Fetishistic disorder

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INTRODUCTION

Fetishistic disorder is characterized by a distressing and persistent pattern of sexual arousal involving the use of nonliving objects or specific, nongenital body parts. In clinical usage, the term “fetish” delineates an object, such as a partner’s foot, which is used by an individual to attain sexual arousal and orgasm. Persons with sexual fetishes may need to be touching, wearing, smelling, or looking at their unique object, or engaging in fantasy about it, to become or stay aroused, either alone or with a partner.

In the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) fetishism is considered a paraphilic disorder. The diagnosis is given in individuals with at least six months of recurrent and intense sexual arousal from either the use of nonliving objects or highly specific focus on nongenital body parts as manifested by fantasies, urges or other behaviors. The symptoms cause stress or impairment in social or occupational functioning [1].

There has been relatively little research on fetishism/fetishistic disorder. In the absence of clinical trials, treatment is based largely on clinical experience and published case reports.

This topic addresses the epidemiology, pathogenesis, clinical characteristics, course, assessment, diagnosis, and treatment of fetishistic disorder. Evaluation and management of other sexual and gender identity disorders are discussed separately. (See "Evaluation of male sexual dysfunction" and "Treatment of male sexual dysfunction" and "Overview of sexual

dysfunction in females: Epidemiology, risk factors, and evaluation" and "Overview of sexual dysfunction in females: Management".)

EPIDEMIOLOGY

The incidence and prevalence of fetishistic disorder in the general population are not known. It is not clear whether the rarity of fetishistic disorder as a presenting complaint represents a low prevalence or a lack of reporting by people with the condition.

Fetishism is typically not investigated separately from other forms of paraphilia. Across numerous studies, voyeurism and fetishism are often described as the most common paraphilic interests among males [2]. A community survey of 1040 people selected randomly and demographically representative of the general population in Quebec studied fetishism (not necessarily associated with distress or impairment, ie, not a fetishistic disorder) [2], finding:

- 44 percent desired to engage in fetishistic behavior
- 8 percent claimed an intense desire for fetishism
- 26.3 percent engaged in the behavior at least once
- 3.4 percent often engaged with a fetish

The results suggested that fetishism was neither rare nor unusual and that its prevalence was approximately equal among males and females.

Risk factors — Although cases of fetishistic disorder have been reported in females [3,4], fetishistic disorder presents almost exclusively in males [5].

In our clinical experience, fetishistic arousal patterns appear to be overrepresented in samples of males with significant developmental disabilities such as autism, intellectual deficiencies, and severe cerebral palsy.

PATHOGENESIS

Fetishistic disorder is considered a sexual developmental disorder because it places an unusual condition beyond the typical requirements for arousal, which include the partner's body, receptivity, and behaviors. The pathogenesis of the development of fetishistic disorder is not known. This should be viewed in the larger context that the development of sexual identity in childhood is not well understood. Neurobiologic, interpersonal, and cognitive processes are believed to play a role in the development of fetishistic disorder.

Neurobiology — The possibly higher prevalence of fetishistic disorder among individuals with cognitive developmental disabilities suggests that neurobiologic factors may play a direct role in the pathogenesis of fetishistic disorder or an indirect role through limited peer social interactions. In our clinical experience, a case is occasionally encountered where symptoms occurring with intoxication will abate during sobriety. (See 'Risk factors' above.)

Psychodynamic model — Contemporary psychodynamic theory posits that the fetish object is utilized as an unconscious defense against anxiety. The causes of this anxiety may be any manner of painful feelings faced in childhood [6]. Normal development involves coming to terms with aggressive feelings, lack of control, potential loss of one's physical integrity, loss of a parent's love, and separation from caregivers or parents [7,8].

While these are normal sources of anxiety, it is hypothesized that the children who are to develop a fetish have less resilience due to past traumas. These traumas are thought to be related to abuse or neglect, or other significant attachment difficulties in early years.

