

The use of cognitive behavioural therapy on two case reports of paraphilic infantilism, substance misuse and childhood abuse

Abstract

Very limited research has looked at the use of cognitive behavioural therapy on paraphilic infantilism. Two case descriptions of paraphilic infantilism coexisting with substance use disorders and anxiety and/or a mood disorder are discussed. Both cases presented with a history of childhood physical and sexual abuse. One of the cases also reported engaging in transvestism during periods of stimulant abuse and paraphilic infantilism during substance misuse stabilisation or opiate intoxication. The application of cognitive behavioural techniques revealed that both cases' paraphilic conduct was associated with their substance misuse and whilst they attended a drug maintenance programme, they did not wish to pursue any treatment intervention regarding their paraphilic behaviours. Both case descriptions of paraphilic behaviour are discussed in the context of substance misuse, mental health and the triggers associated with relapse.

Keywords: paraphilic infantilism, substance misuse, dual diagnosis, childhood abuse, cognitive behavioural therapy, relapse

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Abbreviations: APA, American Psychiatric Association; AB, adult baby; SB, 'sissy babies'; DL, diaper lovers; CBT, cognitive behavioral therapy; SSRIS, selective serotonin re-uptake inhibitors; PTSD, posttraumatic stress disorder

Introduction: An overview of paraphilic infantilism

Paraphilia refers to the intense and persistent sexual interest and arousal towards objects, situations or individuals which are atypical, equal to and/or greater than normophilic sexual interests.¹ Paraphilic disorders in the DSM-5 include exhibitionism, fetishism, paedophilia, sexual masochism, sexual sadism, transvestic fetishism and voyeurism possess a formal diagnostic criteria (APA, 2015). However, paraphilic infantilism is classified as a sexual disorder under, 'other specified paraphilic disorder'.¹

It was during the 1960's that reference to clients' exclusive wearing of diapers as a means of attaining sexual arousal became documented. Tuchman & Lachman² reported a child sex offender, who had been molesting his 4 and 6 year old daughters. He would wear rubber pants over his diaper and enjoyed urinating and masturbating in them. Malitz³ describes a 20 year old male who had broken into a house with the sole intention of wearing diapers and defecating in them and subsequently reaching orgasm. Dinello⁴ provided a diagnostic understanding of a 17 year old male who wore diapers, had eaten baby food, drank from a baby bottle and masturbated whilst wearing a diaper.

During the 1980's, Money⁵ termed the paraphilic condition of impersonating a baby, autonepiophilia, diaperism or paraphilic infantilism. Money⁶ distinguished between infantilism, autonepiophilia and paraphilic diaper-wearing, stating that the latter is a paraphilic fetish involving an erotic attraction to an article of clothing whilst the former is a non-fetishistic paraphilia aimed at regressive age identity

role play. Paraphilic infantilism was described as an individual acting as an infant including associated behaviours of drinking from a baby bottle, being fed baby food, being breast fed, wearing baby cloths, wearing diapers and sleeping in a crib. This may have involved the assistance of a 'nanny', 'daddy' or 'mommy' to accommodate the infantilists requirements.^{6,7}

When role play involves regressing back to an infant state the individual is referred to as an adult baby (AB). The AB's like to dress up as a baby, get baby fed, have diaper changes and so forth.⁷ 'Sissy babies' (SB) are adults who also play the infant role however, the role played is the opposite gender and may involve cross dressing SBs. Those who only engage in wearing diapers, as a sexual fetish, without the regressive fantasies are referred to as diaper lovers (DL).⁷ Those who experience both the sexual aspect of wearing diapers and the enjoyment of engaging in infantile play are referred to as adult baby/diaper lovers (AB/DL).⁷

Money⁶ also referred to paraphilic juvenilism or age play. Age Play predominately involves adults who role play at being babies, children or younger adults. Money⁶ examined the similarities between paraphilic juvenilism and paraphilic infantilism observing, that for some, the garments have a fetish appeal and that, both syndromes may also incorporate a masochistic element of spanking and verbal humiliation.⁶ Paraphilic infantilism can sometimes be confused with paedophilia and whilst clinical case examples may include this, the majority of paraphilic infantilists' do not desire children as sexual partners.⁸

