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LOVE HURTS. AN OLD CLICHÉ REBORN A PROPOS OF A CLINICAL CASE

DOLORES DE AMOR. UN CLICHÉ RENACIDO A PROPÓSITO DE UN CASO CLÍNICO

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ABSTRACT

Introduction: The spectrum of sexually motivated behaviors is extremely wide, including behaviors that are not biologically reproductive and hold exclusively ludic functions. We refer to the persistent and recurrent patterns of sexual arousal resulting from the exposure to non-normative sexual stimuli as paraphilias, and they are paradigmatic of the broad heterogeneity of human sexuality. Among these, paraphilic infantilism was first reported in the scientific literature by Tuchman and Lachman in 1964. It is characterized by the presence of sexual arousal or pleasure when playing childhood roles or using objects proper of childhood.

Objective: We intend to describe a clinical case, with a focus on the atypical profile of sexual interests and behaviors comprising paraphilic infantilism and sadomasochism phenomena. We also seek to discuss the understanding of these phenomena in the context of the global clinical picture, their nosological framework, and their implication in the psychotherapeutic process.

Methodology: In this study, we present the clinical case of a patient observed in the outpatient clinic of the first author. A targeted literature review was carried out through a bibliographic search in the PubMed database and a selection of reference works in the Sexology field. These data provided a basis from which we develop our clinical discussion of the case.

Results: This article illustrates the case of a patient referred for psychotherapeutic intervention due to an anxious-depressive syndrome. During follow-up, a cluster of sexual behaviors was observed that involved preferential sexual interest for role-playing as a baby, and practices that involved physical suffering, dominance and submission.

Conclusions: Paraphilia is a controversial clinical category. As a broad category, it mirrors the diversity of human sexual behavior and is spread over a spectrum that ranges from nearly normal sexual behavior to being hurtful or destructive to oneself or others. Clinical work with these phenomena requires a special focus on the individualized clinical formulation, with a particular emphasis on the detailed assessment of subjective suffering and the personal and social deficits that underpin it, while taking the cultural context in which it occurs as reference.

Palabras clave: paraphilia, paraphilia in women, paraphilic infantilism, autonepiophilia, sadomasochism, BDSM.

RESUMEN

Introducción: El espectro de conductas con motivación sexual es muy amplio, abarcando conductas que no son biológicamente reproductivas y que sostienen funciones exclusivamente lúdicas. Se denominan parafilias a los patrones persistentes y recurrentes de excitación sexual resultante de la exposición a estímulos sexuales no normativos, y su existencia resulta paradigmática de la amplia heterogeneidad de la sexualidad humana. Entre ellas, el Infantilismo parafílico fue descrito por primera vez en la literatura científica Tuchman y Lachman en 1964 y se caracteriza por obtener excitación o placer sexual a través de la representación de roles infantiles o del uso de objetos propios de la infancia.

Objetivo: Nos proponemos describir un caso clínico, enfocando el perfil atípico de intereses y conductas sexuales que comprenden fenómenos de Infantilismo parafílico y Sadomasoquismo. Pretendemos discutir la comprensión de estos fenómenos en el contexto del cuadro clínico global, su marco nosológico y su implicación en el proceso psicoterapéutico.

Metodología: Se relata el caso clínico de una paciente observada en el ámbito de la consulta de la primera autora. Se realiza una revisión no sistemática de la literatura científica a través de una búsqueda bibliográfica en la base de datos Pubmed y de la consulta de obras de referencia en el área de la Sexología. Se procede a la discusión clínica, basada en los datos presentados.

Resultados: Este artículo ilustra el caso de una paciente, derivada a intervención psicoterapéutica por síndrome ansioso-depresivo. Durante el acompañamiento, se identificó un patrón de respuesta sexual caracterizado por un interés sexual preferencial en representar el rol de un bebé y prácticas que implicaban sufrimiento físico, dominación y sumisión.

