

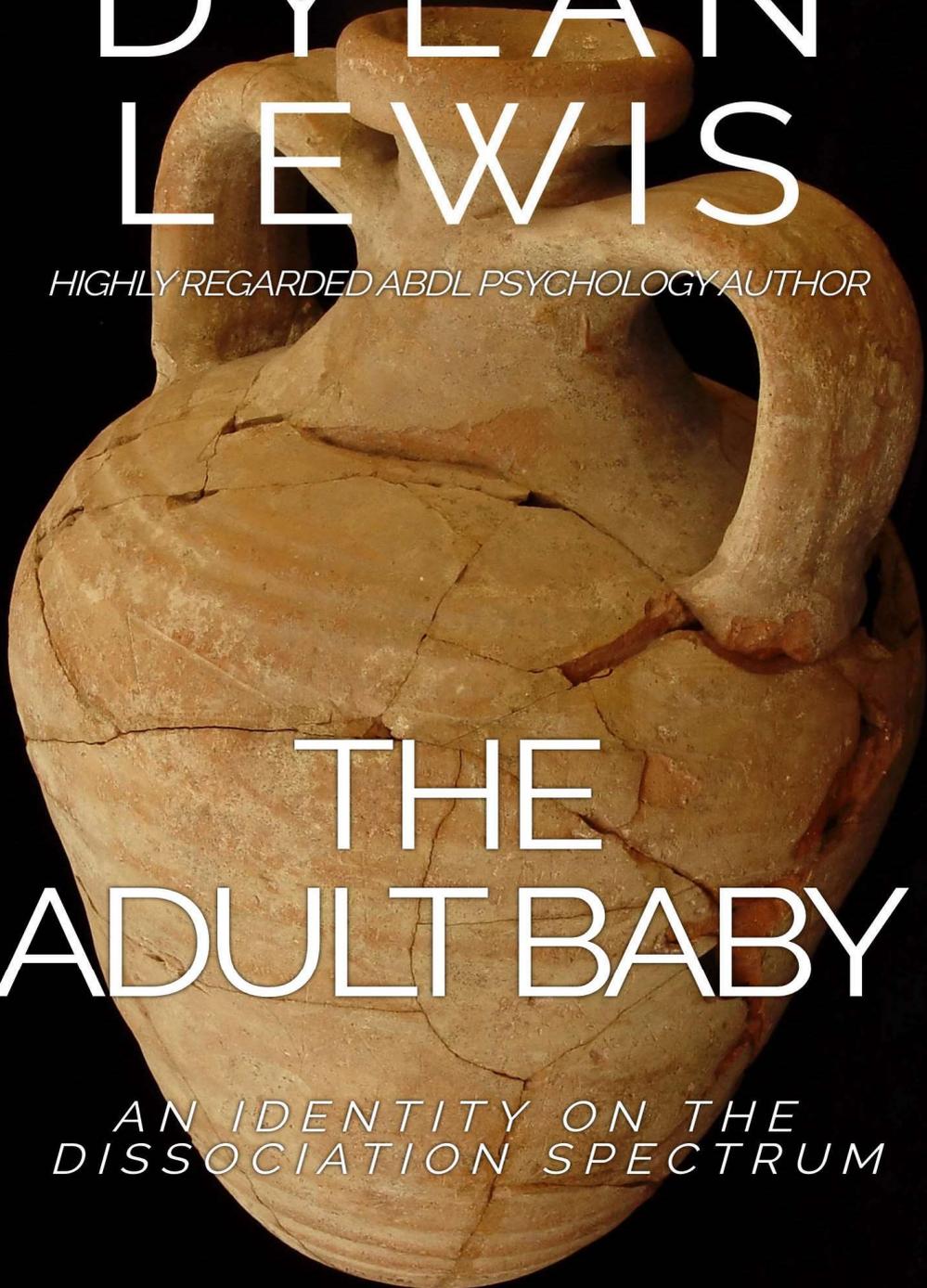
AN AB DISCOVERY BOOK

DYLAN LEWIS

HIGHLY REGARDED ABDL PSYCHOLOGY AUTHOR

THE ADULT BABY

*AN IDENTITY ON THE
DISSOCIATION SPECTRUM*



The Adult Baby – An Identity on the Dissociation Spectrum

*By Dylan Lewis
with Dax Jordan*

Other Books from AB Discovery

The Adult Baby Identity – coming out as AB DL
The Adult Baby Identity – Healing Childhood Wounds
Living with Chrissie – my life as an Adult Baby
The Adult Baby Identity – a self-help guide
The Adult Baby Identity – the dissociation spectrum
Six Misfits
Six Misfits – A man and his dog
The Six Misfits – the seventh misfit
Becoming Me – The Journey of Self-acceptance
Living happily as an Adult Baby
Adult Babies and Diaper Lovers – a guidebook

Other Books from Dylan Lewis

There's still a baby in my bed!
So, Your teenager is wearing diapers!
Where Big Babies Live
Home Detention
Adult Babies: Psychology and Practices
Coffee with Rosie
Being an Adult Baby
The Three Chambers
A Brother for Samantha
Mummy's Diary
The Hypnotist
Chosen
The Snoop
The Washing Line
My Baby Callum
A Baby for Felicity
The Regression of Baby Noah

A Baby for Melissa and her Mother
Baby Solutions
Discharged into Infancy
The English Baby
A Mother's Love
The Psychiatrist and her Patient
The Reluctant Baby
The Book Club Baby
The Rehab Regression
The Daycare Regression
The Aeviternity Gateway
A Woman's Guide to Babying Her Partner
The ABC of Baby Women
Overlapping Stains
The Babies and Bedwetters of Baker St
The Bedwetter's Travel Guide
Me, Myself, Christine
The Joy of Bedwetting
Diaper Discipline and Dominance
The Epitome of Love
Australian Baby: a life of nappies, bottles and struggles
Fear and Joy: a life in and out of nappies
The Fulltime, Permanent Adult Infant

Dedication:

To my wife for her constant love and wisdom.

*To Rosalie Bent and Michael Bent for letting
adult babies (and the world) know we aren't
mad, bad or alone.*

Contents

The Adult Baby – An Identity on the Dissociation Spectrum	2
Foreword	12
1. Introduction.....	14
2. Preview.....	21
Account 1	21
Account 2	22
3. Dissociation.....	25
What is Dissociation?	26
Spectrum.....	28
More Common Than You Think.....	28
Doesn't Stop People Being Successful	29
Components.....	30
Identity Alteration.....	31
Trauma and Splitting	32
Repression and Denial.....	35
Dissociation Becomes Dysfunctional	39
The Dissociation Spectrum Revisited	40
Summary	41
4. Dissociative Identity Disorder (DID) and being an Adult Baby (AB).....	42
Concepts.....	42

The Adult Baby – An Identity on the Dissociation Spectrum

What is DID?	43
What about being AB?	44
DID on the Dissociation Spectrum	45
Overlap Between DID and AB	47
Being AB on the Dissociation Spectrum	51
The Psyche is Wired Differently	55
Childhood Trauma	57
Validation.....	59
Summary	62
5. Regression.....	63
Not Reversion to Biological Childhood	64
Identity Alteration.....	66
Identity Confusion.....	66
Self-Nurturing.....	67
6. Dax and Dylan	68
Dax.....	68
Dax on DID.....	70
Dylan.....	71
Stage of Life When We Accepted Our Identities.....	74
7. DID Autobiographies.....	76
8. Living With Alters.....	81
How It Feels	81
Triggering.....	85
Alters Are Fundamental.....	87
Relationships With Loved Ones	88

