Brit. J. Psychiat. (1963), **109**, 404–407

Fetishism Treated by Negative Conditioning

By D. F. CLARK

Introduction

Negative conditioning or aversion therapy is most frequently thought of in relation to the treatment of alcoholism. The article by Franks (1958) gives an excellent review of the general principles involved. However, Eysenck (1960) includes several papers in his book to illustrate the effectiveness of such treatment in cases of homosexuality, writer's cramp (Liversedge and Sylvester, 1955) and fetishism (Raymond, 1956). A suggestion made in the latter was that the fetishist may well become such because of an unusual capacity for quickly forming conditioned responses, and therefore by the same token might equally easily respond to a deconditioning technique. For this reason, the following case was treated by behaviour therapy by a psychiatrist and clinical psychologist in collaboration, and is reported in support of Raymond's (1956) advocacy of this technique of treatment in similar cases.

Case Report

The patient was a married man of 29, a skilled leather worker, who was referred through his general practitioner because of the patient's own, and his wife's, anxiety about his habit of wearing a woman's girdle and stockings. The wearing of this gave the patient great sexual satisfaction, but did not exclude normal heterosexual activity. The patient's activities had begun some 12 years previously when he had masturbated wearing various female clothes. Later he had a protracted affair with a young girl he described as "very sexy", who practised many kinds of sexual refinement and deviation and whom he remembers as often wearing a girdle, during loveplay before sexual intercourse. Later the patient took to having sexual intercourse while wearing his wife's nightdress, eventually preferring a girdle and stockings. The latter he was compelled to wear to prevent the girdle rolling up. When originally seen, however, the patient stated that he felt the need to wear a girdle especially during the day, but that at bedtime he had no difficulty in removing it. If he were deprived of it during the day, however, he suffered increasing agitation and need until he got a girdle on, even to the point of coming home from work. Eventually he had to wear this all the time during the day and when his wife jibbed at missing her clothes, he bought another for himself. He assumed the role of being a breaker-in of new roll-ons for his wife but by 1961 had become anxious lest he be found out at work to be wearing these garments. Furthermore, his wife, rather a "Victorian" type of person, was finding their relationship progressively more difficult to maintain.

The patient was extensively tested in the Psychology Department, but no gross neuroticism was found. He was slightly extroverted but no M.M.P.I. scores were outside normal limits. Only the Mf scale, in which the T score was 69, approached deviant levels. T.A.T. analysis showed some mother-fixation, essentially heterosexual adjustment and good motivation to accept treatment. The psychologist's report suggested a behavioural approach to symptom removal.

Treatment

The patient was asked to come into hospital for 7–10 days for intensive treatment and to bring with him all the photographs and pin-ups of girdlewearers he found stimulating, together with the necessary garments. On admission these were handed over to the charge nurse who made sure the patient had no access to them between treatments. Treatments were timed for 10 a.m. and 4 p.m. approximately each day. On each occasion he was given subcutaneous apomorphine 1/20 gr. on the first occasion and 1/10 gr. thereafter. This was the U.C.S. The stopwatch was started as the syringe emptied and nausea was found to supervene in 6 to 7 minutes. At the 5th to 6th minute the patient was handed the girdle and stockings (the C.S.) and told to put them on. As nausea increased a recording the patient had made previously was played back repeatedly to him and reinforced by the psychologist's comments on the pleasures of the fetish object and the patient's present sickness. The patient had made the record in private the evening before the first treatment, and in it he soliloquized on the special delights of his fetishism. As nausea progressed this recording was replayed at maximum volume and the patient was strenuously invoked to

https://doi.org/10.1192/bjp.109.460.404 Published online by Cambridge University Press