Conclusiones: La Parafilia es una entidad clínica controvertida. Una amplía categoría de condiciones, refleja la diversidad del comportamiento sexual humano y se distribuye en un espectro que va desde la conducta sexual casi normal hasta el comportamiento prejudicial o destructivo hacia uno mismo o los demás. El trabajo clínico con estos fenómenos implica especial atención a la formulación clínica individualizada, con énfasis en la evaluación detallada del sufrimiento subjetivo y déficits psicosociales que les subyacen, mientras se toma como referencia el entorno cultural en que se produce.

Keywords: parafilia, parafilias en la mujer, infantilismo parafílico, autonepiofilia, sadomasoquismo, BDSM.

RESUMEN

Introdução: O espectro do comportamento sexual humano é extremamente amplo, incluindo comportamentos que não são biologicamente reprodutivos e que têm funções exclusivamente lúdicas. Denominamos de parafilias os padrões persistentes e recorrentes de excitação sexual resultantes da exposição a estímulos sexuais não-normativos como parafilias, e estas constituem um paradigma da ampla heterogeneidade da sexualidade humana. Entre estes, o infantilismo parafílico foi descrito pela primeira vez na literatura científica Tuchman and Lachman em 1964 e caracteriza-se pela obtenção de excitação ou prazer sexual através da representação papéis infantis ou uso de objetos típicos da infância.

Objetivo: Pretendemos descrever um caso clínico, com foco no perfil atípico dos interesses e comportamentos sexuais, onde encontramos fenómenos que se enquadram nas condições de infantilismo parafílico e sadomasoquismo. Procuramos também discutir a compreensão destes fenómenos no contexto do quadro clínico global, o seu enquadramento nosológico e as suas implicações no processo psicoterapêutico.

Metodologia: Relata-se o caso clínico de uma paciente observada na consulta da primeira autora. Foi realizada uma revisão não-sistemática da literatura científica através de uma pesquisa bibliográfica na base de dados Pubmed e da consulta de obras de referência na área da Sexologia. Procede-se a uma discussão clínica, baseada nos dados fornecidos pela revisão.

Resultados: Este artigo ilustra o caso de uma paciente, referenciada para intervenção psicoterapêutica devido a uma síndrome ansio-depressiva. Durante o acompanhamento, foi observado um conjunto de comportamentos sexuais que envolviam um interesse sexual preferencial por dinâmicas de *role-playing* em que assumia o papel de bebé juntamente com práticas que envolviam sofrimento físico, dominação e submissão.

Conclusões: A parafilia é uma entidade clínica controversa. Nas suas distintas expressões, espelham a diversidade do comportamento sexual humano e estão distribuídas ao longo de espectro que vai desde o comportamento sexual quase normal até ao comportamento prejudicial ou destrutivo para consigo próprio ou para os outros. O trabalho clínico com estes fenómenos implica uma atenção especial à formulação clínica individualizada, com particular foco na avaliação detalhada do sofrimento subjetivo e dos défices psicossociais que lhe estão subjacentes, tendo como referência o contexto cultural em que se produz.

Palavras-chave: parafilia, parafilia na mulher, infantilismo parafílico, autonepiofilia, sadomasoquismo, BDSM.

INTRODUCTION

It has often been said that any object can become a trigger for sexual arousal, but a satisfactory explanation for how this process occurs is still lacking[1]. The strength and persistence of sexual arousal patterns vary, and we do not know what factors influence the likelihood of a sexual interest to become intense and recurrent[1].

The term "Paraphilia", rooting from the Greek *para-* "besides, aside", + *-philos* "affinity, attraction", was coined by the Slavic ethnologist Friedrich Krauss in 1903 to describe the variants of sexual behaviour that did not serve the purpose of procreation[2, 3]. Currently, there is still no scientific consensus for its definition[1], and some authors prefer to use the term "sexual variations"[4-6]. As a functional definition for the purpose of this paper, we define paraphilia as a pattern of intense and recurrent sexual arousal to unconventional erotic stimuli – i.e., that are considered not acceptable by the dominant culture[4].

Paraphilias are spread over in a spectrum from nearly normal sexual behaviour to behaviour that is hurtful or destructive to oneself or others[7]. Efforts to definite it in an any absolute way are disappointing, given the malleability of sexual norms across time and cultures. It follows that it is crucial to consider the cultural context in which they take place[8]. Currently, it is widely accepted that they are not necessarily pathological unless they are associated with significant personal distress or impairment[9].

