Clinical Case Studies
2014, Vol. 13(4) 336–351

DOI: 10.1177/1534650113512020
ccs.sagepub.com
SAGE

A Modern Behavioral Treatment to Address Fetishism and Associated Functional Impairment

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Abstract

The clinical research and treatment options for sexual paraphilias are scant and have generally been limited to psychodynamic and early behavioral approaches. This article highlights the application of two existing evidence-based modern behavioral interventions, specifically behavioral activation and sensate focused therapy, to treat foot fetishism/sexual impulses and co-occurring mood/anxiety symptoms in a 57-year-old male Vietnam War veteran. This brief 6-week treatment addressed the patient's complicating psychosocial factors and medical conditions, and focused on targeting behavioral avoidance symptoms associated with fetishism and depression (e.g., increasing socially and sexually appropriate and positive reinforcing behaviors in his environment). The patient no longer met diagnostic criteria for fetishism and endorsed significant reductions in depressed mood, anxiety, and stress at post-treatment and 1-month follow-up. This case illustrated how current behavioral treatments may be used to successfully treat patients with rare symptom presentations who may otherwise be neglected within a medical system.

Keywords

behavioral treatment, behavioral activation, sensate focused therapy, fetishism; paraphilias

1 Theoretical and Research Basis for Treatment

Fetishism is defined in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association [APA], 2000) as recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the use of non-living objects (APA, 2001). Due to frequently undisclosed sexual deviant behaviors, the data are scant with documented estimates of the incidence of fetishism varying widely from 0.1% to 8.3% (Darcangelo, 2008; Kafka & Hennen, 2002). Among fetish behavior, the preference for body parts (e.g., feet and toes) and related objects (e.g., socks or shoes) have been documented as the most prevalent (Darcangelo, 2008; Scorolli, Ghirlanda, Enquist, Zattoni, & Jannini, 2007). The duration of the fetishistic desire and behaviors is at least 6 months, and by definition, results in clinically significant distress or impairment in social, occupational, or other areas of functioning (APA, 2001;

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Kafka, 2010). Indeed, individuals frequently report extreme feelings of guilt, shame, and distress regarding their unusual sexual preferences (Darcangelo, 2008), as well as interference with sexual functioning (De Silva, 1993).

Fetishism has also been linked to the diagnosis of other comorbid psychiatric disorders, including depression, anxiety, and personality disorders (Chalkley & Powell, 1983; Kafka & Hennen, 2002). In a comorbidity study of 120 males with paraphilias and paraphilia-related disorders (Kafka & Hennen, 2002), the most prevalent comorbid Axis I disorders were mood disorders (71.6% lifetime prevalence), including dysthymic disorder (55%) and major depression (39.1%). The second most prevalent comorbid Axis I disorders were anxiety disorders (38.3%), including social phobia (21.6%), generalized anxiety disorder (9.1%), panic disorder (7.5%), posttraumatic stress disorder (PTSD) (5.8%), and obsessive-compulsive disorder (OCD) (6.6%). In addition, there were significant associations between males with paraphilia/related disorders and comorbid PTSD, and a developmental history of physical or sexual abuse (26.6%; Kafka & Hennen, 2002). Regarding impairment, males with paraphilia/related disorders reported a history of behavioral problems at school (32.5%), unemployment/disability (13.3%), criminal justice involvement (62.5%), and psychiatric hospitalization (19.1%).

The literature on the etiology of fetishism has reviewed several theoretical orientations including psychoanalytic and early behavioral explanations (Darcangelo, 2008; Wiederman, 2003; Wise, 1985). The psychodynamic perspective postulated that fetishism develops as a result of intrapsychic conflicts stemming from unresolved Oedipal conflicts, castration anxiety, or traumatic/humiliating experiences that date back to childhood (Bass, 1997; Socarides, 1960). However, experimental testing of the aforementioned psychoanalytic theories for fetishism is absent. In contrast to the psychodynamic perspective, early behavioral explanations speculated that fetishism may be an acquired phenomenon whereby sexual arousal to unusual stimuli (e.g., feet or shoes) may have developed through learned pairing with early sexual experiences, and demonstrated evidence for classical conditioning of male sexual arousal (Lalumiere & Quinsey, 1998; O'Donohue & Plaud, 1994; Plaud & Martini, 1999).

Early case studies reported treating fetishistic behavior from a psychoanalytic approach (Bemporad, Dunton, & Spady, 1976; Sawyer, 1996) and focused on identifying significant developmental milestones and working through the underlying conflicts or unresolved issues with techniques such as interpretation and free association. Unfortunately, the psychodynamic approach to treating fetishism may be problematic for several reasons. First, the psychodynamic treatment structure often required long-term, intensive individual sessions that occur 2 to 5 times per week, which may be costly and impractical for patients who desire short-term treatments. Second, despite the recent increase in research support for the psychodynamic approach (Leichsenring & Rabung, 2008; Leichsenring, Rabung, & Leibing, 2004; Shedler, 2010), these treatments have lacked randomized controlled trials (Leichsenring, Hiller, Weissberg, & Leibing, 2006; Leichsenring & Leibing, 2007; Wiederman, 2003) relative to other well-supported treatments.

