Chapter 11
Fetishistic Disorder

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Introduction

Fetishistic disorder is a DSM-5 recognized paraphilic disorder that is less likely to involve illegal behavior or victimization, but is essential in characterizing the versatility of the human sexual imagination. This disorder is demarcated by a distressing and persisting pattern of sexual arousal involving the use of nonliving objects or atypical, nongenital body parts. In the field of cultural anthropology, the term fetish refers to idols and talismans that have symbolic religious meaning. In medical usage the term delineates an object, commonly an item of clothing, which is used by an individual to attain sexual arousal and orgasm. Sexual fetishists frequently need to be touching, smelling, or looking at their unique object, or engaging in fantasy about it in order to function sexually alone or with a partner. Like the religious fetish, the sexual fetish can have significant meaning, but it is a meaning held only by the individual and is not shared by the larger community.

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Fetishism has been recognized as a sexual variation for over 100 years, and has very often been considered a disorder in all of its presenting forms. Recent and ongoing social developments through the exposure of the internet have confirmed the high incidence of fetishistic behavior. We see eccentric behaviors that are met with acceptance by online communities of like minded individuals, and ready availability of means for adaptation and integration into the mental and sexual lives of individuals so affected. Clinical distress of affected individuals, when present and persisting, can now be highlighted as an essential diagnostic feature of fetishistic disorder, and can be considered as a potential target for treatment.

Even when accompanied by high levels of distress, fetishistic disorder remains a rare patient presenting complaint. Fetishists may not understand it to be an appropriate target of medical intervention, or they may be embarrassed to discuss their requirement for arousal, especially if a psychiatrist or other physician has not created a comfortable environment for the discussion of sexual matters.

Research into fetishistic disorder also remains rare. The focus of research has been on the specific diagnostic criteria needed to define this condition as a disorder, and on making rudimentary estimations of prevalence in the general population. The evidence for understanding and treating fetishistic disorder is largely based on clinical experience and on case studies, but not on controlled trials.

Diagnostic Criteria

The descriptive terminology of atypical sexual behavior has included Fetishism since the early twentieth century, and is included in the writings of Freud and of Binet, Krafft-Ebing, and Ellis before him [1]. This early usage of the term fetishism did not refer distinctly to pathological behavior but to a form of eroticization that lay on a continuum from pathological to normal. Early use of the term also included body parts and body products as the object of eroticization. Current DSM terminology has evolved and now DSM-5 has

reincorporated the use of nongenital body parts, previously referred to as Partialism.

DSM-5 has also clarified the terminology, allowing again for the term fetishism to refer to the non pathological presence of particular erotic urges or behaviors, but specifying that fetishistic disorder be used for the uniquely pathological entity where a clinical level of distress is experienced by the patient.

The current DSM-5 criteria are as follows (Reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (Copyright 2013). American Psychiatric Association):

- *Over a period of at least 6 months, recurrent and intense sexual arousal from either the use of nonliving objects or a highly specific focus on nongenital body part(s), as manifested by fantasies, urges, or behaviors.*
- *The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.*
- *The fetish objects are not limited to articles of clothing used in cross-dressing (as in transvestic disorder) or devices designed for the purpose of tactile genital stimulation (e.g., vibrator) [2].*

The focus on body products remains absent from the criteria. A new challenge with the inclusion of nongenital body parts is how to delineate the pathological (from toes and feet to ankles to more traditionally eroticized areas such as legs, hips, buttocks, breasts, and hair). Criterion B, clinical distress, remains a crucial consideration in separating pathology from variations in normal expression.

Diagnostic accuracy requires that fetishistic disorder not be mistaken for an undefined paraphilic disorder, despite common usage of the term fetishism in referring to any unusual (and not otherwise categorized) sexual behavior. The eroticization of animals or of body products does not constitute fetishistic behavior, nor would an excessive focus on genital parts such as breasts, even if the behavior or fantasy interfered with partnered sexual functioning. There is also a differentiation to be made between an erotic focus on an

object or use of that object, and an eroticization of more complex behaviors, such as solitary or partnered role-play, that utilizes certain objects. This is a distinction between the object itself and the meaning of the object to the individual, or the way in which it is incorporated into the erotic imagination, and may offer guidance in considering treatments.