Paraphilias' definition and diagnostic framework are the subject of a lively scientific and sociological debate, which has been contributing to its conceptual and nosological evolution along the years[1]. The diagnostic classification systems have been accompanying this change. The Diagnostic and Statistical Manual of Mental Disorders, 5th Ed (DSM-5), made the move to distinguish paraphilias from paraphilic disorders, allowing atypical sexual interests to be identified and studied as variants and regarding them as disorders only when they cause distress or dysfunction.[10] Although abstaining from the inclusion of a non-pathological paraphilic entity, the International Classification of Diseases, 11th Revision (ICD-11) got

conceptually closer to DSM-5, asserting that the diagnosis of a Paraphilic disorder requires a "sustained, focused, and intense pattern of sexual arousal as manifested by persistent sexual thoughts, fantasies, urges, or behaviours, the focus of which involves others whose age or status renders them unwilling or unable to consent and on which the person has acted or by which he or she is markedly distressed"[11].

There is no general theory on the origin of paraphilias, allowing the formulation of aetiological models from different perspectives to arise. From a biological perspective, abnormalities in the frontostriatal reward system have been highlighted.[12] Current research also shows that environmental and experience-related factors play an important role. Negative experiences in early socialization and childhood (sexual and physical abuse, neglect, peer rejection, child history of maltreatment) in connection with unsecure attachment experiences might be essential for the genesis of paraphilic interests.[12] Behavioural approaches postulate social learning processes to be etiologically relevant, and these are categorized in three types: participatory model learning (e.g., modelling of the perpetrator following childhood sexual abuse); non-participatory model learning (e.g., exposure to paraphilic practices in pornographic contents); symbolic model learning (e.g. individual imaginative arrangements of sexual impulses).[13]

The maintenance of paraphilic behaviour is mostly explained by mechanisms of positive reinforcement (masturbation and orgasm). Negative reinforcement may also be relevant, particularly in cases in which sexual behaviour is being used to cope with negative emotional states.[14]

Among the diverse category of paraphilias, paraphilic infantilism was first documented in the scientific literature by Tuchman and Lachman in 1964[15]. It is characterised by the presence of sexual arousal or pleasure when playing childhood roles or using objects proper of childhood[16]. The phenomenon is nowadays represented by a sexual subculture called Adult-baby/Diaper Lover (ABDL), with preferential expression in online communities.

To date, there are few published works addressing this phenomenon and they consist mostly of clinical case studies of individuals seeking treatment for reasons other than their atypical sexual interests[17-20]. We find a noteworthy contribution to our understanding of this condition in the work of Zamboni et al.[21], who conducted an exploratory study with the purpose of providing descriptive information on the ABDL population using a large community sample. The authors extracted data supporting that[1] ABDL phenomena were diffuse mostly among males, who represented 93% of the sample;[2] ABDL community consists of at least two subgroups with differing characteristics, namely the adult-babies (those who derive sexual pleasure through role playing as infants) and the diaper lovers (those who wear diapers for sexual arousal);[3] there is a significant relation between negative mood states and adult-baby role-play enjoyment, suggesting that role-playing could be used as a strategy to help some individuals decrease negative mood states;[4] the majority of the sample did not experience distress for the ABDL behaviours, was generally comfortable with the sexual practices and had no increased risk of psychopathology and[5] therapy is indicated only when the atypical sexual features represent personal distress or impairment in an important area of life.

METHODS

We present the clinical case of a 20-year-old female patient observed in the outpatient clinic of the first author. We carried out a targeted review of the scientific literature through a bibliographic search in the Pubmed database using the terms "paraphilia", "paraphilic disorder, "paraphilic infantilism", "adult baby syndrome", "autonepiophilia", "BDSM" and "sadomasochism". We also reviewed a selection of reference works in the field of sexology, based on a knowledgeable selection of these. These data provided a basis from which we develop our clinical discussion of the case.

RESULTS

CASE DESCRIPTION

Identification

The present report describes the case of a 20-year-old female patient in her first contact with mental health services. She was single, with no children and had completed secondary school. She was natural from a city in northern Portugal, where she lived with her parents and one sister, a lower-middle class household. At the time of observation, she had a temporary part-time job.