Summary	89
9. Child Alters – The Key Similarity.....	90
DID Young Child Alters.....	90
DID Child Alters and Partners	94
AB Child Alters and Partners	97
Similarities In Relations With Partners	100
A Difference	101
Summary	103
10. Alters Don't Stand Still.....	104
Coming to Terms with Alters.....	104
Alters Are Dynamic.....	109
Nature of Changes	112
Summary.....	114
11. DID and Being AB Are Not The Same	115
Origins.....	115
The Nature of Division Within the Psyche.....	117
Dax on Living With Fragmentation.....	119
The Complexity of Relationships Within the Psyche..	124
Psychological Function of Dissociation and Alters.....	126
A Final Word on Differences	130
12. Alienation and Self Absorption.....	132
Alienation	132
Self Absorption	135
Summary.....	137

The Adult Baby – An Identity on the Dissociation Spectrum

13. Are AB's Child Alters Real Children?	138
Subjective Reality	138
Validation.....	140
Objective Reality.....	142
Summary.....	145
14. Are Alters Psychologically Healthy?	147
Alters Are a Psychological Risk.....	147
A Positive View of Alters.....	155
Identity	160
The Nature of Identity	161
Summary.....	163
15. The Challenges for ABs Living With Alters	164
The Middle Road.....	165
Challenges to Our Psychological Balance.....	166
Cognitive Dissonance.....	167
Denial of Subjective Reality.....	169
Nurturing.....	170
Denial of Objective Reality.....	171
Fantasies of Permanent Regression.....	174
Replicating the Physical Lifestyle of a Biological Child	176
What's Real?	179
Summary.....	180
16. Alters and AB Sexuality	181
Fetish.....	182

Switching and Sex.....	183
The Erotic Target.....	186
Child Alters and Sex.....	191
Summary.....	192
17. Self Care for ABs	194
Safe Physical Environment	195
Internal sanctuary.....	196
Acceptance By Loved Ones	197
Fellowship With Like Others.....	199
Service and Creativity	199
Be Cautious In Disclosure.....	200
Come to Terms With Past Trauma.....	203
Summary.....	204
18. Conclusion	205
Accept Your Dual Nature	207
Good Self Care.....	208
Be Proud.....	209
See the Gift	210
Appendix 1 – Two Magnetic Resonance Imaging (MRI) Studies of DID.....	212
2006 Study.....	212
2008 Study.....	213
Appendix 2 - Thoughts on Therapy for ABs as an Identity on the Dissociation Spectrum	216

The Adult Baby – An Identity on the Dissociation Spectrum

Diagnosis.....	218
Finding a Therapist.....	223
What to Look For In Treatment/Therapy.....	224
Psychotherapy is Likely to be More Useful Than Medication or Hypnosis	224
Effective Psychotherapy for Multiplies is Based on Working with Alters	226
Psychotherapy Does Not Require Re-living the Original Trauma.....	230
Most of the Healing is Self-Directed	232
Support of A Loving Partner.....	234
Consoling Faith.....	235
You Define the End Goal of Therapy	235
Provisional Self Diagnosis is Okay	236
Glossary.....	238
Annotated List of References.....	246
Books on DID and Dissociation	246
Books on ABs and Other Topics.....	255

Foreword



In 2011, Rosalie and I set out to write a book about Adult Babies.

Initially, we were unsure about exactly what to write and the scope of the topic. This was because the amount of non-fiction material available about ABs was appallingly small and much of it was of little to no value. Being an adult baby and wearing nappies was considered just a sexual fetish and as someone who has wanted nappies since I was three years old, I knew that to be nonsense. So, we spent a lot of time researching and interviewing other adult babies and we fell upon a definition that we perhaps had known all along. Adult Babies are subjectively *real* babies and toddlers. It is not a sexual fetish but, it is in fact, a viable *personal identity*. And so the book, “*There’s still a baby in my bed!*” was born, not in small part out of personal pain and a desire to help others avoid or mitigate that pain.

We now understand a lot more and accept that the adult baby is a complex, almost incomprehensible person that is both adult and infant, often at the same time. The causes, the structure of this is only just now being slowly revealed. PhD candidates are now looking at the detail of AB life having finally – and long overdue – recognising that it is not a sexual fetish at all, but a genuine regressive identity that both needs – and demands – acceptance.

Our book was never intended to be the final word. Rather, we hoped that others would take up the mantle and continue the task of discovering more about who we are and how we can deal with it. Dylan Lewis is one of the foremost authors and researchers in this field and this latest book is his crowning achievement.

The Adult Baby – An Identity on the Dissociation Spectrum

The notion of dissociation is a scary one. It certainly scared me, even though I suspected it to be true from my very early years. I am sure it scares you too, but this brilliantly-crafted book removes the fears and replaces it with facts, understanding and a comprehensive 'aha!' moment of finally putting the pieces into place.

This book is *the* next step in understanding the complexities of the adult baby and opens windows that let light and fresh air into a soul that may be stale and listless because it stands alone and hidden. But we stand alone no longer because we know that who we are and who we can become, is both real and refreshingly healthy.

Dylan Lewis is to be applauded for taking his own experience of being an adult baby and enlightening us all about who we are.

It is okay to be an adult baby. And now we know why.

Michael and Rosalie Bent

1. Introduction



Being an adult baby is a big deal.

It is a mind-blowing, one-in-a-thousand identity.

I am an AB – an Adult Baby. At some point, each of us realizes our psyche is hard-wired differently to everyone else we know.

We are sane, functional adults. Yet we have a compelling need to wear nappies. They comfort something deep inside us. We need to see ourselves in nappies. We want others to see us wearing them (whether we act on that or not). Many of us at least wet them. Many of us fantasize about being babied – cuddled, changed, fed, disciplined etcetera. And that’s without all the rest – stuffed toys, pacifiers, baby clothes, bottles etc.

WTF!

It is no wonder coming to terms with being an AB isn’t simple.

This is a book for ABs who are ready to understand that nappies are the tip of the psychological iceberg. It is about understanding ourselves so that we can live happily and safely as ABs.

Accepting being AB is a permanent and central part of my psyche and sent me on a journey to understand exactly why that is true. I’m the kind of person who hates not knowing. I can (eventually) handle difficult truths, much better than I can handle not knowing.

The Adult Baby – An Identity on the Dissociation Spectrum

I discovered being AB is an identity on the dissociation spectrum. That's the same spectrum as Dissociative Identity Disorder (DID) - which used to be known as Multiple Personality Disorder (MPD).

For some ABs, that information may be unwelcome. I can imagine the internal dialogues – “shit! It's tough enough already accepting or explaining being AB, and you go and dump being crazy on top!”

Hear me out. Forget the movies. Dissociation does *not* equal crazy. There are many high-functioning people with some form of dissociation. It forms a broad spectrum. Everyone on the spectrum has an individual ‘footprint’ with its own unique experience of self and life. DID is at the further end of the spectrum, and being AB is akin to *next door*. Dissociation is common. It is estimated ten per cent of the population has substantial levels of dissociation. That makes it as common as mood disorders like depression and anxiety. As with ABs, people with dissociation do not disclose and commonly hide amongst us in plain sight.

I believe dissociation is the most valid way of explaining being AB. Let's face it, the hard wiring in our psyche is pretty different and rather deep. You know that because, like most ABs at some time or other, you have tried giving it up. Any valid explanation for being AB is going to have to go pretty deep into the psyche. There is no clear empirical or clinical evidence backing any explanation. We are left to make up our own minds based on our logic, reading and self-reflection. The other explanations for being AB are shallow (‘it's a kink’) or fall into the category of ‘bad or mad’ – it's a fetish or a psycho-sexual disorder. Dissociation not only offers a better explanation, it also shows how being AB can be a healthy and stable personal identity.