As examples:

- A common means of handling the anxiety associated with separation from one's caregiver or parents is with the use of a transitional object, such as a blanket or plush toy. Fetishistic disorder can be understood as a permanent attachment to a thing that is more dependable and less frightening than the caregiver [3].

- Diaper fetishism is hypothesized to indicate a wish to return to an infantile state in order to be cared for [9]. This form of fetishism may be an attempt to make up for gross deficiencies of parental nurturance in early childhood. Diaper fetishism and other age regression patterns point the clinicians towards understanding the patient's childhood experiences.

Cognitive-behavioral model — The cognitive-behavioral model hypothesizes that the development of arousal to a nonsexual object occurs through repetitive and recurrent associations between the fetishistic object and pleasurable activity [10].

As an example, spontaneous arousal occurs in an individual during childhood when rubbing a parent's foot. The patient later finds the memory of this pleasant experience to be arousing. The memory is conjured repeatedly during childhood masturbation, which positively reinforces the link between feet and arousal. The initial experience and repeated recollection may have to occur within a specific development time period, before sexual arousal is common or clearly understood. In contrast to the psychodynamic model, the cognitive development model posits

a development of habit through repetition, and does not associate this developing eroticization with the presence of current or past psychic trauma.

Other — Fetishistic disorder has alternatively been characterized as a disorder in the development of erotic target locations [11]. An individual's innate and differential sensitivity to various stimuli, when combined with that individual's experience, may focus on an atypical target. In the case of fetishistic disorder, this targeted feature may be clothes rather than the person in the clothes.

As example, a man may be preoccupied with bras but have little interest in the breast itself. He has no distress about his erotic preoccupation until his partner identifies the pattern and convinces him that the relationship itself is being threatened. He may then become distressed and pass from a paraphilia to a paraphilic disorder. If his partner calms down, his distress may dissipate. Males with fetishistic patterns are not inherently distressed because the patterns allows them to become aroused to orgasm.

CLINICAL CHARACTERISTICS

The central characteristic of fetishistic disorder is a distressing, persistent pattern of sexual arousal involving the use of nonliving objects or specific, nongenital body parts, such as the partner's foot, hair, or lips. Fetishistic disorder either greatly augments the arousal of a patient with the disorder or the patient may not be able to function sexually if the object is not present.

Patients may be reluctant to tell a clinician about a fetish despite their distress, either due to embarrassment or because they may not understand it to be an appropriate subject of clinical attention.

Fetishistic disorder typically presents in our clinical experience in one of two basic forms:

- The patient enters treatment after his behavior has run afoul of social standards and, in some cases, because the experience led to the sudden realization that others do not enjoy his sexual interest.

  As an example, a man was found viewing fetish pornography at work. A supervisor required him to seek treatment as a condition of keeping his job.

- The patient's entry into treatment derives from complaints from a couple about their psychological and sexual intimacies. The clinical presentation is often complicated by the partners' anger at one another.

As an example, a couple presents for treatment with a complaint that superficially seems to be about the wife's hypoactive sexual desire disorder. As the history unfolds, however, it emerges that the husband has a fetish, and the wife's "disorder" arose when she refused to continue lovemaking that relied on the fetish for arousal.

The husband expresses anger at his wife's betrayal while his wife has grown enraged and humiliated, as she has come to realize that they were not playing a harmless little game together. She now thinks that she never was the true object of his desire; it was the shoe, panty hose, or the bra. She was demeaned by her realization that her body and her being were not the actual source of his pleasure.

Descriptive data on the characteristics of fetishistic disorder are very limited and come from nonrepresentative studies with low generalizability, including forensic and clinical studies of other paraphilias in which there is a high rate of comorbid fetishistic disorder and from internet-based sources. These studies have a major sampling bias.

- An observational study of 262 patients with a self-reported foot fetish found high rates of fetishistic interest in footwear (ie, fetishistic disorder) [12].

