Adult Baby – Healthy Personal Identity or Psychosexual Disorder?

Summary:

Being a regressive adult baby can be considered either (a) a personal identity or (b) a psychosexual disorder. This article makes the case that being an adult baby is a *personal identity* – psychologically healthy if internal conflicts are resolved. However, standard psychological practice and texts treat being AB as a psychosexual disorder, a fetishistic paraphilia. The difference matters greatly – especially if a regressive AB seeks counselling.

A case study from a respected textbook on psychotherapy is used to illustrate the differences in these two views of adult babies. It shows the harm caused by treating being an adult baby as a psychosexual disorder. The article is also intended to assist (a) regressive adult babies select a therapist or counsellor and (b) therapists counselling regressive adult babies.

This article can be read alone, but is best read in conjunction with the book 'Becoming Me – The Journey of Self-acceptance: A Guide for Adult Babies Traversing Life' (www.abdiscovery.com.au 2018).

Adult Baby as a Personal Identity

There are strong grounds to consider that being a regressive adult baby is a personal identity, in a similar way that being lesbian, gay, bisexual, transgender or queer is a personal identity.

Regressive Adult Baby is a term originated by Rosalie and Michael Bent and it describes adult babies who have a baby persona with feelings and needs that must be recognized and met for the AB to live happily, without distress and disruption.

The baby persona of a regressive adult baby is a sub-personality construct or alter-ego. It co-exists with the adult personality as part of the person's identity. The baby persona is not an autonomous personality in the sense of Dissociative Identity Disorder. The baby persona has feelings and needs which are distinct from the adult personality, although those feelings and needs are ultimately those of the person concerned. A regressive adult baby will often give their baby persona their own name. It is not uncommon for male regressive adult babies to have a female baby persona.

Regressive ABs can be distinguished from other Adult Babies or Diaper Lovers (ABDL) for whom diapers, baby clothes or baby activities are an optional extra they can freely live without if they so choose, and/or those for whom these things are a fetish confined exclusively to sexual arousal and expression. This article is concerned only with Regressive Adult Babies. Most adult babies do however, have an element of regression and some, an extremely high level of it.

Regressive adult baby can be considered to be a personal identity (not a disorder) on two key grounds –

(1) it is an innate and permanent feature of the person's psyche AND,

(2) in the absence of internal conflict and external prejudice, is a psychologically healthy and sustainable expression of the person's psyche.

As an innate part of the psyche, being a regressive adult baby is beyond the conscious choice of the person. It's pretty much impossible to consciously choose *not* to be a regressive adult baby if you are one. Many adult babies can trace their first consciousness of liking nappies or

wanting to be babied, back to their earliest childhood recollections. For regressive adult babies, this is commonly well before puberty and clearly didn't start out as a fetish.

To be a personal identity as opposed to a disorder, it is not sufficient that the trait is permanent. Personality disorders are also commonly permanent – that is long standing and unlikely to change. To be a personal identity, a trait must also be psychologically healthy and sustainable. By psychologically healthy, I mean that it is an identity compatible with being a responsible, loving and creative adult able to sustain positive personal relationships, meet their personal and social obligations, work, play and express personal creativity. By sustainable, I mean that the person sustains this identity by and for themselves and is not dependent for sustaining the identity on others – though they can choose to share themselves and their identity with others. This is important, as otherwise, this trait is a form of psychological dependency.

I consider it most likely that regressive adult babies developed this identity as a result of unmet needs and buried emotions resulting from an insecure attachment between the AB as a actual baby and their mother (primary caregiver). As Attachment Theory suggests that around one third of the population has an insecure attachment, this is not too much of a stretch. I don't know why only a few of the many children with insecure attachments go on to develop adult baby identity. That doesn't invalidate the proposition.

