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# The psychopathology of fetishism and Body Integrity Dysphoria (BID)

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## Editorial

Fetishes gain in strength when other avenues of sexual gratification are not available owing to extreme shyness, fear of sex, a physiological dysfunction, or socio-cultural inhibitions. Thus, fetishism should be more prevalent in sexually repressive cultures and societies and among women, homosexuals, and other sexual minorities. Yet, fetishism has been noted mostly among men, both homosexual and heterosexual. The phenomenon may go under-reported among women, though.

Western society encourages what the sexologist Magnus Hirschfeld called "partial attractiveness". Women are taught to emphasize certain organs and areas of their body, particular fashion accessories and clothing items, and gender-specific traits. These serve as "healthy and socially-acceptable fetishes" to which males respond.[1–10]

Other "explanations" of fetishism are so convoluted that they either defy reason or cannot be regarded as science by any stretch of the word. Thus, Freud suggested (Standard Edition, Vol. 21, pp. 147-157, 1927) that fetishism is the outcome of an unresolved castration anxiety in childhood. The fetishist attempts to ward off the lingering stress by maintaining unconsciously that women are really possessed of an occult penis and are, thus, made "whole". Fetishes, in other words, are symbolic representations of phalli.

In his article "Splitting of the Ego in the Process of Defense" (Standard Edition, Vol. 23, pp. 275-8), Freud offered yet another mechanism. He postulated that the fetishist's Ego harbors two coexistent, fully functional, and hermetically sealed "attitudes" towards external reality: one taking the world into account and the other ignoring it.

Adherents of the Object Relations school of psychodynamics, such as Donald Winnicott, consider fetishes to be "transitional objects" that outgrew their usefulness. The fetish originally allowed the child to derive comfort and compensate for the withdrawal of the Primary Object (the mother, or caregiver). Winnicott, too, believes that the fetish amounts to an anxiety-ameliorating substitute for the missing maternal phallus.

**Paper**

**The sexual fetish is like "the fetich in which the savage sees the embodiment of his god"**

**S. Freud, "Three Contributions to the Theory of Sex" (1905)**

## The disorder

The propensity to regard and treat other people (caregivers, parents) as objects (to "objectify" them) is an inevitable phase of personal development and growth during the formative years (6 months to 3 years). As psychoanalysis and the Object Relations school of psychology teach us, we outgrow this immature way of relating to our human environment and instead develop a sense of empathy.

Yet, some of us remain "fixated" and do not progress into full-fledged adulthood. Arguably the most ostentatious manifestation of such retardation is the sexual paraphilia known as fetishism.

There are three types of fetishes:

An inanimate object, usually with a sexual connotation (such as a bra);

A body part that is clearly still connected to a complete body, dead or alive (e.g., hair, feet);

A reified trait, usually a deformity or idiosyncrasy that implies inferiority, helplessness, or dependence (for instance, a lame, or grotesquely obese, or hunchbacked person).

Consequently, there are three categories of fetishism and fetishists:

**Objective fetishists**, for whom the inanimate fetish stands for and symbolizes a desired whole that is out of reach.

**Somatic fetishists**, for whom the body part stands for and symbolizes a coveted human body (and, by extension, a relationship) that is unattainable.

**Abstract fetishists**, who latch on to a trait or a characteristic as a means to indirectly interact with their "defective" bearer and thus fulfill the fetishist's grandiose fantasies of omnipotence and innate superiority (pathological narcissism).

Arguably, people who prefer autoerotic, partialist, necrophilic, coprophilic, urophilic, or anonymous sex are also fetishists with the fetish being their own bodies or the organs or excretions of their sex partners.

Sexual fetishism is predicated on a pathological sexual attachment to a fetish. The fetishist climaxes only in the presence of the fetish and cannot reach orgasm otherwise. In the absence of their fetish, most fetishists are sexually dysfunctional (for instance, they suffer from erectile dysfunction or are sexually hypoactive). Some forms of fetishism involve sado-masochistic and domination/submission fantasies (with fetishes such as feet or boots and shoes).

The circumstances surrounding the sexual encounter are immaterial to the fetishist, as is his environment. Thus, a fetishist who is fixated on bras or feet is unlikely to mind the physical characteristics of the proprietress of either.

This "tunnel vision" is common to other mental health disorders, such as the autistic spectrum, schizophrenic, or somatoform ones. It

may indicate the existence of underlying mental health problems or traumas that either give rise or exacerbate fetishism.

Fetishism can be confined to recurrent and intense fantasies and urges, or acted upon (behavioral). It invariably involves masturbation. The fetishist interacts with his fetish in five ways: by watching it (worn by a sex partner or as an isolated item); by holding it; by rubbing it or against it; by smelling it; and by vividly fantasizing about it.

## Etiology

The fetish has to be "exactly right" in smell, texture, and appearance. Fetishists often go to great length to make sure that their fetish is just "the way it should be". It would seem that fetishes are "triggers", akin to objects that provoke flashbacks and panic attacks in the post-traumatic stress disorder. It stands to reason, therefore, that the same mental mechanism gives rise to both: association of learning.

