a regressive Adult Baby, or what I call Little One. Rather than something to be feared, it is in fact an aspect that can greatly enhance and build the relationship" (Bent, 2012, p. 5). She mentions the difference between regression and role play stating that the

common aspect of regression is that the individual *thinks* as a child. This is the defining difference between regression and role-play. She states that even during the deepest regression, the individual is essentially still an adult with access to all the adult abilities and emotions if needed. Choosing to sideline the adult side does not mean the adult disappears, just that the adult is in the background while the child is in the foreground (Bent, 2012, p. 26). Bent explains that Adult Babies have regressive needs and if these needs are not met, it leads to frustration, anger and other negative experiences (Bent, 2012, p. 27). She does discuss how this is different from Dissociative Identity Disorder and that the person who needs this regressive experience does not have a separate inner personality (Bent, 2012).

One of the unique aspects of her book is where she created a Regression Scale, going from Level Zero to Level Five, where she describes the levels of regression, the pros and cons of each with the exception of Level Five which she states is entirely negative and dysfunctional. The levels she describes are as follows:

- Level Zero – Here the adult is fully in charge however the *child* personality is in existence and the adult side is aware of the child side. For someone who has their regressive needs met, they will spend most of their time at this level.
- Level One – At this level the adult steps back from the front and shares the limelight with the child. She states it is a safe level where people often spend large amounts of time, it can be comforting to the individual, yet does little to meet any deep needs.
- Level Two – The child moves to the front and the adult behaviors are partly removed and replaced with some childish ones. This is an easy level for the child

to live in for extended periods of time. It lacks much of the internal conflict of higher levels as the adult is still easily accessible if needed.

- Level Three – The first of the two deeper levels. The adult is now some distance away and the child is primarily responsible for most of the behaviors. While the adult is accessible, he is rarely used for much beyond speech, walking and some sexual behaviors. Here this level of regression will ease much of the internal adult pressures.
- Level Four – Similar to Level Three except there is little influence from the adult part of the personality. Child-like behavior begins to mirror the self-identified age far more closely. Due to the depth of the level it is fine to experience for short periods, yet not considered healthy for extended periods of time. Those individuals who want to spend extended periods here indicate deep-seated past traumas and the recommendation is to seek professional help.
- Level Five – The regressive child and behavior almost totally overwhelms the adult side of the personality. While the adult technically remains capable of control, it is difficult to exert. The child may refuse to revert to the adult side without external help and assistance. This is a potentially dangerous situation and is always unhealthy. (Bent, 2012, p. 29-31)

Bent gives an in-depth account regarding her thoughts about the identification, communication, interaction and modification of the Parent/Child relationship with an Adult Baby. For the spouse/partner dealing with these types of issues, her book is a wealth of information despite much of it being based on her personal experiences rather than empirical evidence based information

The Survey Project

Understanding.infantilism.org is an Internet web site started in 1995 by B. Terrance Grey to provide information resources to the AB/DL community. Between 2006 and 2013 the site began *The Survey Project*, to get a better idea of how alike the AB/DL community was as well as how it fits into the larger fetish and BDSM communities ("AB/DL surveys," 2011). The surveys have led to a much more detailed picture of the AB/DL community overall. While some would state that some archetypes are typical of all or most AB/DL's, this would be an oversimplification. The surveys ask those in the AB/DL community who they are and while they show a number of trends, there are exceptions to the rule. The surveys cover a number of areas of interest including 'The Range between AB and DL', 'The changing AB/DL community', 'Mapping Paraphilic Infantilism and Diaper Fetishes', 'Girls, Boys, and Diapers', 'Trauma and Exposure among AB/DL's', 'Diaper Preference', 'Other Conditions prevalent among AB/DL's', as well as an in-depth exploration into AB/DL practices ("ABDL surveys," 2011, p. 1-2).

The spectrum between adult baby and diaper lover has not always been easy to define. The obstacle to understanding the AB/DL community is their diversity as well as how to define those who practice it. The surveys found that the trend from diaper lover to adult baby appears to be an increased emphasis on role-play, younger roles, and more elaborate collection of paraphernalia. One common differentiation is based on role-play: adult babies act like babies, while diaper lovers do not. If asked to define themselves 47% would state they are exclusively or mostly a diaper lover, 19% consider themselves equally adult baby and diaper lover, while 25% state they are mostly or exclusively an adult baby ("The Basics," 2013, p. 5). When the issue of regression was added in, the differences became even more apparent. 91% of adult babies admitted to regression sometimes or more, while 0% of diaper lovers regress. While diapers are

often a sexualized component for diaper lovers and adult babies, the survey found a significant minority for whom AB/DL practices do not include sex. This is important in the debate regarding whether AB/DL can be summarized as a fetish. The majority of AB/DL's (93%) find diapers to be sexually arousing yet most (57%) also found a human sexual partner more sexually arousing than diapers (Grey, 2006).

The issue of whether this phenomenon can be a fetish continues to be difficult to define. The results show that 85% of AB/DL's consider the feel, sound, and smell of diapers either important or very important. For contrast, only 18% considered sexuality most important or one of a few most important aspects. This observation is especially interesting given that sexuality and paraphilia are often strongly associated in the clinical literature. While many in the AB/DL population practice sexually, many do not consider it an inherent part of their scenes, games or fantasies (Grey, 2007).

The surveys addressed the issue of gender and while they found that the majority of AB/DL participants were male (86%) they discovered that 8% were female with the final 6% falling somewhere on the transgender continuum (transvestites, MTF or FTM transsexuals, and intersexed). The research showed that the age of first interest was similar for males and females with peaks at five and twelve years of age. However, females were more likely to develop an interest after the age of 20 which therefore skewed the average age as 13.1 years for females compared with 9.8 years for males. Females are far more common in paraphilic infantilism than other paraphilias. The ratio was roughly ten-to-one male to female and actually higher than expected. By comparison, the APA places the sex ratio for masochism (which up until DSM 5 included paraphilic infantilism) at twenty to one (Grey, 2008).

It has been assumed that past childhood trauma could be a cause for paraphilias so a survey was done regarding this area. Depending on how trauma was defined, only 2-3% thought that their interest in AB/DL could have been caused by some form of trauma. 30% felt that their interest had always just been a part of them, while 52% thought it may have been caused by some event which could include stumbling across a reference to adult babies/diapers, being introduced to it by someone, wanting to try a new kink or an emotional incident where they sought out comfort. While some individuals may have believed their fetish was caused by their trauma the research would show that if this were possible, due to the large percentage of individuals who have experienced childhood trauma (physical, sexual and emotional) the percentages of those having paraphilic infantilism or diaper fetishes would be much higher. The observations do not support the conclusion that trauma generally causes infantilism or diaper fetishes (Grey, 2009).

In addition to the issue of trauma, there has been the belief that other psychiatric conditions may be associated with paraphilic infantilism and autonepiophilia. To explore the possibility, a survey of data was gathered on ten specific conditions. These conditions were Asperger's Syndrome, Attention Deficit/Hyperactivity Disorder (ADHD), autism, Bipolar Disorder, Borderline Personality Disorder, Dissociative Identity Disorder, epilepsy, fecal incontinence, Obsessive-Compulsive Disorder and urinary incontinence. For most of these conditions the report of them was usually lower than expected. Autism, epilepsy, and Dissociative Identity Disorder were reported by only 2% of the respondents so not analyzed further. 11% of respondents were reported as being incontinent. For many of them, this was a desired aspect of their infantilism. Five percent of AB/DLs reported having been diagnosed with Asperger's Syndrome, and eight percent reported a diagnosis of Obsessive-Compulsive Disorder.

For both of these, the prevalence and sex ratios were significantly higher than expected due to coincidence. It is believed that the over-representation of Asperger's Syndrome and Obsessive-Compulsive Disorder among AB/DLs is consistent with a relationship between these conditions and a desire for diapers and/or babyhood. Other possible explanations include a general over-diagnosis of these conditions among those who have AB/DL issues (Grey, 2010).

Regarding the mental health community the surveys found some conflicting views and opinions. When asked, many from the surveys had positive experiences with therapists, believed that it would be helpful for those of the younger generation to seek therapy to help them with self-acceptance, and that there needed to be more studies and additional training of psychotherapists in these specific areas. ("Odds and ends part 4," 2013) Yet it appears many from the survey do not take their own advice. When asked if they have talked to a therapist or counselor about their AB/DL interests 53% have never seen one, 21% have seen one yet never discussed their fetish interests, 13% mentioned it while being seen for another reason, 5% sought a therapist out because of their interest, and 7% went because family/spouse asked them to go. Of those 25% who went and mentioned it to a therapist, 16% found it very helpful, 28% somewhat helpful, 47% neutral with only 6% hurtful and 3% very hurtful ("Odds and ends part 3," 2013).