The same is true of other personality types, for example people with clinical Attachment Disorder – they are all likely to have had insecure attachments as children, but not all children with insecure attachment have Attachment Disorder. There is a possible explanation in that the exact configuration of the internal working model by which a child internalizes their attachment pattern is a highly individual matter – mediated by the perceptions and unconscious choices of each individual. Compared to some other identities or personality traits which might have resulted from an insecure attachment, the adult baby identity keeps the symbols of infancy and its unmet needs, nappies etcetera, very much in view.

So how does locating the source of the regressive adult baby identity in an insecure attachment between a young child and their mother help?

Firstly, by validating that the original wound – that is the unmet infantile and child-like needs for comfort and safety – is real. The regressive adult baby is not mad or indulgent. The regression to the stage where the insecure attachment happened is understandable.

Secondly, Attachment Theory recognizes that an insecure attachment is not fixed. Through various mechanisms, including therapy or a good marriage, a person can change the internal working model that shapes their present and future relationships, and in adulthood they can move from an insecure to a secure attachment. In short, healing is possible. A person who had an insecure attachment as a child cannot 'wipe that slate clean', but they can heal (or at least make peace with) the wounds that damaged themselves and their lives.

Thirdly, Attachment Theory points to the particular emotions and unmet needs that require healing. An insecure childhood attachment arises because the mother did not respond appropriately, to the child's fear and rage about everyday separations, or because of an unmet need. In turn, the child learned to suppress their rage – to fear and deny their own negative emotions. They learned not to trust themselves or others. However, in conflicted regressive adult babies, that fear and rage is still there, buried. Mostly, it is turned against the adult baby themselves – in the form of scourging internal conflict and self-sabotaging behaviours.

It is true that being a regressive adult baby is an identity that can be associated with disruption and distress in one's life. And this is likely to be the way that regressive adult babies present to therapists and counsellors. It is also important to not determine that simply being a

regressive adult baby is in itself a disorder or source of significant distress. A common problem with therapists is to make that assumption because they only deal with Adult Babies who present with disorder or distress. Many, many Regressive Adult Babies function well and safely without such disorder or distress.

It is important to recognize that this disruption and distress is not intrinsic to the identity, but is a product of two factors –

a. internal personal conflict and difficulty in self-acceptance

b. the rejection, fear and prejudice of others and any associated detriment or feared detriment

The internal conflict can be savage in its intensity. For a discussion of the sources and resolutions of internal conflicts for regressive adult babies, see the book 'Becoming Me' cited above. Driven by this internal conflict, many adult babies have struggled to accept themselves and periodically tried to set aside their nappies and adult baby clothes. Mistakenly thinking of their identity as an addiction, like alcoholism, they have tried to adopt solutions based on abstinence. We know this always fails.

As with other LGBTQI identities, if the regressive adult baby's internal conflict is resolved this personal identity is healthy and sustainable. The healthy adult baby identity includes not only the baby persona, but a nurturing Inner Parent, and a strong, responsible and compassionate adult self. The latter is the custodian of the person's self-acceptance and ensures the baby persona is only shared safely and appropriately with other parties. As with other personal identities, full self-acceptance is associated with enhanced confidence, security, resilience and creativity.

A regressive adult baby is a non-'vanilla' personal identity, so therefore fits into the LGBTQI (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex) category. It is perhaps a Queer identity as this seems to be a catch-all for any non-vanilla identity and allows that it can be combined with any of the sexual preferences/identities – heterosexual, lesbian, gay or bisexual. ABDL really does need its own category however.

It is important, and confronting, to recognize that this is not how most people and perhaps many therapists and counsellors see regressive adult babies.

The worst fear for many adult babies is that this identity will be conflated with paedophilia. Adult babies don't have a sexual interest in children – they want to (re)experience being babies or children themselves. However the prospect of having to explain this distinction, potentially in an emotionally charged context, either for the individual or as a matter of public debate, is daunting.

