Making sense of fetishes

Jeanine Connor offers vignettes and reflections on her work with adolescent clients who engage in sexually fetishistic behaviour

I've had plenty to say, in training and in print, about adolescent sexuality. I've contemplated ordinary sexual development, troubling sexualised behaviour, and issues affecting young LGBT clients, with a particular emphasis on T. I've ventured into more challenging arenas by reflecting on adolescents who engage in bondage, dominance, and sadomasochism (BDSM) and/or sugar-daddying. This article ventures further still by considering adolescent sexual fetishes. In order to protect the anonymity of my clients, what I present here are amalgamations of therapeutic experiences with young people of various ages and genders, consolidated into four unidentifiable clinical vignettes. Working with this client group provokes a tension for me between developing a psychodynamic understanding of the sexual fetish, and employing an ethical need to maintain my clients' safety. My hope in writing this article is that it will help other counsellors and therapists to reconcile such dilemmas in their own work with adolescents who engage in sexually fetishistic behaviour.

Sexual fetishes come under the broad spectrum of paraphilia, which includes sexual arousal in response to atypical objects, situations, fantasies or individuals. DSM-IV defined paraphilias as deviations or disorders. However, DSM-V, published in 2013, made a distinction between paraphilia and paraphilic disorder – and between fetish and fetishistic disorder – stating that behaviour should only be regarded as a disorder if it causes distress or dysfunction.[1] An article in *The Journal of Psychiatry and Neurological Sciences*, titled 'Sexual Fetishism in Adolescence', supports my clinical observations that fetishism usually presents in males and has typically begun by adolescence.[2] Yet, despite this, there is limited literature and much misunderstanding. The same paper[2] declares that one boy 'was able to admit his interest and behavior [sic] was unacceptable and shameful'; which I find shameful in itself. However, it is worth noting that psychiatrists had the option of defining homosexuality as a mental disorder up until 1986, 12 years after it was removed from the DSM. By this reckoning, it will be a long time before sexual fetishes are accepted as lifestyle choices rather than 'unacceptable and shameful' sexual perversions.

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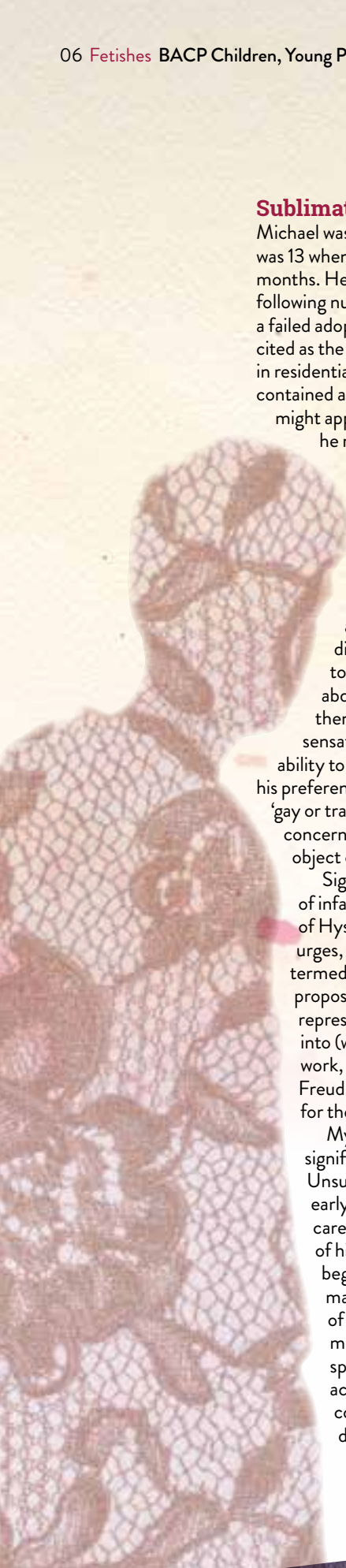

Sublimation

Michael was a well-presented, attractive young man, who was 13 when we worked together over a period of three months. He was a looked-after child in residential care following numerous breakdowns of foster placements and a failed adoption. Michael's 'unmanageable behaviour' was cited as the reason his placements had failed. He had been in residential care for six months when we met, and seemed contained and relatively content. He told me that while he might appear normal, he was in fact abnormal, because he masturbated most days. When I wondered why Michael defined himself as 'abnormal' and whether his masturbation bothered him, he said he was turned on by wearing women's clothes, and that this was the reason that each of his placements had ended.

Michael described feeling aroused by the sensation of women's underclothes; items such as nightdresses, knickers or tights that he disposed of after he'd finished with them. He told me that he wrapped the garments around his abdomen, thighs, penis and sometimes his face and then masturbated inside them until he climaxed. The sensation of the fabric was important to him, as was the ability to be inside it. The thing that bothered Michael was his preference for *female* clothing – he insisted that he wasn't 'gay or trans' – and because he highlighted this as his only concern, I was also curious about the significance of his object choice at a symbolic level.