When it comes to the issue of diapers the majority of AB/DLs follow a typical profile. They were raised in diapers, and were taken out of them once toilet trained, most at a typically normal age. Then, years later, they desired to wear diapers again. Often without a clue as to why the desires occurred. In contrast a small number of AB/DLs remained in diapers late due to late toilet training, bed wetting, or incontinence. While some with later toilet training or bed wetting whose parents had them wear diapers shunned the experience and were happy to finally get out

of diapers, others came to find the experience enjoyable and arousing for some unknown reason (Grey, 2009).

The Survey Project provided a number of insights into paraphilic infantilism and diaper fetishes. The report comparing the views of those in the community born at different times shows changes that are mirrored in the culture in which they grew up. Developments such as the sexual revolution and the broad growth of the Internet have greatly affected the AB/DL community. Along with a historical perspective this study also shed some light to the question: Are infantilism and diaper fetishes disorders, conditions, or merely interests?

Infantilism and diaper fetishes can be troubling issues for many. The survey shows that 52% have tried to quit at some time yet virtually no one reports any success. This could suggest that for many these are serious paraphilias as opposed to mere interests. However, those who have grown up in the Internet age were more than twice as likely to report positive views of their infantilism or diaper fetish compared to previous generations. By DSM Criterion B standards, Fetishism is a disorder if it causes clinically significant distress or impairment. It is believed that while the same number of individuals might develop infantilism or a diaper fetish, fewer in the younger generations will experience them as a disorder. Those born since 1950, who meet Criterion B has decreased by an average of 1.5% for each 5 year period. The negative impact may be partly cultural. With increased cultural awareness and access to information AB/DLs are viewing their interests more positively. The probability is that this trend will continue (Grey, 2011).

To conclude the review of the literature, it is clear that atypical sexual behaviors have a long history of being suspect, if not downright criminal in our society. It is no surprise that those who find they enjoy paraphilic infantilism and/or autonepiophilia are less than eager to share

their interests with spouses, family or even their therapists. While the mental health community is believed to be a safe and understanding haven for those who need our help, reviewing the seven editions of the DSM as well as peer reviewed journal articles show that the beliefs within the community have a strong judgmental bias against those with what are considered to be different sexual behaviors. A look at information written by members of the AB/DL community clearly shows that they see the biases of the mental health community and fear the consequences if they are brave enough to seek us out for assistance. There is a lot of work to be done to improve both the publics and professionals knowledge of paraphilic infantilism and autonepiophilia before those in that community will seek the help they need to improve their self-acceptance, treatment of mood disorders, and navigating relationship challenges.

Chapter 3: Methodology

Introduction

The purpose of this phenomenological research study, using the Modified van Kaam Method by Moustakas (Moustakas, 1994), with questionnaires and semi-structured interviews, digitally recorded and transcribed, assessed using NVIVO-10 conversational analysis software is to understand, identify and describe the lived experiences of four American males who self-identify as AB/DL along with their experiences with the mental health community. Once the data was analyzed by the NVIVO-10 software, it was further analyzed by data mining to discern themes from the patterns identified through NVIVO. It is hoped that explanation of the lived-experiences of the target population sample will provide more knowledge about this particular paraphilic population, and better understand what causes people of this community to lack trust in the mental health community.

Research Plan

Empirical, qualitative research, particularly phenomenological investigations of lived experiences, such as those of individuals who engage in paraphilic infantilism and autonepiophilia, was utilized among the participants of this study. Given the nature of the problem statement and that there is little academic research into this area of research, a phenomenological approach was deemed most appropriate for this study.

Moustakas' modified van Kaam method (Moustakas, 1994) of analysis of phenomenological data was used as a vehicle of exploration (Moustakas, 1994). The research design includes data collection, data analysis, presentation of findings and conclusions consistent with the seven steps of the Moustakas model. According to Moustakas (1994), an empirical phenomenological approach involves a "return to the phenomenological experience" in order to

obtain comprehensive descriptions that provide the benchmark for a comprehensive, reflective structural analysis (p. 13, paraphrased). Creswell (Creswell, 2014) stated that phenomenological research is the nature of the epoch that the researcher identifies as the essence of human experiences concerning a phenomenon.

In his book *Phenomenological Research Methods* (Moustakas, 1994, p. 120) Moustakas describes the seven-step model for analyzing the transcribed interview of each research participant. Once each interview is transcribed in its entirety, the following steps must be taken:

1. Listing and preliminary grouping,
2. Reduction and elimination,
3. Clustering and thematizing the invariant constituents,
4. Final identification of the invariant constituents and themes by application,
5. Using the relevant, validated invariant constituents and themes constructed for each co-researcher an individual textural description of the experience,
6. Construct for each co-researcher an individual structural description,
7. Construction for each co-research participant a textural structural description of the experience (pp. 120-121) that includes the researcher co-participating in the study.

Appropriateness of the Research Design

The three main approaches of research design for most research studies are quantitative, qualitative, or mixed method approach. During much of the nineteenth and twentieth centuries, psychology research used quantitative research, mainly survey and experimental research (Creswell, 2014). Qualitative research designs have become more popular in the late twentieth

and into the twenty-first centuries and are composed of various types of narrative and phenomenological research. Quantitative research is applied to describe current conditions, investigate relationships, and study cause and effect phenomena (Bloomberg & Volpe, 2012). Qualitative research is suited to promote a deeper understanding of a social setting or activity as viewed from the perspective of the participants. The approach has an emphasis on exploration, discovery, and description (Bloomberg & Volpe, 2012).

There were a number of qualitative research designs from which to choose for this research study. Of the various genres, the following were considered: case study, ethnography, phenomenology, grounded theory, narrative inquiry, hermeneutics, action research, and postmodernism/post-structuralism. After reviewing the various strategies, the three best research methods for this particular subject and population of study were found to be case study, phenomenology, and postmodernism/post-structuralism. Each was then studied and considered in more detail.

According to the definitions by Bloomberg and Volpe, case studies are an intensive description and analysis of a bounded social phenomenon, be this a social unit or a system (Bloomberg & Volpe, 2012). The researcher explores the bounded system over time through in-depth data collection methods involving multiple data sources. Case studies involve a detailed description of a setting and its participants, accompanied by an analysis of the data for themes, patterns, and issues (Bloomberg & Volpe, 2012). Phenomenological research is meant to investigate the meaning of the lived experiences of people in order to identify the core essence of human experience or phenomena as described by research participants (Bloomberg & Volpe, 2012). This research involves studying a small number of subjects through extensive and prolonged engagement to develop patterns and relationships of meaning (Bloomberg & Volpe,

2012). Finally, postmodernism/post-structuralism challenges the historical assumptions of neutrality in inquiry, asserting that all research is interpretive and fundamentally political. In this approach, truth is multifaceted, and subjectivity is paramount (Bloomberg & Volpe, 2012).

The technique of case study, while initially the preferred method; was eliminated after further research into the method. Postmodernism/post-structuralism was strongly considered due to its use in areas such as queer analysis, feminist research, cultural studies, and multimodal studies, yet the belief was that it might have too much of a political undertone for this particular research population. The AB/DL community is mostly hidden from the public view with a few exceptions of sensationalistic television programs. Few of those within the community are willing to talk with researchers openly, so having a political tone was believed to carry the possibility to scare off potential study participants. The use of a qualitative study that did not employ any explicit theory was also considered, since the case could be made that no qualitative study begins from pure observation and that prior conceptual structure composed of theory and method provides the starting point for all observation (Creswell, 2014). For these reasons, both of these methods were ultimately rejected.

Eventually the phenomenological research design was chosen. It comes from the world of philosophy and psychology in which the research describes the lived experiences of individuals about a phenomenon and culminates in the essence of the experiences for several individuals who have all experienced this particular phenomenon (Creswell, 2014). It involves studying a small number of subjects to develop patterns and relationships of meaning. The focus is describing what all participants have in common in order to reduce individual experiences with a particular phenomenon to a description of the universal essence (Bloomberg & Volpe, 2012). In terms of this study, this approach allows for an exploration of more depth into the perception and

real-life experiences of a few individuals regarding their feelings about their fetishes and experiences with the mental health community. This description was best suited for the topic as well as the study's participants.

Due to the small sample size of the study participants, a qualitative social constructivism perspective was also chosen as the worldview for the study. Ultimately, a qualitative research model was chosen over a quantitative research model because qualitative research is characterized by its aim to relate understanding of an aspect of social life (Patton & Cochran, 2002). The basic premise of constructivism is that reality is socially, culturally, and historically constructed (Bloomberg & Volpe, 2012). The goal of the research is to depend on the participants' view of the situation being studied (Creswell, 2014); in this case, their sexuality and how they engage in it.