Clinical Case Example

> A man who is singularly sexually aroused by cowboy fantasies is filled with sexual energy upon smelling or even imagining the smell of the leather holster or boots that he utilizes in masturbatory behaviors. The handling and smelling of these objects is sufficient for him to achieve full sexual arousal. However, the fantasy gets played out much further and includes hours of reading the stories of outlaws, dressing and acting the role of outlaws, and finally imagining their hangings or engaging in an autoerotic asphyxiation routine that can culminate in ejaculation free from tactile stimulation. The role play and masturbation are always solitary and require the use of these or other similar objects, but the elements of ruthless behavior and of hanging, in addition to the wearing of costumes and acting out of fantasy roles, all add to the erotic charge. This man wishes that he could rid himself of this elaborate sexual interest, and has many times destroyed his props and vowed never to repeat the behavior. He has tremendous guilt and fear of being discovered, possibly in an asphyxiated state despite the precautions that he takes.

Due to this significant level of distress in combination with the required use of these specific objects, fetishistic disorder is appropriately diagnosed, but comorbid would be multiple undefined paraphilias that include the outlaw fantasy and role playing, the hanging fantasy and asphyxiation behavior, and the accompanying sadistic and masochistic elements. This patient has benefitted from a supportive psychotherapy and has increasing periods of self-described “sobriety,” but the urges and behaviors return, in a form similar to when they developed in his adolescence decades prior.

A recent examination of the Adult Baby Diaper League has also confirmed the distinction between the fetishist’s sexual excitement elicited solely from wearing a diaper, in private or concealed, and more elaborate erotic role-play [3].

This latter behavior, endorsed by some but not all of Adult Baby Diaper League respondents, requires diapers to be worn by the fetishist but also holds essential the parenting behaviors, for some caring and containing and for others shaming and sadomasochistic. Of note, a minority of respondents (13 % of males, 9 % of females) reported ever having a period of more than 6 months when their fetishistic interests caused them problems or distress.

One must proceed carefully when making a diagnosis based upon behaviors that are considered "unusual." Cultural norms play a role in our understanding of health and illness, and have unavoidable impact on our definitions of disease. In addition, cultural norms may contribute to a patient's distress if their behavior is not socially acceptable and considered "deviant" or "perverted." In the area of sexual medicine, homosexuality and masturbation are both examples of behaviors that were historically considered disorders based upon their status as socially unacceptable. In fetishistic disorder, as the DSM criteria indicate, the distinction must be made between those with varying degrees of sexual interest in a fetish object and those who are significantly distressed or facing psychosocial impairment due to a disorder.

Summary of Evidence

Evidence for the characteristics of fetishistic disorder comes only from several sources, most of which cannot be generalized to the entire population.

The forensic population of psychiatric patients is commonly evaluated for sexual crimes involving the paraphilias. The conditions primarily seen are Pedophilic, Exhibitionistic and Voyeuristic, and Frotteuristic disorders, and while comorbid cases of fetishistic disorder exist, they are relatively uncommon amongst sexual offenders and rarely the focus of clinical intervention [4].

Evaluation and treatment of gender dysphoria frequently reveals cases of transvestic disorder, which differs from fetishistic disorder as defined above but which also includes overlap or comorbidity of conditions. Blanchard investigated

247 males who reported transvestism (sexual arousal from dressing in women's clothing) and found that 60.3 % of them also met the independent criteria for fetishistic disorder [5].

Evaluations of subsets of populations, for example, Weinberg et al. who surveyed a group of self-described homosexual and bisexual foot fetishists called the "Foot Fraternity" [6]. This study included 262 individuals and reported primary and overlapping objects of sexual arousal to be clean feet (endorsed by 60 %), boots (52 %), and shoes (49 %). Socks were also found to be sexually arousing "a lot" of the time, notably with smelly socks being more often arousing than clean socks. This reflects their conclusion, based also upon answers to open-ended questions, that the fetish object induces a multi-sensory experience, including smell as well as taste, touch, and sight. A significant percent also emphasized the symbolism of the object as the primary source of arousal, in this case the symbolism of varying type and degrees of masculinity (boots vs. sneakers vs. wing-tips). Of particular diagnostic note in Weinberg's survey, 22.5 % of the individuals reported distress associated with their fetishistic interest, including loneliness, shame, and problems with intimate relationships. The conclusion here was that fetishism (as opposed to DSM-5 diagnosed fetishistic disorder) does not necessarily cause relationship or other psychosocial distress. Sixty percent of those surveyed were able to incorporate their interest in feet and/or footwear into their sexual lives with partners, with the remaining 17.5 % either satisfied to keep their interest secret from their partners or to confine their sexual lives to masturbation.

