Case Report

Fetishistic Transvestism in a Patient with Mental Retardation and Psychosis

Rajmohan Velayudhan, Asfia Khaleel, Nideesh Sankar, Manoj Kumar, Firoz Kazhungil, Thazhe Mangool Raghuram

ABSTRACT

Fetishistic transvestism is a disorder of sexual preference associated with fantasies and sexual urges to dress in opposite gender clothing as a means of arousal and as an adjunct to masturbation and coitus. The disorder has been reported in people with learning disabilities. The disorder has been reported in a young male with dull normal intelligence. Transvestism though has been described in schizophrenia and psychosis and fetishism has been described in the course of simple schizophrenia, there are no reports of fetishistic transvestism in a patient with mental retardation and psychosis. A case of fetishistic transvestism in a patient with mental retardation and psychosis with treatment and relevant review of literature is reported.

Key words: *Fetishism, mental retardation, psychosis, transvestism*

INTRODUCTION

Fetishistic transvestism is a disorder of sexual preference associated with fantasies and sexual urges to dress in opposite gender clothing as a means of arousal and as an adjunct to masturbation and coitus. The disorder has been reported in people with learning disabilities.[1] The disorder has been reported in a young male with dull normal intelligence.[2]

Transvestism though has been described in schizophrenia and psychosis,[3,4] and fetishism has been described in the course of simple schizophrenia,[5] there are no reports of fetishistic transvestism in a patient with mental retardation and psychosis.

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CASE REPORT

An unemployed 22-year-old man, from a Hindu family of low socio-economic background presented in our clinic with a 6 year history of suspicion and withdrawn behavior and a 2 year history of wearing undergarments of women. He was single, had below average academic achievements and lived with his parents in a small village in North Kerala. He was brought to our clinic as he had increased social withdrawal and suspicion during the last 2 months and had been constantly stealing women's lingerie from the neighbors' cloth line causing constant altercations with the neighbors. Detailed assessment showed that, the patient had a 6 year history of suspicion and used to think that people around him were constantly talking about him. He used to stay in his room for hours at end and would not take any interest in household activities and would avoid talking to family members and guests. He was mostly preoccupied and used to walk about in his room or brood or occasionally goes out to the yard and even during these brief visits to the yard, he avoids interacting with anybody. He had no history of any muttering to self or laughing to self. There was

Department of Psychiatry, MES Medical College, Perintalmanna, Kerala, India

Address for correspondence: Dr. Rajmohan Velayudhan
'Vidya' 1/4711, Near Bilathikulam Housing Colony, Calicut - 673 006, Kerala, India. E-mail: rajgiggsmohan@yahoo.com

no history of fear of being harmed, suspicion of being controlled or history of hearing voices. There was no history suggestive of any first rank symptoms. He did not have any depressive, anxiety or manic features. There was also no history of any repeated ritualistic behavior. His self-care was generally poor and he did not show any interest in going to work. In the past 2 years, he developed the habit of wearing women's clothes. He used to go out to the neighboring houses and steal women's clothes mostly undergarment from the cloth line. He then returns to his room and wears them and sits or walks about in his room for a few minutes and later masturbates using the underwear. Once this is over, he throws the clothes away or dumps it in the corner of his room and the next time he has the desire, he goes out and steals clothes from the neighboring houses. He normally does this once or twice a week and when the parents or siblings prevent him from doing so, he gets irritable and angry and most of the time, he sneaks out in spite of their warning. He did not have any depressive, anxiety or manic features. There was also no history of any repeated ritualistic behavior. There was no history of any seizures, blackouts or episodes of confusion or history of substance use. His self-care was generally poor and he did not show any interest in going to work.

The history regarding birth and early development revealed that it was a term normal delivery without any perinatal or post natal complications. The antenatal period too was uneventful. He had no recurrent childhood illnesses or seizures. He had normal motor development but had delayed language, social and adaptive development. He started speaking only by 2½ years and had attained bladder control by 6 and bowel control by 7 years. His self-help skills were adequate and there was no history of any gross behavioral abnormality or self-injurious or disinhibited behavior during childhood. He started schooling at around 5 years of age and was very poor in academics and failed most of the subjects and dropped out of school while he was in the fourth standard. He reportedly could write his name and do addition with small numbers, but while shopping, he was unable to keep correct account of the transactions and usually used to return home without collecting the balance. He used to relate well to his family members and used to go out and play with children in the neighborhood and used to love going to the market with his parents. There was no history of any physical or sexual abuse during childhood or adolescence.