This book explores ‘being AB’ as an identity on the dissociation spectrum. It does that through a comparison between

being AB and DID. You may be an AB who finds a comparison with DID confronting. That is understandable. I ask you to set aside preconceptions and prejudice about DID – the same way, as ABs, we ask others to set aside their preconceptions and prejudice about us.

TRIGGER WARNING: *If you are in the initial stages of understanding your identity, either with DID or being AB, a comparison with another misunderstood minority identity may be over-loading and confronting. You may wish to put this book aside for a later time.*

What is the benefit of the comparison? There is a compelling similarity between the two identities. Both have alternate personalities which powerfully shape their experience of self and life. For ABs, it is our child alters who need nappies and all the rest, to feel recognized, nurtured and safe. For both identities our reality is subjective. It is invisible and incomprehensible to others. There is no way of directly proving the existence of alternative personalities to a doubting person. They are visible only through behaviours which are otherwise inexplicably at odds with the personality we present to the world.

I liken being AB to finding out you are adopted. Adoptees are confronted by the fact they do not share DNA with those around them. That's like ABs realizing our psyches are hard-wired differently than everyone else's. For me, realizing I shared some of my hard-wiring with people with DID was like an adopted person finding their only close living relative. At last, someone who really gets what it's like to live with the subjective reality of an alter which is compelling to me, but incomprehensible to others. Someone who can help me understand the wiring in my psyche. Some people with DID refer to themselves as 'multiples'. ABs often refer to themselves as having a 'Little' and an adult side. We are multiples too – a different kind from people with DID – but still multiples.

The Adult Baby – An Identity on the Dissociation Spectrum

The comparison is largely between one AB (myself, Dylan) and one person with DID – Dax, my co-author. Dax is a member of my extended family. He is high functioning, a teacher who taught special needs children around the world. I also read autobiographies, case histories and the published work of four psychiatrists who know DID. Each AB or person with DID is unique. No one individual can be representative, but I hope Dax and myself exemplify some of the key traits and issues for our respective identities.

The book shows what it feels like to live with DID and being AB – when it feels similar and when it feels different. There are compelling similarities between the child alters of ABs and people with DID. It also demonstrates being AB is not DID. There are clear differences. The comparison pinpoints what they are.

Why did I think of this comparison? Let me explain. Until my early fifties, I experienced being AB largely as a conflicted sexual fetish – nothing to do with identity, dissociation or DID. Then Dax visited from overseas and stayed with my wife and myself several times over two years. My wife is a psychotherapist. She suggested that like Dax, I too might have alternative personalities. The thought fell on fertile ground – a few years before I had read Rosalie Bent's ground-breaking book *'There's a Baby In My Bed: Living With the Adult Baby in Your Relationship'*. It viewed being AB as an identity, not a fetish. Therapy confirmed I had child alters. It was an epiphany that revolutionized my understanding of my AB identity. My need to wear nappies, wear baby clothes and all the rest, was not the product of a sexual fetish, but having a subjectively real alternative personality, a very young child.

That discovery caused me to change my view of dissociation. I could be 'messed up' at times, but I am a sane and functional adult. I have a long happy marriage and I am happily retired from a successful career. That didn't fit with the uninformed view of dissociation as crazy and debilitating.

Understanding that ABs are multiples also helps us understand our complicated sexuality. A later chapter shows the unconscious logic behind our sexual needs and compulsions.

This book is a collaboration between Dax and myself. I asked lots of questions about DID, and advanced hypotheses about the similarities and differences between the two identities. Dax sent me lengthy emails explaining his experience of DID and responding to my hypotheses. On this basis, I prepared the text which Dax reviewed. Dax's grasp on DID is insightful and articulate. I believe the most compelling understanding of DID comes where I have quoted directly from his emails.

This is a self-help book. The key audience is ABs and those who love them. It assumes you know a lot about ABs and where you fit on the ABDL spectrum, but know less about dissociation and DID. The book is my best attempt to understand our shared identity. I have no formal qualifications in psychology, but I have a layman's lifelong interest in the subject. Every AB is different, and some will disagree with my views. I do not intend to disparage those whose views are different from mine.

As adults, we all construct our own identities, based on what we choose to believe about ourselves. Those beliefs can change over time and our identity changes with it. At any point in time, our identity represents what we need to believe to feel safe and okay, with ourselves. In terms of our personal identity, no one has the right to tell us what we should believe about ourselves. So, if after scanning or reading this book, you want to think of being AB as a kink, or a fetish, and/or being AB has nothing to do with subjectively real alters or childhood trauma, that's okay. That's you, defining you. This book is about offering people information based on my best honest understanding, and giving them a choice about what they believe. Take what is helpful from the book and leave the rest behind.

The Adult Baby – An Identity on the Dissociation Spectrum

The other intended audience is mental health professionals, who I hope will be prompted to think more deeply about the AB identity. The health professions' present ways of understanding 'being AB' are just labels that explain little or nothing. How can the obvious pointers to fundamental issues in AB's early childhood be ignored? How can being AB be thought of as just a paraphilia or sexual fetish? Sure, it is often a fetish as part of its expression. That's a symptom, not the cause. It doesn't explain why ABs seek and derive emotional comfort from their nappies and fantasies of infancy. How long can the involuntary character of many AB behaviours (triggering etc) - so at odds with the AB's adult personality - be viewed simply as a compulsion or addiction? These symptoms require dissociation and repressed childhood trauma be included in any competent differential diagnosis.

This book is based on the pioneering work of Rosalie Bent and Michael Bent in identifying and understanding ABs as a personal identity. I recommend their books and website abdiscovery.com.au. I refer to their insights throughout the book.

By adult baby, I exclude role players and diaper lovers for whom diapers, baby clothes or baby activities are an optional extra they can freely live without, and pure fetishists for whom these things are confined exclusively to sexual expression.

This book follows my *'The Adult Baby Identity' trilogy* – *'Coming Out as an Adult Baby'*, *'Healing Childhood Wounds'*, and *'A Self Help Guide'*.

The journey of self-discovery is not an easy one to undertake alone. You need a confidant who you can trust, and who will be an ally in your healing. If there is no one in your life with whom you can safely share your feelings about your life as an adult baby, seek professional support – preferably from an LGBTQ-friendly therapist who understands dissociation and personal identity. If you are in

The Adult Baby – An Identity on the Dissociation Spectrum

crisis or deep distress about being an adult baby seek professional therapy.

2. Preview



There were times when researching this book was a revelation for me. I was very surprised to see the similarity between the child selves of AB's, their 'Littles', and the child alters of people with DID.

Below are two accounts of a 'Little' or child alter written by the person's partner. See if you can pick the one that belongs to an AB, and the one that belongs to a person with DID. I have edited out identifying text but otherwise, the accounts are quoted verbatim.

Account 1

[Chrissy's husband says] "Chrissy [was] so excited to be out and about with me, seeing all of these wonderful new sights. ... We had barely walked half a block when Chrissy yanks me into a charming shop with a variety of handmade wooden toys, puzzles and dolls. Chrissy is quietly sharing with me her delight and excitement of this wonderful world of toys. ... With much exuberance, she pulls me up the stairs to a wall loaded floor to ceiling with stuffed bears. ... Pink bears, green bears, and rainbow bears. The pleasure Chrissy feels in seeing the princess and ballerina bears light up her sparkling eyes. ... no one pays much attention until I push a button hidden in the first dancing bear's paw. The music starts and the graceful bear spins around and around. Before I can comprehend the implications of this one bear, Chrissy waltzes her way to five more paw-activated bears. Now they're all singing, laughing and talking while Chrissy cries out in joy and claps her hands. Soon even more of these once-cute but now loud and obnoxious bears are gyrating and convulsing, with Chrissy laughing all the way.