The largest assessment of atypical sexual interests self-defined as fetishistic is from Scorolli et al., who gathered data from English-language Yahoo internet discussion groups [7]. They reviewed message boards from 381 groups that included 150,000 total members, though recognizing that these anonymous individuals may belong to multiple groups. Their observation was of the sexual preferences expressed by these discussion participants. The participants were not assessed clinically and there was no means to assess whether they were

distressed by their sexual interest (fetishistic disorder), but the results contribute to the evolving taxonomy. Scorolli et al. found the predominant sexual preferences to be for non-genital body parts and features (33 %) and objects associated with the body (30 %). Body parts were predominantly feet or toes (47 %) followed body fluids such as blood or urine (9 %), body features such as obesity or height, and hair, muscles, and body modifications such as tattoos and piercings. Objects associated with the body were those worn on the legs and buttocks such as stockings and skirts (33 %), footwear (32 %), whole-costumes, and less commonly stethoscopes, wristwatches, and diapers. Secondary preferences were expressed for the category "other people's behavior," such as smoking, and then "own behavior," "social behavior," and objects unrelated to the body (5 %). Internet studies have a presumed major sampling bias, but so do samples of psychiatric patients or arrested sexual offenders. It is unclear how these data reflect what exist in general populations and in various countries. The Internet is a new and evolving reflection of the variations in sexual behaviors, perhaps even impacting the development and flexibility of the sexual imagination.

Published clinical case studies, mostly in the psychoanalytic tradition, as well as the clinical experience of the author at the Center for Sexual and Marital Health, provide for additional observations that can be made regarding characteristics of fetishistic disorder. The following is a synthesis of those observations:

Fetishism presents almost exclusively in males. Theories as to why this is the case involve characteristic differences in power dynamics and expressions of control, gender prescribed outlets for initiating courtship and expressing attractiveness, and developmental variations in the flexibility and windows of fixity in establishment of erotic targets. Cases of fetishism in females have been reported [8], and a review of fetish oriented internet message boards reveals females in addition to males who are relieved to find that they are not alone in their variant sexual interests.

Fetishistic arousal patterns seem to be overrepresented in samples of men with significant developmental disabilities such

as autism, intellectual deficiencies, and severe cerebral palsy. One must consider the effects of limited peer socialization as well as unknown direct biogenic causes in these situations. Temporal lobe dysfunction has been documented as a treatable cause in three cases of fetishistic disorder [9].

Fetishistic disorder is not diagnosed in children and rarely if ever in adolescents, though patients report that their unusual sexual interests were present from a young age. Abel et al. present cases where the object of sexual interest is unique enough for the patient, presenting in later years, to be able to trace back an initial presexual preoccupation or excitement in which the object (rings, cigarettes, feet) figured prominently [10]. It is usual for patients to recall an initial sexual preoccupation with the fetish object developing in adolescence during masturbation, either in the accompanying fantasies or the material objects held, caressed, or worn during penile stimulation.

In patients who present for treatment and who meet DSM criteria for a diagnosis of fetishistic disorder, the distress experienced is often in the realm of relationships. Unlike patients with strictly sadomasochistic paraphilic disorders, it is often more difficult for patients with fetishistic disorder to establish and maintain a place in their sexual relationship for their unique preoccupation. Ultimately, the fetish is not a shared object or interest, and what may begin for the partner as a curious or exciting oddity that they are willing to accommodate will very often be less welcome and precipitate conflict when the fetishist's sexual interest in the partner does not grow along with the relationship, but the excitement remains exclusively focused on the shoe or undergarments.

The interpersonal conflicts that develop in patients with fetishistic disorder commonly go beyond the functional difficulties described above and often reflect deeper disruptions of both identity and the ability to relate to others with a mature emotional intimacy [12]. Themes of control, power, and dehumanization often play important roles in the relationships of those with paraphilic disorders. Aggression towards a partner is rarely overt in fetishistic disorder, but the partner often feels

hurt and may feel unloved or ashamed to find that their lover has sexual interest only in their toes or feet, and not in the partner as a whole emotional and sexual person. Theories (discussed below) do not agree on whether fetishistic disorder is a result or a cause of this further pathology.