Cognitive behavioural therapy appears to be the preferred therapeutic choice for paraphilic disorders.⁹ Interventions have centred on decreasing inappropriate arousal whilst enhancing appropriate sexual arousal. Complimentary approaches to treatment include for example, cognitive restructuring, psycho-education, and self-regulation models.^{10,11}

However, understanding paraphilic infantilism in the context of substance misuse and the effective application of cognitive behavioural therapy remains limited. Indeed, the focus of cognitive behavioural therapy has centred on sexual offending including child sex offending, paraphilic rape, and exhibitionism.⁹ According to Pate & Gabbard,¹² 'Unusual behaviours may escape psychiatric classification if they do not create subjective distress, do not distress others, and do not involve functional impairment or legal problems'. Since no formal diagnosis is currently available for paraphilic infantilism, such activities may not be fully recognised by health care practitioners working with these clients.

Psychodynamic conceptualisation of paraphilic infantilism: Informing CBT

Whilst CBT is regarded as the preferred model of treatment for paraphilic infantilism, it nevertheless remains weak when it comes to the aetiology and intrapsychic origins of paraphilic presentations. Psychodynamic theory instead, is well suited to offering a more in depth perspective on the aetiological and developmental underpinnings of sexual variation, given psychoanalysis's nuclear examination of unconscious intrapsychic processes in object-seeking; and the nature of the libido, as a central motivating force behind human behaviour. The historical split between the two models is beyond the scope of this paper; what is intended instead, is the provision of psychodynamic insights which can inform cognitive behavioural interventions both in terms of the conceptualisation of the disorder and subsequent clinical formulations in practice. Driven by pluralistic epistemologies, psychology is now in a position to accept that differing schools of thought may polemically co-exist, but the undivided schism between them may nevertheless lend itself some hope of reconciliation, through a constructive meta-dialogue, devoid of political interests other than clinical applicability and effectiveness.¹³

In paraphilic infantilism a psychodynamic understanding would imply a thorough comprehension of how this activity interacts with the client's underlying personality structure. For instance, clients with neurotic organisation may use paraphilic activity to maintain genital potency and other more towards the psychotic border may engage with such behaviours to fend off a sense of dissolution of the self. Sexual abuse and trauma are considered central to the comprehension of infantilism. For instance, if baby-like activities and objects like bottles, lactophilia and nappies, produce sexual arousal then they can constitute an aspect of fetishism. Freud S¹⁴ originally saw fetishism as stemming from castration anxiety and linked the fetish to ego-splitting, in terms of denial of castration and the affirmation of it, occurring at the same time. Because of early traumatic experiences, the healthy mother-infant interactions may have been disturbed (Greenacre, 1970); as a result the individual may regress to an infant-like state to master the conflict of the pain arising from an unavailable soothing transitional object. The regressive qualities of infantilism may suggest a turn to auto-eroticism, a return to the innocence of the self as a narcissistic object of libidinal cathexis, either as a response to traumatic abuse or an inability to channel libidinal energy to human-objects due to unavailability or countertransgression. This theory may be particularly well-suited to explaining cases of early sexual abuse where the young child was not allowed a health entry to the oedipal stage but was instead savaged of its opportunity to express sexual arousal (symbolically) in a healthy and adaptable manner. A reversal occurred instead where the helpless child became the target of sexual desires in terrifying and wounding way stripped from power or control.