Sigmund Freud first wrote about the significance of infantile sexuality in his 1896 paper, 'The Aetiology of Hysteria'.[3] He suggested that the origins of sexual urges, impulses and desires, which he collectively termed 'libido', could be traced back to infancy. Freud proposed that childhood sexual impulses are often repressed, while those that are acted out can develop into (what *he* called) 'sexual perversions'. In a later work, 'Three Essays on the Theory of Sexuality', Freud defined fetishism as the 'unsuitable substitute for the sexual object'.[4]

My work with Michael focused on exploring the significance of his 'substitute sexual object'. Unsurprisingly, we were able to trace its origins to early childhood, when Michael was first taken into care. He remembered missing the 'smell and feel' of his mother and aching for her physical touch. We began to understand that Michael had recreated the maternal sensation he craved through sublimation of desire onto female clothing. If we consider libido more generally as physical gratification, rather than specifically sexual pleasure, it's not such a leap to accept that the behaviour Michael relied on for comfort as an infant was the same behaviour that drove his sexual desire as an adolescent.

Substitute objects

Reggie was a 'rough and tumble' 12 year old, who resembled a whirlwind in the therapy room and the wider world. His clothes were grubby, often ripped, and he generally had cuts and bruises, sustained either from falls or fights. He and his younger brother lived with their single mother, who clearly had her hands full. It was difficult to engage Reggie in dialogue, as he was often distracted and seemed unable to grasp the to and fro of conversation. His language was littered with expletives that seemed to spill out in a stream of consciousness that became the soundtrack to our sessions, in a singsong kind of way. Reggie and I played simple games together, such as snap and dominoes. He had an inability to 'stay with' me – or any activity – for long, and seemed to have an unbearable fear of losing. Reggie repeatedly grabbed at his crotch and wiggled about in a way I couldn't help but notice. I think he wanted me to think of him as a male with a penis, which of course he was, and with potency.

A shift came about when, in one particular session, Reggie appeared to masturbate. At first I said nothing as he rubbed at his groin while we played a game of cards. His actions became more purposeful as he put his hand inside his shorts, and quite deliberately moved it up and down while singing a made-up song about 'dicks'. Reggie was provoking me to react to his behaviour, while his direct eye contact seemed to be saying 'what do you think about *this*, clever lady?' Gauging an appropriate response felt crucial, and I proceeded with caution by stating the obvious: 'It seems as if you want me to notice something...' Reggie continued to look me in the eye, while also continuing to simulate masturbation. I wondered aloud if he could tell me about what was happening with words. When he said nothing, I ventured on and said it seemed to me that he was rubbing himself inside his shorts. We maintained eye contact, and I wondered how long we would go on like this, while also trying to contain my internal sense of panic. Reggie pulled his hand slowly out of his shorts and with it came a fidget spinner, followed by another, and then a spoon.

Immediately what flashed through my mind were the numerous times he had attempted to take things from my room – dominoes, pencils, pebbles – by pretending to overtly secrete them down his pants. I realised now that I had under-interpreted his actions as a desire to take something of mine away with him. This may have been partly true, but I had missed the clues that Reggie had provided about *where* he was taking them: down his pants. It also made sense to me, now, that this usually happened at the end of sessions, during the 'doorknob' moment, so that there was never time for me to comment or explore.

As with Michael, I was curious about the significance of Reggie's 'substitute objects'. I knew it was unlikely that he would talk with me about this, so I decided instead to talk to his mother. What I discovered was that Reggie had been secreting seemingly random objects in his pants for as long as she could remember. She shared examples of finding small toys inside his nappy, which he continued to wear into his fourth year. Like me, she hadn't initially assigned any sexual meaning, but she agreed with my observation that, more recently, Reggie seemed to garner a sort of sexual

satisfaction from his 'habit'. In accepting that his sexual urges focused on inanimate objects, we were able to redefine his habit as a fetish. As Reggie's mother elaborated, I had the sense of an addiction, and was mindful that the purpose of any addictive behaviour is to dispel painful feelings. I knew something of Reggie's history. He was born into a traveller community and his teenage mother had relocated countless times. Reggie had witnessed both physical and sexual violence, as well as drug and alcohol abuse, and had received no formal education.