Selection of Participants

Convenience sampling was used to select the various participants. Convenience sampling is using participants with whom the researcher has contact (Auerbach & Silverstein, 2003). Four participants were ultimately selected. Two of the participants were current patients from the researcher's psychotherapy practice who volunteered to share their story upon hearing of the pending study. The subjects were not asked directly to participate in the study. Upon learning of the study during casual conversation at the end of a therapy session, each eagerly volunteered to participate. One of the participants was a former patient from the researcher's private psychotherapy practice. Since he was no longer in therapy an email was sent to him asking if he would have any interest in participating and he stated he would be happy to join the study. The fourth participant was from the researcher's social network and volunteered to be in the study

upon hearing about it from his wife. His wife told him about the study as the researcher was unaware this participant had any experience with the subject being researched.

The criteria for participation was as follows: 1) participants must be between 25 and 45 years of age; 2) participants must actively be engaging in either age play or a diaper fetish; 3) participants needed to have a range of experience with mental health, ranging from some experience to little or none; 4) participants required an educational level of either currently enrolled in college or already graduated, with the minimum of a bachelor's degree; 5) participants must be engaged in consenting fetish play; and 6) participants' sexual behavior needed to be non-exclusive in regards to their fetish; i.e., their fetish needed to not be the only sexual behavior they engaged in. The age requirement of 25 to 45, along with the higher educational requirement, was important to analyze the effect of the Internet during the years when their fetish originated.

In an effort to discover additional participants, snowball sampling was used. Snowball sampling begins with a few individuals and asks them to suggest others from their social networks (Auerbach & Silverstein, 2003). As part of the questionnaire given to participants, each was asked if they knew anyone in the AB/DL community who might be interested in participating in the study. While two participants knew a few individuals in the AB/DL community, none of them were interested in participating so the snowball sampling did not procure any additional study participants.

Instrumentation

The information was gathered by the combination of a self-administered questionnaire and a face to face personal interview with six semi-structured questions. The self-administered questionnaire allowed for greater confidentiality and privacy with the hope of providing a greater

sense of comfort for the participants as well as gaining more honest and in-depth information. As part of the questionnaire each participant was asked if they believed there were any important questions that needed to be asked in order to better understand the phenomenon being studied.

The questionnaire was designed to request information in five areas:

1. Socio-demographic information
2. Specific information about fetish behaviors during participants' childhood/teen years
3. Current information about fetish behaviors in participants' adult years
4. Any mental health issues participants may have experienced or be experiencing during the time of the study
5. Participants' experiences with the mental health community
6. Additional questions the participants felt were important to be asked regarding their worldview for the research

Once the questionnaires were returned and analyzed, a series of six questions were finalized based on themes from the answers to the questionnaires that the researcher did not anticipate asking during the initial design. Since the participants were truly the experts about both paraphilic infantilism and autonepiophilia, this approach appeared to provide opportunities to discover unanticipated topics. This allowed the researcher the opportunity to bring up unanticipated topics, so the importance was to be flexible about the questions asked while still maintaining some structure (Auerbach & Silverstein, 2003).

The development of the questionnaire as outlined in Appendix C and the six semi-structured questions as outlined in Appendix D were influenced by much of the research literature. Speaker's ground-breaking research was the first to look at paraphilic infantilism with a portrayal of individuals who were functional members of society rather than the highly

dysfunctional ones likely to come to the attention of law enforcement or psychiatric treatment facilities (Speaker, 1986). His research strongly influenced the creation of the questionnaire. The majority of the influence for the development of the remainder of the questionnaire and the semi-structured questions came from the multiple surveys of Grey that were produced by *The Survey Project* (Grey, 2006-2011).

Speaker touched on the subject of AB/DL's mental health experience while Grey asked much more direct questions about individuals experiences in his survey on "Ways to help younger AB/DL's" ("Odds and ends part 4," 2013) as well as another survey that directly asked questions regarding whether individuals have sought mental health treatment ("Odds and ends part 3," 2013). Other surveys by Grey that were used in the development of the six semi-structured questions included looking at how views of AB/DL's may change over time, (Grey, 2011), whether trauma had any significance in the development of paraphilic interests (Grey, 2009), and how important diapers and baby play are to individuals sexuality ("Sex and the future," 2008).

Throughout the questionnaire the terms used were those most likely used by members of these fetish communities, found on AB/DL online websites or printed in AB/DL literature and not the clinical psychological terms. The rationale for this was to promote an environment of non-judgment and empathy, and environment that could have been lost by using terms such as *paraphilia.* These terms have a greater social stigma and carry the pathologizing image of mentally dysfunctional or even criminal connotation (Fankhanel, 2006).

Ethical Concerns

Given the nature of the study and the researcher's relationship with the participants, numerous ethical concerns arose in the design and implementation of the study. In order to better

understand the ethical issues involved in this study, the American Psychological Association "*Ethical Principals of Psychologists and Code of Conduct*" was consulted. Standard 8.04: Client/Patient, Student, and Subordinate Research Participants, under Standard 8: Research and Publication states, "When psychologists conduct research with clients/patients, students or subordinates as participants, psychologists take steps to protect the prospective participants from adverse consequences of declining or withdrawing from participation" (APA, 2010, p. 6). In order to protect participants' ethical and privacy rights, several considerations were written into the consent form for participants. These included the following:

1. You may refuse to participate or withdraw once the study has started. You will not lose any benefits to which you are otherwise entitled, nor will you be penalized. If you are a current patient, withdrawing from this study will not affect your ability to continue with the mental health care you have been receiving.

2. If upon withdrawing from this study you feel your continued mental health care has been compromised in any way, you may request and will receive a list of three other local therapists who are competent and skilled in working with alternative sexual expression.

3. The information used in the research will only come from the self-administered questionnaire and the face-to-face interview. No information obtained solely from your psychotherapy sessions will ever be used.

In order to ensure confidentiality, patients' names were not used; instead, alphanumeric codes were devised. All information received from each participant was coded with a number specific to them along with a first letter of their first name. In order to assure privacy, each participant was also allowed to slightly alter other demographic information to information of their choosing if they felt items such as age, occupation, etc. were unique enough to possibly

violate their privacy. While the option was given, none of the participants chose to execute this option so there was no effect on the veracity of the data.

In addition to the above concerns about the participants, ethical concerns regarding the treatment of the data were also taken into account. Once participants agreed to the study and signed the consent forms, they were emailed or given a hard copy of the questionnaire to complete in private. Once the questionnaire was returned and all the questionnaires were analyzed, face to face interviews were conducted at the researcher's office.

The transcripts and consent forms will be saved for at least three years. For those participants who had been previous patients in the researcher's private psychotherapy practice, this information will be kept separate from their psychotherapy chart. The information gathered will be kept in a locked file cabinet according to HIPAA standards.

Data Analysis

The data collected by the participants was analyzed by NVivo 10 computer software as well as mining the data for patterns and themes to the specific experiences discussed by the participants in the face to face interviews as well as their questionnaires. The results of this data analysis are discussed further in Chapter 4.

Summary

Through the use of self-administered questionnaires along with personal interviews, several men, selected through convenience sampling, discussed their experience with paraphilic infantilism and/or autonepiophilia and the effect their fetish has on their romantic relationships, daily lives, attitudes about the mental health community, and mental health issues such as depression, anxiety, and self-acceptance. The use of a phenomenological research method allowed the study to discover common themes and form hypotheses for further research. The

goal of this research was not to test hypotheses, but rather to develop them. It is hoped that this research will increase the understanding of these unique fetishes within the mental health community, improve the treatment approaches used when they present for mental health counseling, and improve the fetish community's perceptions of the mental health field and mental health professionals.

Chapter 4: Results

The research focused on understanding the worldview of four men from the AB/DL community in Colorado. Unlike previous studies conducted by Speaker (1986), Hawkinson and Zamboni (2014), or Grey (2006-2013) in which all of the participants were anonymous to the researcher, these individuals were known to the researcher and interviewed face to face with the set of questions identified in Appendix D, as well as given the questionnaire in Appendix C to answer privately. For research purposes, each of the participants was given a code to identify them and protect their confidentiality.

Due to the small sample size of this study, the findings presented cannot be generalized to the larger AB/DL community. Rather, the themes and patterns that emerged are an addition to existing studies as well as a means to promote ideas for future research in this unique area of sexuality studies.

The results of this study are mixed for the four research questions outlined in Chapter One, with research question #1 showing the strongest results. Following a reporting of the results of the research questions, larger patterns and themes that emerged from the research are discussed.