Memory has been proven to be state-dependent: information learnt in specific mental, physical, or emotional states is most easily recalled in similar states. Conversely, in a process known as redintegration, mental and emotional states are completely invoked and restored when only a single element is encountered and experienced (a smell, a taste, a sight).

In 1877, the French psychologist Alfred Binet (1857-1911) suggested that fetishism is the outcome of a repeated co-occurrence of an object (the fetish) and sexual arousal. The more frequent the association, the more entrenched, persistent, and enhanced it becomes (i.e., the stronger the allure of the fetish and the more secure its exclusivity as a modus of sexual expression).

Behaviorist psychologists largely concurred with Binet, though they preferred to use the term "conditioning", rather than "association". Others (Wilson, 1981) suggested that fetishism is nothing but faulty imprinting. Yet, imprinting has never been demonstrated in humans and fetishists, whatever we may think of their predilections, are human beings.[12–20]

Fetishes gain in strength when other avenues of sexual gratification are not available owing to extreme shyness, fear of sex, a physiological dysfunction, or socio-cultural inhibitions. Thus, fetishism should be more prevalent in sexually repressive cultures and societies and among women, homosexuals, and other sexual minorities. Yet, fetishism has been noted mostly among men, both homosexual and heterosexual. The phenomenon may go under-reported among women, though.

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## Apotemnophilia, acrotomophilia, Body Integrity Dysphoria (BID)

Body Integrity Dysphoria (aka BIID: Body Integrity Identity Disorder) appears only in the ICD 11. It is the overwhelming desire to be rendered disabled (usually by amputating a limb) or the extreme discomfiture with being able-bodied. Confusingly, it has several diametrically opposed clinical manifestations, the most prevalent being apotemnophilia (the wish to be amputated) and acrotomophilia (being sexually aroused exclusively with a disabled partner, usually an amputee). Acrotomphiles enjoy dominating the amputee partner during sex and are stimulated by the need to position her and take care of her needs.

BID should not be confused with somatoparaphrenia ("transabled": denying ownership of a limb–usually the left arm - or of an entire half of the body, typically the left one, in the face of evidence to the contrary) or with asomatognosia (loss of recognition of one's limbs and mistaking them for other people's, reversed upon confronting proof of body integralness).

In general, single leg amputations with a stump are preferred to any other intervention, to bilateral disability, or to deafness and blindness. Otherwise "(d)evotees adhere to standard conceptions of attractiveness in all other matters outside of amputations" (Solvang, 2007).

BID patients present with a mismatch between the mental map of the body and its actual layout (possibly an error in proprioception or kinaesthesia mediated via damage to specific proprioceptors, mechanosensory neurones, or owing to problems with the vestibular system). Sufferers of BID seek to remedy this incongruence by removing the redundant, colonizing, or alien parts thus restoring a sexually exciting (autoerotic), aesthetic, perceived wholeness via self-mutilation (the same way cancer patients resent their tumors and seek to excise them or, maybe, the same as pregnant women who feel whole only when the baby is expelled from their bodies in childbirth). The anger felt towards the superfluous body part gives rise to sexual excitation (sex involves sublimated aggression in multiple ways).

BID may be reconceived as a body dysmorphia. BID patients resort to role play (for example: the use of prostheses or casts) and, in extremely rare cases, self-harm. The preference for the surgical removal of left-sided organs indicates damage to the right parietal lobe. The line of desired amputation remains stable over the life span and skin conductance is markedly different above and below it.

We can only speculate as to the psychology of BID. Modifying our bodies in order to attract mates and to keep them and also to conform to social mores regarding body image is common practice: makeup, diets, and plastic and cosmetic surgeries are all examples. So, the aforementioned restoration of a sense of corporeal completeness may be one important reason.

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Controlling a disabled and dependent partner in order to fend off debilitating abandonment anxiety (akin to the psychodynamic of Borderline and Dependent Personality Disorders) may be another. Such etiology may indicate the existence of underlying narcissism: narcissists psychologically objectify their partners, reduce them to body parts or fetishes, and seek to disable them mentally and also by rendering them physically ill.

Pedophilia may be a form of acrotomophilia: children are not yet fully formed and are socially and functionally "disabled". There is also the issue of infantilization (the wish to be taken care of and to avoid having to grow up to be an adult). In Acrotomophilia, the reverse dynamic applies: parentifying. The acrotomphiliac is grandiose ("I can see beyond the body into the soul") and acts as a benevolent and caring parent to his disabled or deformed intimate partner, perhaps in an attempt to re-enact and resolve early childhood conflicts with caregivers with a hoped-for different outcome.

Finally, the ability and courage to modify the body is an autoerotic "private ritual of self-ownership and freedom of choice", a reassertion of self-control also witnessed in eating disorders.[21–27]

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## Conflicts of interest

The author declares that there is no conflict of interest to declare.

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