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The Clinical Description of Forty-Eight Cases of Sexual Fetishism

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Summary: This study surveys the discharge register of a large London teaching hospital over 20 years and presents data on its 48 cases of clinical sexual fetishism. An attempt was made to answer two questions: (1) What are the clinical problems these patients present? They have more to do with the perception of fetishes as personally or socially unacceptable than with 'objective' restrictions placed on sexual activity. (2) What is the classification used to describe? The data have not enabled any conclusions to be drawn about the existence of particular fetishist syndromes. Certainly, a fifth or more of the sample had fetishes for clothes or rubber or rubber items, or wore or stole a fetish or fetishes; but this information is insufficient to allow one to assume that these patients had something significant in common, and leaves open the question of what more precisely each individual was attracted to.

The most usual approach adopted in clinical studies of sexual fetishism is to take a single case or a fairly small number of single cases. In this way a wide range of diverse clinical material has accumulated under the label 'fetishism' over the 100 or so years this term has been used in psychiatry. However, few, if any, generally accepted descriptive generalizations have emerged and this may owe something to a method which draws attention away from any typical or recurring clinical features of the condition. Arguably it would be sensible to follow the suggestion of Marks (1972) and work with large samples and a loose concept of fetishism, and in this way gradually enhance our understanding of the subject. As he points out, this is not easy to do.

One difficulty is the uncertainty about what phenomena research into fetishism should explain. Marks suggests that the problem is in large part due to the inadequacy of information on the sexual tastes and practices of 'normal' people. In the present climate of opinion this gap in knowledge is hard to fill, while to talk about 'fetishism' without this information begs questions not just about the likelihood of fetishists in the non-clinical population, but about the possible place of fetishes in normal sexual attraction.

The lack of data makes it hard to establish in what way, if any, a fetish is statistically abnormal. A possible solution is to accept that it may not be, but to argue that in certain circumstances it becomes a clinical problem. Such circumstances might include heavy dependence on one rather narrowly defined fetish, a strong attraction to a fetish that is hard to come by, anxieties about what having a fetish means or the perception by someone else (a wife, a coroner) of a particular fetish as abnormal. In other circumstances, however, a fetish may not be a clinical problem (Gosselin, 1979).

In the study to be reported as few assumptions as possible are made about the meaning of the word 'fetishism'. An attempt is made to obtain an adequate description of the clinical phenomena relevant to the referral, and to understand the use of the diagnostic term. It appears important to concentrate on sampling an adequate number of patients, working so far as possible with cases not selected for 'interesting' or 'unusual' clinical features. This draws one away from the published literature towards a survey of the larger number of cases seen in a clinical setting, but not written up.

Method

The case numbers of patients diagnosed under the appropriate classifications of the *Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death* (WHO, 1957; 1967) were obtained from the discharge register of the Bethlem Royal and Maudsley Hospitals, the joint postgraduate teaching centre where we worked. This is highly specialized and draws patients from outside its catchment area. It is therefore not a wholly typical clinical setting. Initially, 64 patients were identified, but six sets of notes had been mislaid. A further 10 early cases who cross dressed, but reported no attraction to items of clothing or any other stimuli, were eliminated from the study on the grounds that most clinicians would now probably call this transvestism rather than fetishism. The remaining 48 patients

had been referred and classified during the period that the 7th and 8th editions of the Manual had been in force at the hospitals (1958–1978). These were not all new admissions. One had been first seen in the late 1940s and nine between 1952 and 1957.

None of the patients was contacted and all the information was taken from the case notes. A coding sheet was completed for each patient. Appropriate items were entered as the case notes were read through and then the notes searched through again to fill in the gaps. This procedure was also adopted by a second independent rater who, working with a set of written instructions, completed six sets of case notes to provide a measure of inter-rater agreement.

Any object, material or observed event, which apparently gave the patient sexual excitement, was recorded as a fetish, however slight or common. So was anything expressly stated to be a fetish. Where there was a description such as 'rubber, especially rubber macs', both rubber and rubber macs were included. Where two fetishes were included, one a sub-class of the other, for example, 'steals clothes and dresses in panties', both were entered (82.9 per cent agreement). Descriptions of fetish-related behaviour were checked off against a list of 38 items on the coding sheet (66.8 per cent agreement). These items, which included, for example, following/pursuing and fondling/caressing, were taken from the published literature on fetishism and conditions with which it has been associated. Other data reported ranged from 83 per cent to 100 per cent agreement.