handle the fetish objects and gaze at the plethora of pictures of corseted women around him. At one session by a particularly happy chance one of his favourite pictures fell into the vomit in the basin so that the patient had to see it every time he puked. Throughout the 15 to 20 minutes during which the patient vomited and was obviously ill a continuous commentary on the fetishism and current nausea was kept up by the psychologist while the psychiatric registrar took blood pressure readings (which remained fairly steady at 130/80) at 6-minute intervals. The aim of this commentary was to reinforce at a verbal level (whether ordinarily vocalized or not) the connection between phantasies of a pleasurable fetishistic nature and the patient's physical condition of illness. For example, just as the patient's voice had finished a description of his erotic pleasures the psychologist would cut in with ". . . but now, when you do that you feel . . ." (Patient says) "sick". (Psychologist) "How do you feel?" (Patient) "Sick". (Psychologist) "And now you're wearing . . ." (Patient) "a girdle and stockings". (Psychologist) "And you just feel . . ." (Patient) ". . . sick and ill", etc. (Psychologist) "You're sick when you listen to what you enjoyed about girdles and stockings". (Plays patient's recording again) "Now it makes you vomit", etc. The recording volume was increased to flood the patient's auditory input and to be heard over his retching and vomiting noises.

On the first two occasions emesis was inhibited by intravenous nikethamide and chlorpromazine intramuscularly, but on subsequent occasions spontaneous recovery was found to be almost equally rapid. As the patient began to recover he was told first to gather up and put away the pictures, then to remove the stockings and then the girdle. Recovery was then hastened by suggestion and tea. Sixteen treatments were given with the addition of one test session after 12 treatments when the same ritual was followed with the difference that saline rather than apomorphine was injected. This was done in order to estimate how far nausea had already been conditioned to girdle wearing in the absence of the U.C.S. Nausea but no vomiting was produced, but discomfort was present and relief obtained on removing the girdle. The patient was followed up at out-patient clinic after 3 weeks and then declared himself cured. He has been back at work, enjoying a normal sex life and symptom free for over 3 months. He occasionally thinks wistfully of his erstwhile pleasures, but has never wanted to wear a girdle since treatment ended.

Discussion

One of the first points to be decided in this case was whether the symptoms were reducing a primary drive or a secondary, or acquired drive. In view of the fact that the patient seemed able to enjoy normal sexual intercourse with his wife without wearing a girdle the second was more likely. Had the former been the case then the possibility that all sexual activities might be inhibited would have precluded treatment following the lines it did. The patient's history of ultra-sophisticated sex play with his early girl friend, and even earlier of masturbation while wearing female garments, however, suggested an acquired or learned drive, in addition to the basic drive to sexual outlet. Further detailed evidence about the patient's early life is not available, so that one is compelled to speculate only that this secondary drive derives from the accidental discovery of the sexual pleasures of female garments at a stage when the patient's sex drive had not fixed completely on a full heterosexual object. The cue, as well as the goal, had become drive reducing.

Secondly, it had to be decided whether the more effective treatment would be to stamp out the anxiety provoked by not wearing the girdle during the day or to decondition the gratification experienced at wearing it. Two considerations determined the latter course. In the first instance, it was found that the patient, having worn the girdle all day, quite naturally removed it before going to bed. This occasioned him no anxiety at all. In other words, in the "lying in bed" situation as in treatment, the patient might experience very little deprivation anxiety. Further the technique of tranquillizing or sedating the patient when he was girdle-deprived was a dubious procedure since the

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C.S. consisted of "something absent" rather than something present. It would also be impossible to separate in the event girdle deprivation anxiety from other anxieties.

The method chosen, therefore, was to have the effect of conditioning nausea rather than gratification to girdle wearing and secondarily, to condition recovery and well-being instead of anxiety to girdle removal. Most fetishists are usually rather specific about the sorts of pleasure their fetish object affords them and so that the deconditioning would operate at these specific levels the continuous verbal reinforcement and playing of the patient's own special comments was necessary. It was apparent early in the examination of this patient that much erotic satisfaction was being derived not only from the simple fact of wearing a girdle but also from the special sensations and phantasies the patient could indulge in when it was on. Positively reinforcing or not, these sensations and phantasies were also part of the behaviour to which nausea had to be associated and consequently the remarks of the psychologist as described above were intended to intensify the association. Had this connection not been made the later emergence of these phantasies might have made a reversion to girdle wearing more likely by their function as cues. The patient was also made when sick to walk and move in a way he had heretofore found especially erotic and fortunately this made him feel even more ill.

