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Review Article

Sexuality in the 21st century: Leather or rubber? Fetishism explained

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ABSTRACT

The sexual physical act is related to sexual attraction, sexual fantasy and sexual behaviour. Fetish has been recognised as an attraction to objects with the aim of achieving sexual gratification. There have been historical accounts of fetishism, and the subject has been of significant interest to clinicians especially those who work in the field of managing mental illnesses. There are various types of fetishism. Reported for the first time in the 19th century, the condition is of various subtypes. Of these, fetishistic disorder can be recognised as sexual fantasies, sexual urges and sexual behaviours which cause significant distress or impairment in an individual in social, occupational or other important areas of function. Fetishism may be related to specific body parts, non-living objects or others. In clinical settings, patients with fetishistic disorders are often referred because of having got into trouble with the law. Fetishism needs to be differentiated from paraphilias. Various explanations including psychoanalysis and behavioural theories have been offered to explain the genesis and management of fetishistic disorders. A fetish is attraction to an object. Treatments can include behavioural, cognitive or psychoanalytic strategies. In this review article, a brief overview on the fetish is offered with suggestions for management.

Introduction

Fetishism, although not so rare, is often not seen in clinical conditions. On such occasions, patients are referred to clinics as a referral from the courts consequent to criminal or illegal activity. Cases who are sexually turned on by inanimate objects may fall foul of the law in a number of ways. In the UK, in early October 2015, a man was arrested for having had sex with 450 tractors. According to the news report,[1] he was found to have over 5000 tractor images on his laptop. He had a special desire for John Deere and Massey Ferguson tractors, particularly the green ones. He was into axle grease, which apparently turned him on sexually. He was placed on the Sexual Offenders' Register.

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Fetishism was reported first in the 19th century. Van Krafft Ebbing[2] and Havelock Ellis[3] described the conditions and believed that the attraction occurred as a result of associated experiences. The term fetishism is derived from French and Portuguese languages, and initially, the term was reported as something that has supernatural powers.

The sexual act is related to sexual attraction, sexual fantasy and sexual behaviour. These are all related to sexual orientation. But it is quite possible that a heterosexual man may indulge in same-sex behaviour (for a number of reasons), and his sexual fantasy may still remain heterosexual. They may also be attracted to inanimate objects, and this might relate either to the object itself, its shape, its consistency or its surface. Furthermore, these may be related to touch, feel or vision.

Often patients will present to the clinical settings only if either there is a problem in their relationship or the individual has been reported to the police (as previously mentioned) and has been forced to seek clinical treatment. Thus, the motivation for seeking treatment may vary, which will influence engagement and the therapeutic alliance and therapeutic adherence.

The word 'fetish' is used to describe an inanimate object which can arouse sexual desire. It is worth noting that a fetish may apply to parts of the body as well as objects, situations or activities. Paraphilias are generally seen as originating from childhood or early adolescence,[4] and perhaps become better defined as an individual enters adulthood. Inevitably, various other factors such as social stressors, other mental disorders and opportunities can all play a role.[5] Fetishism is more focused than paraphilias, and the latter can include voyeuristic disorders, exhibitionism, frotteurism, sadomasochism, paedophilia, and so forth. DSM-5 includes fetishistic disorder in the list of paraphilias.

Fetishism

Fetishistic disorder is defined as fantasies, sexual urges and behaviours which cause significant distress or impairment in social, occupational or other important areas of function. Fetishism may be related to body parts, non-living objects or others, and should be ascertained to see if it occurs in a controlled environment or is in full remission.

The paraphiliac focus of fetishistic disorder involves the persistent and repetitive use of or dependence upon non-living objects or a highly specific focus on a body part (typically non-genital) as primary elements associated with sexual arousal.[6] Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5) suggests making a clear distinction between fetishism and fetishistic disorder.

Definitions

DSM-5 defines a paraphilia as any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners[6] (p 685). It is also seen as any sexual interest greater than or equal to normophilic sexual interest. Paraphilias include preferential sexual interests and may be focused on anomalous activity preferences (subdivided into courtship and algolagnic disorders) or anomalous target preferences.