Recommendations

Treatment of fetishistic disorder is without a strong evidence base, due in part to inadequate sample sizes. Psychotherapy is the primary accepted treatment modality, but can be time intensive and does not necessarily change the poor prognosis. Psychoanalysis has been used with reports of success, and psychodynamic psychotherapy is likewise thought to be beneficial, if not in altering the fetishistic preoccupation then in helping patients in the realm of relationship difficulties and in self-esteem and coherent identity development. Cognitive behavioral therapy and learning and conditioning theory may be employed in treatment but again have not been consistently proven effective. It is important to find a good fit between the presenting condition and a theory-driven treatment modality that is comfortable to both the clinician and patient.

Numerous theories have been advanced over the decades regarding the mechanisms that come into play in the development and persistence of fetishism and fetishistic disorder. The development of sexual identity in childhood, including the development of sexual intention that is disordered in fetishistic disorder, is not well understood. The psychoanalytic tradition has been the primary source of current theories, but more recently conditioning and social learning theory has also contributed.

Psychoanalytic thought tends to agree that the fetish object is utilized as an unconscious defense against anxiety. Freud found the source of this anxiety to be the confusion experienced during childhood at the realization of physical differences between the sexes, and the child's realization that the child does not have his mother to himself [8]. Termed

castration anxiety, these feelings include but are not limited to the child's (and later adult's) ability to relate closely with others in the face of this potential (literal as well as figurative) loss. The over-investment in a fetish, according to the theory, is a compromise that allows an individual to function with a relatively coherent sense of identity, but with the limitations that the disorder entails.

Contemporary analytic theory agrees in large part with Freud's basic premise, but includes a wider variety of childhood emotional developments, and the accompanying anxieties provoked as painful feelings surface and are faced. Normal development requires learning to manage aggressive feelings, struggles with lack of control, separation from one's parents and the potential for loss of a parent's love. It is theorized that children who have less resilience, due to experiences with overwhelming abuse or neglect or to other disturbances to parental attachment, will struggle more in managing the normal sources of anxiety and will be more likely to develop a fetishistic disorder as compensation [12]. For example, the early struggles to manage separation from one's parents are commonly managed with the development of a transitional object, a blanket or toy, to which a child has a strong but temporary attachment. Fetishistic disorder can be understood in these terms as a more permanent attachment that less advantageously manages this developmental anxiety.

Abel utilizes conditioning theory to propose an alternative schema for understanding the fixation on a fetish object [10]. He suggests that early association of strong emotion with any given object can, if that object maintains a significance and becomes associated with the development of sexual arousal and masturbation, be reinforced with extensive repetition to the point that arousal cannot occur apart from that object, resulting in fetishistic disorder.

Blanchard also characterizes fetishistic disorder as a developmental disorder [13]. He proposes that it is a disorder of an individual's innate and differential sensitivity to various stimuli that, when combined with that individual's experience, may erroneously locate an erotic target that is oriented

toward a "non-essential" feature of an ideally desired object (clothes rather than the person in the clothes).

The diagnostic criteria for fetishistic disorder provide little guidance for treatment and do not represent the variation that will be evident with clinical presentation. Clarifying the reason for presentation and characterizing the nature of the disorder will help clarify the target of treatment.

A patient who has run afoul of social standards or violated professional boundaries, whose fetish has been discovered, may have no motivation to change an otherwise pleasurable means of sexual gratification but may regret being discovered and work to prevent recurrence. The man who has been discovered by his employer while viewing images of nude men in new shoes, or the man charged with stealing women's underwear from a neighbor's dirty clothes hamper, may benefit from a focus on reducing the compulsive nature of the behavior that allowed it to slip beyond their control, treating compulsive sexual behavior or kleptomania. Alternatively the podiatrist who has come to attention for innocently asking a known patient to suck on her toes may have personality pathology or interpersonal dysfunction that precipitated the gross misjudgment of social propriety and neglect of professional ethics.

Treatment is not begun until a systematic developmental sexual history is completed. This process is part of a larger effort to understand the nonsexual developmental forces of the patient's life—i.e., his dynamics. When the physician has spent a considerable effort to understand the man's history, intellectual and social capacities, and private attitudes towards his fetish, a treatment process can begin.

A common mode of presentation derives from complaints about the psychological and sexual intimacies of a couple, with motivation to change in order to accommodate the partner. The most distressed person is usually the partner who has insisted upon getting professional assistance. As the history unfolds beyond a presenting complaint of low sexual desire, it emerges that both partners are angry at one another and that the relationship is in crisis. He, the fetishist, is feeling betrayed that after years of marriage she is now demanding that he

desist with the behavior that she had until then permitted. The wife, seeking to deepen the intimacy of their marriage, is enraged and humiliated as she sees more clearly that she is not the source of his pleasure at all, and perhaps never has been.