Cases and methods

The following two clinical case descriptions (consented anonymised clients), 1 and 2, appear to be characteristic of adult babies as postulated by Money & Taormino.^{6,7} Case 1 and 2 are receiving 20, 60 minute weekly CBT sessions. Case 1 is a 36 year old heterosexual unemployed male who has engaged in paraphilic infantilism for approximately 20 years. Further, he has a long history of substance misuse including heroin and alcohol which began during the same period. Case 1 did not report that one had precipitated the other or that a relationship existed between engaging in paraphilic infantilism and substance misuse, other than he was 'trying to avoid childhood abuse issues' by reverting to a time prior to the abuse. It became evident that he used drugs to get through the abuse which involved his step father sexually and physically assaulting him up until age 16 years. Case 1 presented to a drug maintenance clinic 2 years ago and has recently engaged in CBT. Prior to attending the clinic he has undergone 4 drug detoxifications and 2 drug rehabilitations. Case 1 has been diagnosed with a depressive anxiety disorder and was being prescribed methadone, an SSRI and diazepam at the time of the interview. He had not been formally diagnosed with PTSD.

Case 1 reported

"I was four years old when my step father started abusing me. He was an alcoholic and mom used to work a lot, she was never around. This continued into my teens until he died of cirrhosis of the liver. I was aware of the scene (adult baby) and purchased a few things. Mom was out and it gave me enough time to play with these things and when he (step father) was alive during the times he wasn't abusing me he was asleep. My nappies weren't often changed when I was young but when they were on it meant I was safe from abuse. So I guess I was in nappies longer than most and I didn't feel the need to change. The feeling I get from wearing nappies now feels like my first shot of heroin. It's an amazing safe feeling. And since I didn't get much love from either parent it's like I'm being looked after by a mommy (case 1 attends a nursery where a mommy caters to his needs). I feel like I'm getting the childhood I wanted. I've had years of therapy and I know why I'm doing it but I see how it helps. It's my abuse issues which make me relapse on drugs, being a baby helps me through it and I'm not harming anyone. The drugs have done more harm. I don't masturbate when I've got my nappy on, it would link it with the abuse when I was masturbated and I don't want that association. But I do defecate and urinate in them and I like being bottle fed and tucked into bed by a mommy. This is a way of life for me and it's something I'm not going to change".

Case 2 is a 43 year old heterosexual male who has engaged in paraphilic infantilism for 15 years and transvestism for approximately 10 years. Further, he has a long history of substance misuse including heroin, crack and alcohol which began prior to the development of both paraphilia's. He presented to a drug maintenance clinic 3 years ago and has recently embarked on CBT. Prior to him attending clinic Case 2 had undergone 3 drug detoxifications and 1 drug rehabilitation. Case 2 had a current diagnosis of bipolar disorder and was being prescribed methadone and a mood stabiliser at the time of the interview. He has not been formally diagnosed with PTSD. Certain triggers related to childhood abuse issues prompted the misuse of drugs and the incorrect use of his mood stabiliser. Both crack and heroin appeared to be used as self-medication for his bipolar disorder. During these episodes, he becomes a transvestite whilst intoxicated with crack cocaine and becomes an adult baby following the use

of heroin to 'bring him down'. Whilst the stabilisation of drugs has reduced the incidence of paraphilic activity, the exact frequency could not be established. Case 2 did not wish to elaborate upon this.

Case 2 reported

"I have two perversions apparently. Being an adult baby is my favourite but I am aware that they are there for my problems. I think my drugs problems came first which started with alcohol, then heroin and then crack and sometimes I do all of them together, even when I'm on methadone and diazepam. My dad was a single dad, I don't really remember my mom but apparently she died when I was very young. My dad kept all her things and used to lock himself in this shrine like room for hours. He was a drunk and physically abusive. It's actually his smack head girlfriend who abused me. She was very heavy handed apparently social services were involved as I was left dirty and hungry for hours. When she was angry she used to pull back my foreskin very hard and quickly. I'm confused but I don't think it was sexual I think it was physical. It was her drugs I used, in fact she was the first person to inject me- but before then I was drinking a lot since I was 12. I ran away and for a while I lived with my girlfriend and I guess things just progressed, I missed out on having a mom, well a nice one and I started dressing up. But I think I was into things a lot younger and this is where the guilt is I guess I regress to an age when my dad's girlfriend wasn't around even though my dad was abusive when he was drunk. I got diagnosed with bipolar in my early 20's. My girlfriend was my mommy when I became a baby normally when I was off stimulants or I was using heroin. I would say this happened a few times a week maybe. I feel comfortable wearing a nappy and being babied and I like to get my nappy changed and cleaned and then bottle fed before I get put to bed. But I never get turned on when I wear a nappy it's dressing up and being a girl which does that. I had my own wardrobe and although I did this after being a baby, I did dress up in my mom's clothes and masturbate. The stimulants would keep me up for hours and being a girl made me feel powerful, I would dress up, wear a wig with make-up and masturbate in front of the mirror".