In contrast, early behavioral techniques focused on changing behavior through aversion therapy and covert sensitization (Barlow, 1974; Barlow, Agras, Leitenberg, Callahan, & Moore, 1972; Barlow, Leitenberg, Agras, & Wincze, 1969; Rashman, 1961). These early behavioral techniques were highly aversive in which the undesired behavior (e.g., sexual arousal from viewing pictures of feet) was commonly paired with a noxious stimulus (e.g., descriptions of nausea and vomiting; Barlow, Leitenberg, & Agras, 1969), apomorphine injections to induce nausea (Clark, 1963), smelling salts (Wise, 1985), or electric shock (Marks & Gelder, 1967; Marks, Rachman, & Gelder, 1965; Pinard & Lamontagne, 1976). The aversive stimuli may have been applied in learning paradigms such as classical fear conditioning, punishment, escape, and avoidance. However, due to the unpleasantness of these practices and increasingly cautious practice guidelines in modern health care facilities, these treatments may also be impractical. In addition,

it was recommended that various therapeutic treatment programs be combined to treat a case of fetishism because a simple aversive conditioning program alone yielded relatively ineffective treatment outcomes (Marshall, 1974).

In summary, despite the various etiological explanations for fetishism, the empirical data investigating its origins were scant and early treatment options for fetishistic behavior have been limited. Ironically, psychodynamic interventions have reappeared more recently as the primary option to address paraphilias (Chirban, 2006; Fink, 2003; Horne, 2003; Parfitt, 2007; Tan & Zhong, 2001). This is concerning given the controversy over the efficacy of psychodynamic interventions (Leichsenring et al., 2006; Leichsenring & Leibing, 2007; Wiederman, 2003). In particular, the psychodynamic treatment efficacy research is much less well documented relative to the efficacy of modern cognitive-behavioral therapy (CBT). Within the context of a cognitive-behavioral approach, CBT goals primarily focus on problem solving and modification of any problematic thought/behavioral patterns to alter sexual preferences (Leichsenring et al., 2006). The efficacy of CBT has been extensively documented and meta-analytic findings have demonstrated the efficacy of CBT for a wide range of psychiatric disorders (Butler, Chapman, Forman, & Beck, 2006), including sexual offending paraphilias (Kaplan & Krueger, 2012; Marshall, Marshall, & Serran, 2006; Nagayama Hall, 1995). In addition, the cognitive-behavioral approach to treating fetishism may be particularly promising given that CBT has a high rate of success in addressing disorders (e.g., depression and anxiety) that may co-occur in individuals with fetishism.

Thus, in the present case of Mr. C, we described a modern cognitive-behavioral intervention used to treat his fetishism, related sexual impulses, and co-occurring mood/anxiety symptoms. The treatment focused primarily on behavioral principles that targeted Mr. C's avoidance of positive activities and reinforcement (based on the behavioral activation model; Hopko, Lejuez, & Hopko, 2004), and avoidance of appropriate sexual behaviors (based on the sensate focused model; Masters & Johnson, 1970). The treatment principles were integrated from these two models because of the efficacy of sensate focused therapy for sexual disorders (Carr, 2009; McGuire & Wagner, 1978) and the efficacy of behavioral activation for depression (Cuijpers, Van Straten, & Warmerdam, 2007). It was hypothesized that the combination of pleasant events scheduling and graded sensate focused exposures would provide the patient with greater positive reinforcement for appropriate/healthy behaviors (e.g., engaging in pleasant activities from behavioral activation and healthy sexual behaviors from sensate therapy) and therefore reduce the need to seek additional reinforcement from engaging in inappropriate/unhealthy behaviors (e.g., fetishism behaviors). Last, commonly used CBT techniques such as psychoeducation, communication skills, and relapse prevention skills were also integrated into the treatment because these techniques have been efficacious in the treatment of paraphilias (Fedoroff & Marshall, 2010; Kaplan & Krueger, 2012; Leichsenring et al., 2006; Marshall et al., 2006; Nagayama Hall, 1995).

2 Case Introduction

Mr. C was a 57-year-old, married, Caucasian male veteran who served for 2 years in the Army during the Vietnam War. He initially sought mental health services at a Veterans Affairs Medical Center (VAMC) in 2006 and has since received several trials of psychotherapy over the course of 6 years (e.g., individual psychotherapy, couples counseling, and supportive counseling). One month prior to our work with Mr. C, he completed six weekly sessions of "prolonged exposure" psychotherapy (Foa, Hembree, & Rothbaum, 2007) for combat-related PTSD symptoms. He reported significant reductions in nightmares, thought avoidance (e.g., discussed his combat traumas with significantly reduced anxiety), situational avoidance (e.g., joined a crowd without a gun for protection), and hypervigilance at the conclusion of that treatment. However, despite those symptom improvements, Mr. C was then referred to us for additional treatment within a specialty

Table 1. Pre- to Post-Treatment Differences in Symptoms of PTSD, Anxiety, Depression, Stress, and Impairment.

