

## Adult Baby Syndrome

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**A**lthough our standard diagnostic nomenclature in psychiatry covers many conditions, patients still appear in psychiatrists' offices who do not fit a well-defined psychiatric disorder. Unusual behaviors may escape psychiatric classification if they do not create subjective distress, do not distress others, and do not involve functional impairments or legal problems. Entire subcultures related to these behaviors may exist outside of the awareness of psychiatrists and other mental health professionals. When no descriptive diagnosis is apparent, clinicians may still use psychodynamic knowledge and skills to assess a patient's conscious and unconscious agendas and understand a patient's complex reasons for seeing a psychiatrist.

With this case conference, we present the case of a man who appeared as a "baby" for psychiatric evaluation and treatment. It soon became apparent that the patient's request for treatment was complicated by a variety of other motives.

### Dr. Pate

Mr. A, a 35-year-old single Caucasian man, contacted our clinic by telephone to schedule an evaluation because "I am supposed to be a 35-year-old, but I want to be a baby. I won't ever get married or have kids if I am stuck as a baby." During our initial telephone contact, Mr. A spoke in a soft, childlike voice. He had some difficulty providing basic demographic data and would answer questions by saying, "I don't know." After a brief initial interview, Mr. A requested an intake appointment with a female therapist.

Mr. A arrived on time for his appointment. He was dressed as a child and continued to speak in a childlike voice. During the first interview, Mr. A stated that he had wanted to be a baby since the age of 12 and he began wearing diapers at age 17. He was now seeking treatment because his desire to be a baby interfered with interpersonal relationships. He was unable to identify any precipitating events or stressors preceding his desire to be a baby or his subsequent return to wearing diapers. He began wearing diapers when he moved out of his parents' home and was able to purchase and wear diapers secretly, without his parents' knowledge. He continued to be secretive about his baby activities, but he would wear his baby clothes outside his home to several specific places, including toy stores, the barber shop, the massage, and the psychiatry clinic. Mr. A repeatedly stated

that he wanted "to be taken care of by a mommy who can hold me and rock me and give me a bottle." He frequently reiterated his wish to go to a place "where they would make me be a baby." Mr. A acknowledged that his desire to be a baby interfered with his social activities because he preferred to stay at home and engage in activities associated with being a baby, including wearing diapers and baby clothes (which he purchased from a web site for adult babies). He slept in a crib in his closet and explained, "A crib is a real baby bed, and that makes me a real baby." He drank out of a bottle and often ate baby food. He liked to play with blocks, cars, and Playdoh.

Mr. A reported during the first interview that wearing diapers was "a kind of a sexual thing," but he was initially unable to describe what he meant by this statement. During a later session, when he was asked about the sexual nature of wearing diapers, he reported that he masturbated while wearing his diapers. He reported that wearing diapers was sexually stimulating and that he would often think about "how I am a baby" and masturbate in his diapers several times per day. He masturbated only while wearing diapers. He also urinated and defecated in his diapers and used approximately five di-

apers per day. On several occasions, Mr. A asked for "a prescription for diapers." When asked about the need for a prescription, he stated that "it would make me be a baby" and that with a prescription, the diapers would be less expensive.

Obtaining additional history from Mr. A was extremely difficult because he was frequently reluctant to provide detail and would often answer questions by replying, "I don't know." He seemed impatient with the gathering of historical data, as though it interfered with his own agenda.

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### Past Psychiatric History

Mr. A reported that he had sought psychiatric evaluation on one earlier occasion but did not return for follow-up because "The lady was mean." He had never been involved in psychiatric treatment and has never received a prescription for psychotropic medications. He has never been hospitalized for psychiatric reasons. Mr. A also has no history of suicide attempts.

### Past Medical History

Mr. A had had a tonsillectomy at the age of 5. He had no chronic medical illnesses. He had no history of significant childhood injuries or illnesses. He currently took no medications.

### Social History

Mr. A lived alone in an apartment. He was employed in law enforcement in an outlying community. He said that he enjoyed his work and that while he was at work, he did not feel like a baby. According to Mr. A's report, his desire

to engage in infantile activities did not interfere with his work. His colleagues did not know about his baby-related activities. He reported significant social isolation due to his desire to be a baby. Although he had dated women in the past, his last date was several years ago.