  Primary objects of sexual arousal in the study included clean feet (60 percent), boots (52 percent), and shoes (49 percent). The study also found that:

  - The fetish object induced a multisensory experience in some cases, including smell as well as taste, touch, and sight. As an example, some subjects reported that smelly socks were more often arousing than clean socks.

  - Many of the subjects emphasized the symbolism of the object as the primary source of arousal. As examples, boots, wing-tipped shoes, and sneakers were associated with different perspectives on masculinity, albeit not consistently.

  - Twenty-three percent of subjects reported their fetish was a source of distress, resulting in relationship problems, shame, and loneliness. Eighteen percent of subjects kept their fetish secret from their partner and confined their use of the fetish to masturbation. The remaining subjects reported being able to incorporate their fetishistic interest into their sexual lives with partners.

- An observational study of 247 male patients with gender identity disorder, who reported sexual arousal from dressing in women's clothing (ie, transvestic fetishism), found that 60 percent of subjects additionally met diagnostic criteria for fetishistic disorder [13]. (See 'Differential diagnosis' below.)

- A study of English-language internet discussion groups on fetishistic disorder described findings from message boards belonging to 381 groups with a total 150,000 members. The members, who registered anonymously, may have belonged to multiple groups. Discussion participants were not assessed clinically and information was not available on whether they were distressed by their sexual interest. Their predominant sexual preferences, as expressed on the message boards, were for:

  - **Nongenital body parts** (33 percent) – Body parts were predominantly feet or toes (47 percent of this group) followed by body fluids such as blood or urine (9 percent), body features such as obesity, height, hair, and muscles, and body modifications such as tattoos and piercings.

  - **Objects associated with the body** (30 percent) – Objects associated with the body included those worn on the legs and buttocks such as stockings and skirts (33 percent), footwear (32 percent), costumes, and less commonly stethoscopes, wristwatches, and diapers.

  - **Objects unrelated to the body** – Five percent of patients reported them as a secondary preference.

As with all of the paraphilias, fetishistic disorder can be classified as a disorder of sexual intention. The other components of sexual identity (gender identity and sexual orientation) may be independently problematic, but fetishistic disorder is a disruption specifically of the erotic (mental fantasies, urges, preoccupations) and behavioral components of intention (ie, what an individual wants to do with their body or partner's body during sexual arousal) [14].

> It is often difficult for patients with fetishistic disorder to integrate their preoccupation into a mutual sexual relationship. A partner may consent at first to allow undergarments, shoes, or foot-play into the bedroom, but problems often arise and precipitate psychiatric evaluation or relationship counseling when the partner realizes that the fetishist actually has little interest in the partner or the partner's breasts and genitals at all.

The relationship problems that commonly present in patients with fetishistic disorder often go beyond sexual intention and reflect deeper disruptions of both identity and the ability to relate to others with a mature emotional intimacy. Themes of power and dehumanization often figure prominently in the relationships of those with the paraphilias [7]. In fetishistic disorder, the aggression towards a partner is typically less overt, though the focus on an object at the expense of the whole emotional and sexual person can leave the partner feeling, at the very least, unloved. Theories underlying fetishistic disorder do not agree on whether the fetishistic behavior is a result or a cause of this pathology. (See 'Pathogenesis' above.)

In thinking about fetishism as an abnormal intention, it is hypothesized that some individuals are flirting with the idea that they belong to the other sex while retaining their masculinity. As an example, a masculine man presented for help for his inability to sustain an erection since his wife refused to have sex with him while he dressed in a full length slip. He liked to pretend that he was a woman but beside the slip, he had no interest in feminizing himself. Clinicians should not be surprised to discover, upon careful questioning, that the man with a fetish at times nurtures himself with a fantasy of himself as a woman or being transformed by others into one.

Co-occurring disorders — Fetishistic disorder has been reported as a comorbid condition in forensic patients with psychiatric disorders who commit sex crimes involving paraphilias, but the condition is relatively uncommon in such patients [7,15]. They typically receive primary diagnoses of pedophilia, exhibitionism, voyeurism, or frotteurism (a paraphilia in which sexual arousal or orgasm is achieved by actual or fantasized touching and rubbing against a nonconsenting person, usually in a crowded place).