I soon feel that the situation is out of my control. I glance down the stairs and notice the shop owner scowling up at me. ... I don't want Chrissy to sense my discomfort. She is truly just experiencing what any child would the very first time in a toy store or even on Christmas Day. You wouldn't want to stifle a child then, but I am feeling anxious.

Sadly, I am unable to prevent Chrissy from noticing my discomfort, and what began as a splendid adventure of wonder turns into her feeling confused and ashamed. ... She sheds many tears while apologizing for embarrassing me. I hold her tight, trying to reassure her that she didn't embarrass me, the situation did."

Account 2

[[Joanne's wife and mother says] "Joanne was happy and content and her needs were being well met. Then one overnight there was a storm. My little three-year-old is terrified of wind and storms at night and so we had night-time tears, fear and when morning came, there was just a scared little infant in bed and the adult was as far away as he has ever been. Joanne was thoroughly and irredeemable regressed and she would not and could not grow up. We had plans for that day. Adult plans. They were cancelled as there was no adult there – just an infant behaving at her youngest age level of 12 months old.

It was a difficult day. It was difficult to communicate with her beyond limited baby talk or gestures. By evening she was communicating better but the following morning there she was again, very little and quite regressed. I felt like we were still back in the nursery level.

It took two full days for her to really return back to her place of balance and peace and I am reminded again that just as in the parenting of physical children, you can do all the right things and still get bad things happen. Joanne is normally a delightful and happy child and it is an exciting and happy time for her and for me. But those two

The Adult Baby – An Identity on the Dissociation Spectrum

days were difficult for us both because for at least one of those days, we had lost control.”

Account 1 is from Christine Pattillo’s autobiography *I Am We: My Life With Multiple Personalities*, and is narrated by her husband who is the father of six-year-old alter Chrissy.

Account 2 is from Rosalie Bent’s on-line blog (cited in the references). She is the wife of her AB husband, and mother to his ‘Little’, baby Joanne.

You may have picked correctly, you may not. But I think the similarity in the character of the two accounts is compelling. The similarity is not a one-off. I chose these two out of a larger sample cited in Chapter 9. Compare Rosalie Bent’s account with another description of a similar night-time incident by Christine Pattillo.

“Well, last night there was a small windstorm in our neighbourhood ... We were all snoozing soundly when a power transformer, less than a mile away, shorted out. The sound was like a gunshot and startled Chrissy, even though she was asleep inside Cita’s [Christine Pattillo] mind. Chrissy’s fear was so acute she burst into tears and shifted right out, waking Christopher. Christopher immediately began to comfort her and calm her down.”

The similarity represents the two closest points in the experience of DID and AB. Christine Pattillo’s account of her DID is unusual in the warmth and openness with which she and her family have embraced her child alters. Rosalie Bent’s husband is a regressive AB. The latter term is one used by Rosalie to describe ABs who have a powerful need to express their ‘Little’.

Many people with these two identities would not have this degree of commonality in their experience and expression of self. But even where the overlap is not so strong, I believe it is still there. The

rest of this book is about exploring the origin and nature of that commonality.

Rosalie and Michael Bent are the foremost public authorities on the adult baby identity. Rosalie is the wife of Michael, an adult baby. In 2012 Rosalie published the landmark book 'There's A Baby in My Bed' intended for the partners of adult babies. It was the first published work to seriously address adult babies as a personal identity, beyond a sexual fetish. It was updated in 2015 as 'There's Still A Baby in My Bed. Rosalie has also written a book for the parents of teenage adult babies. Michael has published a text 'Adult Babies: Psychology and Practices' and an anthology of insightful articles 'Being An Adult Baby'. Rosalie and Michael are the owners of the website abdiscovery.com.au which is dedicated to helping adult babies understand themselves, and fostering public understanding of the identity.

3. Dissociation



I believe dissociation is key to understanding ABs.

To help guide an understanding of dissociation, this book references the published writing of four psychiatrists.

Marlene Steinberg is an American who developed a key diagnostic questionnaire for dissociative conditions, the *Structured Clinical Interview for Clinical Disorders* (SCID-D), sometimes cited as the gold standard for such identification. Her excellent 2010 book *The Stranger in the Mirror: the Hidden Epidemic* demystifies dissociation and DID. Contrary to the prevailing wisdom she focused on dissociation from the beginning of her career in the early 1990s.

David Yeung is a Canadian who retired in 2006 after a forty-year career. He worked with about one hundred DID clients in the latter half of his career. He was concerned at the scarcity of mental health professionals willing and able to work with DID clients. After retirement, he wrote a set of case studies and therapeutic guidelines for mental health professionals (*Engaging Multiple Personalities Volumes 1 and 2*). His approach is notably empathic and client-centred.

Colin A. Ross (b. 1950) is another Canadian. He is a widely published authority on trauma and dissociation, and the author of a key textbook on DID, *Dissociative Identity Disorder: Diagnosis, Clinical Features, and Treatment of Multiple Personality*. He developed another key diagnostic questionnaire for dissociative disorders, the *Dissociative Disorders Interview Schedule* (DDIS). His grounded approach emphasizes working with the internal logic of DID. He has powerful insight but understates the subjective reality

of alters. I draw most on his recent (2018) book *'Treatment of Dissociative Identity Disorder: Techniques and Strategies for Stabilisation'*.

Jeffrey Smith is an American. He was the therapist of Robert Oxnam, one of the most high-profile people who have 'come out' with DID. The latter is known for his 2013 autobiography *'A Fractured Mind: My Life With Multiple Personality Disorder'*. Dr Smith does not claim to be an authority on DID/MPD. However, his epilogue to the above autobiography, *'Understanding DID Therapy: The Case of Robert B. Oxnam by Jeffrey Smith MD'*, is outstanding for its insight and clarity.

What is Dissociation?

In essence, dissociation means detachment or disconnection - detachment from external factors (others, the environment), or detachment from the self, or both. Dr Colin Ross states –

"Dissociation basically means disconnection. A person can be disconnected from thoughts, feelings, memories, sensations or any aspect of the mind and body."

Dissociation is a common and functional coping mechanism for dealing with a range of situations. It can be voluntary, such as when there is a compelling need for intense single-minded focus, or involuntary, such as in a car accident or a heart attack.

The Adult Baby – An Identity on the Dissociation Spectrum

Dr Yeung gives an example of a common, functional example of dissociation –

“Dissociation is not always pathological. For example, a surgeon in the midst of a nasty divorce must remain able to concentrate in the operating room. The act of separating the ordinary stream of divorce-related thoughts from the task of surgery at hand requires effective dissociation.” [Engaging Multiple Personalities (Volume 1): Contextual Case Histories.]

Colin Ross comments:

“... every woman who has given birth has been in an extreme dissociative state.”