Clinical Case Example

> A couple with three grown emancipated children presented for help because of erectile dysfunction. Only on the third visit did the couple reveal that their lovemaking for 30 years was dependent upon a ritual. He insisted that they both put on full-length slips and lie in bed silently for a few minutes. He then would begin to caress her and quickly move to intercourse. When she insisted that she no longer could tolerate making love to a man who had to pretend she was an old lady, he asked whether he could at least hold the slip. When she refused even this compromise, he was unable to erect. On occasion, when she relented he was securely potent.

Goals of treatment in this or other cases of fetishistic disorder may include:

1. Decreasing the intensity of the fetishistic arousal
2. Increasing interest in normative sexual behavior, as negotiated with the partner
3. Decreasing shame associated with the erotic fixation
4. Preventing victimization or illegal activity
5. Improving romantic or other interpersonal disturbances that are pervasive in a patient's social or occupational life

Behavioral treatments have been attempted, utilizing a range of aversion techniques in addition to reconditioning to traditional erotic targets. Effectiveness of these treatments has been reported, but without evidence for sustained decreases in eroticization of a fetish [14]. Cognitive techniques of thought stopping, in combination with gradual and repeated introduction of more acceptable fantasies and behaviors may be utilized [15, 16], with success depending upon the motivation of the patient or couple, and the quality of the working therapeutic relationship. Traditional techniques to improve relationship dynamics, from teaching assertiveness and communication skills to education on patterns of sexual desire and

arousal, or sensate focus exercises to target sexual functioning may all be a part of treatment.

Treatment of couples who present often involves helping both partners to understand the need for a fetish in developmental terms. Many of these men had significant discontinuities in their parental relationships. The man and his wife often benefit from an explanation that is beyond the verification of the behavioral sciences. The explanation is actually a hypothesis that gathers in the details of the man's development. For example, the fetish sometimes is a representation of the mother and functions just as a soft toy does for a toddler at bedtime, enabling self-soothing. It comforts him and distracts him from his anxiety about being an adequate man or his fears about a woman's dangerous body, and allows him to be excited. What explanations to share depends not only on the therapist's grasp of and belief in the childhood origins of fetishism but in the patient and the partner's capacity to make sense of the sexual limitations in terms of his past attachment and fears. Fetishistic disorder is not so much cured as managed by the couple over time with understanding, affection, and humor, and it may not matter what ideological form of explanation is offered.

Medication treatment may have a role in managing fetishistic disorder. Case studies have indicated some successes [17], but medications have not been subject to randomized controlled trials and are not FDA approved. Positive effects of serotonergic modulation have been reported, separately with fluoxetine and clomipramine [18, 19]. The effectiveness of these medications may utilize either the suppression of sexual functioning or the treatment of the obsessive fixation on an object seen in fetishistic disorder, given the similarities to obsessive compulsive disorder, though the latter theory remains untested. Anti-androgenic or anti-dopaminergic agents are also likely to have effect in global suppression of sexual functioning, including fetishistic behavior but also desire and drive. Risk profiles need to be discussed with the patient in addition to the perceived benefits of the asexual state, were this to be the patient's preference. Suppressive therapies should only be pursued if efforts in psychotherapy of normalization and acceptance, integration, and other behavioral change techniques have failed or are not options.

Opioid and oxytocin systems also hold promise in moderating fetishistic drive and increasing normosexual partnered activity, though evidence for this is largely absent. Naltrexone has been identified in several case studies as having positive effect in combination with psychotherapy at managing fetishistic disorder comorbid with substance use disorders [20].

Conclusion

Fetishistic disorder may be challenging to diagnose and difficult to treat, and the research base to guide these practices has not developed significantly. Mental health professionals have long observed the nuances of fetishism in the sexual lives of their patents, though modern research is yet to find the impetus to expand the evidence base on this subject. Fetishistic disorder has maintained its place in the DSM as well as in the popular imagination, due to a combination of fascination and prevalence of the condition, though the latter remains difficult to quantify. The vast growth in recent years of technologies to facilitate individual expression of sexual variance as well as subcultural intercommunication and allegiance have already played a role in normalizing sexual variation. The paraphilia of fetishism is high on the list of sexual variations that stand to develop further in upcoming years, both in the cultural landscape and the annals of evidence based medicine. These developments are likely to bring changes both to the diagnosis and management of fetishistic disorder, and to further enrich our clinical understanding of the sexual imagination.

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