The psychoanalyst Joyce McDougall wrote that 'objects of desire perform the function of a drug,'[5] and we know that the function of a drug is escape from reality. Reflecting on Reggie's sexual fetish in the context of his developmental history allowed us to assign meaning. Its purpose, it seemed, was to disavow overwhelming childhood experiences. While Reggie was unable to *verbalise* feelings, it now seemed obvious that he could *feel* them. McDougall[6] called this inability to put words to feelings 'disaffection', and used the term to describe individuals who had experienced overwhelming emotion that threatened to break down their sense of identity. This fit with my sense of Reggie as a vulnerable little boy who wanted to present as a powerful, potent male. McDougall also wrote that disaffected individuals have 'an inability to contain and reflect upon an excess of affective experience'.[6] By working with Reggie's mother to better understand his behaviour, we were able to adjust our responses to him. At home and in therapy, we shared our observations aloud with Reggie – 'it seems you have put something inside your pants' – and demonstrated that we understood his motivation – 'maybe it feels nice'. Over time, we elaborated further: 'Maybe it feels nice to do that when you're scared or confused…' Gradually the behaviour diminished, as Reggie began to feel less overwhelmed by his feelings and more contained by us. This piece of work demonstrates what can be achieved when therapist and family work together to contain a young person, even when the explicit trauma remains unnamed.

Fixations

Zion was a 15-year-old looked-after child, who had recently moved to a new placement at the time I met his foster carers for consultation. His previous placement had ended because the family had concerns about 'sexually inappropriate conduct'. They described an 'unhealthy fixation' with their new baby grandson, and said that Zion seemed to be sexually excited by him. There had also been a number of incidents of finding Zion in ladies public toilets, which had resulted in the breakdown of several previous placements due to his 'potentially predatory behaviour'. His new carers wanted my help to understand Zion's behaviour so that they could support him and break the cycle of rejection. I encouraged them to talk to Zion in a non-condemnatory way and to hear what he had to say. It soon became apparent that Zion wasn't sexually attracted to babies, but that he had a fetish for babies' nappies. And the reason he frequented ladies public toilets was to acquire them from nappy bins, which are still mostly missing from gents public conveniences. That Zion wasn't a risk to women or babies came as a relief to the carers, and allowed them to think with him about how they could help him to satisfy his fantasy in a safe way. As with Reggie, this indirect working allowed Zion to feel contained and understood, and his sexual fetish gradually gave way to more ordinary adolescent sexual behaviour.

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Partialism

My work with Eric focused explicitly on his sexuality and sexual preferences. The 18 year old had requested therapy to explore 'issues with intimacy' and concerns about his inability to maintain an erection, either alone or with another man. Eric had come out as homosexual aged 15. He had experimented sexually with girls during his early teens in an effort to fit in with his peers. This included mutual masturbation and oral intercourse, which left him feeling dissatisfied and inadequate. Once he was 'out', Eric started hooking up with men he met online in the hope of forming a relationship. Inevitably, the men he met wanted sex, which Eric declined because he was fearful about anal penetration and unsure about his preferences. Although Eric was frequently attracted to the men he met, he never experienced an erection during masturbation or digital penetration. And so the cycle of dissatisfaction and inadequacy that brought him to therapy continued. Things changed when he met Austin, who was able to turn Eric on by cutting his thighs and abdomen. This felt double-edged for Eric, who was finally able to achieve sexual satisfaction, yet in a way that *he* felt was perverse.

What struck me was both that Eric had subverted pleasure and pain, and also that sexual pleasure was assigned to non-genital parts of the body, which is sometimes referred to as partialism. I shared with Eric my concerns about safety, and assessed the risk, as I would with any young person who self-injures.[7] He assured me that clean blades were used and that the cuts inflicted were superficial. I encouraged Eric to describe the feelings elicited from being cut. He described an almost hallucinatory, trance-like state, whereby all other senses were numbed except that of pleasure. In *Theatre of the Mind*, McDougall writes that the 'perverse sexual act functions like a dream, a kind of hallucinatory creation of an alternative reality and serves as a solution to avoid painful internal conflicts'.[8] Eric's internal conflict centred on his sexuality. He'd experienced disingenuous heterosexual flirtations, followed by a hesitant acceptance of his own homosexuality. It made sense that he had (unconsciously) redirected sexual pleasure away from the genital area, which he associated with confusion and sexual dysfunction. Once this was understood, Eric was less self-critical and more at ease with his sexuality.

Conclusion

Sexual behaviour in adolescence originates in infancy – where tensions are set up between primitive internal drives to comfort, soothe and satisfy, and external cues that disallow them. My work with adolescents supports the notion that 'human sexuality is inherently traumatic'[5] – particularly for those struggling to make sense of their sexual preferences, including paraphilia. Very few clients present with an explicit wish to change their predilection, but most display an admirable desire to work with me to better understand it. To do this, we explore their developmental narrative through a psychodynamic lens. I share as much or as little of my interpretations as I think my client will find helpful. What is most reassuring for them to hear is that – thought about in context – their behaviour makes sense. This frees them to make sense of it too and to accept it or let it go.

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