Fortunately, in recent years there has been a growth in public knowledge about adult babies so that the risk of it being conflated with pedophilia is reduced. It is likely that some of this exposure is driven by sensationalist and salacious interest in what is seen as a 'kinky' sexual practice, and knowledge is not synonymous with understanding or acceptance.

This was exactly the situation that confronted me when I happened to recently pick up one of my wife's textbooks on psychotherapy when reading on another topic. (My wife is an experienced psychotherapist).

The Textbook Case Study

The textbook is the 'Oxford Textbook of Psychotherapy' (editors Glen Gabbard, Judith Beck & Jeremy Holmes). It is a mainstream text published by Oxford University Press. On amazon.co.uk the publisher's 'blurb' states the following –

With the publication of this book, psychotherapy finally arrives at the mainstream of mental health practice. This volume is an essential companion for every practising psychiatrist, clinical psychologist, psychotherapy counsellor, mental health nurse, psychotherapist, and mental health practitioner. … The first of its kind, this is a 'must have' volume for all trainee and practising psychological therapists, whatever their background - psychiatry, psychology, social work, or nursing.

The textbook was first published in 2005 and from the above, still appears to be current. It references the 2000 edition (DSM-IV-TR) of the Diagnostic and Statistical Manual of Mental Disorders, the standard diagnostic tool published by the American Psychiatric Association (APA). This was superceded in 2013 by the DSM-5. However, the latter still treats being an adult baby as a paraphilia.

The textbook doesn't conflate adult babies with paedophilia. However it is only step beyond that. It categorizes being an adult baby as a paraphilia. At the introduction to Chapter 17 on paraphilias the textbook explains -

Paraphilias are psychosexual disorders in which the individual experiences recurrent, intense sexual fantasies or urges to engage in unusual or unacceptable sexual behavior. To quality as a psychiatric disorder according to the diagnostic criteria of DSM-IV-TR (Diagnostic and statistical manual of mental disorders, 4th edn), the behaviours, sexual urges, or fantasies must 'cause clinically significant distress or impairment in social, occupational, or other important areas of functioning' (American Psychiatric Association, 2000, p566). … The most commonly diagnosed paraphilias listed in alphabetic order in DSM-IV-TR are : exhibitionism, fetishism, frotteurism, pedophilia, sexual masochism, sexual sadism, transvestic fetishism, and voyeurism. …

Adult babies are lumped together under the same broad category as flashers, gropers, paedophiles and peeping toms! To be fair, all 'kinks' would be in the same category. Still, it's indicative of a mindset. A generation ago, all the LGBTQI identities were lumped in this category too*. (I believe that, partly, it was Rosalie Bent's concern and outrage at adult babies being labelled as a psychosexual disorder, that caused her to write her landmark book 'There's A Baby In My Bed: Learning to Live Happily With the Adult Baby In Your Relationship' in 2012. Thank God she did because it kicked off understanding adult babies as a healthy personal identity.)*

Again, to be fair, the chapter introduction includes the follow caution for therapists –

Human sexuality is diverse and complicated. Practitioners must always remember that many individuals with unusual sexual fantasies, interests, or practices do not experience significant distress or impairment, and must be careful not to pathologize the diversity of human sexuality.

Unfortunately, the case study of a person we would recognize as a regressive adult baby does demonstrate how this identity IS pathologized. It also illustrates how the subsequent treatment based on this pathologized understanding is likely to have caused significant harm.

The case study is introduced as follows -

Case example: relapse prevention

Tom was a 32-year-old attorney whose marriage had recently been jeopardized by his wife, Joan, after finding several inexplicable changes to their credit cards totaling $480. She confronted him with the bills. At first, he said that there must be some mistake and that someone must be using his credit card number. But his wife persisted and eventually Tom admitted that he had been visiting the website 'babe-in-arms.com' and also a local massage parlor for the past 6 months and

using them for sexual gratification. It did not help that during these 6 months, Joan was caring for their newborn daughter, their first child. Tears flowed from both.