Research Questions

Research question #1. *The research indicates that many individuals who engage in paraphilic infantilism cannot identify a trauma or event that caused their atypical sexual interests. Could these atypical sexual interests be a type of sexual orientation similar to heterosexual, homosexual, or bisexual?*

According to the questionnaire results, all four participants reported a desire to wear diapers that appeared to have no preceding traumatic event, starting as early as age 6 (#003M),

with two reporting approximately age 8 (#002V, #004B) and one with vague memories of a fascination with diapers at age 9, which became a desire to wear them by age 12 (#001R). Participant #003M summed it up in his face to face interview stating that as early as first or second grade "for whatever reason I had this thought that I wanted to wear a diaper… … why I do not really know." This response was similar to most of the other participants in the study.

Conversely, participant #002V had the most unique experience. Starting at the age of 3 he reported having a condition called encopresis in which an individual holds their bowels and refuses to allow solid waste to be expelled from the body. This causes the bowels to become impacted, causing the liquid waste to go around the impaction and giving the person frequent accidents. While he stated that he was not sure what caused this condition, he said, "my diaper loving interest and an extension of that is toilet play definitely can be traced right to that."

Use of diapers for sexual arousal during childhood (described as from the ages of 10 to 20 years) was reported on the questionnaire from a low of two times a year (#002V) to once every few months (#001R) to twice a month (#003M, #004B), and sexual fantasies involving diapers were reported more often, with one fantasizing monthly (#002V), one fantasying weekly (#001R), and two fantasying daily (#003M, #004B). For each participant, the results for frequency of sexual fantasies that did not include diapers were identical to the frequency of sexual fantasies involving diapers. In addition, the percentage of sexual fantasies that included diapers during the ages of 10 to 20 ranged from a low of less than 25% of the time (#002V) to approximately 50% of the time (#001R, #004B) to a high of 75% of the time (#003M). Participant #004B reported that his thoughts and fantasies involving being a baby started as early as fourth or fifth grade "when I first noticed I like to rub myself on carpet… There would be a

little bit of stimulation there but never ending in ejaculation or anything like that." By age nine or ten he "was very resourceful, as I was able to make my own diapers" and

> "had desires for some of the neighbor ladies and older girls in the neighborhood. I wanted them to baby me, diaper me, and take care of me. I just had that fantasy, and I eventually began when I started masturbating that is what I would masturbate to."

Participant #001R reported the thoughts began as early as fourth grade and "I really started to think about this on a more consistent basis in probably sixth or seventh grade."

The participants were not asked specifically about the relationship with their mothers to explore whether there were any unresolved issues that may have also played a role in their desire for nurturing and being cared for in such a manner. The small amount of information provided by participants about their early maternal experiences does not give the impression that maternal care was lacking or that his had an influence on their later ABDL desires.

When asked if their other sexual interests were weaker than, equal to, or greater than their sexual interests in diapers, the results showed a strong preference for diapers. The responses were one weaker than (#002V), two equal to (#001R, #004B), and one greater than (#003M). The reason for engaging in diapers was unanimous, with 100% of participants responding that they "cannot help it." Answers to the question "How often do you find diapers to be sexually arousing?" was split evenly, with half stating "most of the time" (#003M, #001R) and half stating "always" (#002V, #004B). Participant #001R stated that "over the years… it has become more sexual, and it has become more prevalent." Participant #003M stated "going through puberty and becoming online sexually… it kind of morphed into this emotional, sexual, stress-relieving entity."

These results, while small and not completely conclusive to the larger AB/DL community, indicate a strong likelihood that additional research is needed by the sexology community to investigate the possibility of broadening the definition of sexual orientation beyond our current understanding of the genders with whom people want to be sexual. While all of the participants reported positive sexual relationships with others at various points in their lives, and denied any specific childhood trauma that could be a contributing factor, and yet the desire for diapers and fantasies of being the baby remained.

Research question #2. *Is it possible for individuals who desire paraphilic infantilism to engage in these behaviors in a psychologically healthy manner? Is it possible to treat the symptoms with which many in this community suffer (depression, anxiety, low self-esteem, shame, and embarrassment) by encouraging the use of their atypical sexual behaviors in a consenting manner?*

Study participants were asked if during their childhood years, between the ages of ten to twenty, they engaged in their fetish activities alone or with a consenting or non-consenting partner. 100% of participants answered that they engaged in these activities alone, with one (#004B) stating he once surprised a lover by wearing diapers on one occasion. He described this situation by saying, "it ended very quickly, and it ended very poorly." He was unclear whether this happened during his teen years or during his early twenties. The value wearing diapers had to their emotional state during these years was also assessed, with 100% of participants stating that wearing diapers made them feel better and 50% (#003M, #004B) stating that it also functioned as a self-soothing mechanism. Participant #003M stated, "I have noticed… …wearing a diaper actually calms me down and helps me sleep." Participant #003M was not clear whether wearing diapers to help him sleep was an activity he discovered in childhood or adulthood

although he was clear he wore diapers in childhood. It appears the wearing of diapers along with fantasies of being taken care of served not only as an early sexual fantasy but also as a coping mechanism and a means of self-soothing when dealing with anxiety, depression, and stress, despite the price these individuals paid via the increased shame and embarrassment that came from doing something they knew their peers or families would not approve of them engaging in or understand.

All of the participants mentioned struggling with issues of shame, anxiety, depression, and fear of being discovered. As participant #004B stated, "I was depressed, and I was definitely anxious because you do not want anybody to find out, I mean you do not want anybody to know about this stuff, and it creates anxiety and stress."

All of the participants reported using their fetishes not only as a private means of sexual arousal in fantasy and masturbation and most of them reported using their fetishes as a means of self-soothing relating to issues of stress, anxiety, depression and difficulty sleeping. There was only one report of a study participant surprising a non-consenting partner with diapers and this appeared to have happened on only one occasion. Aside from that one occasion, all participants involved sexual partners in their fetishes, if they did so at all, after first talking with their partners about their fetish interests.

Research question #3. *According to the research, only a small percentage (12%) of individuals who engage in paraphilic infantilism will admit to a therapist about their atypical sexual behaviors and seek treatment. Of those, the majority (91%) report the experience as between very helpful to no effect and only 9% report the experience as hurtful or very hurtful. If this is true, what causes so many in the paraphilic infantilism community to be distrustful of the mental health community?*

The four participants in this study all sought out therapy for a number of reasons. 100% of them sought therapy to help them understand their diaper fetish and difficulties in their relationships. It was not specifically stated by the participants whether their relationship difficulties were related to their fetishes or other non-related relationship issues. Of the various options listed on the questionnaire, 75% listed understanding age play and depression, 50% listed anxiety and looking for a "cure," and only 25% listing anger management, self-esteem, and non-fetish sexual issues. 50% made their disclosure to their therapist in the first session, while 50% took several sessions, without stating how many sessions was defined by 'several', in order to build that level of trust. 100% stated that their therapists' reaction to their issue was knowledgeable, compassionate, and understanding with no desire or intent to "cure" them of their fetish. Two of the participants entered therapy initially wanting a "cure" for their fetishes and chose to remain in therapy upon learning there was no cure and learning to accept them as they were was the best approach to treatment.

In the AB/DL community, beyond the on-line world of anonymous web sites there appears to be a lack of a true face to face community, as most of the participants in this study (75%) did not know or have friends within the larger AB/DL community. Therefore, most could not answer the question as to what caused others not to seek therapy. #003M was the only member with ties to others in the local AB/DL community, and in his opinion many he knew avoided therapy due to their fear of judgment by a therapist as well as their belief that a therapist would pathologize their fetish as the cause of the symptoms of depression, anxiety, or self-esteem issues. He stated,

> "From the people I know in the community and myself, it does seem like depression, anxiety, anger, stress—all that stuff can really, kind of—it seems to be quite apparent

within the community, and it seems like a large part of that is due to the fact that most people keep this very secret."

It was the expectancy that this research would shed further light onto the question about what stops those who engage in paraphilic infantilism and autonepiophilia from seeking help from the mental health community. Unfortunately, the data collected from these research participants was inadequate to fully answer that question.

Research question #4. *Many individuals who engage in paraphilic infantilism suffer with untreated conditions that are easily managed with psychotherapy due to their distrust of the mental health community. What, if anything, could the mental health community change to improve the level of trust from the paraphilic infantilism community?*

The answers to questions that related to this research question were not as consistent among the participants as with previous questions, so a clear answer to this question continues to be elusive. The most consistent answer the participants agreed upon was that the therapeutic community needs to be able to express that it is possible for those with these fetishes to be accepted for whom they are and that therapists will also teach them the tools to accept themselves. Participants stated what was helpful for them, such as #003M's statement that

> "from all my experience actually getting to sit down with somebody and discuss this and being able to feel safe about it… …has helped tremendously with me being able to kind of integrate the whole AB/DL thing into me and not have the depression and stress and everything surrounding it as much."