In sudden trauma, dissociation involuntarily quarantines incapacitating fear or pain in one part of the psyche so we can continue to function. Dr Steinberg defines traumatic dissociation as

“...an adaptive defence in response to high stress or trauma characterized by memory loss and a sense of disconnection from oneself or one’s surroundings”. ... To help us survive, certain perceptions, feelings, sensations, thoughts, and memories related to the trauma are split off from full awareness and encoded in some peripheral level of awareness. Miraculously, dissociation alters reality, but allows the person to stay in contact with it in order to help himself.” [The Stranger in the Mirror: Dissociation The Hidden Epidemic]

There are many misconceptions about dissociation. I discovered it –

1. is a broad spectrum ranging from mild forms through to clinical conditions;
2. is a lot more common than people think;

The Adult Baby – An Identity on the Dissociation Spectrum

3. need not prevent a person from being functional and successful;
4. has five components which may be present in differing combinations and strengths depending on the individual, so everyone with dissociation has their own unique 'footprint'.

Let's look at each of these.

Spectrum

The spectrum ranges from -

- mild dissociation which can take such forms as an intense single-minded focus, or 'zoning out' from disturbing or confronting situations;
- sub-clinical dissociation which involves altered states of consciousness, which may have a significant effect on a person's experience of self and life, but does not trigger medical intervention; and
- clinical conditions which trigger medical intervention and include separate streams of consciousness, identity and/or self. These can include a sense the self or the world is unreal (depersonalization and derealization), fragmentation of identity, such as DID, or complex post-traumatic stress disorder.

More Common Than You Think

The Wikipedia article 'Dissociation (psychology)' states –

"... in the normal population, dissociative experiences that are not clinically significant are highly prevalent with 60% to

The Adult Baby – An Identity on the Dissociation Spectrum

65% of the respondents indicating that they have had some dissociative experiences.”

A recent meta-analysis of around one hundred other studies indicated around 10 per cent of the population would meet the criteria for a dissociative disorder (see *‘The prevalence of Dissociative Disorders and dissociative experiences in college’* by Mary-Anne Kate in the references). Dr Steinberg’s 2010 book cites a survey which estimates that 14 per cent of the US population experiences *substantial* dissociative symptoms. These figures indicate the prevalence of dissociative conditions is on a par with the better known and accepted mood disorders such as depression and anxiety.

DID, the most extreme form of dissociation, used to be thought of as very rare. That’s no longer thought to be true. Within the broader population with substantial dissociation symptoms, Dr Steinberg estimates up to one per cent of the population may have DID. Wikipedia, in the article on DID, cites a figure of two per cent. The International Society for the Study of Trauma and Dissociation’s (ISSTD) 2010 Guidelines for Treating Dissociative Identity Disorder in Adults cite estimates that one to three per cent of the population have DID.

Doesn’t Stop People Being Successful

There are many high functioning people with dissociative conditions. Dr Steinberg states that they –

“... run the gamut from PhDs to prostitutes and are generally highly intelligent, creative, brave, articulate and likeable. Many are accomplished professionals, married, raising children, holding down responsible jobs.”

People with DID work successfully in many walks of life. Dr Yeung states –

“Without conscious effort, many DID persons utilize their dissociative abilities to enhance their work. Teachers with DID can be exceptionally perceptive and sensitive to their students’ difficulties because their young alters easily attune to their students’ needs. Similarly, a therapist with alters can be readily attuned to their patients in therapeutic work.”

Amongst the autobiographies of people with DID I read, one person was a high powered US Department of Justice lawyer (Olga Trujillo), another a prominent international academic (Robert Oyam), and another a very high profile sportsman in the US NFL (Herschel Walker).

Because of fear of being thought crazy people with dissociative conditions commonly do not disclose. Friends, colleagues and acquaintances are mostly not aware the person has a dissociative condition. Given the prevalence indicated above, it is very likely one or more of the people you interact with on a weekly basis have, or have had, substantial dissociative symptoms (in the same way you interact with people who have depression or anxiety).

Components

Dr Steinberg identifies five components of dissociation. These are -

1. Amnesia – gaps in memory or ‘lost time’;
2. Depersonalisation – a feeling of detachment from your emotions or your body, or looking at yourself as an outsider would;
3. Derealization – a feeling of detachment from your environment, such as feeling the environment or other people aren’t real, or familiar people are Strangers;

4. Identity confusion – a feeling of uncertainty, puzzlement or conflict about who you are - perhaps a continuing struggle going on inside you to define yourself; and
5. Identity alteration – a shift in role or identity, accompanied by such changes in your behaviour that are observable to others – you may experience the shift as a personality switch or loss of control over yourself to someone else inside you.

Each individual on the dissociation spectrum has a different 'footprint'. They may have all five components or only some, and in different strengths. Each different 'footprint' produces a unique experience of self and life. Your footprint is *your* footprint. Accepting that you are on the dissociation spectrum doesn't mean your experience has to conform to anyone else's.

Identity Alteration

It is the fifth component - *identity alteration* - which is most important to understanding DID and being AB. People with identity alteration have one or more subjectively real personas, distinct from the host-birth personality. The depth of those personas can vary. With moderate levels of identity alteration, the personas maybe only two dimensional, feeling states – barely personas. With stronger levels of identity alteration, the personas have a repertoire of thoughts, emotions, capabilities, and needs that represent a fully formed alternative personality.

Dr Steinberg states -

"... research has found that identity alteration, as with all the dissociative symptoms, occurs along a spectrum of intensity:

mild levels in the general population; mild to moderate levels in people with nondissociative psychiatric disorders, but also with people with dissociative disorder not otherwise specified (DDNOS); severe levels of identity alteration in people with dissociative identity disorder (DID).

A person with moderate levels of identity alteration may act as if he or she is like two (or more) different people, but it's not clear whether these identity alterations assume complete control of a person's behaviour or represent separate personalities. ...

Severe identity alteration, the *sine qua non* of DID, involves a person's shifting between distinct personality states that take control of his or her behaviour and thought. These alter personalities are more clearly defined and distinctive than the personality fragments that characterize moderate levels of identity alteration. Each alter has its own name, memories, traits and behaviour patterns.

Identity alteration differs from identity confusion in that identity confusion represents the internal dimension of identity disturbance, whereas identity alteration represents the external dimension. A person with identity confusion, in other words, has thoughts and feelings of uncertainty and conflict related to his or her identity; a person with identity alteration manifests the uncertainty and conflict **behaviourally**.

Trauma and Splitting

Alternative personalities emerged as the psyche's response to trauma, typically in early childhood. To understand that phenomena we need to recognize trauma can have deep and lasting effects on the psyche.

The Adult Baby – An Identity on the Dissociation Spectrum

Dr Ross describes the nature of trauma –

“The impacts of trauma on a person can be profound, and multiple. Trauma could affect a person in terms of the cognitive, behavioural, emotional, interpersonal and even physiological aspects of self. Why?”

Trauma may make a person feel like the world is dangerous and unpredictable.

Trauma may make a person think that no one can be trusted.

Trauma may make a person believe that he/she is not loveable.

Trauma may make a person feel very angry, depressed or frightened.

Trauma may make a person try hard to avoid any similar situations and anything that could remind him/her of the traumatic event.

Trauma could profoundly affect one’s body (eg. Amygdala, hippocampus, autonomic nervous system). After trauma, a person may become very sensitive and hyperaroused; his or her stress response systems are also affected, and he/she may have difficulty in relaxing or getting to sleep.

Trauma leaves a person with unprocessed memories and unaddressed emotions, which may become nightmares or lead to flashbacks.” [Be a Teammate with Yourself: Understanding Trauma and Dissociation]

Trauma is a challenge for someone at any age. But it is particularly challenging for a child who’s psyche is still dependent on the care and support of others. Trauma can be caused by abuse. It

can also be caused by more mundane events - the 'ordinary catastrophes' of childhood such as accidents, temporary separations from caregivers, or bullying. It can happen in any situation where a child experiences great distress or fear, and feels themselves to be physically alone, or feels unprotected by those to whom they might look to for protection.