Upon his wife's insistence, but with agreement from him in order to save the marriage, Tom began both individual and group therapy. … Tom admitted that he longed to be treated like a baby by his sexual partners and had in fact visited massage parlors that catered to this desire. He found it very arousing to imagine being cleaned and diapered by a woman. His experience in vivo was limited to being in diapers: being verbally scolded for soiling them and engaging in noncoital cuddling. Apparently, the scene of his wife changing the diapers of his daughter brought back sexual fantasies that had long lay dormant. he admission of this paraphilic arousal pattern was very embarrassing to Tom, but he also admitted relief that his secret was now shared with others who he had found on the internet. The group responded with support, and to the best of their abilities, understanding.

My first response, as I am sure is the reader's, is deep compassion for Tom, his wife and his baby daughter. This is an awful situation for all three. The birth and care of a child is not a good time to deal with the deep and confronting personal and marital issues associated with being 'outed' as an adult baby. This is particularly so with a partner who evidently had no prior knowledge of this deep seated and long-standing identity.

It is almost certain that Tom is a deeply conflicted regressive adult baby. He is living a double life. On the one hand, he is establishing his career in a private law firm – a notoriously competitive environment. He is likely to be concerned to be the employee and person that he is expected to be. Yet, inside he is driven by a deep need to experience being cared for and nurtured as a baby; a need he clearly doesn't understand and is deeply ashamed of. When he presents for therapy, that need is a compulsion. It is so great that he is willing to put his marriage and likely his career at risk. The case study refers to his fantasies as long-dormant. What we know, and the textbook doesn't, is that these fantasies and the needs which drive them are likely to have been present since childhood and persistent through his life ever since. Dormant?

I suspect, in a climate of judgement and effectively 'shaming', Tom may not have volunteered the persistent and ongoing presence of his fantasies. I further suspect, given the risk of his visits to the massage parlor being discovered from his credit card statement, that Tom was at the peak of a binge and purge cycle, specifically the binge part. *(For a discussion of binge and purge cycles see 'Binge and Purge: the ABDL Frustration' on abdiscovery.com.au under the ABDL Articles tab)*. He would have been caught in gut-wrenching internal conflict with a maelstrom of self-loathing, shame and remorse. Very likely, that conflict would include a self-sabotaging impulse to be punished for his need for nurturing, and having acted on it, as well as a positive cry for help and recognition of that need.

Tom's behavior and distress meet the diagnostic criteria of the DSM-IV for a paraphilia in that 'the behaviours, sexual urges, or fantasies must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning'. The therapist would have been satisfied that Tom's case was a fetishistic paraphilia.

Based on the subsequent treatment plan, the therapist evidently identified three grounds for therapy –

1) Tom's compulsive behaviours – he does not have control over his impulses and actions and at the peak of his compulsion is behaving like an addict seeking 'a fix'

2) Tom's infidelity to his wife in visiting massage parlors, and the issues for his marriage related to his behaviours and his need for nurturing

3) the obstacles that Tom's distress poses for him being the father his baby daughter needs, and that he wants to be for her

Each of these are grounds that merit and necessitate therapy.

So let us see how therapy progressed. The case study continued -

The methods used in both Tom's individual and group therapies were cognitive-behavioural. Especially helpful was his recognition of the envy he felt at the attention his wife gave to their newborn. He replaced thoughts of sibling envy with the correct thought that this was his daughter and she was entirely dependent upon him. Behaviourally, he countered this envy by helping his wife care for their daughter. What Tom was surprised to learn was that the more he cared for his daughter, including changing her diapers, the more he felt love for his daughter and a grateful love from his wife for sharing the child-care.

With treatment and the threat of divorce, the behaviours of utilizing the website and going to the massage parlors ceased immediately. After 9 months of treatment, even the infantilism fantasies had decreased in frequency and intensity. For 6 months he had not masturbated to the thought of his being cared for like a baby. Tom considered his problem a sexual addiction, and in addition to therapy, attended group meetings of Sex and Love Addicts Anonymous (SLAA). He felt when therapy was concluded, he could continue to attend the 12 step group for the support and program it gave to his 'sobriety'.