Whilst engaging in paraphilic infantilism, both case 1 and 2 became deeply immersed in a baby-like mind set. When wearing diapers, both cases urinate and defecate in them and report feelings of comfort and security when their diapers are changed and their body and genitals are cleaned. Whilst some adult babies engage in masturbation and ejaculation or orgasm whilst wearing diapers, case 1 and 2 did not engage in the sexual fantasy as it was not deemed 'baby like'. Further, masturbation and ejaculation had appeared to become associated with prior childhood sexual abuse.

According to Lehne & Money¹⁵ multiplex fantasies and behaviours may dominate different aspects of the paraphilic history and are interconnected around a primary fixation.¹⁶ Paraphilic variations in case 2 are evident through the varying symptomatic presentations in his clinical history which have, along with substance misuse, become a means of self- medicating against extant mental health and issues relating to prior childhood abuse.

Case 1 and 2 had a long history of substance misuse along with an anxiety and/or a mood disorder. In Mehdizadeh Zareanari & Ghafarinezhad,¹⁷ detailed a case study where a man engaged in paraphilic transvestism whilst intoxicated with methamphetamine. It is not uncommon for substance misusers to experience difficulties with sexual performance owing to the effects of for example, opiates, methamphetamine and certain SSRI's.¹⁶⁻²⁰ Further, Arndt²¹ stated that

paraphilic infantilism often co-occurs with fetishism, masochism and/or transvestism. Case 2 had expressed his sexuality via paraphilic transvestism whilst reverting to paraphilic infantilism following stimulant drug abuse.

Unresolved childhood abuse has a profound impact upon the developing child.^{22,23} According to Lawson, Back, Hartwell, Moran-Santa Maria et al.²⁴ exposure to traumatic events is common among individuals with substance use disorders. Case 1 and 2 had experienced childhood abuse which has resulted in self-medicating against prior abuse issues with poly-substance use Khantzain.²⁵ Reverting to an age prior to the sexual abuse had provided what the cases referred to as 'a safe place'. However, this may be reflective of the cases avoidance in addressing prior childhood abuse issues, or addressing their substance misuse problems, which may trigger drug use and reinforce paraphilic behaviours. Indeed, this becomes compounded with co-occurring mental health problems.

Discussion of case reports

Both cases presented to a drug maintenance programme with poly substance addiction and dual diagnosis. However, they did not seek any treatment for their paraphilic behaviours which have since been discussed in CBT as a 'life style' choice rather than a presenting concern. The cognitive developmental model of substance abuse^{26,27} and the ABCD model of emotional disturbance²⁸ have been employed to support case 1 and 2 with substance misuse treatment needs. Further, relapse prevention training, communication skills training and cognitive behavioural mood management training have been included in the cases therapeutic treatment programme.²⁹⁻³¹ Both cases kept a drug diary which revealed that reference to substance misuse in the context of paraphilic infantilism and transvestism during CBT had sometimes acted as a trigger to engage in these behaviours. Indeed, relapse is quite often associated with the cues, triggers and dopamine production associated with drug use.³²⁻³⁵

Whether the same cognitive and biological processes are involved in the paraphilic triggers, has yet to be established, particularly if an association is apparent between drugs use and paraphilic conduct. Further, as illustrated in case 2, when this individual did not take his mood stabiliser correctly this further precipitated illicit drug use and engagement in paraphilic behaviours. Whilst a cognitive behavioural approach had indicated a relationship between drugs use, prior childhood abuse and paraphilic behaviours, both case 1 and 2 were reluctant to acknowledge this association.