Symptom measure	Pre-treatment	Post-treatment	Follow-up	RCI
PCL (PTSD)	54	19[a]	18[a]	7.1
DASS-D (depression)	12	1[a]	0[a]	6.2
DASS-A (anxiety)	11	1[a]	0[a]	4.9
DASS-S (stress)	14	2[a]	2[a]	4.6
IIRS (impairment)	46	16[a]	20[a]	16.4

Note. PTSD = posttraumatic stress disorder; RCI = Reliable Change Index; PCL = PTSD Checklist; DASS-D = Depression, Anxiety and Stress Scale–Depression subscale; DASS-A = Depression, Anxiety and Stress Scale–Anxiety subscale; DASS-S = Depression, Anxiety and Stress Scale–Stress subscale; IIRS = Illness Intrusiveness Rating Scale. These scores were computed using Jacobson's Reliable Change Index (Jacobson & Truax, 1991). Reliable change scores are computed as a function of the standard deviation of the measure in the target population before treatment, and the measure's reliability. Standard deviations and reliabilities for the PCL, DASS-A, DASS-D, DASS-S, and IIRS were derived from Gros, Yoder, Tuerk, Lozano, and Acierno (2011).
[a]Change from the pretreatment score is reliable.

psychotherapy clinic for mood and anxiety disorders because he continued to endorse clinically significant symptoms of depression, anxiety, marital conflict, and stress (see Table 1). The referring provider stated that the patient "still experiences anxiety about finances and pain, as well as . . . preoccupation with women's feet and shoes . . . ." Indeed, Mr. C's fetishism and "preoccupation with women's feet/high heels and other distractions" has been documented in historical reports for several years. Mr. C made multiple attempts to seek services to alleviate his preoccupation with women's feet/shoes and associated distress (including undergoing extensive neuropsychological testing). However, with the exception of increasing psychiatric medications, no outpatient mental health service providers addressed his fetish thoughts or behaviors in treatment. This case illustrates how patients with rare symptom presentations (e.g., paraphilia) may be suffering and neglected within a medical system. While it is possible that practitioners feel uncomfortable discussing matters related to paraphilia or feel unqualified to provide the necessary treatment, it is also possible that providers' comfort in this area could increase as modern, evidence-based behavioral treatments become more readily available.

3 Presenting Complaints

Mr. C's primary complaint was his "preoccupation and obsession with bad thoughts," specifically referring to women's feet/shoes and his desire for women to step on his stomach for sexual pleasure ("stomach trampling"). He reported spending excessive amounts of time searching for women's feet, shoes, and stomach trampling on pornographic websites. He endorsed difficulty controlling these impulses and that "a few minutes often turn into an hour or couple of hours" of preoccupation. He endorsed difficulty concentrating because the intrusive fetish thoughts and images disrupted his sleep. In terms of daytime function, Mr. C reported attempting to distract himself by watching television shows all day long. He expressed shame, guilt, and remorse for his behavior and difficulty controlling these fetish urges. Mr. C also reported several high-risk behaviors related to his fetishism, including paying prostitutes and homeless people to engage in fetish-related behavior (e.g., stepping on his stomach while he masturbated). He endorsed high levels of marital discord and dissatisfaction with his sexual relationship with his wife because "she would not step on my stomach." He indicated that his wife, Mrs. C, drove and waited for him during each of his appointments because she wanted him to get help. Mr. C believed that she was disgusted with him for his sexual fantasies and preoccupation with stomach trampling. In

addition, Mr. C endorsed subclinical levels of PTSD and depression that were independent but related to the etiology and maintenance of his paraphilia (see the History section below). During the intake assessment, Mr. C was simultaneously worried about the therapist judging him as "crazy" and relieved that a professional would finally listen to his fetish problem. He also endorsed experiencing increased premonitory urges to release the pressure, and asked the therapist to alleviate the discomfort and satisfy his fetish by stepping on his stomach.

Prior to starting psychotherapy (pre-treatment), Mr. C received regular medication management from a psychiatrist to manage his mood and anxiety (bupropion 75 mg, fluoxetine 20 mg, trazedone 100mg), and erectile dysfunction (sildenafil citrate 100 mg, 1 hr before sexual activity). He received regular pain medications from a specialty pain clinic to manage chronic pain from a herniated disk and acute pain from a shoulder injury (cyclobenzaprine 10 mg prn, gabapentine 100 mg, meloxicam 15 mg). In addition, he regularly visited primary care to manage medications for his heart (aspirin 325 mg), cholesterol (niacin 750 mg, simvastatin 80 mg), blood pressure (hydrochlorothiazide 25 mg), bowel problems (lactulose 10 g/15 ml), and allergies (loratidine 10 mg). All of these services were provided within the same VAMC. After his first session of psychotherapy, Mr. C received only non-psychiatric medication adjustments, including the addition of hydrocodone for pain and roprinirole for restless leg syndrome.

4 History

Mr. C was married three times and lived with his third wife of 12 years. He had four adult daughters and four grandchildren. He received a GED education and worked in various blue-collar jobs (i.e., construction, truck driving, and shipyard) prior to being on long-term disability for chronic pain over the past several years. Mr. C reported increasing financial difficulties since his disability, which was exacerbated by a recent acute shoulder injury.