Some unease was felt about the relative inaccuracy of timing in both the presentation of the C.S. and in its removal. It is probable that more accurate timing might have produced more ready conditioning but care was always taken at least to make sure the C.S. was presented before the U.C.S. This is about as much as can be done in a case of this kind, since it may be that the patient will have different thresholds for the action of the U.C.S. (apomorphine) from treatment to treatment, which would make nonsense of a fixed time relation between C.S. and U.C.S. Further, as Eysenck (1962) points out in a recent paper, "within a given type of conditioning, there are many important parameters which must be explored in detail in order to discover their relevance to the hypothesized relationship. Thus in eye-blink conditioning the C.S.–U.C.S. interval is usually taken at the population optimum of about 450 m.sec.; it is quite in line with theory to assume that introverts and extraverts have different optima, so that variations in this interval from experiment to experiment may change the nature of the relationship between conditioning and personality".

Finally, treatments were spaced more widely than in the case quoted by Raymond. This was done partly for humanitarian reasons, but more importantly because the larger interval meant that drive strength would be greater when the patient tried to reduce it by putting on the girdle. This meant that the deconditioning would be more effective under conditions of intensive drive—the very time it would be most useful to the patient. It was the case that before treatment the patient felt more and more need to don a girdle the longer he refused to do so. Theoretically, the interval between treatments could have been cut down in proportion to the effected negative drive generated, but the patient, in spite of his slight extraversion, conditioned so well that a long series of treatments was unnecessary. It is true that experimental evidence indicates that massed trials produce a more rapid extinction of a habit, but in view of the readiness (16 sessions) with which deconditioning was in fact, achieved, the distress involved in submitting the patient to more intense or more frequent treatments each day did not seem warranted. Furthermore, over-intensive treatment with apomorphine tends to allow the cumulative sedative effect of the drug to outweigh its emetic effect. The longer the patient remains well now, the more likely it will be that no resurgence of symptoms will arise. The patient's wife seems likely strongly to reinforce new and more acceptable patterns of behaviour!

Summary

In view of the isolation of Raymond's (1956) report on the treatment of fetishism by deconditioning, a further case of longstanding symptoms successfully dealt with by an intensive treatment programme is reported. As

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a result of this experience some aspects of technique are stressed and others appear to be less important than theory and pure experimental work might suggest.

ACKNOWLEDGMENTS

The writer is indebted to Dr. H. B. Kidd for permission to treat his patient and to Dr. S. Fine, who carried out the necessary injections and otherwise attended to the patient's medical needs.

REFERENCES

EYSENCK, H. J., *Behaviour Therapy and the Neuroses*, 1960. London: Pergamon.

—— "Conditioning and Personality", *Brit. J. Psychol.*, 1962, 53, 303.

FRANKS, C. M., "Alcohol, alcoholism and conditioning, a review of the literature and some theoretical considerations", *J. Ment. Sci.*, 1958, 104, 14–33.

LIVERSEDGE, L. A., and SYLVESTER, J. D., "Conditioning techniques in the treatment of Writer's Cramp", *Lancet*, June 1955, 1147–1149.

RAYMOND, M. J., "Case of fetishism treated by aversion therapy", *Brit. Med. J.*, 1956, 2, 854-856.

D. F. Clark, M.A. *Principal Clinical Psychologist, Leicester Area Psychological Service*

https://doi.org/10.1192/bjp.109.460.404 Published online by Cambridge University Press