TABLE I

Numbers of patients with different types of fetish, listing individual fetishes which occurred more than once

Types of fetish	No of patients
Parts of the body:	7 (14.6%)
Legs 3	
Clothes:	28 (58.3%)
Clothes (including baby's clothes 1, 'mod' clothes 1, but otherwise unspecified) 11	
Knickers, panties, men's pants 10	
Underwear 7	
Stockings 5	
Mackintoshes and raincoats 4	
Suspenders and suspender belts 3	
Dresses 2	
Skirts 2	
Corsets, girdles 2	
Slips 2	
Soft materials and fabrics:	3 (6.3%)
Silk 2	
Clothes made of soft materials and fabrics:	4 (8.3%)
Nylon knickers and panties 2	
Footwear:	7 (14.6%)
Shoes 3	
High-heeled shoes 2	
Boots 2	
Leather and leather items:	5 (10.4%)
Leather jackets 2	
Rubber and rubber items:	11 (22.9%)
Rubber macs 6	
Rubber tubes and enemas 4	
Rubber 3	
Other objects:	7 (14.6%)
Handkerchiefs 2	
Other	2 (4.2%)

TABLE II

Numbers of patients with different types of fetish-related behaviour, disregarding behaviour which only occurred once among the sample. (Where particular types of fetish recur in connection with a particular kind of behaviour, these are specified)

Fetish-related behaviour	No. of patients
Seeing someone dressed in:	11 (22.9%)
Clothes 6	
Rubber and rubber items 4	
Gazing at:	6 (12.5%)
Footwear 2	
Legs 2	
Fondling:	4 (8.3%)
Sucking:	2 (4.2%)
Inserting up rectum:	6 (12.5%)
Rubber items 4	
Footwear 2	
Following:	2 (4.2%)
Stealing	18 (37.5%)
Clothes 12	
Hoarding:	6 (12.5%)
Clothes 3	
Wearing:	21 (43.8%)
Clothes 14	
Rubber and rubber items 5	
Footwear 4	
Leather and leather items 3	
Rolling in:	2 (4.2%)
Burning:	2 (4.2%)
Cutting or snipping:	2 (4.2%)

Results

Two of the 48 patients have been reported elsewhere as single cases (Bebbington, 1977; Marks *et al*, 1965). Short descriptions of each case are available in Chalkley (1979).

Age and sex: The median age of the 48 patients was

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28 with a range from 12 to 59 years. Forty-seven of the 48 patients were men. The only woman was a lesbian and had a fetish for breasts.

Referral: Thirteen referrals came from the courts, probationary service or police, the remaining 35 from GPs. Of the 35, we judged 14 to have been self-referrals, mainly because of feelings of anxiety or guilt, five to have been prompted by family or close friends and 10 to have occurred for reasons other than fetishism.

Types of fetish: These data have been summarized in Table I.

Numbers of fetishes: The total number of fetishes was 122. Seventeen patients had 1 fetish, nine had 2, twelve had 3, six had 4, and one each had 5, 6, 7 and 9.

Other psychiatric classifications: Sixteen patients had one additional psychiatric classification, thirteen had more than one. There were 3 classifications of paranoid schizophrenia, 7 of depression, reactive depression or depressive neurosis, and 2 of anxiety neurosis; there were 13 classifications of personality disorder (and sub-classifications of personality disorder); there were 9 classifications of sexual dysfunction or sexual deviation (apart from fetishism and apart from homosexuality which was used by some psychiatrists and not others. Ten patients stated a homosexual sexual preference.)

Fetish-related behaviour: These data are summarized in Table II.

Discussion

Firstly we must consider whether fetishism is a clinical problem. 'Clinical problem' is used here in a way similar to the term 'psychological dysfunction' proposed by Shapiro (1975). It covers experiences found distressing by patients or those close to them, disablement of sexual function, and behaviour judged to be socially inappropriate in the context of the prevailing culture. Four possible sources of difficulty for the patients in the sample are looked at:

(a) *Were there restrictions on what the patients found sexually arousing?* Seventeen of the 48 patients (35.4 per cent) reported only one fetish and it has been suggested by Grant (1949) that restriction of number may distinguish clinical cases of fetishism. Number would not in itself be especially handicapping unless the patient was at the same time markedly dependent on the fetish for sexual arousal (Gebbard, 1969). Few patients stated this to be the case. The three who did had similar fetishes (a mackintosh, a rubber mackintosh and a white raincoat), and could not make love without their partners wearing the particular object.

