FURTHER CONSIDERATIONS REGARDING FETISHISM[1]

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In a paper on fetishism (1953) I made an effort to organize the clinical picture and life-historical findings of such cases as I had observed, in relation to the development of the body image, since the fetish itself so clearly acts as some kind of stabilizer or reinforcement for the genital functioning of the patient. From this angle, my clinical material indicated rather clearly, I thought, the nature and timing of the special faults in the body image, which were patched up by the use of the fetish in later life. This was a limited presentation, but for me a useful one, since it offered a frame of reference for organizing clinical material, which at the very least is complex and confusing.

The main points of that paper were as follows: The disturbance of the fetishist appearing clinically as an unusually severe castration fear comes essentially from disturbances of pregenitality which render the child structurally unsound and insecure to meet genital-oedipal problems and especially to meet the normal castration threats of this period. In those cases which I saw these threats were already overwhelming, having appeared before the full oedipal development in unusually severe actual traumata of a specifically castrative type—threats not merely by seeing the mother's genital and observing her apparent castration at a time of special masturbatory arousal, as was first postulated by Freud (1927), but much more than this by witnessing or experiencing bloody mutilating attacks in the form of operations (on the self or others), childbirth, abortions, or accidents. These traumatic events, although unknown to the patient early in the analysis, have generally been accessible to validation after they have been brought to consciousness through analytic reconstructions.

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Such traumatic events seemed to occur at two specially vulnerable times: in the last half of the first year or first half of the second, and at the time of the early phallic phase. Sometimes the disturbances of the two eras were remarkably similar, the second seemingly reinstating the disturbances of the first with greater specificity—this being commensurate with the clearer perceptiveness combining with the special body sensitivity of the phallic period. In the first period, however, the occurrence of "internal traumas," as in attacks of infantile rage, spasms, fevers, anesthesias, also created severe disturbances of body sense of self, apparently with feelings of imminent dissolution. The traumas of the anal-phallic period were more consistently genital castrative threats. The effect of the disturbances of the first period was to increase the clinging reaction, and prolong the primary identification tendency. This meant that the fetishist, who is characteristically male,[3] identified in infancy with the mother or even with a sister (if there was one close in age and in constant contact with the patient). The bisexuality of later life was derived in part from this, and from the continued activity of primary identification, and not so completely from postoedipal female identifications, as is true in neurotic cases. The mediation of primary identification through vision, which substitutes for or combines with oral incorporation in some situations, could be seen in its reactivated form in the vicissitudes of foreplay and sexual intercourse in the fetishistic patient, who can then only stabilize his basic sexual identity through the use of the fetish, which can be felt as well as seen. The fetish is a further safeguard against the anxiety due to feelings of change of body size, resulting primarily from body-phallus problems, and to dissolution anxieties which may have further become attached to fear of the orgasm.

The present rather brief communication must be devoted to taking up some of the considerations omitted in the earlier paper and making further suggestions, rather than drawing new conclusions. I have not added to my clinical experience since that study except for the two posthumous analyses of Swift and Carroll recently attempted by me (1955). The amassing of material for clinical study is particularly difficult

[3] It is only fetishism at a clearly genital level that is restricted to males. This is probably due to the fact that the exposure of the male organs and the consequent visibility of achievement or failure of potency and orgasm constitute a special narcissistic hazard to the male. The sense of failure due to frigidity in the female is softened by the possibility of concealment. Forms of fetishism which are not always clearly linked to the genital functioning (such as certain drug addictions, kleptomanias, special religious practices, the use of lucky charms)—and even those linked to the genital activity but not demanding the objective fetish—such as set fantasies or rituals preparing for masturbation or intercourse, seem to occur in female as well as male.

in these cases, as relatively few patients suffering from perversions come to analysis, although one gets the impression that they are not so infrequent in the population at large. When the perversion works successfully, the person does not seek help unless he gets into social or legal difficulties. In analytic practice the perversion is likely to turn up as one of the complications of some other condition. Such analyses are long and tedious. One cannot accumulate many in a lifetime.

The main topics which I would like to bring out now have to do with (1) the interrelation between different types of perversion; (2) certain problems of body reality and their relation to the general sense of reality; and (3) aggression and acting out in relation to the reality sense.

It is hard to estimate the frequency of the "pure" monomorphous perversion. Fenichel (1954) said, "The typical pervert has one way only of gaining sexual pleasure. All of his sexual energies are concentrated on one particular partial instinct, the hypertrophy of which competes with his genital primacy—The capacity for genital orgasm is blocked by some obstacle that is more or less overcome by the perverse act" (p. 325). While this concept of such pure forms of perversion is undoubtedly useful in understanding the differentiation of the perversions from unorganized polymorphous perverse infantile states and from the earlier concept that the perversion represented the negative of the neurosis, still it is doubtful whether it states the general situation in perversions. In my own clinical experience it has generally been true that while there was one preferred perversion, other perverse activities might be instituted at different times in life or even concurrently with especially active periods of the perversion of choice. Bisexuality especially seems to be ubiquitous; and homosexuality nearly always breaks forth in some overt form, not merely being represented in nongenital activities and attitudes.