Based on an understanding that Tom is a conflicted regressive adult baby, we can see that the therapy included a mix of good and negative elements – unfortunately mostly the latter.

The positive and appropriate components of the therapy include –

a) Tom disclosing his envy of his daughter and becoming more engaged, alongside his wife, in the care and nurturing of his daughter

b) him ceasing visit to massage parlors (which would have fueled his internal conflict about being an adult baby)

By contrast, the harmful features of the therapy are fundamental. They include –

i. identifying Tom's issues exclusively as a sexual addiction, that is an exclusively negative trait – a fetishistic paraphilia – thus precluding a therapeutic exploration of its source or the possibility of disclosing a positive personal identity beneath the internal conflict and compulsive behaviours

ii. failure to address Tom's deep need for nurturing and any healing of the wounded inner child hungry for that nurturing

iii. failure to address the savage, harmful and dysfunctional internal conflict associated with being a regressive adult baby

iv. basing a long-term solution solely on maintaining abstinence in a manner akin to a drug addict - essentially the solution is based on, and relies on a denial of, any ongoing needs for nurturing or a positive personal identity as an adult baby

The failure to recognize Tom's need for nurturing is incomprehensible and reprehensible. He is desperately acting in the most obvious fashion on a deep-seated need to be nurtured and this forms no part of the therapeutic diagnosis or treatment! Tom was diagnosed as having a sexual fetish, ignoring the glaring fact that the culmination of this 'fetish' is described as 'non-coital cuddling' with a mother-substitute!

The case study illustrates the need for care regarding a malign alliance between an unwitting therapist and the conflicted regressive adult baby's punitive Inner Parent. The latter is seeking to punish and exile the adult baby's wounded Inner Child – locked away 'out of sight and out of mind'. An adult baby in crisis or distress will be desperate for help, likely deeply shamed and remorseful, with their punitive Inner Parent in the ascendant.

The treatment program largely reflects the worst errors and gaps in the therapeutic approach. The case study continues -

Tom recognized that it was important for him to establish a relapse prevention program (RPP) to employ for the post therapy future. … This is the RPP that Tom and his therapist developed:

1. Identify risk states before sexually acting out: negative emotions, like being ignored by my wife; being criticized by partners or clients at work; feeling ineffective or lonely; being bored. Feeling that I deserve a reward and to be cared for.

(a) What I can do instead: use the … Daily Mood Log and Cognitive Distortions Checklist. Do something positive and fun for myself – rent a DVD, buy a CD, take my wife out to dinner; get more involved in caring for and playing with my daughter. Don't be a PIG (problem of immediate gratification)!

2. Recognise Seemingly Unimportant Decisions (SUDS) that place in high risk situations: carrying extra cash beyond what I would need; driving by areas where there are massage parlors; leaving work early for 'unaccounted for' time; being in a private area at home with the computer.

(a) What I can do instead: never carry more than 15 dollars. Do not carry an ATM card; carry only one credit card, which wife pays the bill for each month. Post picture of wife and child in prominent place on car dashboard. Work out and map alternative routes so that never have to drive by high-risk areas. Call wife before leave to establish time record if feeling tempted to drive by risky areas. Look at relapse prevention card (carry in wallet). Move the computer to a room into which privacy is not given and face the screen toward the entrance door of the room.

3.Avoid lapse in thoughts or behavior: thinking about past experiences with massage parlor women or images and chats on the internet. Masturbating. Driving near areas where massage parlors are located. Reading the ads for sexual services in the newspaper.

(a) What can I do instead: talk to SLAA sponsor, attend extra meetings. Call therapist to discuss. Substitute a positive activity such as a regular exercise program.