He did not endorse any clinically significant early mood or anxiety symptoms but described himself as "a loner" since childhood who had difficulty relating to other people. Mr. C reported two instances of childhood sexual trauma by older teenage boys when he attended boarding school at ages 7 and 12. He reported that his fetish for women's feet began in adolescence shortly after the sexual trauma but believed that his fetish-related behaviors increased in intensity and severity during his military service in the Vietnam War (1973-1975). He reported feeling fearful for his life during his military service and endorsed one particularly traumatic incident during which he was part of a helicopter crash and close-range fire fight. He reportedly avoided thinking about the helicopter crash and dealt with the distress by frequently engaging in fetishistic behaviors. He reported specifically asking Vietnamese women to step on his stomach while he masturbated to their stimulation as a way to escape from the war and achieve sexual satisfaction while avoiding any sexually transmitted infections (STIs). He reported experiencing symptoms of PTSD when he returned from service but that the disorder was not diagnosed until he presented to the VAMC for services several years later. Mr. C also reported that these sexual behaviors became more problematic after returning from Vietnam. He described that his fetish-related behaviors were at their worst over the past decade and resulted in increasing anxiety, depressed mood, and functional impairment across different areas in his life (e.g., isolation and avoidance of places where women congregate, difficulty with day-to-day attention and concentration, marital discord, and sexual dysfunction). His wife, Mrs. C, endorsed extreme dislike and felt bothered by his fetishism because "it's weird, he keeps looking at other women's feet in public and asking me to step on him or push his stomach during sex."

5 Assessment

Mr. C completed an initial intake assessment that included a semistructured clinical interview, the Mini International Neuropsychiatric Interview (MINI; Sheehan et al., 1998), and several

self-report measures, including the PTSD Checklist (PCL; Blanchard, Jones-Alexander, Buckley, & Forneris, 1996; Weathers, Litz, Herman, Huska, & Keane, 1993), Depression Anxiety and Stress Scales (DASS-21; Lovibond & Lovibond, 1995), and Illness Intrusiveness Rating Scale (IIRS; Devins, Binik, et al., 1983; Devins, Dion, et al., 2001). Despite recently completing a trial of prolonged exposure for PTSD, Mr. C met diagnostic criteria for fetishism as well as evidenced subclinical symptoms of PTSD and major depressive disorder (MDD) at pre-treatment based on diagnostic criteria in the *DSM-IV-TR* (APA, 2001). No Axis II diagnoses were identified. Axis III included chronic pain (back and limb), obesity, erectile dysfunction, hyperlipidemia, hypertension, chronic ischemic heart disease, and sleep apnea. Axis IV included marital conflict and financial stressors. His Global Assessment of Functioning (GAF) score on Axis V was 65 (pre-treatment). Behaviorally, Mr. C was observably anxious and distressed when discussing his presenting complaints (e.g., fidgety, limited eye contact, blushing, tense, shaky voice, and tearful). He frequently referred to himself as "crazy" for having sexual fantasies about women's feet/shoes, stomach trampling, and acting on these impulses. He denied suicidal/homicidal ideation and did not endorse any past or present hallucinations/delusions. His thought processes, memory, and orientation were intact, and his judgment and insight were fair.

As presented in Table 1, Mr. C completed pre-treatment self-report questionnaires that assessed mood and anxiety symptom severity and impact. Mr. C endorsed clinically significant symptoms of PTSD, anxiety, depression, and stress on these measures. He reported overall moderate interference on the IIRS, with the most impairment noted in his health, sex, relationships, and religious expression.

6 Case Conceptualization

Mr. C reported mild sexual arousal to women's feet during his early adolescence but denied acting on these urges prior to joining the military. Mr. C was highly sexualized, potentially related to being a victim of molestation as a child. After joining the military and being deployed to the Vietnam War, Mr. C sought ways to address his sexual urges but was discouraged by the high rates of reported STIs among the local prostitutes. As a result, Mr. C engaged in sexually arousing behaviors (e.g., having prostitutes step on his stomach while he masturbated) as a version of "safe sex," which became highly reinforcing due to the sexual satisfaction and reduced risk of acquiring an STI. Mr. C's behavior continued on returning from his deployment to Vietnam, and then worsened over time as he became increasingly isolated due to his primary employment (e.g., long-distance truck driver for many years) and combat-related PTSD following his Vietnam War service. As his chronic pain increased, Mr. C began to withdraw and decrease his social and physical activities. Subsequently, this change increased the amount of time available for him to engage in fetish-related behaviors (e.g., hiring prostitutes to engage in stomach trampling, and masturbating while viewing fetish-related materials online). Over time, despite feelings of guilt and shame, these fetish-related behaviors were reinforced and became Mr. C's primary source of sexual gratification. He attempted to isolate himself (e.g., avoided public locations where there is an availability of women's feet) and avoid female feet cues (e.g., watched specific television programs about hunting). Together, these fetish-related behaviors and efforts to avoid cues for future fetish-related behaviors evolved into barriers between Mr. C and his friends and family.