This combination of various perverse forms in the individual life seems to be understandable. Severe disturbances in the period from six to eighteen months of life which produce the need for a strengthening of the clinging dependent relationship to the mother, are generally severe, permeating, and sometimes repeated. I believe it is of particular importance that these severe disturbances occur at a time of the gradual transition from dominance of the primary process to that of the secondary process. They constitute an enormous stimulation of aggression (with which the infant is more liberally supplied than at any time later in life) which affects all of the developing libidinal phases and tends to make for some confluence of discharge routes, or at least the ready availability of alternate routes. I have referred to this condition in earlier papers (1954), as occurring in some extremely severe neuroses or so-called borderline

cases, but I have come to consider it as contributing especially the ground work for the development of perverse organizations of the aggressive and libidinal components of the development. Incidentally, I am not impressed by the constitutional inferiority of perverse patients or by selective inferiorities and hypertrophies in them. In these respects they seem to me to contrast with malignant schizophrenics, many of whom show irregularities of development which are apparent or foreshadowed at or soon after birth. The earliness and the sweeping character of the first group of infantile disturbances probably contribute the stamp of the combination of tendencies to action and to body-grounding (or reflection in physical symptoms) which is characteristic of many perversions.

It is the traumatic disturbance of the phallic period, however, which leaves, I believe, the deposit of the specific content, compulsively repetitive or ritualistically acted out in the search for sexual relief in fetishists. In this connection it is to be noted that the perverse fetishist may have a real problem of establishing a tender sexual relation with his loved one. He may feel tenderness for her and the wish for an active yet tender consummation: yet the sexual act, once approached, is too aggressivized, and the fear of castration fits too readily with the identification through vision and with the fantasy of punishment for killing, so that continuation of intercourse becomes a struggle for relief and to preserve some sense of body integrity rather than to achieve much positive pleasure or to give any. Indeed, it may be suspected that perverse individuals do not readily achieve a high degree of object relationship with their partners, who are used rather for narcissistic than for mutual gratification, especially at the genital-sexual level. When there is a fair degree of object relationship otherwise, it is jeopardized rather than supported by the sexual act.

W. Hoffer (1950) has described clearly the special significance of the latter part of the first year (from about four months on) in the development of the body ego, and the necessity for the integration of the visual and tactual sensory explorations in appreciating the self-body as separate from the outer world. Winnicott's article (1953) on transitional objects and transitional phenomena clarifies the development of this period further. He shows that in the nearly ubiquitous infantile fetish there is normally a transitional preferred object, usually a toy or something else closely associated with the infant, used in the development of secure relationship to the objects of the outer world. It is an object which is both a me-object and a not-me object, until the not-meness can be thoroughly accepted. The route of the early possible derivation of this transitional object—from the genital as well as from the breast and the behavior of

the infant in relating the own body to the transitional object—is described in an anecdote told by Loewenstein (1950). He writes of a ten-month-old child who caught sight of his own penis, touched it with seeming pleasure, and then lost it again due to his "letting out" his own protuberant abdomen which then hid it. He succeeded in rediscovering his penis by pulling in his abdomen. But in the course of his maneuvers of repetitive rediscovery, he would crawl away from where he had been at the time of the loss, and look back over his shoulder to see if the penis, like a toy, had been left behind. Only after repetitive game-playing did he learn consistently to pull in his abdomen in order to find his penis. In the same article Loewenstein concluded, on the basis of additional clinical material, that "processes of the phallic phase such as fear of losing the penis under the pressure of castration anxiety, might indeed follow or reactivate traces of that period of formation of the body image, however short it may be, in which there remains an uncertainty as to the penis belonging to one's own body." These eras of development pointed out by Loewenstein are those of special biological and pathological significance in the pre-fetishist.

It is exactly the period of the transitional object which is the first disturbed one in the fetishist. I suspect that at this time the integration of visual (and/or oral) aggression with its accompanying libidinal component and tactual sensorimotor drives does not occur adequately. Clinically the visual-oral aggression remains overly strong and the assumption of tactual support does not occur automatically but has to be specially maneuvered in the construction of the fetish of adult life. I have dealt with these same clinical phenomena in my earlier paper (1953) in speaking of continued primary identification through vision.

The sense of identity and object reality of the self as a separate individual is further naturally much influenced by the clearness of the sense of sexual identity. This depends in a fundamental way on the clear awareness of the own body, especially the genital organs, and on the reciprocal awareness of their differences from those of certain other individuals. It is the vulnerable phallic phase which is the second period of traumatic disturbance in the fetishist, of a nature to undermine the child's appreciating his own organ appropriately. Since, as pointed out by Loewenstein, this is a time maturationally linked to the first period, the whole sense of separateness from the other and especially from the *other sex* is impaired, but in a characteristic way. There is not a fusion with the other or continuous confusion. (Again, I would contrast with some schizophrenics). But there is an oscillation in sense of body-self with quick identifications with others, mediated largely through vision, especially in

sexual situations. The changeability from feelings of possessing a strong penis to feelings of not having any, occur with great rapidity. These changes in sense of body image seem to be concentrated chiefly on the genitals but affect the whole body secondarily.