4. Relapse: surf on the internet for sexual sites. Go to massage parlor.

(a) What I can do: remember that this is not the end of the world. I can be sober. Don't give up hope!! Go to SLAA meetings and therapy sessions.

This treatment approach contains significant harmful elements, including -

i. It is based on the denial of the underlying needs for nurturing (renting a DVD or buying a CD is not a substitute for nurturing).

ii. It is predominantly based on abstinence – a pass/fail model of sobriety along the lines of alcoholism - and in light of the other failures in the therapeutic approach, this is bound to fail given the ubiquity of access to the internet etc.

iii. The behavioural management techniques – in terms of cash, credit cards and citing of the computer - deepen Tom's mistrust of himself (exacerbating a negative trait which was an outcome of the original insecure attachment/ childhood wound). By giving Tom's wife oversight of his behavior, it also creates a co-dependency which will have a corrosive longer-term effect on the marital relationship.

iv. An apparent proscription on masturbation which is unsustainable (to be fair, this may not be the intention of the abbreviated reference in the treatment plan).

Given the deficits of the therapy, Tom is likely still very much a conflicted regressive adult baby. This is because the therapy has done nothing to address the unmet needs of his wounded inner child, or the savage internal conflict that results. In light of this, there are significant doubts regarding the prognosis. The case study concludes –

Two years following treatment, Tom continues to employ the RPP that he developed. He and his wife were in marital therapy for 6 months, which helped to clarify the expectations each had of the other in areas such as domestic chores, sex and affection, and leisure activities together. He had one 'relapse' within the first 3 months of ending therapy in which he went into a massage parlor. He immediately felt guilty and remorseful and left without having sexual contact. Tom called his SLAA sponsor and reported the incident. They agreed he would increase the frequency of meetings to three times a week. Tom also had a consultation with his therapist. The therapist helped Tom to recognize how he had allowed risk states and SUDS to creep back into his life. They agreed that he would return every 6 months for a 'check-up' consultation.

Tom relapsed relatively quickly and is principally 'protected' from further relapsing by shame and remorse. Many adult babies will recognize that Tom is still caught up in the binge and purge cycle and its' savage internal conflict. It is very unlikely that Tom would have been able to sustain the unreasonable objective of abstinence which cruelly set him and his family, up to fail.

Further Consideration

In the textbook, it is noteworthy that the section immediately after the case study is titled 'Behavioural modification' and includes treatment options for paraphilias generally, including aversive therapy with electric shocks or nauseating ammonia odour. This is followed by a section titled 'Biological treatment' including drugs to reduce the sex drive and psychotropic medications. This highlights the potentially very negative view of being an adult baby, when a client in crisis or distress related to this identity, presents to a psychotherapist.

It is salutary to remember that a generation before, this is exactly the type of program that would have been applied to if a person came for therapy because they were in crisis or in distress related to having an LGBTQI personal identity. Thanks to the historic struggles and victories of the gay and lesbian community we now understand personal identity. We know that it can't be 'cured' away by psychology, therapy or religious faith. It can be denied – at great cost to a person's wellbeing – but it can't be wished away. If a person presents to a therapist in crisis or distress related to their LGBTQI personal identity, we now understand that the therapeutic issue is the crisis or distress and how to positively resolve it – not to deny or change the underlying personal identity.

Once we accept that being a regressive adult baby is a personal identity then Tom's treatment program can be seen as very similar to 'gay conversion therapy'. That is, it is based on denying the non-vanilla personal identity, not because it is intrinsically harmful or unhealthy, but because it is seen as unacceptable to society at large. We now understand that gay conversion therapy is professionally unethical, causes great harm and doesn't work.

Therapy for a conflicted regressive adult baby needs to be based on the fact that it is a personal identity – a healthy identity if the internal conflict is resolved – and not a fetishistic paraphilia. This applies even if the client presents in crisis or distress.