Prevalence

The data for actual prevalence of various types of paraphilias are limited. Most of the published data are case reports or small case series.[7] It is clear that a vast majority of the cases are male. Weinberg et al.[8] found that 88% of 262 respondents who had a footwear fetish were homosexual, and 12% reported themselves to be bisexual.

Types

As previously mentioned, the types of fetish may include clothing, rubber and rubber items, leather, footwear, material or fabrics. In a now-classic article, Chalkley et al.[9] reported from 48 cases attending a clinic. The case note studies revealed that the median age of the sample was 28; 47 out of 48 were men; more than half had an interest in clothes and nearly a quarter, in leather. Among these 48 individuals, the total number of fetishes was 122. Out of the 48 individuals, 17 had only one fetish; nine had two fetishes; 12 had three fetishes; six had four fetishes; and one each had five, six, seven and nine fetishes. They reported a case series and, not knowing the denominator, it is difficult to extract prevalence rates. However, the study confirms that it is more common in men.

Gosselin et al.[10] noted that those who had a rubber fetish and those with a leather fetish scored high on introversion when compared with those with sadomasochistic tendencies. They had normal socioeconomic variations. Weinberg et al.[8] studied 262 foot fetishist members of a society. He reported that among homosexual men, foot fetish was not uncommon. The prevalence data are often limited and not easy to extrapolate from case series or case reports. In a summary of 2450 individuals in Sweden, it was found that men and those who had lower levels of satisfaction with life and used drugs or alcohol were more likely to have fetishistic behaviours.[11,12] Langstrom et al.[13] observed transvestic fetishism in 0.4% of women and 2.8% of men. These individuals (with fetish) showed higher rates than expected rates of separation from their parents in childhood and also showed high levels of arousal and masturbation.

Two important theories regarding possible underlying causes that have been put forward are as follows:

(i) Psychoanalytic perspectives: Kernberg[14] proposed three different psychoanalytic theories to explain what he calls 'perversions'. These Freudian theories define perversions as permanent and obligatory deviation from the normal. The second concept is derived from object relations theory related to paranoid distortion of early parental images. The third theory focuses on regression which transforms the symbolic relation with the genital phallus and that early relation with the mother is of fundamental aetiological importance in perversions. Kernberg[14] notes (p 277) that normal sexual behaviour can be more inclusive than the classical psychoanalytic

definition. Thus, there may be some issues related to regression and transformation of symbols.

(ii) Behavioural factors: Classic conditioning can play a role,[15] as can instrumental learning[16]. Authors demonstrated the latter that men could learn to become sexually aroused in the absence of erotic stimuli when they were provided with feedback and contingent monetary reinforcement. Another possibility that has been put forward is that of social learning (which incorporates both operant conditioning and social cognition[5]). La Torre[17] showed that men who had experienced rejection in a relationship were more likely to rate pictorial stimuli or pictures of women's garments and body parts.

Aetiological factors

Sexual instinct is said to be powerfully driven by inflexible emotions which arise deep within the ancient parts of the brain[18], and these include innate releasing mechanisms and imprinting. Instinct and hormones appear to set the stage for sexual responding and learning changes the script.[19]

Sociocultural factors

Culture and socialisation influence human sexual desire. Certain cultures place major importance on certain body parts and certain sexual practices.[20] It is inevitable that consequent upon patriarchy and male control in many societies, female sexuality is subjugated and more likely to be affected by social and cultural factors.[21]

Darcangelo[5] suggests that sociobiological studies note that fetishism is also seen in primates, but why the cultural variations in prevalence as well as presentation are not clear. Socialisation does play a role in the formation and maintenance of fetishistic behaviours.

Biological factors

Ramachandran[22] proposed that the region in the brain which processes sensory input from the feet is next to the region which processes genital stimulation, and there may be an accidental link between the two. Epstein[23] proposed that fetishism may be based on a reflex component within the temporo-limbic region of the brain, and, although usually inhibited, it may be released under certain circumstances such as brain injury.