### *Developmental History*

Mr. A was the older of two children who were adopted at birth. His sister was married and did not have children. Although his sister had met her biological parents, Mr. A said that he had never wanted to meet his biological parents because his adoptive parents felt like his “real parents.” Mr. A described his adoptive parents as being “very nice and always there. They are religious but not overly religious. Just normal.” He has always felt closer to his adoptive father than to his adoptive mother and enjoyed going fishing with him. Mr. A described his adoptive mother as “boring because she reads a lot.” He described his life growing up as “fun.” He reported no history of sexual, physical, or verbal abuse. He attended regular classes and made average grades, despite not enjoying school. He was a college graduate. He had worked in law enforcement for the past 10 years. He described his sexual orientation as heterosexual. He was not currently involved in a romantic relationship. He dated his first girlfriend at the age of 17 and had had about five girlfriends. He had never been involved in a sexual relationship and stated that he planned to “wait until I get married.” He was in a relationship with his last girlfriend “for a couple of months a couple of years ago.”

Mr. A reported no symptoms of depression, anxiety, or psychosis. He reported no problems with substance use. He said that he consumed alcohol infrequently and had no current or past history of illicit drug use. He had never been arrested and reported no involvement in illegal activities.

### *Mental Status Examination*

Mr. A was a Caucasian man who appeared to be approximately his stated age but was dressed as a child in *Winnie the Pooh* overall shorts with a *Winnie the Pooh* shirt underneath. He was well groomed and had a strong odor of baby powder. He had a pacifier in the pocket of his overalls. He carried a diaper bag with a bottle in the side pocket and a bib, baby blanket, and adult-sized diapers inside. He spoke in a quiet, childlike voice. He often answered questions by saying, “I don’t know” or “Okay.” He was cooperative but extremely passive during the interview. He appeared embarrassed and anxious. He sat on his hands throughout most of the interview and often rocked back and forth. Eye contact was generally appropriate. Mr. A removed a bottle from his diaper bag, lay down on the couch with his feet propped up on the arm of the couch, and stared at me for several minutes while he drank from his bottle. His mood appeared to be euthymic. His affect was anxious, in a constricted range, and blunted in intensity. His thought processes were logical and goal directed. He volunteered little additional information and provided brief answers to the questions I asked. With regard to thought content, he reported no auditory or visual hallucinations or suicidal and homicidal ideation. He often perseverated on his desire to be a baby and at times appeared almost delusional in his belief that he actually was a baby. However, when

pressed, he could acknowledge that he was not “really a baby”—he just wanted to be one.

Over the five sessions that we met for this extended evaluation, Mr. A stated that he felt that we worked well together. When asked what was “mean” about the clinician who conducted his earlier psychiatric evaluation, he replied, “I think she is just always mean.” I asked him about things I might say or do that could potentially feel mean, and he responded by saying that he did not feel I was mean and could not imagine situations in which I would be perceived as being mean.

Although he reported feeling comfortable discussing his problems openly during our sessions, he seemed intent on controlling our agenda. During his telephone calls to schedule appointments, he always asked, “What is going to happen when I come there?” I felt he did not trust me as much as he stated he did. In addition, his desire to “go to a place where they would make me be a baby” often served as an obstacle to developing a therapeutic alliance and diverted our attention to why I could not fulfill this desire.

I had complicated countertransference feelings toward this patient. Initially, I was eagerly anticipating the opportunity to work with such an unusual patient. I often imagined working with him for several years to come and feeling the pride of seeing him “grow up.” Along with the positive feelings associated with working with Mr. A, I also felt trepidation. One of my primary goals was to avoid “being mean,” like his earlier therapist. I often felt restricted by this constraint and censored what I said. I wanted Mr. A to keep returning for our sessions, and I was afraid of saying something that would alienate him. I felt I had to tiptoe through a veritable minefield or I might lose my extraordinary patient. I was disappointed by the absence of any literature about working with this type of patient. As a neophyte psychiatrist, I still prefer the guidance provided by books and supervision. As Dr. Gabbard, my consultant with this unique patient, often said, “To quote Indiana Jones, we are making this up as we go along.”