Reason for referral

She initially presented to outpatient clinic, referred by her general practitioner, with a depressive syndrome and with

4-year evolution and antecedents of self-injury. She was offered psychopharmacological and psychotherapeutic treatment in day hospital.

Patient's background

She had no knowledge of particular adversities, stressors or diseases during early childhood and school-age.

In her adolescence however significant relational stressors started to surge. She reported an abusive episode when she was 11 involving a 4-year older cousin, in which he leaned her against a wall and put his hands inside her clothes, touching her genitals. She experienced these approaches as unwanted, feeling shame and embarrassment.

She recalled relational difficulties with her father starting in early adolescence. The relationship became conflictive and hostile, leading to frequent physical aggressions. The content of the discussions focused mainly on the father's control behaviours over her. While she asserted that the frequent alcohol abuse from her father's part was the most determinant factor in this dynamic, she considered she played an active role in the arguments, associating it with a generalised rebellious attitude and frequent displays of temper.

She said that she had her first sexual intercourse at the age of 14 with a school friend 4 years older with whom she was dating for a few weeks, stating that, although there was no explicit coercion, she felt pressured in the specific situation. She explained that after this sexual relationship, the boy stopped contacting her with no explanation and exposed the sexual encounter to the school community, which made her feel despised and humiliated.

At the age of 15 she started her a relationship with a boy of the same age, which continued for 4 years. She depicted a very unstable, tumultuous, on-and-off relationship, with frequent displays of temper from both sides. She defined him as manipulative, controlling and aggressive. She considered that, as a legacy of this experience, she started associating the feeling of being loved with controlling conducts from her partners ("I expect a lot from the person who is with me, he was obsessed with me and I now think that if they like me, they also have to be obsessed, there is no in-between, they have to be 100%" sic).

During these years, she started to develop depressive and anxious symptoms and engaging in self-injury behaviour (self-cutting her wrists) that she used as a relieving mechanism for her emotional suffering, denying suicidal ideation.

Yet, she managed to keep adequate social and academic functioning until about one year ago, when she left school. Indeed, she described herself as a lively, easy-going teenager and popular in her peer group, somehow being able to dissociate her subjective distress from the social roles she assumed.

Regarding family history, father's history of a psychiatric admission at a young age, around 20 years old, stands out. In this regard, she does not know any further details.

She denied any relevant medical or surgical antecedents.

Present clinical state

At the time of observation, she reported worsening of the depressive and anxious symptoms for the last year, in which general loss of interest, a lack of future prospects, social isolation and feelings of self-worthlessness and hopelessness stood out. Self-injury behaviour had remitted for two years.

She also reported enduring feelings of emptiness and a general unstable sense of self that had been present for the last 4 years ("My feelings literally change like the wind...I switch so much between my thoughts...I don't actually know how to define myself" sic). Anxiety symptoms were also reported, described as a tense and hypervigilant state present during most of the day and in the context of which illusions were also arising (perceiving human figures in the dark as a threatening stimulus). She was experiencing brief episodes of depersonalization about once a week, where she suddenly felt detached from her body and thoughts, with no apparent precipitating factor.

Regarding current family dynamics, she reported a poverty of emotional content in communication. She considered that currently the confrontational situations with her father were less troublesome, in the sense that they did not evolve into physical violence. However, she described his behaviour as erratic and unpredictable and her mother's as usually passive and emotionally detached.

She presented an athletic morphology, usually wearing practical and comfortable clothes, with sportive style, long loose hair and adequate body hygiene. No disturbances of motor activity were documented, keeping an agile attitude.

Her posture during the observation was defensive, with arms tight against the body. Facial mimic was lively and expressive, establishing a collaborative but anxious rapport, with fleeting eye contact.

The mood was depressed, with predominant feelings of self-worthlessness and a negative vision of the future and the outside world.

Speech was spontaneous and fluid, with a note of authenticity, coherent, organized, with content polarised on personal conflictive experiences, becoming more abundant according to the associated emotional charge, but interruptible. Appropriate tone and timbre, with expressive vocal inflections. The underlying thought had no formal disturbances and was polarized towards contents of negative tonality. Subjective sensation of slowing of time was reported.