Participant #002V stated, "I think it is lack of acceptance [that keeps people from getting help]. Even myself, I think a lot of people are afraid that they are going to be judged by the therapist."

This research question failed to create the data necessary to fully support an adequate answer. Further research would be necessary to better understand the changes necessary to bring more AB/DL people into therapy and help them to feel they will be treated with understanding and acceptance rather than the judgment they fear.

Patterns and Themes

The data from this research produced a number of patterns and themes about the individuals who engage in these unique fetishes. The comments from the face to face interviews identified in Appendix D as well as the self-administered questionnaire in Appendix C suggest that there is little in common amongst members of the AB/DL community. Many in this community live an isolated existence involving very few people whom they trust with their secret life. Most appear to make few connections with others in the AB/DL community, and, other than their intimate partner and therapist, they lack a strong support network for their AB/DL issues.

Participants were asked in their current adult life which typical AB/DL behaviors they engaged in and then quantify it as “never,” “rarely (less than once a year),” “sometimes (1-10 times per year),” “often (1-20 times per month),” or “daily.” 75% stated they wore diapers “often,” while one participant (#002V) indicated “sometimes.” Wetting diapers during the day was at 50% stating “sometimes” and 50% stating “often.” Wetting diapers at night was less frequent an activity, with 75% stating “sometimes” and one participant (#002V) stating “never.” Soiling a diaper was a less frequent activity, with 75% stating “sometimes” and one participant (#003M) listing it as “rarely/sometimes.” Rarely/sometimes was not an official category however this participant marked both categories so it was listed in the data this way. Masturbating in

diapers was a more common activity yet still split between the participants, with 50% stating "sometimes" and 50% stating "often." This information is shown in Figure 1 below.

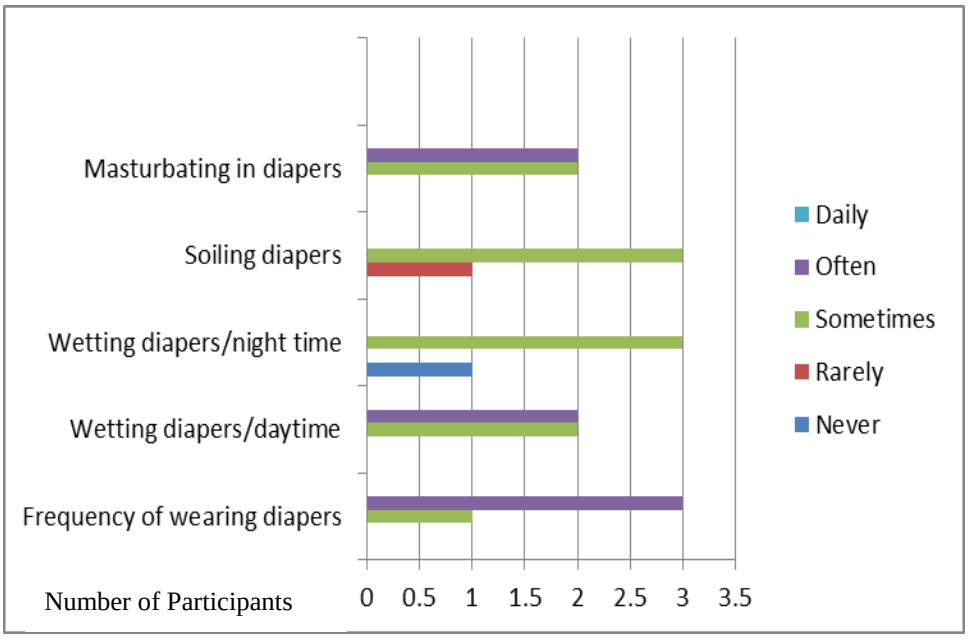

Figure 1. Diaper behavior

Themes of BDSM (bondage and discipline, dominance and submission, sadism/masochism) appear to be a common practice linked to many of those who enjoy AB/DL play. 75% admitted to enjoying receiving bondage from "sometimes" to "rarely," and 100% of them stated they enjoy being submissive to a partner, with 75% citing this as "often" and 25% as "sometimes," although sex play with a partner while in diapers was low on the response scale (50% "never," 25% "sometimes," and 25% "rarely"). Part of the reason for the lower frequency of those behaviors could be based on whether the participants had consenting partners who wished to engage with them in these behaviors rather than their interest in the behaviors. Two of the participants stated they did not include their partners in sexual play that involved diapers because their partners preferred not to do it, and one answered that his partner will do it sometimes, yet begrudgingly. The majority of their AB/DL activities were performed alone, despite 75% of the participants reporting they were married and the single participant stating he

had girlfriends/friends with benefits yet rarely had sex play with diapers. Two of the married participants admitted to AB/DL play with a professional Dominatrix and one with a phone sex operator. Across the board, 100% of the participants reported always playing the baby role when asked what role in diaper play they enjoy and prefer. This information is shown in Figure 2 below.

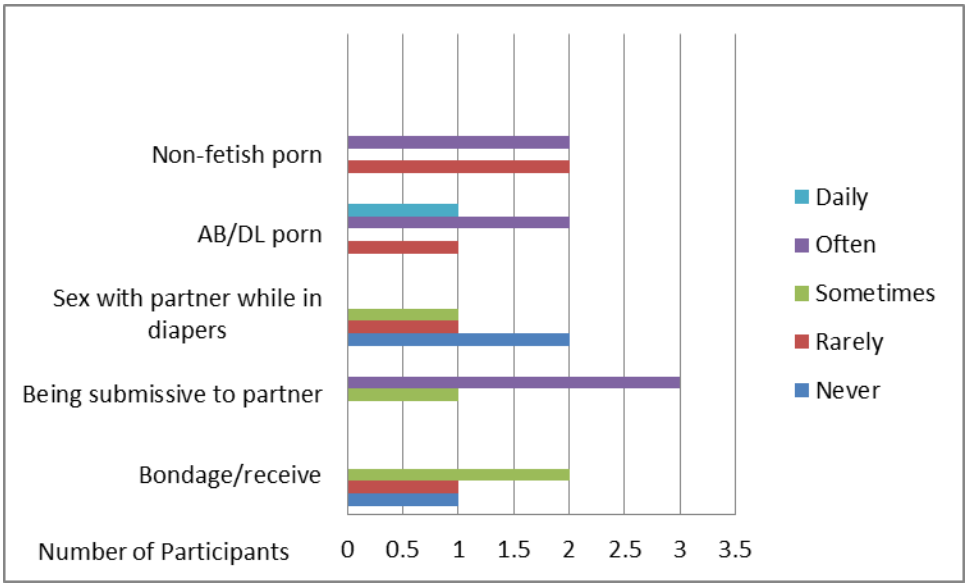

Figure 2. AB/DL sex play

Patterns

Patterns are items where at least 50% of the participants indicated an affirmative response to an answer. As studies by Speaker (1986), Hawkinson and Zamboni (2014) and Grey (2006-2013) have shown the interest in age regression, role-play, or diapers as a sexual fetish varies among the AB/DL community. The participants of this study were no different, with two participants (#003M, #001R) stating they enjoyed age-play regression, one participant (#004B) stating he enjoyed age-play role-play and sexualized diaper fetish, and one (#002V) preferring sexualized diaper fetish over age-play. Nursing from a breast was a behavior that only two participants stated they engaged in with any frequency (#003M stated “rarely” and #004B stated

"sometimes"). Behavior such as use of pacifier was listed by two participants as "sometimes" (#003M, #004B) and two as "rarely" (#001R, #002V), and items such as use of bib, eating baby food, sleeping in a crib, using of high chair or playing with a teddy bear were only mentioned by one participant (#003M) as "rarely" or "sometimes." Two of the participants reported no recollection of any child abuse (#003M, #001R) with one (#002V) reporting some emotional neglect and one (#004B) reporting some mild to moderate spankings.

Themes

Themes are areas where at least three or all four participants indicated a particular behavior, emotion, desire, or other issue. From the behavior standpoint there were a number of behavioral themes. Receiving bondage was a theme, with 75% of participants reporting it on occasion. All of the participants enjoyed masturbating and wetting in diapers during the daytime with various frequencies ranging from "sometimes" to "often," while 75% enjoyed wetting them at night with a frequency of "sometimes." 100% of the participants reported using AB/DL pornography to supplement their sexual lives, with one reporting it "rarely" (#002V), two "often" (#003M, #004B), and one daily (#001R). Most of the participants (75%) reported having sex exclusively with women, while one (#002V) reported having sex primarily with women.