COURSE

Fetishistic disorder is not diagnosed in children and rarely in adolescents; however, patients have reported that their unusual sexual interests were present from a young age [16]. A case series described six adult patients, who reported that they were able to trace a fetish back to an initial presexual preoccupation or excitement in which the object (eg, rings, cigarettes, feet) figured prominently [10]. Patients commonly recalled an initial sexual preoccupation with the fetish object developing in adolescence, with the object the subject of fantasies, or held, caressed, or worn during masturbation. Sexual experimentation with diverse stimuli and fantasies is not uncommon during teen sexual development, and does not mean that these interests will continue into adulthood.

Many patients with fetishes are capable of engaging their partners sexually without the fetish some of the time, but not others. The level of distress and psychosocial impairment caused by the disorder depends upon the nature of the distress.

When the fetishistic disorder is present well into adulthood, in our experience, the future course is likely to be chronic. The intensity of the fetishistic preoccupation may fluctuate, but the degree to which the patient is capable of eroticized behavior or fantasy apart from the fetish is generally fixed.

Some patients who initially meet diagnostic criteria for fetishistic disorder may later not experience a clinically significant level of distress, often because they have learned to integrate

the fetish into their masturbatory or partnered sexual activity, or because they have normalized the experience by integrating themselves into a community of like-minded individuals, which has become feasible through the internet.

ASSESSMENT

Fetishistic disorder is typically detected by clinicians in the process of taking a sexual history that includes a discussion of a patient's sexual behaviors and fantasies; a patient rarely presents with a chief complaint of fetishistic disorder. Such a history requires adequate time, a clinician who is comfortable asking a patient about sexual issues, and patient trust of the evaluator. A clinician who is experienced in discussing sexual concerns and curious about the patient's private inner life can help a patient feel comfortable in this area. Letting the patient know that a wide variety of sexual intentions exist in the population may facilitate patient comfort and trust. Some of these patients already know this from their internet pornography explorations. (See "Overview of sexual dysfunction in females: Epidemiology, risk factors, and evaluation" and "Evaluation of male sexual dysfunction".)

The assessment of fetishistic disorder, as with any other disorder of sexual intention, requires an understanding of the developmental forces, sexual and nonsexual, in an individual patient's life. The clinician should seek to understand whether and how the fetish causes the patient (or his partner) distress, the fetish's role and effects on the patient's masturbatory and partnered sexual activity, and what has changed to motivate the patient to seek help. The psychiatric assessment needs to consider the individual's private attitudes toward the fetish, as well as his intellectual and social capacities. These latter characteristics will inform clinical decision making, including the degree to which the patient would be able to participate in psychotherapy.

Specific questions about a patient's patterns of sexual intention include:

- What was the age of initial interest in the fetishistic object?
- What was the nature of the early associations to this object?
- Were there prior different fetish objects?
- What was the context in which this experience took place?
- To what extent has the preoccupation been a predominant erotic force in the patient's life, during the teen years and later?
- Does the intensity of fetishistic arousal vary with environmental or interpersonal distress?

- Describe the specific aspects of the fetish; for example, if a shoe fetish, are shiny shoes more arousing? What about wet shoes?
- How often and under what circumstances is the fetishistic object required for masturbation or for sexual arousal and functioning with a partner?
- Are there behavior patterns in the partner independent of the fetish which might augment arousal in the patient?
- Are there ways the couple can integrate the fetish into love making that are acceptable to the partner?

DIAGNOSIS

DSM-5-TR diagnostic criteria for fetishistic disorder are as follows [1]:

- A. Over a period of at least six 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.
- B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The fetish objects are not limited to articles of clothing used in cross-dressing (as in transvestic disorder) or devices specifically designed for the purpose of tactile genital stimulation (eg, vibrator).