Her intelligence was estimated to be average to above average. There was no evidence of actual psychotic disorder or gender dysphoria.

She exhibited critical judgment regarding his psychic suffering, feeling the need to seek medical attention.

Sleep was fragmented. No alterations in appetite and weight or loss of libido.

Description and analysis of the condition

During her follow-up, a pattern of atypical, intense, and persistent sexual preferences was identified. It involved two types of sexual stimuli: infantilist elements (role-playing as a baby) and masochistic practices (being subjected to physical pain by her partners').

She stated that her interest began when she was 15 years old and assigned their origin to her relationship with her first long-lasting sexual partner, when he proposed practices in which she played the role of a baby. Later on, sadomasochistic practices were also introduced, in which she assumed a submissive role. Their sexual rapporteur progressively became restricted to these practices.

She described that usually she entered a very regressed role, in which she would not communicate in words and only vocalized moans mimicking those of a baby, crawling on the floor, thumb sucking while being held and rocked, drinking from individual milk cartons and from baby bottles and playing with child toys. She dressed up in accordance with this role, having her hair done in two side braids, using a soother and appropriate make-up. Initially, he assumed a position of command complementing this role as a caretaker. Then, while she kept a submissive role, he would become more aggressive, slapping her in the face and punching her on the body.

The patient reported having three longstanding sexual partners at the time of the follow-up, who had been her boyfriends and exclusive partners in the past and with whom she maintained an affective bond. She mentioned having shared and suggested infantilist and masochistic practices to these partners. They refused to comply to the adult-baby role-playing and reacted with disapproval and dispite, relating it to paedophilia, which she described as a negative aspect and source of dissatisfaction that eventually weakened the affective bond of her relationships. However, two of them adhered to sadomasochistic practices after her appeal.

Regarding current sexual dynamics, she claimed that she never takes the initiative to start sexual activity with these partners. During the initial caresses she reported experiencing desire and excitement but had little pleasure during coitus. Sometimes she suddenly interrupted the sexual act or else consents to it "out of pity" (sic). She reported feeling uneasy in the resolution phase, referring shame and "feeling used" (sic).

She kept her "adult-baby" interest alive by keeping a soother for adults and childlike costumes at home, along with other objects such as small milk packages, that she used to take pictures and post on social media, on a specific account she kept for this purpose.

She occasionally had sexual encounters with men she knew in this context and who shared this preference with her, reporting unprotected sexual intercourse. She reported that these experiences were satisfying, as the strength of arousal and pleasure she got were comparatively higher and more constant throughout the sexual act, unmatching those she got from other type of stimulus.

These preferences were essentially bound to a dyadic interpersonal dynamic and had little autoerotic extent. Remarkably, she revealed that she never had interest in solitary masturbatory activity, mentioning that she felt uncomfortable in the few experiences in this sense and did not use adult-baby fantasies to feel aroused in a solitary context. She rejected the hypothesis of this behaviour be acting as a soothing factor to negative emotional states.

The interest in playing the role of baby was limited to the sexual sphere.

Also, she assertively denied any sexual attraction or interest in children as well any believes that her preferences could be linked to paedophilia, and this was not a personal concern for her.

However, her description was hued with feelings of shame from her perception of the social judgement and disapproval towards these behaviours, namely from the part of her partners. During her follow-up she stated that she had no wishes to change this condition and she did not consider changing this aspect of her life.

The diagnostic evaluation and monitoring were based on clinical observation.

Because of the pervasive and enduring pattern of malfunctioning, present in various contexts of her life, we regarded personality disorder as the primary diagnosis. The pattern of unstable and intense interpersonal relationships alternating between poles of idealization and devaluation, marked reactivity of mood, unstable sense of self, presence of chronic feelings of emptiness, existence of persistent dissociative symptoms and frequent displays of temper, was consistent with Borderline Personality Disorder. In association, we distinguish a Major Depressive Disorder with anxious distress, characterized by the combination of depressed mood, anhedonia, loss of pleasure and interest, feelings of worthlessness, diminished ability to concentrate, feeling tense and in a perduring hypervigilant state, and accounting for the impairment in social functioning observed in the previous year.