Cultural aspects

Bullough[24] described societies as either sex positive or sex negative. Sex positive societies see sexual activity as fun, whereas sex negative societies view the purpose of sexual activity to be purely procreative. It has been postulated that societies which are sex negative may show lower rates of paraphilias.

In a review, Bhugra et al.[25] suggested that various dimensions of culture may well play a role in the development or prohibition of paraphilias and fetishistic behaviour. In understanding epidemiological data, it is important that dimensions of cultures are explored too so that the context can be utilised correctly. Ayonrinde et al.[26] propose that the symbolic meanings embedded in cultures need to be linked with biological as well as non-biological factors. Cultures determine attitudes towards sexual behaviours such as masturbation, oral sex, premarital sex, and so forth and fetishistic objects and objects of desire. Kaplan[27] sees a fetishist as someone who is 'devoted to these practices', which may in itself be culturally modified.

Munroe[28] examined 44 cases ethnographically and noted that paraphilias are almost non-existent in traditional societies. This may reflect the 'functional and procreative' focus on sexual activity rather than as a pleasurable activity.

Culturally modulated behaviours must be seen in the specific cultural context, and any study and interventions have to be placed within the same cultural context. Occasionally, an individual's cultural values and behaviour will be in direct or indirect conflict with their culture. This conflict needs to be recognised and dealt with in a specific cultural milieu.

There is no doubt that developmental, biological and cultural factors often interact with each other, and such an interaction needs to be recognised. Socialised gender roles and gender role expectations must be borne in mind and dealt, accordingly, in a gender neutral and sensitive manner. Men have higher rates of fetishistic thoughts and behaviour, and they are more interested in sexual behaviour and also have more intrusive sexual thoughts and fantasies. Fetishistic behaviour may occur as a result of socialisation problems and may lead to poor social functioning as well.

Assessment of fetishes

Areas that should be explored are as follows:

1. Development and content of sexual fantasies, age of onset, frequency and masturbatory practices. Fantasies in childhood, adolescence and adulthood.
2. Detailed exploration of various fetishistic tendencies
3. Use of pornography
4. History of violent and sexual assaults
5. Sexual and general delinquency

Various comorbid psychiatric conditions should be excluded. These include schizophrenia, affective disorders, substance use and addictions, anxiety disorders, obsessive compulsive disorders, impulse disorders such as pathological gambling, intermittent explosive disorders, personality disorders and intellectual disability.

Management

One of the major aspects of the initial assessment is to focus on the reasons for referral and why now and why here? If the patient does not experience difficulty because of their problem, they may not take the assessment seriously or form any therapeutic alliance. Furthermore, if they have been referred by the courts, their motivation may well be suspected.

The first step in engaging patients is to explore the reasons for seeking help, and it is important to discuss treatment goals and explore their expectations. They should be made aware of limitations of the treatments and treatment strategies. Risk to themselves and to others must be explored. Treatment strategies include managing comorbidity and adequate intimacy and self-regulation. Cognitive behavioural therapies may help manage anxiety and also lead to building an egosyntonic understanding of the sexuality and coping skills. Masturbatory reconditioning and satiation therapy have been recommended.[29]

Depending upon the type of fetish and underlying potential causation, the therapist may choose behaviour therapy or cognitive behaviour therapy models for intervention. In addition, supportive work may assist. In rare circumstances, the patient may require androgen-suppressing drugs.

Conclusions

Fetishism or attraction to inanimate objects for purposes of sexual gratification is not rare, although epidemiological data are not sufficiently widely available, and thus, the evidence is scanty. Often these occur in a relationship setting where both parties agree, and therefore, no clinical intervention is required. Reaching a diagnosis and recognition of distress are culturally influenced values and should be seen as such. Clinicians must place these behaviours in the right context, understand and explore them in a social and cultural context.

Conflicts of interest

The authors have none to declare.

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