Subtypes and specifiers — Specify if fetish object(s) is:

- Body part(s)
- Nonliving object(s)
- Other

Specify if:

- In a controlled environment – This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to engage in fetishistic behaviors are restricted.
- In full remission – There has been no distress or impairment in social, occupational, or other areas of functioning for at least five years while in an uncontrolled environment.

A diagnosis of fetishistic disorder should not be made until the late adolescence, following the completion of puberty and an initial consolidation of sexual identity.

One must take great care whenever making a diagnosis based upon “unusual” preoccupations or behaviors. Cultural norms do not define diseases yet they play a role in our understanding of illness and health [17]. There are, for example, subcultures in America and internationally where fetishistic interests are not considered abnormal. As examples, Denmark, Norway, and Sweden have all removed fetishistic disorder from their national lists of accepted medical diagnoses in the past 15 years [18].

Differential diagnosis — Fetishistic disorder’s clinical presentation is relatively unique among psychiatric disorders. It does need to be distinguished from transvestic disorder, which may present with sexual arousal from cross-dressing, a subtype that is distinguished by the specifier, “with fetish” in DSM-5. Central to the diagnosis of transvestic disorder are issues of sexual identity, which are not apparently present in fetishistic disorder.

Patients with a fetishistic disorder should also be distinguished from individuals who utilize fetishes but do not experience distress or impairment associated with their use.

TREATMENT

As there are no clinical trials to guide treatment, our treatment is based on clinical experience and case studies:

- We suggest psychotherapy over other interventions as first-line treatment for most patients with fetishistic disorder.
- For individuals with fetishistic disorder who experience inadequate response to psychotherapy or in those with comorbid anxiety or depression, we typically augment psychotherapy with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI). (See 'Medication' below.)
- For individuals with a fetishistic disorder and a developmental disability who lack the cognitive or interpersonal capacities to participate in psychotherapy, we use serotonergic antidepressants as first-line treatment.

Psychotherapy — Psychotherapy is first-line treatment for most patients with fetishistic disorder [17]. The techniques, goals, and components of psychotherapy will vary based on the specifics of each case (see 'Common components' below). In our experience, the intensity of some patients’ preoccupations with the fetish and its effects on sexual functioning vary;

psychotherapy addressing moderating factors (eg, relationship problems) can lead to less preoccupation and improved functioning. In chronic cases of fetishistic disorder where the preoccupation and its impact on sexual activity are fixed, the goal of psychotherapy may be to help the patient to integrate the fetish into partnered sexual activity, or to address related issues such as the patient's self-esteem. (See 'Course' above.)

Common components — Common components of psychotherapy for fetishistic disorder include:

- Education – Addressing the nature of fetishistic disorder, societal perceptions of fetishistic behavior, the fact that others experience fetishistic disorder, and that there are treatments that may lead to improvement or adjustment to the condition.
- Support – Supportive components of psychotherapy include reassurance, empathy, and positive regard.
- Increasing awareness – Patients may not understand the reactions of others to the fetish. As an example, a patient may need help to understand the impact of the fetish on a partner who has reacted angrily.
- Addressing low self-esteem – Patients experiencing distress related to fetishistic disorder often present with low self-esteem, which should be addressed as part of the therapy.
- Problem-solving – This approach involves helping the patient to identify problems associated with fetishistic disorder and his distress, and for each, to evaluate the advantages and disadvantages of possible solutions, choose an approach, implement it, and evaluate the outcome.

  In our clinical experience, some of the problems that can be effectively addressed are not sexual in nature. A man failing at his job, for example, may be dealing with his anxiety by increasing preoccupation with his fetish as a distraction. Identifying the vocational problem and helping him take steps to save his job by improving his performance may lessen his fetishistic preoccupations and behaviors.

There is no published evidence on the effectiveness of psychotherapy (in general or specific psychotherapies) in fetishistic disorder. Specialized psychotherapies offer potentially explanatory models of fetishistic disorder as well as general principles and specific techniques, as described below.