Intervention

This patient was offered pharmacological treatment, which consisted of escitalopram in dose escalation up to 20 mg id. Simultaneously, an individual psychotherapy process was initiated, based on cognitive and dialectical behavioural techniques. Family sessions were also proposed, but refused by the patient, as she was not willing to disclose her contact with the mental health services to her family.

The psychotherapeutic treatment took place in weekly sessions. The first phase of treatment (first two weeks) was directed at building an initial therapeutic alliance, creating engagement, and allowing for roles to be defined and therapeutic goals to be established. These were identified as: reduce distress and anxiety symptoms, improve intimate relationships with a reduced sense of dependency and being able to resume a course of study. During a second phase (from third week to third month), we moved to consolidating the therapeutic alliance and provide supportive interventions, offering validation and reassurance. During the third phase (up to the sixth month), we focused on developing emotional regulation strategies, identifying cognitive distortions, and helping replace them as well as finding other sources of structure, according to the goals defined at the beginning (she started a technical course on veterinary). During this phase, we had the opportunity to make what we had intended to be our first approach to the sexual function. We addressed sex educational aspects such as the use of condom. We provided information on paraphilia and helped detangle the concepts of *atypical* and *pathological* sexual patterns, aiming at destigmatizing the paraphilic interests and reducing the shame that hued her experience and providing information. Also, we could identify automatic negative thoughts, in particular thoughts of withdrawal, such as "when does it finish?", and thoughts of abuse, such as "the only thing he wants is to satisfy himself". She was not willing to address paraphilia as a therapeutic goal and declined when we offered to help her expand her sexual behaviour, but we consider that this intervention may indirectly have contributed to make her sexual interest less fixated and less exclusive on the paraphilic elements and, thus, to a healthier and more satisfying way to experience sexuality.

Along the follow-up, the patient reports were consistent with an improvement in the distress and anxiety symptoms, overlapping with our objective observation. She resumed a professional course in veterinary, which she valued as a fulfilling step and important in acquiring autonomy from her family

After this stage, the therapeutic process concluded because the patient eventually dropped out in the sixth month of treatment.

Discussion

The case presented here raises a discussion on multiple aspects of psychopathological interest. It meshes together developmental, personality and clinical aspects and prompts a reflection on the role of traumatic experiences and history of abuse in the development of personality and psychopathologic symptoms, the reciprocal interaction between relational disturbances and individual suffering and the influence of personality variables on the patterns of information processing and sexual response. For the scope of this work, we will give more emphasis on the features that are more closely related to sexology in our discussion.

The pattern of sexual response described has the characteristics of a paraphilia: there is an intense and persistent sexual interest in a situation of atypical nature (9). We know that paraphilias are not necessarily pathological, and there is currently scientific consensus in this respect (9, 10), so the clinical assessment must include a set of criteria that help determine its pathological or non-pathological nature, which we discuss below.

In a move intended to depathologize unusual sexual interests, the DSM-5 introduced a distinction between paraphilia

and paraphilic disorder. It refers to the former as any intense and persistent sexual interest other than interest in genital stimulation or consensual preparatory caresses with phenotypically normal, physically adult human partners, while Paraphilic disorder implies that at present this pattern causes distress or impairment in the individual or whose satisfaction has occasioned personal harm or risk of harm to another. Thus, paraphilia is a necessary but not sufficient condition for the diagnosis of paraphilic disorder. It does not, by itself, justify clinical intervention[10, 12].

ICD-11 contemplates only paraphilic disorder as a diagnostic entity. This is characterised by persistent and intense atypical sexual arousal patterns manifested by thoughts, fantasies, impulses or behaviours involving others whose age or condition renders them unable to give consent and/or in which the person performing the act feels deeply disturbed. Paraphilic disorders may involve solitary behaviours or consensual individuals, associated with marked disturbance other than just experiences of rejection by others, or with significant risk of causing injury or death.[11]