In the face of overwhelming fear and distress, a child's psyche may 'split off' a distinct alter. This is a sub-conscious process. Dr Steinberg indicates the younger the child, the more susceptible they are to 'splitting'.

Dr Jeffrey Smith describes the process of traumatic 'splitting'

Multiple personality begins with dissociation. When we note that adult victims of disaster seem to be in 'a daze', we are referring to dissociation. There is the dissociation of feeling from fact. Trauma survivors will often remember the moment they dissociated. For example, a child who was molested, focused on a spot on the ceiling. Soon she began to experience herself looking down dispassionately from the ceiling as if the girl below were someone else.

Where there is complete amnesia, the dissociation is more extensive, involving memory as well as feeling. ... what makes a particular trauma severe enough to trigger loss of memory? The first and foremost factor, in my view, is aloneness, the lack of a safe person to share the event. The need for human connection, especially in times of stress, begins very early in life. A six-year-old girl in the process of being abused by her drunken step-father was able to keep from being overwhelmed by hoping that her mother would soon return. When her mother did come back, the girl quickly realized that her mother was no more able to stand up to her abuser than she was. Suddenly aware that her hope was illusory ... she ran out of the house into the night. Years later, the only thing she remembered was

The Adult Baby – An Identity on the Dissociation Spectrum

the image of headlights shining in her eyes. Aloneness makes traumatic events much more damaging, and dissociation much more likely. [A Fractured Mind: My Life With Multiple Personality Disorder – Epilogue]

Splitting quarantines incapacitating fear and pain so the rest of the psyche can continue to function. It can also preserve attributes or capabilities that might otherwise be damaged or lost due to the trauma. Dr Smith states –

“... when events overwhelm emotional defences, the damage is less when it can be encapsulated in dissociation. Trauma survivors who are not able to dissociate often sustain greater damage than those who are able to split. The harm to self-esteem and to the sense of safety affects their entire being. By contrast, multiples often have parts that are entirely spared the effects of trauma. There may be joyful, innocent children existing side by side with those personalities that have been most damaged.”

Dr Yeung describes this response to trauma as the psyche’s ‘self-triage’. Splitting can occur multiple times as dissociation becomes the pattern for responses to trauma.

Repression and Denial

In cases of traumatic dissociation in adults, the memory of the traumatic event is commonly either never lost, or returns shortly afterwards. Dissociation linked to childhood trauma is different. It often has lasting effects on the psyche, effects which persist into adulthood. Yet despite those effects, the memory or full experience of the trauma may be hidden in the unconscious for many years and decades.

Both the original trauma and the resulting alter are initially buried in the sub-conscious in what is called repression. When the alter and memories are repressed we genuinely don't know they are there. It is amnesia.

Repression is key to understanding dissociation.

Based on my personal experience, I think of repression as a high wall. It was erected quickly in an emergency. It was not so much built, as 'thrown up', using whatever materials and labour were at hand. In places, the wall is made of big concrete blocks, well-mortared and on deep foundations, and will never come down. In other places, the wall is just house bricks, sometimes poorly mortared and without a solid footing beneath. In those places, the mortar ages and crumbles and eventually the bricks tumble down, leaving gaps in the wall.

The memories of trauma, and trauma-related experiences, such as the splitting of alters, are not only buried in the unconscious, they are stored in a way that makes their retrieval complex and uncertain. They are not stored as useable, accessible memories (explicit memory). Dr Smith explains the difference between explicit and implicit memory -

*“Explicit memory is processed for storage in a structure [in the brain] known as the hippocampus, while implicit memory is more diffusely spread out in the brain. Simply stated, **explicit** refers to that which is in the foreground of our consciousness and accessible to language, while **implicit** refers to the background, or context, and is nonverbal.”*

Dr Steinberg indicates that –

“the amygdala shapes and stores traumatic memories in the limbic part of the brain, which processes emotions and

The Adult Baby – An Identity on the Dissociation Spectrum

sensations, but not language or speech. As a result, survivors of childhood abuse may carry implicit physiological memories of the terror, pain, and sadness generated by the abuse but may have few or no explicit factual memories to explain their flashbacks and the feelings and sensations they arouse. They live with the repercussions of the event without having a narrative – this is what happened at this time or place – to provide a back story. Memories of traumatic experiences are not retrieved so much as they intrude. They pop up in jagged impressionistic fragments overloaded with sensations and emotions that can distort the details.”

This pattern of memory is applicable to any repressed trauma, not just abuse.

Over time repression breaks down - fragments of memory return. The buried, split off alter 'breaks through' and influences a person's thoughts, feelings, perceptions and behaviours, even when the source of that influence is unrecognized. Repression can start breaking down early. For example, ABs commonly start acting on their desire for nappies around age ten, or sometimes even earlier. That desire is compelling, but incomprehensible because it represents the first breakthrough of repressed unconscious needs.

After that has been happening for a while, repression can start to shade into denial. Unlike repression, denial is a product of the conscious mind. Therapist Lyn Mary Karjala explains -

“It [denial] happens when there's some aspect of the external world that's simply too painful for us to face, so we can't allow ourselves to see it. The classic example is the alcoholic who admits that he drinks but vehemently denies that he has a drinking problem, in spite of the mounting evidence that's increasingly apparent to people around him. He's not knowingly lying when he says he doesn't have a problem – he's

genuinely unaware of it. In other words, he's kept the knowledge of his behaviour in his conscious awareness – he knows that he drinks – but he's dissociated the significance and the danger of the behaviour.” [‘Understanding Trauma and Dissociation: A Guide for Patients and Loved Ones’]

For this book, the reader might replace the reference to an alcoholic and drinking with an AB and their compulsive need for nappies. We might imagine hearing an AB say, *“its just a kink or fetish, nothing to do with deep issues in my psyche and my childhood ... ”*

Dr Steinberg states –

“ ... people suffering from a dissociative disorder often have a huge amount of denial. ... Their worst fear is that if they talk about their symptoms to a therapist, they’ll immediately be labelled as a freak or a crazy person.

Very often, people who have separate parts of themselves keep them hidden, because they don’t think of them as well-defined personalities, but more as ‘aspects’ of their own personalities or different internal voices or puzzling ‘sides’ of themselves with which they are not in touch with all the time.”

“One of the trickier aspects of dissociation is that the more chronic some symptoms are, the less stress they may cause because you’ve adapted to them and they have become as normal to you as breathing.”

As a result of repression and then denial, it can take decades for the unconscious to release its’ secrets. I mean decades! To change analogies, the way repression releases its grip on memory is like the front of a glacier where it meets the sea. Mostly it just melts, releasing the meltwater so slowly that it’s imperceptible. But at other times, great blocks of ice will crack and fall off the glacier and crash into the

The Adult Baby – An Identity on the Dissociation Spectrum

sea throwing up a shower of spray. Then we will have blocks of memory suddenly return. Even years after self-acceptance and therapy, the unconscious continues to release new insights and memories.

Only those who have lived long enough to see the unconscious repression in their own early life break down and be revealed, understand its power. Trying to explain that to others, especially those in the first half of life, can be a bit like trying to explain colour to the colour-blind. Recognizing the power your unconscious has had over your life is confronting. It humbles our pride that we are the ones in conscious control. The first decades of adolescence and adulthood are about establishing that control. It is not a time of life well suited to recognize some of that hard-won control is illusory.