7 Course of Treatment and Assessment of Progress

After reviewing the literature and consulting with local/regional cognitive-behaviorally trained professionals, the research and treatment options for fetishism were scant (Beech & Harkins, 2012), including primarily psychoanalytic approaches (Bass, 1997; Socarides, 1960) with little empirical support, hypnosis (McSweeny, 1972), and outdated behavioral approaches (Kilmann,

Sabalis, Gearing, Bukstel, & Scovern, 1982). As a result, the development of a new, modern cognitive-behavioral treatment approach was needed. Suitable candidate behavioral techniques were identified to address Mr. C's long history of anxiety, depressed mood, and avoidance of positive activities/reinforcement (values-based behavioral activation approach), and avoidance of appropriate sexual behaviors (sensate focused therapy approach). Although cognitive techniques were considered, Mr. C's difficulties with attention and concentration interfered with his ability to effectively identify maladaptive thought patterns or challenge his fetishistic fantasies. Thus, two primary areas of focus were behaviorally targeted in this case conceptualization: (a) to increase socially appropriate and pleasant daily activities in his environment and (b) to increase his engagement in appropriate sexual behaviors with his wife, which may indirectly improve his marital relationship. The treatment plan consisted of six weekly sessions, lasting for 50 to 60 min, that focused on behavioral avoidance symptoms associated with fetishism and resulting depression (e.g., increasing and reinforcing a variety of positive social and sexual activities). Mr. C was also asked to monitor his daily activities, mood ratings, and the frequency of his fetishistic thought/impulses and sexual activity (either masturbatory or with his wife) throughout the course of treatment. The therapist was a pre-doctoral clinical psychology intern (first author) at the time of the case with specialized training in CBT for anxiety and related disorders, supervised by a licensed clinical psychologist (second author) at the VAMC with 10 years of expertise in CBT.

Mr. C returned for his first session 1 week after the intake assessment. He was apprehensive about receiving treatment and believed that he "must be crazy to have these fetish fantasies and impulses all day long." Thus, the first treatment session focused on providing psychoeducation related to his presenting disorders (e.g., fetishism and depressed mood). The purpose of psychoeducation was to orient Mr. C to the theoretical basis of his individualized treatment as well as to normalize and validate Mr. C's experience with fetishism. *DSM-IV-TR* criteria and common symptoms as well as the prevalence of fetishism and associated co-occurring psychiatric symptoms were reviewed. Topics reviewed include common life domains and functional areas of impairment associated with fetishism (e.g., social, sexual, etc.), as well as how co-occurring symptoms such as depression may dampen sexual desire. The case conceptualization was discussed with Mr. C and specific treatment goals were identified (e.g., to decrease frequency of fetish urges/behaviors, and to improve the quality of sex with his wife). Although Mr. C was the primary patient, it was recommended that Mrs. C be involved during the treatment planning process because his ability to engage in satisfying sexual activities partially depended on Mrs. C as his sexual partner. Both Mr. and Mrs. C were amenable to involve her in his treatment plan. Thus, all future sessions were structured to involve Mr. C in individual therapy for 40 min, followed by a conjoint period as a couple for 10 to 20 min. For homework, Mr. C was asked to complete his daily self-monitoring. Mr. C was not instructed to avoid masturbating to his fetishistic fantasy at any point in treatment.

Mr. C arrived to the second session feeling dysthymic and low mood throughout the week. His average mood rating was 3 out of 10 (on a scale ranging from 1 = *really bad* to 10 = *really good*). He was "sad and disappointed" in himself because the self-monitoring assignment showed that he "did nothing all day" with the exception of playing on the computer or watching hunting shows. In spite of having sex on one occasion with Mrs. C, he was irritated at his wife and endorsed high levels of sexual dissatisfaction. He counted 22 instances of fantasizing about women's feet/shoes and stomach trampling and was distressed over these intrusive thoughts. Although the details regarding antecedents or context of his fetishistic fantasies and thoughts were very vague, Mr. C reported these intrusive fetishistic thoughts were not specifically cued or triggered but "just came up" when he was on the computer or watching television.

The purpose of the second session was to provide additional psychoeducation that would prepare Mr. C for the modification of problematic behavioral patterns. We discussed how his use of isolation/avoidance reduced initial negative emotions in the short term (e.g., if he stayed at home

and avoided going out, then he would not be distressed by looking at women's feet in public) but also encouraged future avoidance and prevented the learning of counter information in the long term. The role of this isolation in maintaining his negative emotions (e.g., depressed mood, irritability with intrusive thoughts) and impairing his social relationships and leisure activities was reviewed. The scheduling of daily pleasant activities (behavioral activation model) was presented as a method to improve/end this cycle of behaviors in addition to reducing negative emotions. In general, behavioral activation treatment models involve teaching patients to monitor their mood and daily activities with the goal of increasing pleasant, reinforcing activities and reducing unpleasant events (Gros & Haren, 2011; Hopko, Lejuez, Ruggiero, & Eifert, 2003). Behavioral activation for the treatment of depression has been shown to be effective with meta-analytic data indicating an overall large treatment effect size of 0.87 (Cuijpers et al., 2007). Mr. C was motivated to re-engage in positive activities to target his depressed mood. He was able to identify a number of important values (e.g., family/social relationships, recreation/hobbies, volunteer work, physical/health issues, spirituality, and psychological/emotional issues). For each value, he identified a number of previously enjoyable activities (e.g., having dinner or movie dates with his wife, camping trips, window shopping, sewing, playing guitar, dancing, spending time in nature, fishing, volunteering at a church, exercising, walking, and attending church or male fellowship groups).