Importantly, if paraphilic activities provide security, warmth, assurance and enjoyment then arguably it is up the individual or couple to decide what they wish to embark upon. However, if the activity is used to avoid prior childhood sexual abuse issues, or the behaviours are precipitating substance misuse and vice versa, then this warrants further consideration. Perhaps this should not be directly aimed at their paraphilic behaviours. To expand, what appears to be a common theme in the literature and in both case reports here is that 'adult babies' do not deem that their behaviour constitutes a psychiatric problem. For example, as stated by Pate & Gabbard,¹² 'As with all paraphilic disorders, the treatment is challenging because there is rarely sufficient motivation for patients to change'.¹² As stated, case 1 and 2 argued that becoming a baby assisted with their drug using behaviours and did not wish to acknowledge any association between their drugs use and engagement in paraphilic conduct. Despite encouragement, both cases do not wish to, at this stage of their treatment, stop engaging

in paraphilic behaviours. Whether the reduction and/or substance use cessation could curtail either case 1 and 2's involvement in paraphilic behaviours remains difficult to predict. Therefore, integrating for example covert sensitization and/or systemic desensitization into the therapeutic equation may prove redundant, particularly since the cases argued that engaging in paraphilic infantilism reduces stress. Since both cases have histories of childhood abuse perhaps addressing their own childhood victimisation as postulated by Laws, Hudson & Ward^{36,10} may assist their substance misuse and paraphilic conduct. However, since the clients are not harming others and this is a lifestyle choice, from an ethical perspective unless the cases wish to change their behaviour, imposing certain CBT techniques such as orgasmic reconditioning would be inappropriate.

What could be proven beneficial instead is a broader focus on infantilism as 'erotized regression', in terms of working through intrapersonal and interpersonal conflict, arising from sexual abuse or other deficits suffered in the attachment.

Researching psychotherapy expectations, Speaker (1986) "psychotherapy can be helpful in minimizing the possible harmful 'side-effects' of engaging in infantilism" (Speaker, 1986, Chapter 6). He found the goal of psychotherapy should be to open options for patients from which to choose, remove blocks from conventional scripts, increase control over sexual behaviours currently 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). One way of achieving, better control of sexual. The included CBT techniques have benefited the cases drug using behaviour and prior childhood abuse where these triggers have managed the cases substance use. Case 1 and 2's problem-solving skills centred on the premise that drugs and/or engaging in paraphilic behaviour regulate and control feelings and thoughts including childhood abuse. This triggered the misuse of prescription medication and/or illicit drugs and in the engagement of paraphilic behaviour. However, the cases did not wish to acknowledge any association at this stage of their treatment. Cognitive distortions in Case1 and 2 have facilitated and justified their paraphilic behaviours and substance misuse. Examples included, 'being an AB makes me feel safe', 'it stops me from using drugs', 'it helps me control my drug use', being a baby makes me feel safe' and 'it helps me relax'. From a behavioural perspective, both cases paraphilic behaviours had become conditioned during childhood and reinforced throughout their clinical history. Similarly to Nolen Hoeksema,³⁷ the masturbatory fantasy of engaging in paraphilic transvestism in case 2 had reinforced the paraphilic arousal. Though this requires further exploration.³⁸⁻⁴²

Conclusion

Very limited research has centred on the application of cognitive behavioural therapy for paraphilic infantilism. The presenting cases discussed here have highlighted the possible relationship between substance misuse, paraphilic behaviours and prior childhood abuse. Whether the cases substance misuse was a precipitating or perpetuating factor in the development and maintenance of their paraphilic behaviours remains inconclusive. However, both cases self-medicated their psychological distress with illicit drug use and alcohol to avoid issues of and relating to childhood abuse. It became evident that certain triggers and cognitive distortions were responsible for both substance misuse and paraphilic behaviours resulting in drug

relapse and the engagement of self-medicating behaviours. These triggers and cognitive distortions not only included discussing the paraphilia's but also drug using behaviours and issues of childhood abuse. However, case 1 and 2 do not wish to change their paraphilic behaviours. Certainly the cases cognitive dissonance exhibited had compartmentalized the CBT for substance misuse from their paraphilic compulsions. Understanding the relationship between paraphilia, substance misuse and childhood abuse via a cognitive behavioural perspective would inform and assist the development of suitable evidenced based drug interventions and/or trauma programmes.