There was no family history of any mental retardation, psychotic or other mental illness, paraphilias, seizures, suicides or other major medical or neurological problems. He lived with his parents, two elder brothers and a sister. There was a cordial and caring relationship with the parents and siblings. The patient was treated earlier with antipsychotics for brief periods of time and at no point in the past did he receive treatment for more than 2 months nor was he ever treated in an in-patient setting.

The patient on examination was moderately built and nourished; he was adequately dressed and poorly groomed. He made no eye contact and was preoccupied during the interview. Speech was not spontaneous and he replied in a low tone and tempo and his replies were relevant and coherent. There was no stream of thought abnormalities or formal thought disorder. There were no thought alienation phenomena. The patient communicated delusions of reference and had no ideas of being persecuted. He revealed that he feels the urge to wear the clothes of the opposite sex and said that it is distressing when he is prevented from doing so. He also told that once he masturbates, he wants to remove the lingerie. He did not answer questions regarding any associated fantasies. He had no repetitive intrusive thoughts, images or impulses nor had any compulsions. He did not reveal any depressive ideations, guilt feelings, death wish or suicidal ideations. He said he felt happy when asked about his mood, but objectively he was apathetic with blunted affect. He had no perceptual abnormalities and cognitive testing showed sub average intelligence. His judgment was impaired and had no insight regarding his illness. A detailed physical examination was performed and all systems were found to be normal. Based on the history and mental status examination a diagnosis of psychosis not otherwise specified with mental retardation was made by the consultant based on International Classification of Diseases 10 and a tentative diagnosis of fetishistic transvestism was considered, as it was unclear as to whether the behavior was art of the psychosis. Blood investigations like hemoglobin, total and differential count, random blood sugar, renal function and thyroid function tests were normal. A karyotyping was not possible due to economic constraints. An I.Q. assessment was conducted and it was found to be 64 showing mild mental retardation. Detailed psychometric assessment was not possible due to mental retardation.

Patient was put on risperidone and was followed-up at regular intervals. The psychotic symptoms improved significantly in 6 months and there were no referential delusions, a patient also had better interactions with family members and was showing better affective response. The fetishism however, persisted and was of the same frequency and pattern as earlier. A patient revealed that he feels the urge to wear the clothes of the opposite sex and said that it is distressing when he is prevented from doing so and that once

he masturbates he does not have much interest in them. The diagnosis of fetishistic transvestism was confirmed on review. Behavioral intervention like distraction, covert sensitization and contingency management were implemented. He was started on sertraline along with risperidone. Even at 3 months of follow-up, a patient had decrease in fetishistic transvestism, while his psychotic symptoms were in complete remission.

DISCUSSION

The term fetishism is applied to those who rely on use of nonliving objects: For example, footwear, leather and rubber, as a stimulus for sexual arousal and gratification fetishistic transvestism is applied to those who wear articles of clothing of the opposite sex in order to create the appearance and feeling of being a member of that sex.[6] Fetishistic transvestism typically begins in childhood or early adolescence, but in this case, the onset was in late adolescence, probably owing to mental retardation.[6] The disorder is mainly seen in men. The role of biologic factors like abnormal levels of androgen may contribute to inappropriate sexual arousal. Most studies however, dealt only with violent sex offenders and have yielded inconclusive results.[7] Several authors have observed that fetishism has some obsessive-compulsive character.[8,9] Many of them also have been described as hyper masculine otherwise, which was not the case in this patient. Fetishism also has been associated with epilepsy.[10] Transvestism has also been described as a psychotic symptom, but in this case the treatment for psychosis and improvement in psychotic symptoms did not improve the fetishism, therefore hinting a separate pathology.[11] The serotonin selective reuptake inhibitors (SSRIs), which enhance serotonergic transmission by blocking uptake into the presynaptic terminal, have been reported to be effective at reducing behaviors associated with fetishism and other paraphilias.[12,13] A combination of SSRI and methylphenidate sustained release has ameliorated paraphilia in selected cases.[14] Successful treatment of transvestic fetishism with sertraline and lithium has also been reported.[15] Psychoanalysis, psychodynamic psychotherapy, supportive psychotherapy, a variety of behavioral therapies like aversive conditioning, covert sensitization and cognitive behavior therapy has been tried in paraphilias. Psychodynamic psychotherapy as sole treatment of sexual arousal in some individuals is disappointing.[16,17] The appearance of fetishistic transvestism in a mentally retarded individual and it being unrelated to psychosis and response in part to drug treatment points towards a biologic basis for this disorder.

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