Anyone who has followed closely in an analysis the premenstrual states of young women who have maintained a strong illusory penis fantasy until puberty, is aware how much the subjective reaction to the state of the genitals is regularly reflected in feelings concerning the whole body—and that the impact of two opposing images may contribute to a feeling of body unreality or even more generalized confusion (Lewin, 1948).

Not only is the whole body of the fetishist more than ordinarily equated with the phallus, but every part of it may become genitalized. It suffers *in toto* or in its various parts all of the distresses of castration anxiety in anticipation of intercourse or when the sexual performance has not been successful.

The body is clearly the arena of playing out fantasies and memories which are expressed as body sensations and even body imagery, rather than by thought imagery. In some instances, the fetishist expresses in his body symptoms the same forms which he characteristically reproduces in the fetish or in fetishistic rituals. Thus a patient of mine with a foot and shoe fetish involving the requirement that a girl should wear certain forms of strapped or buckled shoes, binding her around the ankle, or that the slipper be supplemented by a slave anklet, would, in the absence of the fetish, feel these same sensations around his own arms and legs, described as tourniquet-like sensations, or feelings of wearing leggings which bound him around ankles and knees and made his legs exquisitely tender. These were multiply determined, derived in part from observation of beatings of the mother at the hands of the father in sadistic sexual scenes and from witnessing or overhearing abortions performed at home at least twice in his early childhood and again at prepuberty. In his latency period he had acted out rather set fantasies of being the fascinated slave of his girl cousin who impersonated Cleopatra. As part of the mutual mirroring identification between the two, he played the part of the enslaved one and she wore an array of slave jewelry. It was an interesting thing with this patient that the external traumata suffered in the early phallic period combined more or less with a very bloody tonsillectomy which he himself suffered; but especially in connection with the physical grounding of the symptoms, that each period of stress following the mother's abortions was followed after some time by an illness in the patient which was diagnosed as rheumatic fever and once was sufficiently

severe to require hospitalization. Whether or not the emotional reaction of witnessing the mother's operation aroused the response in the boy's body which contributed to the rheumatic fever symptoms cannot be said, but it seems quite certain that, at any rate, the boy's illness took over the picture of the mother's and the bandaging of his own legs during these illnesses became amalgamated with the seeing of the mother covered with a sheet for the operation which was done at home. Back of this was the sadistically exciting primal scene.

The limited nature of the fantasies of the fetishist has further impressed me. These tend under most circumstances to be stereotyped and to be expressed either in body terms and symptoms; in set repetitive thought imagery associated with masturbation or anticipation of intercourse; or in ritualistic acting out. The fantasy life is neither so extensive, so rich, nor so widely invading of life as may be true in the schizophrenic. Neither is it so available for intellectual pursuits. The tendency of the fetishist to express through his body or to act out through it his sadomasochistic fantasies has additional importance in that it adds therapeutic obstacles through the ever-present tendency to resort to this rather than to use language; and to the great hypertrophy of the secondary gain.

Tendencies to action and acting out seem implicit in the character of fetishists and possibly in all perverse characters. This may find its base in the physical soundness of the earliest infancy. But it is probably largely influenced by the preverbal and extreme stimulation of aggression in such infants as the results of strong, sweeping and early actual traumas. There is then a suffusion of the entire body with aggressive stimulation. When this is severe and diffuse, the effect may be compared to that of shock, panic, or horror of later life: direct defense is impossible, running away equally so—and the very diffusion of the aggression results in frozen immobility, but with a susceptibility to active irritability when the crisis is past.

There is accompanying this immobility a psychic state of unreality, since the stimuli cannot be adequately responded to. This corresponds to the *topical* unreality state of the later perverse patient, as in contrast to the more diffused unreality perplexity, or depersonalization of the schizophrenic. When the later, and usually specific, traumata of the phallic phase occur, there is a definite patterning of the activity content, which partakes then of something like the rigid repetitive action tendencies of the traumatic neurosis of later life. These would seem to fulfill the dual need of unconscious efforts to verify the reality of the earlier experience and to master it. But through all this, the full pleasure of the

libidinal maturation has been vitiated by the tensions of the too strong aggressive components.

Moreover, the early suffusion of the infant with aggression, with its resultant paradoxical immobility has established a kind of automatic reversal of reaction at a psychophysiological level, which contributes to and may be the paradigm of later forms of quick denial and reversal (as well as to the topical unreality already mentioned), which are so characteristic of the fetishist, and to a lesser extent of other perversions and of some impulse disorders. (Incidentally, it has seemed to me that this kind of infantile reaction is beautifully illustrated in the Wolfman scene of the Christmas tree with the immobilized and staring little wolves, reflecting the primal scene.) This kind of quick denial is characteristic of the fetishist's sense of reality and so complicating in the treatment that the analyst sometimes feels as though he were working between two mirrors: wherever he looks, the patient is at once absorbed in the view in the opposite direction, and the two views really reflect the same thing. In addition, the acting-out tendencies of the patient have generally led him into reality complications in life, increased his load of reality guilt, and favored an increase in defense by denial, as well as the flowering of of protective screen memories.

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