Ethical issues

All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2000 (5). All informal discussions which took place with case 1 and case 2 were in accordance with the British Psychological Society's (2009) code of ethics and conduct. Additional consent and ethical approval was sought via client's current healthcare services for counselling support. Case 1 and Case 2 did not report any distress following their CBT sessions including their paraphilic conduct.

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Conflict of interest

The authors have no conflict of interest.

References

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. DSM-5. Arlington, USA: American Psychiatric Publishing; 2013.
2. Tuchman WW, Lachman JH. An unusual perversion: the wearing of diapers and rubber pants in a 29-year-old male. *Am J Psychiatry*. 1964;120:1198-1199.
3. Malitz S. Another Report on the Wearing of Diapers and Rubber Pants by an Adult Male. *Am J Psychiatry*. 1966;122(12):1435-1437.
4. Dinello FA. Stages of treatment in the case of a diaper-wearing seventeen-year-old male. *Am J Psychiatry*. 1967;124(1):94-96.
5. Money J. Paraphilias: Phenomenology and classification. *Am J Psychother*. 1984;38(2):164-179.
6. Money John. *Lovemaps—Clinical Concepts of Sexual/Erotic Health and Pathology, Paraphilia, and Gender Transposition in Childhood, Adolescence, and Maturity*. New York: Prometheus Books; 1986.
7. Tristan Taormino. *Still in Diapers*. The Village Voice, USA; 2002.
8. Freund K, Blanchard R. Erotic target location errors in male gender dysphorics, paedophiles, and fetishists. *Br J Psychiatry*. 1993;162:558-563.
9. Kaplan MS, Kruegar RB. Cognitive-Behavioural Treatment of the Paraphilias. *Isr J Psychiatry Relat Sci*. 2012;49(4):291-296.
10. Tony Ward, Stephen M Hudson, Thomas Keenan. A self-regulation model of the sexual offense process. *Sexual Abuse: A Journal of Research and Treatment*. 1998;10(2):141-157.
11. Pamela M Yates, David Prescott, Tony Ward. *Applying the good lives and self-regulation models to sex offender treatment: A practical guide for clinicians*. The Safer Society, Brandon, Vermont, USA, 2010. p. 1-7.