Most of the emotional themes were expected of this group, with nearly all of them expressing emotions of shame, depression, anxiety, stress, and fear as well as often using their fetish behaviors to soothe themselves from these emotions. 75% of participants reported their early sexual experiences were positive ones, even though they did not include their fetish objects or behaviors in these early sexual experiences. Most of the participants felt a strong lack of acceptance by the non-fetish community, and some even felt some disapproval by the larger fetish community regarding age-play and diaper fetishes. Participant #003M, who had the most

involvement in the local AB/DL and general kink community, stated, “AB/DLs are kind of categorized in this taboo category even within the kink community to a certain extent.”

The frequency of desire for wearing diapers as well as finding diapers sexually arousing varied among the participants. 75% often wore diapers, with 50% always finding diapers sexually arousing and 50% finding diapers sexually arousing most of the time. The age that the desire to begin wearing diapers started early for all of the participants, with one at age six, two at age eight, and one at age twelve. This showed that at least 75% of the participants experienced a desire for wearing diapers long before puberty began. The participants were unanimous in their desire to play the baby role, and 75% expressed a desire for a mother or mother figure or the desire to be nurtured and cared for by another.

The last strong theme that came out of the face to face interviews was a desire to express to the world that what they desired was not in any way related to pedophilia. Several of the participants feared being confused with such a label and went to great lengths to explain that they wanted to either regress or role-play the baby role, often in a sexualized way, yet had no desire to ever have any sexual contact with actual children.

Conclusions

The purpose of phenomenological research is to investigate the meaning of the lived experience of people to identify the core essence of human experience or phenomena as described by research participants (Bloomberg & Volpe, 2012). The four participants in this study, most of whom enthusiastically volunteered for the study, were known to the researcher either as patients in her psychotherapy practice or in her sphere of social influence. Because the participants were known to the researcher rather than anonymous participants as in most studies, this gave the researcher a unique insight into the lives of the four participants. All were given the

option to end their participation within the study with no negative consequences to their therapy in order to avoid any ethical issues, and all continued their involvement without hesitation. They bravely chose to share some of their most intimate, embarrassing, and painful memories in the hopes of advancing the academic knowledge of the clinical mental health and sexology community. Much of their motivation was the hope that by participating in this study, there could be greater understanding, acceptance, and treatment for others who in the future become brave enough to trust the mental health community with their secret lives.

The members of the AB/DL community are as varied as the members of many disenfranchised alternative communities. The themes that were discovered by the research represent the values and beliefs of the participants regarding the meaning of their AB/DL desires in their lives. The most critical theme that emerged from the research was the desire for a mother or mother figure despite the evidence that none of those in this study reported a poor relationship with their mothers. Questions about the exact relationship with their mothers were never asked so whether participants had a positive or negative relationship with their mothers were not part of this study. None of the participants stated there was a lack of this relationship in their pasts, and the desire for that nurturing, caring dynamic remained as they grew older. Several of the participants stated in their questionnaires that they sought out professional sex workers to act out these roles when they were not getting enough of these desires met in their primary relationship and the use of fantasy or AB/DL pornography was not enough to satiate the need. The desire for these experiences began early in their lives: all reported they did not know what brought them on at the age they began, and none of them truly wanted to be relieved of their fetishes, even though two initially entered therapy wondering if there was a "cure."

The participants discussed the challenges that these desires presented in their lives and the often elaborate ways they went about hiding their secret life to the majority of the world. While they discovered that using their fetish was a self-soothing way to manage emotions of depression, anxiety, stress, and problems sleeping, it also created strong emotions of shame, guilt, and fear that deeply affected their sense of self.

The act to seek therapy was a strong theme for all of the participants as a way to understand and address the AB/DL desires and behaviors and as a way to learn to manage their depression, anxiety, shame, anger, and stress as well as learn tools to help with self-acceptance. These men sought a way to understand their atypical sexual desires and put them in context with their greater role as productive members of society. All of these participants were college educated, employed, and involved with family, friends, and intimate partners. They sought help to understand that their desire for nurturing and being cared for as a baby. Often when they accepted the “little” side of them, as many called it, they discovered their adult side was better able to handle the stresses of adult life. While 100% sought out a female therapist with whom to share their secret life, this aspect was not part of the research, so its importance is unknown.

Chapter 5: Conclusion and Recommendations

As Pate and Gabbard (2003) noted in their article about Adult Baby Syndrome, the absence of literature about working with this type of patient is disappointing to a therapist looking for the best practices of treatment. While there has been some additional work both within the academic community (Hawkinson and Zamboni, 2014), and the AB/DL community (Grey, 2006-2013), the lack of information continues. This study used a phenomenological research method to investigate the meaning of the lived experience of people to identify the core essence of the phenomena as described by the research participants (Bloomberg & Volpe, 2012).

Limitations

Due to the small sample size of four men located in the state of Colorado who participated in this study, no generalizations about all men or the small percentage of women who engage in paraphilic infantilism or autonepiophilia can be conclusively drawn. The researcher's interpretation of the interviews and questionnaires using a phenomenological research method further limits the scope of the conclusions, which apply only to the four men who participated in the study.

A larger sample size could have yielded more conclusive and accurate results with more generalizability. The attempt to use snowball sampling to discover other members of the local AB/DL community that the participants knew failed to draw any subjects willing to participate in the study. The ability to interview some female members of the AB/DL community would also have created a broader and more thorough understanding of the phenomena from the minority of this community. The addition of a sample of participants who have not sought out or entered therapy may have shed further light on the issues regarding what keeps people from seeking

therapy or if they manage to learn coping mechanisms to deal with their emotions and sexuality without therapy.

Areas for Future Research

It would be recommended that additional research into the area of paraphilic infantilism and autonepiophilia continue, as well as further training of mental health clinicians to better understand this unique sexual behavior. It is clear that when people believe they will be treated with compassion, acceptance, and understanding upon entering therapy rather than pathologized or judged for their unique sexual behaviors and given the tools to help manage symptoms such as depression, anxiety, stress, shame, embarrassment, and anger, as well as learn to improve their own self-acceptance, we may finally see more members of the AB/DL community seek out rather than fear psychotherapy.

This study did not provide enough data to successfully answer the questions of what causes so many within the AB/DL community to be distrustful of the mental health community or what the mental health community could change to improve the level of trust so that more members of the AB/DL community will seek mental health care. These are areas where additional research could be beneficial.

Despite its flaws, this study does provide further evidence that psychotherapy can be beneficial to the lives of those who struggle to understand atypical sexual practices that appear at a young age despite no history of trauma or abuse and remain throughout the subjects' lives. This study also shows that further investigation could be useful to help broaden the definition of sexual orientation beyond its current definition of the gender one seeks to have sexual experiences with. There is the possibility that fetishism is a natural expression of human variation that has been pathologized by the definition of deviance (Hawkinson & Zamboni,

2014). Due to the lack of study into the intricacies of human sexuality, we as a society fail to learn all that we could about this dynamic and powerful aspect of human behavior.

When compared to the other studies, such as those performed by Speaker (1986), Hawkinson and Zamboni (2014), and Grey (2006), most of the participants in these studies are functioning within society quite well despite their fears of disclosure. In their questionnaires the participants report that they are all college educated, employed in professional positions, three of the four are married, and all four have sexual partners who are aware of their fetishes. This is strikingly different than many of the journal articles written earlier with participants in psychiatric hospitals or other mandated treatment (Malitz, 1966, Dinello 1967, Kise & Nguyen 2011). Many of those within the AB/DL community have found inventive ways to use their atypical sexual behaviors as a means of coping with the stresses of life, yet some from Hawkinson and Zamboni's (2014) study reported that their behavior is not designed to cope with negative emotions. The results of this study show that often members of this community use their atypical sexual behaviors as a means of self-soothing from symptoms of depression, anxiety and the stress of life.

Often they discover ways to become comfortable with their sexuality with or without therapy to assist them. The most common theme from all of the studies is that those within the AB/DL community enjoy their unique manner of sexual expression and want to be understood and accepted for who they are as individuals.

Appendix A

Consent Form for Participants

Consent for Participation in Research

American Academy of Clinical Sexologists

Institutional Review Board

3203 Lawton Road, suite 170

Orlando, FL 32803

407-645-1641

Understanding Paraphilic Infantilism and Autonepiophilia (AB/DL)

You are being asked to participate in a research study. Before you consent to be a volunteer, please read the following and ask any questions you have to ensure you understand what your participation will involve.

Investigator

The name of the student conducting this research study is Rhoda Lipscomb, MSC, LPC. The faculty member who is supervising the research is Edward Fankhanel, PhD.

Purpose of the Research

The purpose of the research is to have a better understanding of paraphilic infantilism (adult babies) and autonepiophilia (diaper fetish) and their experience with the mental health community. There is little formal research within the psychological literature and even less on

how to effectively provide treatment for those individuals who do present for mental health care. The goal of the study is to have a better understanding of these particular atypical sexual behaviors, the best treatment approach to ensure those with these fetishes would be more willing to seek treatment when needed and what could be done to improve the level of trust between the ABDL community and the mental health community.