We need to revisit the case study to consider how Tom's therapy might have proceeded if the therapist had recognized that Tom had a personal identity as a regressive adult baby. Key features of a positive approach include –

1. being open to the prospect that Tom's distress relates not to an intrinsic deficit in his identity but to his internal conflict, the behaviours it drives and the prospective rejection by others

2. identifying and addressing Tom's internal conflict and its' internal actors, starting with his shame and remorse and obvious need for nurturing

3. being open to finding and addressing the wounded Inner Child behind the obvious need for nurturing

4. exploring with Tom a model for a healthy, sustainable personal identity as a regressive adult baby – recognizing that he will, initially, have no notion of what this might look or feel like (see 'Becoming Me', cited above, for a description of such a model)

5. address the issues for Tom's parenting of his daughter and his marriage, of a self-acceptance of a healthy sustainable identity as a regressive adult baby

To enable effective therapy, there needs to be an alliance between the therapist and the regressive adult baby's Inner Adult, the custodian of the self-acceptance of the AB's personal identity and broader personal and social responsibilities including as a father and a husband.

There is a fundamental difference in the effectiveness of counselling based on the two views of being an adult baby. The actual counselling based on the view that it is a psychosexual disorder left Tom believing his psyche was subject to an entirely negative trait that he would have to live with and attempt to control for the rest of his life. In essence, it left him believing himself irrevocably broken and perverse. He is not able to fully trust himself, and must depend on his wife to monitor and control his behavior, setting up a co-dependency which will damage his marriage over the longer term. His real need for nurturing which prompted his compulsive 'binge' behavior was not acknowledged, bottling that pain up inside him and closing the door on the prospect of healing. He must spend the rest of his life denying a real and important of himself. The outcome is very similar to using 'gay conversion therapy' to try and convince a person with an LGBTQI identity that they cannot ever be themselves.

By contrast, counselling based on a view that being an adult baby is a personal identity would have identified the internal conflict that tormented Tom and drove his compulsive behaviours. It would have recognized that his obvious need for nurturing was real and lead to an identification of the wounded inner child. That would open the door to the healing of the buried emotions linked to that wounded child and the insecure childhood attachment to his mother. All of this would have opened the door to Tom accepting that he had a non-vanilla personal identity,

which is capable of being psychologically healthy and sustainable – that he is not irrevocably broken and perverse.

Even positive counselling is not a panacea. The prognosis for Tom's marriage would have been uncertain at best. The shock and crisis for Tom's wife of finding out this deep seated and longstanding trait of his character at a time when she is caring for a newly arrived, first born child would be very difficult to overcome. Even with the best counselling, Tom's wife would be faced with accepting that her partner, and the father of her child, had a non-vanilla heterosexual personal identity. She couldn't be blamed if she couldn't accept that. But if she could, it would open the door to healing the wounds to her marriage caused by Tom's internal conflict and compulsive behaviours.

Seeking professional counselling when you need it is a sign of maturity and psychological health. The cost of not seeking professional counselling if and when you need it, is to prolong pain and confusion. This article is a recognition, as any good therapist is aware, that it is important to find the right kind of counselling and that the wrong therapy can be harmful.

It is important if you are a regressive adult baby that you ensure that any counsellor or therapist you seek can accept and work with being AB as a positive personal identity. Likely the best place to start is an LGBTQI - friendly therapist who has an understanding of personal identities.

It is a good prospect if the counsellor uses a 'Rogerian' approach based on the work of the renown American therapist Carl Rogers (b.1902 d. 1987). Rogers developed 'person-centred' therapy. Essentially person-centred therapy starts from where the client is 'at', trusts that the client has a drive towards health and healing and can be assisted by genuine understanding and empathy to navigate their own solutions. A therapist using person-centred therapy is not likely to impose on a regressive adult baby client a judgement that it is a psychosexual disorder as defined in the standard DSM-5 diagnostic tool.

As regressive adult babies, how we see ourselves, and how others see us, matters.

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