Psychodynamic psychotherapy — In addition to the components described above, psychodynamic psychotherapy aims to work with the patient to develop an understanding of

the forces that set up the fetishistic interest and the separate forces that maintain it. These forces are commonly referred to as the psychodynamics of the problem. Understanding the patient's need for the fetish in developmental terms can help the patient to better understand himself. (See 'Psychodynamic model' above and 'Common components' above.)

As an example, some male patients with fetishes have experienced significant discontinuities in their maternal relationships. The fetish may be a representation of the mother in some patients, which functions just as a soft toy does for a toddler at bedtime. It comforts him and allows him to be excited, and distracts him from his anxieties about closeness to a partner or ultimately to bonding with the partner. The patient's ability to identify ongoing sources of anxiety in his life can facilitate insight into the ongoing protective function of the fetish.

Cognitive-behavioral therapy — In addition to the components of psychotherapy described above, cognitive-behavioral therapy focuses on changing distorted cognitions and maladaptive behavior associated with the fetish. Therapeutic interventions are based on a careful analysis of antecedent behavior and consequences of the fetishistic behavior. (See 'Cognitive-behavioral model' above and 'Common components' above.)

Work in therapy to treat paraphilic disorders including fetishistic disorder can be likened to a series of experiments, done collaboratively with the patient to figure out what is helpful and what is not. An important step in understanding the nature of the problem and the courses for treatment may be to examine the effects of stopping the behavior. The patient cannot be forced to stop the behavior but this can be undertaken collaboratively as an experiment to see whether affects such as anxiety or depression or anger result, or whether other behaviors such as substance misuse or more normative behaviors, sexual or otherwise, begin to occur [19].

Behavioral interventions are formulated based on the specifics of the individual patient presentation. Approaches include:

Behavioral repatterning — In behavioral repatterning, the patient and therapist gradually implement changes in the patient's behavior to address specific problems leading to the patient's distress. As an example, in a patient whose partner has become angry about the role of the fetish in their sexual activity, a series of staged changes might include:

- The patient gradually shifts his masturbatory fantasies away from involving the fetish.
- The patient attempts to fantasize about the fetishistic object instead of bringing the object into the bedroom.

- If the patient is unable to function without the fetish, but his partner is willing to work on the problem, the couple might attempt to shift the role of the fetish in sexual activity. A woman having sex with a man with a shoe fetish might initially take off her shoes immediately prior to penetration, then another time during foreplay, then just before foreplay and so on, until shoes are not part of sexual activity.

The goal is to gradually shift the use of the fetishistic object to a less prominent aspect in their sexual activities. This approach is not expected to decrease the arousal to shoes, but can give the patient some voluntary control of its role in sexual activity.

Assertiveness training — If the patient appears to use the fetish as a means of expressing anger in the relationship, the clinician might employ assertiveness training to teach the patient alternative, more constructive approaches to expressing anger [20].

Couples therapy — Couples therapy may be useful if the patient's fetish has led to problems in the relationship or if the intensity of the patient's need for the fetish increases during periods of intensified conflict. Typical elements of couples therapy in fetishistic disorder include:

- Improved communication between the partners
- An increased understanding of each other's feelings about the fetish
- Helping the couple negotiate a compromise on the role of the fetish in sexual activity that would be acceptable to both of them

Medication

SSRI/SNRIs — For individuals with fetishistic disorder who experience inadequate response to psychotherapy or in those with comorbid anxiety or depression, we typically augment psychotherapy with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI).

There are no controlled trials of SSRIs or SNRIs in fetishistic disorder. The potential utility of SSRIs and SNRIs in reducing the sexual preoccupation associated with fetishistic disorder is derived from their effectiveness in treating other types of obsessional thinking (eg, in obsessive-compulsive disorder). (See "Management of obsessive-compulsive disorder in adults".)