Dissociation Becomes Dysfunctional

We have seen that dissociation is functional when a child is faced with overwhelming trauma. It quarantines fear, hurt or pain within one part of the child's psyche so they can continue to function after the trauma. It protects resilience. Dissociation is a creative, subjective denial of objective reality.

However, continued reliance on dissociation when we are adolescents and adults can become dysfunctional. Denying objective reality becomes a two-edged sword. Some denial might not cause too much harm. But denying objective reality too much, or the parts of it that we need to heed to be safe and functional becomes dysfunctional and harmful. It reduces our resilience and makes us more psychologically vulnerable. That is what happens for people with severe uncontrolled DID.

If you have dissociated trauma in your childhood, the problem is that you don't pick and choose rationally when to use dissociative coping strategies as an adult. Those choices are being

made in your sub-conscious and driven by the unhealed childhood trauma. And coming from that fearful and hurt place some of the choices will be bad ones. That's why it's important to identify and heal childhood trauma. Only that allows a person to make conscious and rational choices about how they cope with the difficulties they encounter.

The Dissociation Spectrum Revisited

Now that we are armed with a greater understanding of dissociation we can revisit the dissociation spectrum with greater precision. Dr Ross states –

“The spectrum of dissociation is often portrayed as: no symptoms at the left-hand end – symptoms but no diagnosable disorder – dissociative amnesia – depersonalization/derealization disorder – other specified dissociative disorder (OSDD) – DID at the right-hand end.”
[Treatment of Dissociative Identity Disorder: Techniques and Strategies for Stabilisation”]

ABs who are confronted by the idea they are on the dissociation spectrum might find it easier to think of it as an ‘inner child spectrum’. Dr Ross continues -

“... a good conceptual framework for the spectrum of dissociation is the inner child spectrum. The inner child is therapeutic lingo for unresolved feelings from childhood. The only question is: are these just feelings, or are they contained in an inner structure that has some degree of separateness from the adult self?”

The inner child spectrum goes: no inner child – a metaphorical inner child – a sense of an inner child – a definite knowledge

The Adult Baby – An Identity on the Dissociation Spectrum

that there is an inner child inside – the inner child is visualized internally – the person and hear and talks to the inner child (DID).”

For ABs, the inner child is at the DID end of the spectrum. We may not hear the voice of the child in our heads, but their infantile needs result in persistent behaviours like wearing nappies, using pacifiers and baby clothing.

Summary

Dissociation means detachment from the self, or from the external environment, or both. Dissociation falls on a broad spectrum, ranging from common every-day, voluntary mental states through to involuntary, clinical conditions. Dissociation has five components. Every person on the dissociation spectrum has a different footprint, a unique combination of some or all of the five components, and in differing strengths. Each individual dissociation footprint produces a unique view of self and life.

Identity alteration, having distinct personalities or alters within the psyche, is one of the five components of dissociation. It comes from childhood trauma, where in response to overwhelming fear or pain, the psyche splits off an alter. That alter serves to quarantine the fear or pain to allow the rest of the psyche to function. It can also preserve attributes and capabilities within the psyche which would otherwise be damaged or lost. The memory of traumatic childhood dissociation is buried in the unconscious is what is called repression.

4. Dissociative Identity Disorder (DID) and being an Adult Baby (AB)



This chapter looks at DID and being AB and their respective places on the dissociation spectrum.

Concepts

To understand people with alternative personalities we need to use some concepts from DID.

A person who has an undivided, unitary psyche is called a 'singleton'. Anyone who has at least one alternative personality is called a 'multiple'. I use the term psyche to describe the whole person, whether a singleton or a multiple. When I use the term psyche for a multiple, it refers to all their parts (people with DID often use the term 'the system'). The 'host' is the personality who is out front most of the time. The host may, or may not be, the original personality from whom all the others sprang, directly or indirectly – the latter is the 'birth personality'. Each personality is called an 'alter', short for alternative personality (people with DID sometimes use the term 'parts').

For people with DID who's psyche is fragmented by amnesia, the total stock of memory is compartmentalized within different personalities. If fragmentation is reduced and personalities share memories, they are 'co-conscious'. A personality may be co-

conscious with one or more other personalities, but not necessarily all.

The personality who is in executive control of the person's body is 'out', and others are 'in' (meaning inside). When the personality in executive control of the body changes, that is referred to as 'switching'. If the two personalities involved in the change are not co-conscious, switching can be very abrupt. If the two personalities involved are co-conscious, the change may be smoother and is termed 'shifting'. If more than one co-conscious personality simultaneously shares executive control of the body, they are referred to as being 'co-present'. (*Shifting* and *co-present* are terms which seem have originated with psychiatrist Colin Ross).

What is DID?

People with DID have multiple alters, who have distinct characters which may be similar or different to the host personality. Alters can be adults or children. In a fragmented state, the alter in control of the person's consciousness – their perceptions, thoughts, feelings and actions – can switch unpredictably. Switching can be triggered by a range of factors, for example, stress, anxiety, a set of terms or raised voices. Also in a fragmented state, these alters do not share memories, so the person can find clothes in their wardrobe they don't remember buying or wake up with injuries they don't remember sustaining. The common origin of DID is severe, repeated abuse in childhood.

The experience of each person with DID is unique. Behaviours linked to DID typically manifested early in life, commonly in adolescence. Some people are diagnosed and accept their identity in adolescence. Others are not diagnosed until mid-life, and before that developed coping mechanisms to navigate life while hiding their identity. A parallel is the way in which adults who are illiterate have

developed effective and subtle ways to conceal the fact. Unless they are in acute distress, many people with DID go about their lives without acquaintances, colleagues or even friends being any the wiser. There are people with DID in many walks of life.

The goal of treatment of DID is to reduce the extent of fragmentation of the psyche. The success of treatment varies depending on the individual and the severity of the childhood trauma. At its best, the fragmentation can be healed or greatly reduced.

What about being AB?

Like DID, the experience of every AB is unique. It covers a large range. Some identify as diaper lovers (DLs) who wear diapers/nappies but do not acknowledge any other attraction to the trappings of infancy or early childhood. Adult babies are attracted to nappies, and to the trappings and fantasies of infancy – with a repertoire of baby clothes, stuffed toys, pacifiers, bottles etc, that varies with each individual. ABs often refer to their baby or child side as their ‘Little’ and to inhabiting their baby side as ‘little space’. For either DLs or ABs, the attraction can be exclusively sexual, exclusively for emotional comfort without a sexual dimension, or a combination of both.

The attraction to nappies commonly first manifests at an early age, even before adolescence. There is a strong involuntary dimension to the attraction. It is a deep need. Attempts to suppress it for any period commonly result in the involuntary triggering of an urgent and compelling need to put on a nappy. Attempts at suppression also create a ‘binge and purge’ cycle with sharp, tumultuous and involuntary shifts in mood and behaviour. Conflicted ABs are typically adept at disguising these attractions and behaviours, even from those closest to them. The behaviours and fantasies are commonly incomprehensibly at odds with the

The Adult Baby – An Identity on the Dissociation Spectrum

adolescent or adult personality of the AB, and a source of deep shame and confusion that seeps into many aspects of the AB's life.

Some DLs and ABs come to terms and accept this side of their personality in adolescence (particularly after the advent of the internet and social media age). Many, especially those who grew up in an earlier age, remain deeply conflicted well into mid-life. There is often a high level of denial amongst ABDLs – of the amount of space their 'Little' occupies in their psyche, its' origins and its' implications.

DID on the Dissociation Spectrum

DID is the most extreme form of dissociation.