There were also frequent feelings of frustration in working with Mr. A. I felt annoyed that he was unable to schedule sessions ahead of time; instead, he contacted me after hours in the middle of a week to schedule an appointment for that week. He attributed his inability to schedule appointments at the end of each session to uncertainty about his work schedule. Everything had to be on his terms, leading me to feel controlled. I was also growing impatient with his repeated questions regarding “What is going to happen when I come there?” I had explained this many times. I felt frustration because of his soft, childlike voice. I often could not hear or understand what he was saying. During our sessions, I often felt uncomfortable since he would lie on the couch and drink from his bottle while staring at me provocatively. I questioned the appropriateness of allowing the patient to lie on the couch and drink from a bottle. After discussing the issue with my consultant, Dr. Gabbard, I recognized that forbidding such behavior would fit right into Mr. A’s effort to make me into a maternal figure, telling him what to do and what not to do. Additionally, I did not want to assume a punitive maternal role. Although he was not able to articulate his thoughts or feelings at this time, his constant staring and unwillingness to discuss his feelings disturbed me. There was something vaguely

uncomfortable about it—a cross between being regarded as a sexual object and as a longed-for mother.

### Formulation

Mr. A was a 35-year-old Caucasian man with no known past psychiatric or medical history who came in for evaluation because “I am stuck as a baby.” Because he was adopted at birth, little was known about his genetic predisposition to psychiatric disorders. On one level, Mr. A appeared to have a paraphilia involving diapers. His wearing of diapers was obligatory for sexual arousal, and his desire to wear diapers had an obsessional quality. However, the psychodynamic issues were more complicated. Mr. A had dependent personality characteristics, including an excessive need or desire to be cared for, difficulty expressing opinions and disagreement, and a desire for others to assume responsibility for his life (i.e., to “make me be a baby”). However, there were also aggressive undertones manifested by his refusal to schedule appointments in advance and his displeasure with the interview room because “it’s not a baby room.” His baby-related activities consumed a significant portion of his free time, but he had some ambivalence about his identity as a baby because he sought psychiatric evaluation and reported that he eventually wanted to marry and have children. He recognized that both were incompatible with his “being a baby.”

### Follow-Up

Despite encouragement to bring his work schedule to the session, he continued to avoid scheduling appointments in advance. During our last session, we continued to discuss his desire for me to place him somewhere in which he would “have to stay a baby.” For example, he asked that I admit him to a nursery at a nearby children’s hospital or see him in the child psychiatry clinic. Because I felt that this ongoing desire interfered with the therapy, I spent time explaining that it was not possible for me to admit him to places such as these because he was not actually a baby. At the end of this session, we again discussed scheduling issues. He was unable or unwilling to commit to an appointment time and asked if he could call me next week and come in to see me then. I responded affirmatively, and we concluded the session. I have not met with him again. After presenting this case at a weekly case conference at Baylor Psychiatry Clinic, I was told by several moonlighting residents that Mr. A often calls the local psychiatric hospitals in the middle of the night to engage in lengthy conversations with the nurses about his wish to be a baby.

Several months later, I contacted Mr. A to see how he was doing and to explore his interest in returning for treatment. He reiterated his desire to be seen in a nursery. At the end of our conversation, Mr. A admitted that he liked being a baby and was not sure that he wanted to change his behavior. I wished him well and encouraged him to contact me in the future if he wished to pursue treatment.

### Dr. Gabbard

In a recent episode of the hit television series *ER*, a fully grown man dressed in a diaper was pushed down the hallway of the emergency room on a gurney. A psychiatric res-

ident walked beside the gurney, wielding a copy of the *Comprehensive Textbook of Psychiatry*. He explained to the perplexed attending physician that the patient has “adult baby syndrome.” In reality, even though this syndrome, also called “infantilism,” has made it onto network television, it is not yet included in psychiatric textbooks. Perhaps the reason that it has not found much of a home in our psychiatric literature is that most people who fit this profile do not consider themselves patients. However, there are 68 pages of web sites on Google.com that contain the phrase “adult baby,” and many similar entries are reportedly omitted. In perusing one of the most popular web sites for adult babies, I learned that more than 15,000 people have logged on to this particular web site in the last 23 years. Adult babies can use the web site to arrange meetings at parties, play together, and choose from a large selection of plastic pants, diapers, adult baby outfits, and adult baby-sitting services. This web site, and others like it, also displays a good deal of sexually provocative material, including sexual appliances, photographs of dominatrices, and promises of punishment for being “bad.”

In a search of the psychiatric literature (MEDLINE, 1966 to the present, and PsycINFO, 1987 to July 2002), we were able to locate only three references that were even remotely related to this syndrome, all from the 1960s. Malitz (1) reported a case of a 20-year-old college student who was arrested by police for breaking into a house. He reported that the reason he broke into the house was because of a compulsion to wear diapers and defecate in them. Orgasm regularly accompanied defecation, even if he did not masturbate. He knew that the house in which he was caught would have diapers in it since there was a baby in the house. The patient also liked to wear rubber pants over the diaper. The patient did not, however, think of himself as a baby.