The second session content also focused on psychoeducation regarding the formation and maintenance of normal and abnormal sexual behaviors from a behavioral perspective within the context of conditioning and learning principles. For example, despite his initial fantasies about women's feet/shoes in adolescence, these fetishistic behaviors may have been increasingly strengthened during his service in the Vietnam War when he learned that the only way to achieve sexual gratification safely was to masturbate as women stepped on his stomach. The concept of sensate focused techniques (Masters & Johnson, 1970) was introduced and proposed as a potential treatment component that may benefit his sexual experience (Carr, 2009; McCabe, 2001; McGuire & Wagner, 1978). Sensate focused therapy is an empirically supported cognitive-behavioral program used to treat men with erectile dysfunction (Carr, 2009) as well as sexual dysfunction in women who were sexually molested as children (McGuire & Wagner, 1978). Sensate focus exercises involve retraining their experience of physical intimacy and the pleasure of sexual arousal (Masters & Johnson, 1970; McCabe, 2001). Example exercises involve giving and receiving pleasurable touches, along a graded sequence progressing over a number of weeks from non-sexual to increasingly sexual areas of the body, culminating in full intercourse (Masters & Johnson, 1970). Thus, Mr. C scheduled one pleasant activity per day for behavioral activation homework. In addition, a sensate focused assignment was designed to simultaneously increase their daily non-sexual physical proximity. Mrs. C established the boundaries for intimacy and controlled the pace of these graduated sensate focused exercises. They both agreed to hold hands at least one hour per day, with no expectations for sexual intercourse.

By the third session, Mr. C reported an average mood rating of 4 out of 10 and a decrease in fetishistic behaviors. Specifically, he thought about women's feet and stomach trampling only once briefly. The therapist positively praised Mr. C for not acting on the fetishistic thought. Mr. C also reported that they rearranged their home furniture to sit closer to each other. They increased physical contact on a daily basis, including when they watched movies together on the couch (5 times) and window shopped (2 times). Interestingly, he attributed much of the decrease in his intrusive thoughts to "being busy worrying about things like finances." Mr. C continued to complain of marital dissatisfaction and was distressed over his loss of interest in previously enjoyable activities because of his physical injuries, chronic pain, and financial stress. However, he remained motivated for treatment. The purpose of this session focused on problem solving to brainstorm daily low-cost pleasant activities. Mr. C also agreed to modify his participation in these activities to accommodate for when he is in low versus high pain (e.g., play guitar on high

pain days, and window shop on low pain days). He was compliant and scheduled daily pleasant activities for the behavioral activation homework (e.g., walk for exercise, call old friends, ride a bike, work on hobbies, or attend church). In addition, Mrs. C decided to rub Mr. C's back each day as often as possible throughout their daily routine for the sensate focused exercises.

By the fourth session, Mr. C's average mood rating was 7 out of 10. He attributed his increased mood to a positive change in his wife's behavior with regards to her giving him more attention. For example, Mr. C reported that his wife approached him on one occasion and cuddled with him on the couch because "she felt guilty for being on the computer all the time." He also reported a notable decrease in fetish-related thoughts and only had one dream where his wife refused to step on his stomach. Mr. C endorsed feeling mildly distressed over the dream for a brief period of time but denied any subsequent sleep disruption. He did not report additional thoughts about women's feet. Mr. C also successfully completed daily pleasant activities such as walking with his wife (4 times), speaking to an old friend on the telephone (1 time), riding his bike (2 times), attending church (2 times), and working on hobbies in his shop (daily). He was praised and reinforced for scheduling and completing his pleasant activities. This session continued to focus on problem-solving ways to engage in activities and overcome financial and chronic pain barriers to treatment. Mr. C was motivated and identified several additional low-cost and low-pain activities. For homework, Mr. C scheduled to complete two pleasant events with his wife each day for behavioral activation. In addition, they decided to kiss as often as possible throughout their daily routine for sensate focused exercises.

By the fifth session, Mr. C reported significantly improved mood (average rating 9.7 out of 10). He reported feeling "less bored and more motivated" since he engaged in more social and recreational activities outside of his house. In addition, both Mr. and Mrs. C reported high enjoyment over daily kissing and rated their marriage as much improved (9 out of 10). He rubbed his wife's feet on one occasion but did not endorse having any foot fetish thoughts/impulses, and neither person was distressed about the foot rub. In addition, Mr. C successfully engaged in pleasant activities at least twice daily, including working in the yard (2 times), cleaning his workshop (3 times), selling scrap metal for cash (1 time), playing guitar (daily), calling his brother (1 time), dancing to music at home (1 time), walking for exercise (4 times), and shopping and watching movies with his wife (7 times). This session focused on helping Mr. C identify specific longer term goals for pleasant activities beyond typical day-to-day events and problem solving any potential barriers that may interfere with Mr. C's ability to maintain regularly scheduled and frequent pleasant activities. Mr. C expressed excitement at the possibility of maintaining long-term activities and was engaged throughout the session. As a combined behavioral activation and sensate focused homework assignment, Mr. C agreed to complete as many pleasant activities as possible with his wife each day while incorporating physical contact such as hand holds, back rubs, and kisses.