Dr Steinberg indicates people with DID typically have all five components of dissociation, and to a high degree. Amnesia, not just for past trauma, but for the activities of different alters in the present, is a defining characteristic of DID.

The DSM-5 is the current version of the Diagnostic and Statistical Manual of Mental Disorders - the standard diagnostic tool published by the American Psychiatric Association (APA). It states the following criteria must be met for an individual to be diagnosed with DID:

1. The individual experiences two or more distinct identities or personality states (each with its own enduring pattern of perceiving, relating to, and thinking about the environment and self). Some cultures describe this as an experience of possession.
2. The disruption in identity involves a change in sense of self, sense of agency, and changes in behaviour, consciousness, memory, perception, cognition, and motor function.
3. Frequent gaps are found in the individual's memories of personal history, including people, places, and

events, for both the distant and recent past. These recurrent gaps are not consistent with ordinary forgetting.

The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The differential diagnosis for DID excludes symptoms directly caused by other medical conditions (ie. seizures) or substances (ie. a drug of abuse or medication).

Essentially, the DSM-5 definition says DID is a combination of identity alteration and amnesia. For the purposes of the DSM-5 definition, these two components also subsume the other three identified by Dr Steinberg (identity confusion, de-personalisation and de-realization).

Dr Smith makes clear the link between identity alteration and amnesia –

“The term ‘multiple personality’ does refer to the most striking feature of the disorder, but it also misplaces the emphasis. The key to making sense of dissociative identity disorder is to look not at the personalities but at the memory barriers between them. We could describe a house in two ways, either as a collection of rooms or as a collection of walls. Both are true, but one cannot construct a house out of rooms. Only walls can be constructed, and rooms are the result. When we first confront multiple personality, we see dramatically different personalities before our eyes. We see rooms, and it is easy to forget that their existence is really a consequence of there being walls – that is, dissociative memory barriers resulting

The Adult Baby – An Identity on the Dissociation Spectrum

from trauma. As memory barriers become fixed and are maintained over time, the personalities on opposite sides develop separate histories, values, allegiances, possessions and relationships. ... A consequence of the development of memory barriers is the development of sharply different personalities that diversify even more over time and are capable of vying for control over the body they inhabit."

Even with DID, denial is common. The ISSTD's 2010 Guidelines states -

"Clinicians should bear in mind that some persons with DID do not realize (or do not acknowledge to themselves) that their internal experience is different from that of others. In keeping with the view that dissociation may serve as a defense against uncomfortable realities, the presence of alternate identities and other dissociative symptoms is commonly denied and disavowed by persons with DID. This kind of denial is consistent with the defensive function of disavowing both the trauma and its related emotions and the subsequent dissociated sense of self."

Overlap Between DID and AB

The DSM-5 criteria let us see clearly the relationship between DID and being AB. There is a strong overlap. A conflicted AB matches three of the four DSM-5 criteria for DID.

ABs fit the first DSM-5 criterion for DID - *"two or more distinct identities or personality states (each with its own enduring pattern of perceiving, relating to, and thinking about the environment and self)"*.

ABs fit the second DSM-5 criterion, notably the change in behaviour - *"The disruption in identity involves a change in sense of*

self, sense of agency, and changes in behaviour, consciousness, memory, perception, cognition, and motor function.”

ABs do **not** fit the third DSM-5 criterion – *“Frequent gaps are found in the individual’s memories of personal history, including people, places, and events, for both the distant and recent past.”*

Conflicted ABs *can* fit the fourth DSM-5 criterion – *“The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.”*

We need to look further at the four criteria.

Conflicted DLs and AB’s may consider they don’t have a distinct child alter – it’s just a ‘side’ of their otherwise adult personality. That may be true. In an earlier quotation, Dr Steinberg refers to moderate levels of identity alteration involving ‘personality fragments’ rather than distinct personality states with persistent traits and behaviours.

Conversely, for many ABs, I suspect the non-acceptance of a child alter represents unconscious repression, conscious denial, or the early stage of coming to terms with their confronting identity. For people with DID or ABs, often the personality of alters doesn’t emerge from the sub-conscious until after self-acceptance (refer to Chapters 8 and 10 on alters). Before that, the alters influence behaviour, but largely from the sub-conscious. There are parallels with other minority identities where people don’t accept their non-conforming sense of self until mid-life. That can happen even where they have kept secret over a long time, behaviours and thoughts which pointed towards that non-conforming sense of self.

Behaviour may be a more objective indicator of whether an AB fits the first two DSM-5 criteria for DID (an alternate personality, manifested behaviourally). For ABs, the extent of persistent involuntary behaviour commonly includes –

The Adult Baby – An Identity on the Dissociation Spectrum

- a frequent irresistible compulsion to wear nappies - often triggered involuntarily;
- a deep need for non-sexual emotional comfort from nappies, pacifiers, bottles or the like;
- strong behavioural and mood swings linked to the 'binge and purge' cycle;
- a rich fantasy life deriving emotional comfort from identifying as a helpless or dependent baby, and being babied by caregivers and substitute parents.

We need to focus further on the 'binge and purge' cycle because it is the clearest indication of identity alteration for ABs. The phrase comes from the disease bulimia where the sufferer gorges on food and then, in deep self-disgust and loathing, makes themselves sick until they purge their stomachs empty. For adult babies, it means something different. It means bingeing on a new or extra stock of nappies and often other baby clothes and paraphernalia. Sometimes the binge is downloading digital AB erotic fiction.

The binge prompts recurring bouts of increasingly compulsive masturbation, perhaps fueled by psychologically unhealthy, masochistic AB fantasies. Like the bulimic, the binge causes initial euphoria and then deep self-loathing, which in turn results in a compulsive purge. The AB disposes of their entire stock of nappies and other AB supplies and vows to give up being AB forever. They may delete the digital copies of AB erotic fiction. There is an initial euphoria at being 'cleansed' of something bad. But after an interval, the AB's unmet needs for the comfort of nappies and baby fantasies kicks off another binge and the cycle reboots. The cycle is emotionally wrenching and exhausting.

Both the binge and purge are involuntary. Having been through the cycle before, the AB's adult self is fully aware, but their executive control of decision making and physical action is overridden. In the *binge*, the over-ride is by a part of the psyche that is

desperate for the comfort of nappies. In the *purge*, the over-ride is by an opposing part of the psyche that is terrified and repelled by these infantile needs and behaviours.

The binge and purge cycle and other involuntary AB behaviours fit Dr Steinberg's definition of "severe identity alteration, ... [which] involves a person's shifting between distinct personality states that take control of his or her behaviour and thought." That suggests a distinct child alter, whether acknowledged or not. Such behaviours fit the first and the second DSM-5 criterion for DID.

In terms of the third criterion – amnesia – ABs do not lose memory in the present or the recent past. They only have amnesia in terms of the repression of old childhood trauma and the origin and existence of the alter(s) which split during the trauma. Any alters which do emerge are fully co-conscious. Thereafter, sharing memories, the alters and the birth personality influence each other's traits and behaviours.

In terms of the fourth criterion – distress or impairment – conflicted ABs are intermittently tormented by the involuntary behaviours described above. The see-saw conflict between their adult and child selves constitutes 'identity confusion', one of the five components of dissociation. At its worst, such as the height of the binge and purge cycle, it represents distress and impairment.

The affinity between DID and being AB is illustrated in Dr Steinberg's statement -

"In the most basic terms dissociative identity disorder, or DID, formerly called multiple personality disorder, is what happens when your 'inner child' or some other hidden part of yourself operates independently, seizes control, and makes you act inappropriately or impairs your ability to function."