Tuchman and Lachman (2) reported on another patient with legal problems, in this case, for molesting his 4- and 6-year-old daughters. He would wear rubber pants over his diaper and enjoyed urinating and masturbating in it. This patient made no statement suggesting that he wanted to be a baby.

These two cases were both characterized as antisocial behavior, with a predominant emphasis on the fetishistic or sexual aspects of wearing diapers and rubber pants. Unlike Mr. A, neither patient had all of the characteristics of adult baby syndrome.

A case of a 17-year-old boy, reported by Dinello (3), was more characteristic of the kind of presentation that Mr. A manifested. This patient had worn diapers under his clothing, used baby bottles, and eaten baby food since age 15. He had also received medical treatment for an imbalance of growth hormone. Eventually, however, he gave up wearing diapers and began dressing in women’s clothing. He, too, masturbated while wearing the diaper.

The diagnostic understanding in the case of Mr. A is a complicated matter. A survey of DSM-IV revealed no disorder that truly fit Mr. A’s clinical picture. We could rule out a psychotic disorder since the patient clearly stated that he

knew that he was not a baby but only wished to be one. He also had adequate reality testing and sufficient ego strength to pull himself together when he went to work. From a psychodynamic perspective, he clearly manifested a form of splitting characterized by an unintegrated coexistence of two self-representations—an adult who works in law enforcement and a regressed baby. However, he did not meet criteria for borderline personality disorder. Nor did he have dissociative identity disorder because he was clearly aware of both self-representations, he did not have periods of amnesia, and he did not use a different name to describe the “baby” part of himself. Although he might have fit into the category of dependent personality disorder at first glance, it would have been a mistake to apply this label to him since, in his work, he was apparently capable of making decisions, assuming responsibility, and performing duties on his own. Even in his private life as a “baby,” he lived a fairly isolated existence rather than depending on others to take care of him.

The diaper fetish obviously led us to consider paraphilia as Mr. A's central diagnosis. As Dr. Pate suggests, the wearing of diapers was obligatory for sexual arousal, and classically, we think of paraphilias as involving an obligatory and exclusive scenario for sexual arousal (4). However, as more data have accumulated about the various paraphilias, we have become increasingly aware that exclusivity regarding the means of sexual arousal is not necessarily a hallmark of paraphilia. In one study of 561 men seeking evaluation and treatment for paraphilia (5), fewer than 30% of the subjects confined their deviant behavior to only one perversion.

In the classical view of fetishism, castration anxiety is central (6, 7). The concerns about physical harm were regarded as resulting from chronic traumatic interactions in the first few months of life. To experience bodily integrity, the child needs to be soothed by its mother or by transitional objects. In the absence of the availability of a mother or such objects, the child may require a fetish, something “reassuringly hard, unyielding, unchanging in shape, and reliably durable” (7, p. 102). As psychoanalysis shifted from a sexually based drive theory to a paradigm of internal object relations and self-psychology, the understanding of fetishism also changed. Kohut (8), for example, viewed fetishism as a way of maintaining control over a nonhuman version of a mothering figure. He described a patient who made a fetish of underpants to deal with feelings of helplessness about the traumatic unavailability of his mother. Mitchell (9) stressed that an intense sexual need for a fetishistic object may actually reflect severe anxiety about the loss of one's sense of self. One may obtain a sense of coherence or a firmer sense of identity from having the fetish available.

As the conceptual models of psychoanalysis have moved more and more into the arena of object relations, we recognize that the relational aspects of perverse scenarios are crucial to comprehensively understand patients with paraphilias (8–12). If we consider the case of Mr. A in depth, we would be shortsighted to view his wearing of di-

apers as simply a fetish involving his need for sexual gratification. There is little doubt that he had major difficulties in the area of relationships. For example, he had trouble establishing an intimate relationship, and his social isolation was striking.

One of the best ways of evaluating a patient's problems in the area of object relatedness is in a detailed examination of the transference-countertransference developments in an evaluation process. In other words, the patient's internal object relationships forged in childhood are repeatedly externalized in interpersonal interactions in the present. Mr. A, for example, illustrated his need to control others by the way in which he approached the scheduling of sessions with Dr. Pate. Moreover, by studying the way he used the sessions and related to Dr. Pate, we can identify his wishes and desires within interpersonal relationships. When he arrived at the sessions, he did not use the time with his psychiatrist to identify problems and try to find ways to solve them. Instead, he simply enacted a desired scenario by lying on the couch, drinking from his bottle, and staring provocatively at Dr. Pate as though he wished to establish an eroticized mother-infant relationship with her. By allowing this behavior to unfold in the interviews, Dr. Pate gained a wealth of valuable diagnostic information.