Duration of Participation in the Research and Number of Participants

If you agree to participate, it will take around 90 to 120 minutes of your time for both the original questionnaire and face to face interview. After the face to face interview, you will not need to return for further formal interviews unless you would like to speak with the primary investigator about your experience in the study. Since this is a qualitative study a total of 3-6 participants will be involved in the study.

Procedures to be followed during the Research

If you choose to participate in this study, you will be given or emailed a standardized questionnaire that you can fill out in private and later returned to the researcher, looking at your experiences with these particular fetishes throughout your life. The questions will discuss such areas as when you first noticed the fetish develop, your experiences, both positive and negative, while engaging in the fetish, your emotional responses to the fetish, and your overall mental health and if the fetish was a contributing factor. At points you will be asked about reactions of any others who discovered your fetish and how their reactions affected you and your emotional health. You will be asked about your experience with the mental health community, either positive or negative, and how that experience affected your feelings about yourself. Once the original questionnaires have been analyzed a set of no more than 6 questions will be created for a

face to face interview to further understand any questions that arise. This interview will be recorded on audiotape. All recording instruments will be visible and no recording will take place without your knowledge or consent.

Risks

The risk in this study is that you will be asked to recall memories from your life that may be painful, upsetting, embarrassing, or anxiety-provoking. You may stop the tape and quit the study at any time without penalty. If you feel any trauma from participating in this research and need psychotherapy services, a list of experienced therapists competent in these issues will be provided to you. If you need emergency treatment, you can call the Arapahoe/Douglas Mental Health Network for emergency care. Their emergency care phone number is 303-730-3303.

Benefits of the Research

There may or may not be any direct benefit to you from this study. Some people in the AB/DL community get a sense of satisfaction from helping increase the understanding of the mental health community which you may or may not experience. The hope of this study is to improve the knowledge of mental health professionals on how to effectively treat those with similar fetishes and may help other individuals in the future.

Alternatives to this Research

If you choose to participate in this research, there is no other alternative procedure than what is described. However, you do not have to participate in the research and you may choose to withdraw your participation at any time without any consequence.

Confidentiality

You have a right to privacy, and all information identifying you will remain anonymous and confidential. Your answers to all questionnaires, written inventories, and recordings will be coded with numbers, and only the primary researcher will have access to the names. Names used in the case study will be changed to protect your identity and you may choose any name you like to represent yourself. If you want information such as age, occupation, or other descriptive items that are normally used in a case study altered for increased privacy that will be arranged and you will have the option to decide what information will be used in any written material released in the study. Any information obtained in connection with this research that can be identified with you will remain confidential and will not be disclosed with your written permission or as required by law. The results of this study may be published in scientific journals, presented in psychological meetings, and an electronic version of the dissertation may be posted on the school's website. However, it is possible that under certain circumstances, data could be subpoenaed by court order.

Questions about the Research

If you have questions about the research you can contact Rhoda Lipscomb at 720-530-6545 at any time. Please feel free to ask any questions you may have before signing this form. If you feel you have concerns about how this research was conducted and want for file a complaint you can contact Dr. Fankhanel at Fankhanel@prtc.net.

Subject Compensation for Participation

As compensation for your participation in this study, you will receive a $100 Visa gift card upon completion of the study.

Previous Research Participation

___ I have never participated in a research study

___ I have participated in research study (ies) in the past. The studies I have participated in within the past three months:

_____

_____

Participants Rights and Research Withdrawal

Your participation in this study is voluntary. You may refuse to participate or withdraw one the study has started. You will not lose any benefits to which you are otherwise entitled nor will you be penalized. If you are a current patient, withdrawing from this study will not affect your ability to continue with the mental health care you have been receiving. If upon withdrawing from this study you feel your continued mental health care has been compromised in any way, you may request and will receive a list of three other local therapists who are competent and skilled in working with alternative sexual expression. The information used in the research will only come from the self-administered questionnaire and the face-to-face interview. No information obtained solely from your psychotherapy sessions will ever be used.

We have attempted to explain all the important details relating to this study to you. If you have any additional questions the researcher will be happy to give you additional information.

Signature and Acknowledgement

My signature below indicates that I have read the above information and I have had a chance to ask any questions that help me understand what my participation will involve. I agree to participate in the study until I decide otherwise. I acknowledge having received a copy of this agreement and a copy of the Subject's Bill of Rights. I have been told that by signing this consent form I am not giving up any of my legal rights.

Signature of Participant_____ Date_____

Signature of Researcher _____ Date_____

Adapted from: Dissertations and theses from start to finish, Second Edition, 2006 by John Cone and Sharon Foster

Appendix B

Subject's Bill of Rights

Experimental Research Subject's Bill of Rights

California law, under Health & Safety Code 24172, requires that any person asked to take part as a subject in research involving a medical experiment, or any person asked to consent to such participation on behalf of another, is entitled to receive the following list of rights written in a language in which the person is fluent. This list includes the right to:

1. Be informed of the nature and purpose of the experiment.

2. Be given an explanation of the procedures to be followed in the medical experiment, and any drug or device to be utilized.

3. Be given a description of any attendant discomforts and risks reasonably to be expected from the experiment.

4. Be given an explanation of any benefits to the subject reasonably to be expected from the experiment, if applicable.

5. Be given a disclosure of any appropriate alternative procedures, drugs or devices that might be advantageous to the subject, and their relative risks and benefits.

6. Be informed of the avenues of medical treatment, if any, available to the subject after the experiment if complications should arise.

7. Be given an opportunity to ask any questions concerning the experiment or the procedures involved.

8. Be instructed that consent to participate in the medical experiment may be withdrawn at any time and the subject may discontinue participation in the medical experiment without prejudice.

9. Be given a copy of the signed and dated written consent form.

10. Be given the opportunity to decide to consent or not to consent to a medical experiment without the intervention of any element of force, fraud, deceit, duress, coercion, or undue influence on the subject's decision.

Appendix C

Questionnaire

Background Information

1. Age ___
2. Gender
    i. Male
    ii. Female
    iii. Transgendered
3. Marital status
    i. Single – never married
    ii. Living with partner
    iii. Married
    iv. Separated
    v. Divorced
    vi. Widowed
4. Level of education
    i. Did not graduate high school or GED
    ii. High school diploma/GED
    iii. Some college
    iv. Associate’s degree
    v. Bachelor’s degree
    vi. Master’s degree
    vii. Doctorate/advanced degree

viii. Trade/technical certification

ix. Other _____

5. State you live in: _____
6. Occupation: _____
7. Sexual orientation
    i. Primarily with women
    ii. Exclusively with women
    iii. Primarily with men
    iv. Exclusively with men
    v. A mix of men or women
    vi. Solitary sex, no desire for partner
8. Which of the following sexual behaviors have you engaged in?
    i. Bondage. Receive ___ or Give___
    ii. Domination ___ submission ___
    iii. Spanking. Receive ___ or Give ____
    iv. Watersports. Receive ___ or Give____
    v. Fetishes for particular items (describe and list)_____

    _____

    vi. Preferences for specific parts of a partners body

    _____

    _____

    vii. Pain. If yes, receiving ____ or inflicting_____

viii. Public exposure: _____

ix. Voyeurism. Prefer to watch men ___ women ___ both___

x. Humiliation. If yes, receiving ____ or inflicting ____

xi. Pornography. If yes, is there a particular type of porn you prefer_____

xii. Age play. If yes, do you prefer to role-play ___ or regress ___ and what age or ages do you prefer to role-play/regress to? _____

xiii. Other:

_____

_____

9. As a child did you experience physical, emotional, sexual or other kinds of abuse? If yes,
    i. Physical
    ii. Emotional
    iii. Sexual
    iv. Neglect
    v. Other _____
10. At what age were you potty trained? _____ Don't remember ___
11. After becoming potty trained did you:
    i. Need to wear diapers during the day
    ii. Need to wear diapers at night
    iii. No diapers, yet accidents during the day
    iv. No diapers, yet accidents at night

v. Don’t remember

12. At what age do you remember feeling a desire to wear diapers after no longer needing them _____

13. When you discovered you enjoyed wearing diapers was the feeling:

    i. Erotic & sexually arousing

    ii. Confusing

    iii. Fearful

    iv. Embarrassing

    v. Other. Please describe

    _____

    _____

14. Did you reach puberty

    i. Earlier than your peers

    ii. About the same time as your peers

    iii. Later than your peers

    iv. Don’t remember

15. At what age did you reach your first orgasm _____ Don’t remember ____

16. Did anyone discover your secret regarding wearing diapers? ____ If yes, how did they react?

    _____

    _____

17. Once you began wearing diapers for sexual arousal, how often did you

    i. Wear them _____

ii. Fantasize about wearing them _____

(multiple times a day, once a day, weekly, monthly, or longer period)