(b) *Were there restrictions on the availability of the fetish?* Access to a fetish might be inherently restricted. This holds for fetishes such as red hair (Storr, 1964), spectacles (Meixner, 1939), deaf aids (Hallam and Rachman, 1972), and the various orthopaedic fetishes such as calipers, lameness and one-leggedness. The problems arises because the substantial majority of the population see, hear and walk reasonably well, and do not have red hair. There were no fetishes which clearly fell into this category in the study.

(c) *Did the patient worry about the personal meaning of fetishism?* There were 14 cases, we estimated, where the patient's anxiety about some aspect of the fetish appeared to have played the major part in bringing about the referral. This group could not be described as more 'psychiatric' than the remainder since they did not have a disproportionate share of the other diagnoses, but they and others did voice a number of concerns about their personal adequacy, their sexual identity or their normality. These were sometimes linked to worries about something more concrete, like 'excessive' masturbation or distracting fantasies.

(d) *Did someone other than the patient regard the fetish as abnormal?* Thirteen referrals (27.1 per cent) came at the instigation of the courts, probationary service or police, mainly on account of theft. Another five (10.4 per cent) appear to have been brought about by the intervention of friends or relatives (all these involved either the patient or his partner in dressing). In the sample of 48 cases, 21 patients dressed and 18 stole.

Overall, it appears that the fetish is perceived as personally or socially unacceptable and that this is a more common clinical picture than that of the fetish as a disabling 'objective' restriction on sexual activity. In this context, it is worth noting that ten patients (20.8 per cent) presented initially with some other problem entirely, not with fetishism at all. With these patients too, who complained of marital difficulties in 3 cases and of affective or somatic complaints in another 3, the fetish is better described as distressing rather than disabling.

Next we must consider the use of the diagnostic classification of fetishism. Perhaps the single most striking aspect of the data is how little use was made of the classification in the 20 years covered in the study. Only 64 different patients were discharged with this diagnosis in the period considered, and a number of these were judged to have been misclassified. On the basis of a hand count of all discharges for the years 1971 and 1981, that represents an estimated 0.8 per cent of the total number of adult psychiatric cases.

It remains, however, the largest clinical sample on record and one wonders what general principles governed the inclusion of the eventual 48 patients under one heading. In the past, fetishes have been grouped by types and it seems resonable to assume that they should enable some measure of descriptive

generalization. Fetishism is often seen as a disorder of sexual attraction (e.g. Beach, 1976), so the content of the fetish should be a matter of some importance, particularly if it predicts other clinical features. This study suggested certain types of fetish were relatively common, notably clothes which occurred in the cases of 58.3 per cent of patients and rubber in the cases of 22.9 per cent.

A possible outcome of the study might have been to suggest one or a number of fetishist syndromes, perhaps based on typology, like North's (1970) 'rubber fetishism', or on something else, for example, Epstein's (1960) concept of 'increased organismic excitability'. However, with relatively few patients and many criterion variables, factor analysis was not felt to be appropriate (Everitt, 1975).

It may well be, however, that fetishism is an area where for the present generalization will remain difficult for more than just reasons of sample size. Similarities can be found, but they tend to be trite. For example, to take a recurring pattern in this study, many patients (25.0 per cent) stole clothes. However, one patient stole because he was attracted to stealing clothes, another to procure used and stained clothes, a third to obtain something belonging to someone he had desired and followed to her home. The effective stimulus was different in each case and any expectation that the patients should all in other respects be the 'same' seems likely to be disappointed.

This suggests that fetishes need to be specified in detail and that perhaps there is a complicated and necessarily lengthy task required of the clinician wishing simply to state the inherent sensory attraction of each fetish, or the nature of its instrumental role, let alone its precise meaning for the individual patient. If generalization is sought perhaps this is most readily attained by successfully validating hypotheses about the nature of the clinical problems in fetishism.

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