In case reports [21,22] and in our clinical experience, these agents can diminish the sexual preoccupation associated with fetishistic disorder and appear to broadly suppress sexual functioning while diminishing the fetish symptoms. These agents in combination with

psychotherapy may be useful in fetishistic disorder comorbid with significant, co-occurring levels of depression or anxiety. (See "Generalized anxiety disorder in adults: Management" and "Unipolar major depression in adults: Choosing initial treatment" and "Management of obsessive-compulsive disorder in adults".)

As an example, we often use paroxetine beginning at 20 mg/day, increasing in increments of 10 to 20 mg/day up to 50 mg/day if the clinical response is inadequate. Paroxetine and other SSRIs cause reduced libido in females and males, anorgasmia in females, and erectile dysfunction in males. This side effect could prove beneficial if a patient wished to diminish sexual urges and functioning; however, it is not likely to target the pathological urges selectively. More detailed information on the administration and adverse effects of serotonergic antidepressants is provided separately. (See "Selective serotonin reuptake inhibitors: Pharmacology, administration, and side effects", section on 'Sexual dysfunction and infertility' and "Serotonin-norepinephrine reuptake inhibitors: Pharmacology, administration, and side effects".)

If a serotonergic medication is helpful in reducing the fetishistic urges, the drug should be continued for at least one year to allow the patient to address related factors in psychotherapy and in his/her life. The medication should be tapered off gradually when discontinued to avoid withdrawal symptoms and to observe for renewed intensification of urges.

Other — Single case reports have described reduction of symptoms of fetishistic disorder associated with topiramate [23], mirtazapine [24], fluoxetine, naltrexone, and buspirone.

SUMMARY AND RECOMMENDATIONS

- Fetishistic disorder is characterized by a persistent pattern of sexual arousal involving the use of nonliving objects or specific, nongenital body parts (such as the partner's foot) that causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. (See 'Introduction' above and 'Diagnosis' above.)

- Little is known about the prevalence of fetishistic disorder, but the condition appears to present almost exclusively in males. While females can be paraphilic (eg, masochism), they are rarely have fetishism. (See 'Epidemiology' above.)

- Proposed conceptual models of fetishistic disorder draw on psychodynamic and cognitive-behavioral theory. (See 'Pathogenesis' above.)

- Fetishistic disorder is rarely the subject of a patient's presenting complaint; it is more likely to arise in clinical practice when a patient is compelled to seek treatment after the

individual's behavior has drawn attention, or when a couple presents seeking help for inadequate sexual functioning. (See 'Clinical characteristics' above.)

- Evaluation of the sexual history of a patient with fetishistic disorder should include the onset of the fetishistic fantasy, the duration and type of impairment, and the ability of the patient to experience erotic fantasy and behavior that does not involve the fetish. Asking and obtaining truthful answers to these assessment questions help to create the therapeutic alliance and guides what the patient and the therapist may desire to elaborate upon in future sessions. (See 'Assessment' above.)

- We suggest psychotherapy over other interventions as first-line treatment for most patients with fetishistic disorder (**Grade 2C**). Components of psychotherapy should be customized to the needs of the individual patient; potentially useful components include education, support, increasing awareness, addressing low self-esteem, problem solving, and behavioral repatterning. (See 'Common components' above and 'Behavioral repatterning' above.)

- Couples therapy can be helpful in addressing conflicts arising from the role of the patient's fetish in the couple's sexual activity. (See 'Couples therapy' above.)

- In patients with fetishistic disorder who experience an inadequate response to psychotherapy or have comorbid anxiety or depression, we suggest the addition of a selective serotonin reuptake inhibitor or serotonin-norepinephrine reuptake inhibitor (**Grade 2C**). The serotonergic drugs function by dampening sexual drive.

- Serotonergic antidepressants are used first-line in patients with fetishistic disorder and a developmental disability who lack the cognitive or interpersonal capacities to participate in psychotherapy. (See 'Medication' above.)

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