12. Pate JE, Gabbard GO. Adult baby syndrome. *Am J Psychiatry*. 2003;160(11):1932–1936.
13. Giles J. Adult Baby Syndrome and Age Identity Disorder: Comment on Kise and Nguyen. *Arch Sex Behav*. 2012;41(2):321–322.
14. Freud S. Hypnotism and suggestion. *Int Journal Psychoanal*. 1946;27(1–2):59–64.
15. Lehne G K, Money J. Multiplex versus multiple taxonomy of paraphilia: Case example. *Sexual Abuse*. 2003;15(1):61–72.
16. John Money. *The Lovemap guidebook: A Definitive Statement*. Continuum, New York, USA, 1999.
17. Mehdizadeh Zareanari A, Ghafarinezhad A, Soltani H. Fetishism due to Methamphetamine (Glass) Abuse: A Case Report. *Addict Health*. 2013;5(1–2):73–76.
18. Cioe PA, Anderson BJ, Stein MD. Change in symptoms of erectile dysfunction in depressed men initiating buprenorphine therapy. *J Subst Abuse Treat*. 2013;45(5):451–456.
19. Abler B, Seeringer A, Hartmann A, et al. Neural Correlates of Antidepressant-Related Sexual Dysfunction: A Placebo-Controlled fMRI Study on Healthy Males under Subchronic Paroxetine and Bupropion. *Neuropsychopharmacology*. 2011;36(9):1837–1847.
20. Quaglio G, Lugoboni F, Pattaro C, et al. Erectile dysfunction in male heroin users, receiving methadone and buprenorphine maintenance treatment. *Drug and Alcohol Dependence*. 2008;94(1–3):12–18.
21. Arndt WB. *Gender Disorders and Paraphilias*. USA: International Universities Press; 1991. 394 p.
22. Kirk HW, Weisbrod JOA, Ericson KA. *Psychosocial and Behavioural Aspects of Medicine*. Baltimore and Philadelphia, USA: Lippincott Williams and Wilkins; 2003.
23. Briere J, Kaltman S, Green BL. Accumulated childhood trauma and symptom complexity. *J Trauma Stress*. 2008;21(2):223–226.
24. Lawson KM, Back SE, Hartwell KJ, et al. A comparison of trauma profiles among individuals with prescription opioid, nicotine, or cocaine dependence. *Am J Addict*. 2013;22(2):127–131.
25. Khantzian EJ. The Self-Medication of Substance Misuse Disorders: A Reconstruction and Recent Applications. *Harv Rev Psychiatry*. 1977;4(5):231–244.
26. Aaron T Beck, A John Rush, Brian F Shaw, et al. *Cognitive Therapy of Depression*. New York: Guilford Press; 1987. 425 p.
27. Liese BS, Franz RA. Treating substance use disorders with cognitive therapy: Lessons learned and implications for the future. In: PM Salkovskis, editor. *Frontiers of Cognitive Therapy*. London: Guilford Press; 1996.
28. Albert Ellis, Windy Dryden. *The practice of rational emotive therapy*. 2nd ed. Springer Publishing Company, New York, USA; 1987.
29. G Alan Marlatt, Dennis M Donovan. *Relapse Prevention*. 2nd ed. Maintenance Strategies in the Treatment of Addictive Behaviors. New York: Guilford Press; 1985. 416 p.
30. Miller WR, Westerberg VS, Harris RJ, et al. What predicts relapse: Prospective testing of antecedent models. *Addiction*. 1996;91:155S–171S.
31. Peter M Monti, Damaris J Rohsenow. Coping-Skills Training and Cue-Exposure Therapy in the Treatment of Alcoholism. *Alcohol Research & Health*. 1999;23(2):107–115.
32. Childress A, Ehrman R, Mc Lellan AT, et al. Conditioned craving and arousal in cocaine addiction: a preliminary report. *NIDA Res Monogr*. 1988;81:74–80.
33. Childress AR, Mozley PD, Mc Elgin W, et al. Limbic activation during cue-induced cocaine craving. *Am J Psychiatry*. 1999;156(1):11–8.
34. Robinson TE, Berridge KC. Review. The incentive sensitization theory of addiction: some current issues. *Philos Trans R Soc Lond B Biol Sci*. 2008;363(1507):3137–3146.
35. Hadlock GC, Chu PW, Walters ET, et al. Methamphetamine-induced dopamine transporter complex formation and dopaminergic deficits: the role of D2 receptor activation. *J Pharmacol Exp Ther*. 2010;335(1):207–212.
36. Lawrence AA. Erotic Target Location Errors: An Underappreciated Paraphilic Dimension. *J Sex Res*. 2009;46(2–3):194–215.
37. Nolen Hoeksema S. *Abnormal Psychology*. 6th ed. Boston, USA: McGraw-Hill; 2013. 385 p.
38. Cantor JM, Blanchard R, Barbaree HE. Sexual disorders. In Blaney PH, Millon T, Editors. *Oxford textbook of psychopathology*. 2nd ed. New York: Oxford University Press; 2009. p. 527–548.
39. Dinello FA. Stages of treatment in the case of a diaper-wearing seventeen-year-old male. *Am J Psychiatry*. 1967;124(1):94–96.
40. Kise K, Nguyen M. Adult Baby Syndrome and Gender Identity Disorder. *Arch Sex Behav*. 2011;40(5):857–859.
41. Torkenzy F. *Furries, Babies, and Other Sexual Perversions*. *Adions*. 2002.
42. Wilson GD (1987) *Variant Sexuality: Research and Theory*. UK: Taylor and Francis; 1987. p. 107–111.