By the sixth session, Mr. C reported an average mood of 10 out of 10 as well as increased motivation and greater initiative to engage in pleasant social/recreational activities (e.g., joined as a red cross volunteer, enrolled in a cardiopulmonary resuscitation [CPR] class). He continued to report no fetish-related thoughts or impulses. In addition, Mr. C reported increased exercise (2 times), church attendance (weekly), family visits (once), telephone calls to friends (2 times), play time with his new puppy (daily), and recreational activities with his wife (4 times). Mr. C also reported that his marital relationship and the quality of sex with his wife improved significantly. In particular, Mrs. C spontaneously initiated sex on one occasion and Mr. C rated the quality "a good 9 out of 10 for the first time since a long while." Mrs. C also reported a corresponding increase in satisfaction with sexual intimacy and stated that she felt more in control with "no pressure to perform since he does not mention or ask for my feet to step on him anymore." Mr. C added that he "no longer needs to think about feet, shoes, or stomach trampling for sexual arousal." Behaviorally, Mr. and Mrs. C sat closer to each other, touched the other person's arms,

giggled, and flirted with each other during the session. This purpose of this session was to review Mr. C's treatment progress and reassess his treatment plan. In addition to the therapist's positive praise, both Mr. and Mrs. C spontaneously praised each other for their positive progress with behavioral activation, increased physical/emotional intimacy, and improved mood. They both reported "things are great" and a readiness to discontinue treatment.

Treatment Session 6 included brief psychoeducation on improving their communication through modeling and rehearsing active listening skills. In this session, Mr. and Mrs. C separately generated a list of physical and sexual activities that they enjoyed (i.e., giving/receiving back massages, kissing, fondling), ranked them in order from "most sexually arousing" to "least sexually arousing," and compared their lists to identify mutually satisfying sexual activities. They engaged in a conversation about their sexual needs and desires to each other (e.g., how much he enjoyed when she performed oral sex on him). Session 6 also included psychoeducation on relapse prevention and emphasized the importance of continuing to practice the acquired treatment skills. Mr. and Mrs. C agreed to continue their involvement in as many pleasant social activities as possible. They also committed to performing one item on their shared intimacy list each day (alternating between her choice and his choice) until their 1-month follow-up session.

At post-treatment, Mr. C's mood and affect were observably happy. He completed the same semistructured clinical interview (MINI) and self-report assessment measures (PCL, DASS-21, and IIRS). Post-treatment results indicated that he no longer met diagnostic criteria for fetishism. Mr. C's symptoms of PTSD, depressed mood, anxiety, and stress were also clinically significantly reduced per Jacobson's Reliable Change Index (Jacobson & Truax, 1991; see Table 1). Mr. C no longer endorsed symptoms consistent with subclinical presentations of PTSD or MDD. Axis II and III remained the same. Regarding Axis IV, Mr. C continued to endorse financial stressors but no longer reported martial conflict. Axis V was 70 (post-treatment).

8 Complicating Factors

Mr. C endorsed significant medical problems (chronic back pain, recovery from shoulder injury, overweight, hearing loss) that limited his mobility and financial difficulty that limited engagement in pleasant activities. In addition, he reported minimal social support, with only one male friend who lived a few hours away, and a poor relationship with his wife and his daughters. Thus, behavioral activation assignments were necessarily tailored to be inexpensive, require low physical demands, and increase access to social support (e.g., church). Mr. C was taking a number of different medications, with increasing dosages, for his physical health problems. However, in this case, it appears that the medications were not contraindicated by psychotherapy. Finally, although Mrs. C agreed to help Mr. C throughout the therapy process, she had additional barriers to overcome including a long history of depressed mood, childhood sexual trauma, and chronic migraine pains that may have impacted her libido and sexual performance. To successfully involve Mrs. C in the therapeutic process, joint behavioral activation and sensate focused activities were necessary to help her overcome her own depression and avoidance of pleasant social or sexual activities. With the incorporation of Mrs. C into the treatment process, and the slight alteration in behavioral activation and sensate focused techniques, Mr. C demonstrated significant symptom reductions despite these complicating factors.

9 Access and Barriers to Care

In addition to the complicating factors mentioned above, several access and barriers to care were observed in this case. The first barrier was the lack of evidence-based treatments for fetishism that resulted in Mr. C attempting to seek treatment with multiple providers without symptom relief, with the potential to be lost or neglected within the medical system, and subsequently his increased feelings of hopelessness. The second treatment barrier was Mr. C's complicated

medical conditions (e.g., chronic pain). In fact, even after existing empirically based treatments were identified to target his associated symptoms, the combined treatment required several considerations to be successful. Behavioral activation treatment components required modification and frequent monitoring to ensure that he engaged in appropriate low-pain and paced activities. Sensate focused treatment components also required his wife's consent so that the gradual progression from nonsexual to sexual activities was equally accepted by the couple. The third barrier was Mr. C's limited financial resources and its impact on his ability to afford transportation to appointments or to engage in costly pleasant activities (i.e., watching movies at a theatre versus at home). Fortunately, Mr. C received travel reimbursement for gas mileage to and from the VAMC clinic to offset any financial costs. More importantly, Mr. C's access to an integrated health care delivery system through the VAMC offered him primary and specialty care services in one centralized location to address the complicated case and allow providers to communicate easily and coordinate his care effectively.