18. During this time did you have other sexual fantasies that did not include diapers/age play? ____ If yes, did most fantasies:
    i. Involve diapers/age play
    ii. Involve typical sexual behaviors with a female
    iii. Involve typical sexual behaviors with a male
    iv. Involve typical sexual behaviors with either
    v. Involve other types of atypical sexual behaviors. Please list:

    _____

19. What percentage of sexual fantasies during the ages of 10 to 20 years involved diapers/age play?
    i. Less than 10%
    ii. 10 - 25%
    iii. 25 - 50%
    iv. 50 – 75%
    v. 75 – 100%
20. In your youth were you ever sexual with a partner? ____ If yes,
    i. Were diapers/age play involved? ____
    ii. Did you need to fantasize about diapers/age play to become aroused? _____
21. Were your early sexual experiences with a partner
    i. Mostly positive

ii. Mostly negative

iii. Neutral

22. As a child/teen when you engaged in ABDL activities did you:

    i. Engage only alone in the privacy of your home

    ii. Engage with a consenting friend/lover in private

    iii. Surprise a friend/lover by dressing in diapers without their prior knowledge

    iv. Go outside of your home in a diaper/baby clothes

23. As a child/teen did you ever wear diapers or use baby items to:

    i. Feel better

    ii. Soothe yourself

    iii. Help you sleep

24. Any other childhood/teen experiences related to your diaper/age play fetish that you think is important for this study to know:

_____

_____

Current Information

This section is related to actual experience in your adult life with diapers and age play.

Definition: Rarely – less than once a year; Sometimes – 1-10 times per year; Often – 1-20 times per month

Do you…?	Never	Rarely	Sometimes	Often	Daily
Wear diapers	____	____	____	____	____
Wear plastic/rubber pants	____	____	____	____	____
Use a rubber sheet	____	____	____	____	____
Wet diapers during the day	____	____	____	____	____
Wet diapers at night	____	____	____	____	____
Soil/defecate in diapers	____	____	____	____	____
Masturbate in diapers	____	____	____	____	____
Nurse from breast	____	____	____	____	____
Nurse from a bottle	____	____	____	____	____
Use pacifier	____	____	____	____	____
Wear bib	____	____	____	____	____
Eat baby food	____	____	____	____	____
Sleep in a crib	____	____	____	____	____
Use high chair or playpen	____	____	____	____	____
Play with doll/teddy bear/blocks	____	____	____	____	____
Use baby powder	____	____	____	____	____
Use baby oil	____	____	____	____	____

Use baby lotion	____	____	____	____	____
Use diaper rash ointment	____	____	____	____	____
Use wet-wipes	____	____	____	____	____
Wear onesie	____	____	____	____	____
Wear baby sleeper	____	____	____	____	____
Watch AB/DL porn	____	____	____	____	____
Watch other types of fetish porn	____	____	____	____	____
Watch typical/non fetish types of porn	____	____	____	____	____
Engage in sex play with a partner while in diapers	____	____	____	____	____
Engage in sex play with a partner without diapers	____	____	____	____	____
Engaged in bondage as part of sex play	____	____	____	____	____
Enjoyed being submissive to a partner	____	____	____	____	____
Engage in other fetishes (list) _____	____	____	____	____	____

25. Who participates with you in your age play/diaper practices?

    a. No one

    b. Spouse

    c. Lover

    d. Non-sexual friend

    e. Dominatrix/sex worker

    f. Other _____

26. Would you rate your age play/diaper fetish interests as weaker than, equal to, or greater than your interests for typical sexual interactions?

    _____

27. At any time do you enjoy/fantasize about urination or defecation in a diaper? _____

28. The main reason you engage in age play/diaper fetish activity is:

    a. I cannot help it

    b. I prefer and enjoy it

    c. I am required to do so by another for discipline/punishment

    d. Other _____

29. Do you find wearing diapers sexually arousing?

    a. Always

    b. Most of the time

    c. Occasionally

    d. Never

30. Are you currently involved in a sexual relationship? _____

31. Does your partner participate in your age play/diaper activities?

    a. Never. They do not know about them

    b. Never. They know, and prefer not to participate

    c. Never. They know, and prefer I do it with someone else

    d. Sometimes. They enjoy it too

    e. Sometimes. They don't "enjoy" it yet do it because I like it

    f. Sometimes. They participate begrudgingly

32. Has your enjoyment of age play/diapers ever caused problems for you?
    a. Yes in my personal life
    b. Yes in my career
    c. Yes in my romantic relationships
    d. Yes in all of the above
    e. No in my personal life
    f. No in my career
    g. No in my romantic relationships
    h. No in all of the above
33. In age play/diaper play are you:
    a. Always the adult role
    b. Usually the adult role
    c. Always the baby role
    d. Usually the baby role
    e. Can play either role
34. How much money have you spent in the past 12 months on items such as diapers, baby clothes, supplies, professional services?

    _____
35. Have you ever used the services of a professional dominatrix or sex worker? _____ If yes, how many times? _____

Mental Health Issues

36. Within the larger fetish community, how well accepted do you feel by others with different fetishes/kinks when they discover you engage in age play/diaper fetishes?
    a. Well accepted
    b. Moderate acceptance
    c. Neutral
    d. Some disapproval
    e. Little acceptance
37. Of those people in the non-fetish community, how well do you feel accepted when people learn of your fetish?
    a. Well accepted
    b. Moderate acceptance
    c. Neutral
    d. Some disapproval
    e. Little acceptance
    f. I have never told anyone
38. If you have had negative experiences with in the fetish community or the non-fetish community, how has this affected your self-esteem/sense of self?
    a. My self-esteem is not affected
    b. There is some affect to my self-esteem
    c. There is a moderate affect to my self-esteem

d. There is a significant affect to my self-esteem

e. I feel terrible about myself for having this fetish

39. Have you ever sought out counseling or therapy services? _____ If yes, was it related to your age play/diaper fetish issues? _____

40. If you engaged in counseling or therapy services for what areas did you seek help?

(check all that apply)

a. Dealing/understanding my age play desires

b. Dealing/understanding my diaper fetish desires

c. Difficulty in a relationship

d. Depression

e. Anxiety

f. Anger management

g. Self-esteem

h. Looking for a "cure" to my age play or diaper fetish

i. Non-fetish sexual issues

j. Difficulty with school/work

k. Other

_____

41. How long were you in therapy before you told your therapist about your age play/diaper fetish desires? _____

42. How did your therapist react?

a. With judgment

b. With disgust

c. With curiosity

d. Was he/she unaware this existed

e. Was he/she knowledgeable

f. Was he/she compassionate

g. Was he/she understanding

h. Was he/she attempting to fix/cure you

i. Other reaction

_____

_____

_____

43. If no, what has caused you not to seek therapy services?

a. I felt no need

b. I was afraid the therapist would judge me

c. I was afraid the therapist would try to take away the fetish I enjoyed

d. I wanted to address issues such as depression, anxiety, self-esteem, yet feared the therapist would tell me my fetish is what caused them and just give me drugs

e. I heard horror stories from other fetish friends about bad experiences with therapy

f. I had my own bad experiences with therapy

g. What I read in psychology classes or literature was so negative I was afraid to go

h. Other

_____

44. If you were to seek out therapy, what would be the ideal therapeutic approach to best help you?

_____

_____

_____

_____

45. What other questions that have not been covered by this questionnaire do you believe would be important to be asked in order to give a better understanding to the mental health community?

_____

_____

_____

46. Are there other people you know in the ABDL community who you think would be a good candidate and willing to participate in this study? If so, would you be willing to pass on the contact information (phone number or email address) so they can make contact?

_____

_____

Appendix D

Face to Face Interview Questions

1. How would you describe the origins of your ABDL interests? Are there biological, psychological, and/or sociological aspects to how it developed? Are there sexual aspects of its development? Please explain.
2. Have you noticed changes in your ABDL desires over the years? Have they increased, decreased or stayed the same? If they have changed, how have they changed and are you happy or unhappy with the changes? Please explain.
3. What do those outside the ABDL community, whether mental health or medical professionals and family/friends, need to understand about your ABDL interests that many do not seem to comprehend? How would this make your life better?
4. What do you find to be the most helpful when you are dealing with issues such as depression, anxiety, anger, stress or trouble sleeping?
5. Do you know others in the ABDL community who could use help with issues such as self-esteem, shame, depression, anxiety yet do not seek therapy because of a distrust of the mental health community? What reasons do they give for their lack of trust?
6. What changes would the mental health community need to make to improve the level of trust from the ABDL community?

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