The clinician's reactions to the patient indicated something of the characteristic problems the patient encounters in relationships. Dr. Pate described this mode of relatedness as having elements of treating her as an object of sexual desire while also evoking a feeling that she was supposed to be a maternal caretaker. This type of relatedness has a coercive quality that left little room for Dr. Pate's subjectivity or autonomy. She must be completely under his control, an object that gratifies his fantasy life.

The case of Mr. A illustrates two core psychodynamic principles: 1) patients who come for psychiatric treatment may be ambivalent about getting help and attempting to change, and 2) the conscious agenda that is spoken by the patient may be at odds with the actual behavior of the patient in the interview. Mr. A attempted to establish a relationship with Dr. Pate that fulfilled his wish to be a baby taken care of by a mother, even though he professed that he wanted to stop being “stuck” in his wish to be a baby. Ogden (13) stressed that the transference-countertransference scenario itself may be perverse. In the psychoanalytic setting, he suggested that the patient establishes a perverse mode of relatedness as a way of evading an experience of psychological deadness. The drama that is enacted is designed to present a false impression that the patient is actually alive in his power to excite, rather than deadened and empty. Mr. A used Dr. Pate as though she herself were a fetish that would make him feel alive and whole, and that may have been more important than actually undertaking a treatment process to change his behavior. The fact that he was quite withholding when giving his history may reflect the fact that he was not truly interested in collaborating with Dr. Pate in figuring out how his past was repeating itself in the present.



Although the patient provided a limited history, we got some sense of his unconscious agenda by studying what he created with the evaluating psychiatrist. We learned that he was adopted, and we could speculate that he had a long-standing and ongoing conviction that he missed out on the ideal infancy because he was rejected by his biological mother. We could also observe active mastery over passively experienced trauma. In his relationship with Dr. Pate, he insisted on being the one who made the appointments so that he was in charge and ultimately abandoned *her*, rather than giving her the opportunity to abandon *him*—a preemptive strike, in effect. Another significant part of the history is that his wish to be a baby began at approximately age 12, when puberty must have been approaching. We can speculate that one of the determinants of the adult baby syndrome in this case may have been a wish to avoid the threat of genital sexuality by regressing to an infantile dependent state. Moreover, by his bizarre and provocative presentation, Mr. A assured himself that he would become a special patient to Dr. Pate and, in fact, to the entire psychiatric clinic, where many people would gawk at him as he walked in and out of the clinic.

Adult baby syndrome is still a new entity for psychiatrists, and there are undoubtedly variations within the syndrome. Mr. A's statement that he wanted someone to "make him be a baby" evokes images of the sadomasochistic scenarios enacted by a dominatrix and her clients. Indeed, a significant number of middle-aged men seek out dominatrices to spank them, punish them, and tell them that they have been "a bad boy." The wish to be treated as a baby is probably a spectrum condition that has many manifestations involving men, women, heterosexuals, bisexuals, and homosexuals.

As with all paraphilic disorders, the treatment is challenging because there is rarely sufficient motivation for patients to change. In this regard, Mr. A's situation resembles what is commonly found in transvestism. In other words, male transvestites enjoy dressing as women, and they rarely have any interest in changing their behavior. The adult baby syndrome "flies below the radar" of psychiatric diagnoses because individuals wishing to dress as babies rarely see themselves as patients who need psychiatric treatment. The web sites for this disorder suggest that there is probably some overlap with transvestism, since there are numerous photographs of men dressed as female babies.

Mr. A ultimately decided to stop coming to the clinic to see Dr. Pate when he realized that she would insist on a treatment plan and a set of goals, rather than simply col-

luding with the enactment of a perverse scenario of pretending to be a mother and a baby with him. As with many patients, his request for "treatment" may have been suffused with other agendas. To Mr. A, a relationship with a therapist held out the promise of a blissful setting in which no demands would be placed on him for adult behavior. This clinical presentation is an extreme version of a common form of resistance to psychotherapy—namely, instead of using the process for understanding and change, the patient secretly hopes to establish a perfect parent-child relationship to make up for what he or she felt was missed in childhood.

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