Although several potential barriers were not applicable to Mr. C's treatment case, a number of potential barriers to consider existed more broadly. For example, if physical distance and/or access to care were a treatment barrier for this patient, the VAMC may have offered telehealth treatment modalities as a possible option (Gros et al., 2013). Alternatively, community-based mental health clinics may not have the technology necessary to implement telehealth treatment remotely. It is also possible that community-based mental health clinics have limited training or access to clinical supervision with empirically based treatments. In particular, not all clinicians have the time or resources to conduct a thorough literature search to identify evidence-based care. Finally, an additional consideration when working with patients on long-term disability is that they may have prior beliefs or experiences that strongly reinforce a long-term medication management model, for example they may have questions/concerns that symptom improvement over the course of treatment may jeopardize their qualifications for disability benefits. Thus, it is critical to assess and address any access and/or barriers to care throughout the course of treatment.

10 Follow-Up

Mr. C arrived on time and was accompanied by his wife for his 1-month follow-up session. He endorsed being "no longer bothered by foot fetishism." Mr. C's mood and affect was visibly happy. He successfully maintained his treatment progress and engaged in daily pleasant activities since his last session. He also reported that his concentration and motivation continued to improve (e.g., joined a volunteer position at a hospital, joined a men's club, and began to play guitar at his church), and his daily average mood ratings were 10 out of 10. Mr. C and his wife indicated that they engaged in more mutually enjoyable physical and sexual intimacy daily (i.e., back rubs, kissing, lying together, and fondling). They had sexual intercourse on one occasion and both Mr. and Mrs. C rated the quality "best ever." Mr. C continued to report no distress and no thoughts or impulses about women's feet since his last session.

Mr. C's treatment progress and original goals were also reviewed. His clinically significant reductions in PTSD, depressed mood, anxiety, and stress symptoms were maintained from post-treatment to follow-up (see Table 1). The importance of engaging in pleasant activities in spite of chronic pain or financial difficulty, as well as engaging in mutually satisfying physical/sexual activities for the couple, was highlighted as key factors to maintaining treatment gains. In addition, the general pattern of treatment response was explained. Specifically, symptoms may increase prior to the start of treatment, but decrease during the course of active treatment, and generally continue to decrease at the completion of treatment as patients continue to practice these techniques post-treatment. This pattern of continued symptom improvement over time is based on the learning, practice, and mastery of techniques.

11 Treatment Implications of the Case

This case highlights the application of a new modern behavioral intervention for fetishism. Given the limitations of early aversive behavioral treatments, a number of psychodynamic practices have resurfaced, resulting in limited empirically based treatment options (e.g., Mr. C seeking help from multiple providers for many years and being referred to numerous clinics before receiving appropriate treatment). Subsequently, the current case was conceptualized as reinforcement for undesirable behaviors (sexual arousal to women's feet and preoccupation with stomach trampling) and lack of reinforcement for desirable behaviors (limited social activities and support due to avoidance/isolation). The current case identified and incorporated two existing evidence-based behavioral interventions from related disorders (depression and sexual dysfunction). This integration of two approaches demonstrated quick, effective, and sustained benefits in a foot fetishism case that was otherwise unsuccessfully addressed by other treatments (e.g., increasingly severe medication trials, as well as subclinical anxiety and depression symptoms following prolonged exposure for PTSD).

12 Recommendations to Clinicians and Students

This case represented a valuable learning and training experience on the potential application of evidence-based psychotherapeutic practices when no modern treatments were available. The application of existing or similar evidence-based procedures could be effective if provided in a standardized way. In particular, behavioral activation strategies have been repeatedly demonstrated to be effective in a wide range of psychiatric problems, in a generally brief period of time (Gros & Haren, 2011; Jakupcak et al., 2006). Behavioral activation has also been found to be effective in patients with co-occurring medical problems (e.g., patients with cancer; Hopko et al., 2011). In this particular case, the combination of two existing practices (behavioral activation and sensate focused therapy) was very effective for Mr. C whose fetish-related symptoms were largely ignored by previous providers and left untreated. The inclusion of supportive family members (e.g., spouse or partner) likely aided the treatment response. However, treatment may require further refinement of practices (e.g., if the patient does not have an available partner) and additional investigation in a clinical trial format is warranted. In addition, while it is unclear if this behavioral approach will be successful in the treatment of other paraphilias (i.e., exhibitionism, voyeurism, pedophilia, sexual masochism and sadism, or frotteurism), particular components of this treatment may be used to target specific symptoms. For example, given the high rates of Axis I comorbidity, the behavioral activation components may be used to target any comorbid mood or anxiety symptoms. The sensate focused approach may help patients build confidence in healthy sexual behaviors, thereby improving their sexual/physical intimacy with affected partners and decreasing the likelihood of a relationship conflict. Providing basic psychoeducation about the paraphilia will also help increase patients' knowledge about the associated impairments and may alleviate some of the guilt and shame associated with the disorder. In short, this case suggests that a new behavioral treatment approach for paraphilias, and fetishism in particular, may provide long neglected and untreated patients with symptom relief. However, if no readily available or reasonable treatment options can be found on consultation with professionals/experts and the scientific literature, openness to the application of existing evidence-based psychotherapeutic practices for related conditions/problems (e.g., avoidance/isolation) should be considered.

Authors' Note

The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the U.S. Government.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by the Office of Research and Development, Medical Research Service, Department of Veterans Affairs.

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