In the case presented, the patient's reports denote the existence of subjective suffering. The dissatisfaction experienced by the patient regarding sexual life with current partners and the disturbance in intimate relationships are explicit. However, establishing a causal relationship between this pattern of sexual response and the symptoms is problematic. Other elements, in particular the depressive-anxious symptomatology, the dysfunctional personality structure or affective immaturity are, in our point of view, better candidates to explain these experiences and contribute more strongly to the distress than the sexual interests proper. Per contra, although we can find evidence of a direct association between negative mood states and uncontrolled sexual behaviour in the literature[4], the involvement in risky sexual behaviour, such as unprotected sexual activity with multiple partners, seems to be directly related to the paraphilic condition and brings it closer to the pathological pole. Obviously, the simple change of this behaviour could change this configuration and was an important objective of the intervention.

Hanson[22], in a paper in which he elaborates on the dimensional conceptualisation of paraphilias, states that the ideal number of dimensions to describe paraphilias is not known, but will probably include aspects such as 1) sexual self-regulation (i. e. the ability to manage sexual thoughts, feelings and behaviours in a way that is consistent with self-interest and that protects the rights of others), 2) extent of atypical sexual interests (i. e. the position within a continuum comprised between the co-existence of multiple paraphilias and exclusive interest in "normative" sexual behaviour) and 3) overall intensity of sexual desire and expression (a more ambiguous concept - Hanson proposes, and the authors of the article agree, it be defined as the degree to which sexuality consumes resources that might otherwise be devoted to other productive activities). These are dimensions for which instruments have been developed, respectively Compulsive Sexual Behavior Inventory[23], Clarke Sex History Questionnaire[24] Sexual Excitation/Sexual Inhibition (SIS/SES) Questionnaire[25]. These instruments were designed for the male population and lack adaptation and validation for the Portuguese female population. Working in this sense would make the assessment of these patients more objective and complete.

Studies on the natural history of paraphilias show that deviant sexual behaviour often begins in late adolescence or young adulthood and that its onset is often marked by deviant sexual fantasies associated with masturbation[26]. It is also considered that paraphilia[7], including infantilism[21,27], is mostly a male disorder (90 to 99% of cases), except for masochism where the women represent the majority[28].

These data make the report of this case very relevant. Firstly, because paraphilic infantilism arising in a woman has been shown to be a minority phenomenon. On the other hand, the characteristics of the longitudinal history of the paraphilia in this case, apparently independent of solitary masturbatory activity but associated with dyadic activity with a partner, is noteworthy. We did not find any studies addressing the natural history of paraphilias in the female population, but this case challenges the analysis of this topic, focusing on the differential aspects between genders in the natural history of paraphilias.

Regarding the patient's biographical history, she denied adverse relational factors during her early development, although we cannot rule them out with certainty, especially attending to the lack of collateral information from another member of the family. Starting from her pre-adolescence, we find elements of psychological and physical maltreatment present in the relationship with her father, a climate of emotional neglect in the family and episodes of interpersonal violence in the relationships with her previous partners. Research shows that the presence of these negative experiences during early development may have etiological value in

the development of paraphilias, but no evidence is found for the influence of these during later stages of development, as in the present case. Still, we hypothesize that participatory model learning stemming from these experiences could account for the patient's unusual sexual interests.

We also would like to address the co-existence of paraphilic infantilism and sadomasochistic practices in this case. Some researchers have been finding an association between these practices (29). In fact, the Diagnostic and Statistical Manual of Mental Disorders, 4th Ed., pointed out in this direction: "sexual masochists may have a desire to be treated like a helpless infant and clothed in diapers" (30), but such reference was suppressed in its most recent edition. In this regard, Wilson presented an interesting hypothesis, in which he proposes that paraphilic phenomena would be the result of an imprinting process. Viz, sexual preferences would be affected by learning at a very early stage of development, usually taking parents as a model. The disciplinary practices and care exercised by parents in early development would produce the link between pain, humiliation, infantile scenarios, and sexuality[31]. Although the co-occurrence of two paraphilias in the same individual is not unusual[32, 33], we understand that the coexistence of these two dimensions in this patient is better conceptualised as different manifestations of the same core condition. Viz, being subjected to physical pain and humiliation and the adult-baby role-playing would serve the same purpose and derive their pleasure from the same core element - that of being under the control of another person.

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