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The DSM Diagnostic Criteria for Fetishism

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Abstract The historical definitions of sexual Fetishism are reviewed. Prior to the advent of DSM-III-R (American Psychiatric Association, 1987), Fetishism was typically operationally described as persistent preferential sexual arousal in association with non-living objects, an over-inclusive focus on (typically non-sexual) body parts (e.g., feet, hands) and body secretions. In the DSM-III-R, Partialism, an "exclusive focus on part of the body," was cleaved from Fetishism and added to the Paraphilia Not Otherwise Specified category. The current literature reviewed suggests that Partialism and Fetishism are related, can be co-associated, and are non-exclusive domains of sexual behavior. The author suggests that since the advent and elaboration of the clinical significance criterion (Criterion B) for designating a psychiatric disorder in DSM-IV (American Psychiatric Association, 1994), a diagnostic distinction between Partialism and Fetishism is no longer clinically meaningful or necessary. It is recommended that the diagnostic Criterion A for Fetishism be modified to reflect the reintegration of Partialism and that a fetishistic focus on non-sexual body parts be a specifier of Fetishism.

Keywords DSM-V · Fetishism · Partialism · Paraphilia

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Introduction

Fetishism, as a technical descriptor of atypical sexual behavior, was noted in the writings of the well-known nineteenth century French psychologist Alfred Binet (1857–1911) (Binet, 1887) as well as prominent European sexologists Richard von Krafft-Ebing (1840–1902) (Krafft-Ebing, 1886), Havelock Ellis (1859–1939) (Ellis, 1906), and Magnus Hirschfeld (1868–1935) (Hirschfeld, 1956). In their seminal writings, all of the aforementioned sexologists used the terms "fetish" and "fetishism" to specifically describe an intense eroticization of either non-living objects and/or specific body parts that were symbolically associated with a person. Fetishes could be non-clinical manifestations of a normal spectrum of eroticization or clinical disorders causing significant interpersonal difficulties. Ellis (1906) observed that body secretions or body products could also become fetishistic expressions of "erotic symbolism." Freud (1928) considered both body parts (e.g., the foot) or objects associated with the body (e.g., shoes) as fetish objects.

For the purposes of this review, a "broader" historically-based core definition for Fetishism will include intense and recurrent sexual arousal to: non-living objects, an exclusive focus on body parts or body products.

Methodology

I performed an Internet-based literature search using the terms "fetish," "fetishism," "partialism," "urophilia," "urolagnia," "undinism," "coprophilia," and "coprolagnia" utilizing both PubMed (1948–2008) and PsycINFO (1872–2008) databases through October 2008. I reviewed contemporary sexology book chapters and primary sources, whenever possible, for information regarding European sexologists (in English language

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translated texts). In relevant publications, I reviewed referenced articles as well as those that did not appear during a computerized search.

Fetishism and the *Diagnostic and Statistical Manuals*

In the second edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (American Psychiatric Association, 1968), Fetishism was included as a "sexual deviation," but it was not specifically operationally defined. A definition for sexual deviations is offered:

> This category is for individuals whose sexual interests are directed primarily toward objects other than people of the opposite sex, toward sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstances as in necrophilia, pedophilia, sexual sadism, and fetishism. Even though many find their practices distasteful, they remain unable to substitute normal sexual behavior for them. This diagnosis is not appropriate for individuals who perform deviant sexual acts because normal sexual objects are not available to them.

This definition of Fetishism was abridged in the third edition of the DSM (American Psychiatric Association, 1980) and a more circumscribed diagnostic criterion A for Fetishism (302.81) was operationally defined:

A. The use of non-living objects (fetishes) is a repeatedly preferred or exclusive method of achieving sexual excitement.
B. The fetishes are not limited to articles of female clothing used in cross-dressing (Transvestism) or the objects designed to be used for the purpose of sexual stimulation (e.g., vibrator).

Despite this more circumscribed definition for Fetishism described in DSM-III, in the clinical description of Fetishism that precedes the actual specific diagnostic criteria noted above, the DSM-III text noted: Fetishes tend to be articles of clothing, such as female undergarments, shoes and boots, or, more rarely, *parts of the body such as hair or nails* (p. 268, my emphasis).

Technically, hair and nails are body products but they are also "non-living objects" consistent with the DSM-III definition of Fetishism. Feet, hands, or other typically nonsexualized parts of the body are not "non-living objects," however, and there was no diagnostic entity offered in DSM-III to account for persons whose fetishism-like clinical disorder was delimited by an exclusive focus on non-sexual body parts, such as hands or feet. Such a diagnosis, Partialism, an "exclusive focus on part of body," was included in the publication of the DSM-III-R (American Psychiatric Association, 1987). Inasmuch as there was inadequate empirical evidence at that time as to the distinct diagnostic status of Partialism, it was included as a Paraphilia Not Otherwise Specified (302.9). I have been unable to locate American Psychiatric Association working papers that might have more specifically defined the rationale for the separation of Partialism from Fetishism.

In the DSM-III-R, the core of criterion A for Fetishism (intense sexual arousal to non-living objects) remained the same as in DSM-III but additional qualifying diagnostic criteria were added (Criterion B), as were true for all the paraphilic diagnoses. Criterion B was added to emphasize that psychiatric disorders or diagnoses had to include clinically significant distress or impairment in functioning as essential elements.

In the DSM-III-R, Fetishism was operationally defined as:

A. Over a period of at least 6 months, recurrent intense sexual urges and sexually arousing fantasies involving the use of nonliving objects by themselves (e.g., female undergarments).

Note: The person may at other times use the nonliving object with a sexual partner.

B. The person has acted on these urges, or is markedly distressed by them.
C. The fetishes are not only articles of clothing used in cross-dressing (transvestic fetishism) or devices designed for the purpose of tactile genital stimulation (e.g., vibrator).

In the brief discussion section preceding the formal diagnostic criteria in DSM-III-R, however, there is no longer any mention of body products (or body parts) as associated with the diagnosis of Fetishism. The diagnostic manual continues to note: "Among the more common fetish objects are bras, women's underpants, stockings, shoes, boots and other wearing apparel" (American Psychiatric Association, 1987, p. 282).

The diagnostic separation of Partialism (intense, persistent, and "exclusive" sexual arousal to a non-genital body part) from Fetishism (intense and persistent sexual arousal to non-living objects, including some body products), and the former's inclusion in the Paraphilia Not Otherwise Specified category has continued in the DSM-IV and DSM-IV-TR (American Psychiatric Association, 1994, 2000).

The descriptive paragraph and diagnostic criteria for Fetishism in DSM-IV and DSM-IV-TR are identical. The only changes in diagnostic criteria were to eliminate the qualification note associated with Criterion A and to add further clinical significance variables to Criterion B consistent with the other paraphilic disorders.

In the DSM-IV, Fetishism was operationally defined as:

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the use of non-living objects (e.g., female undergarments).
B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The fetish objects are not limited to articles of female clothing used in cross-dressing (as in Transvestic Fetishism) or devices designed for the purpose of tactile genital stimulation (e.g., a vibrator).

In essence, because of a paucity of published data and the relative clinical rarity of fetishes as diagnostic disorders (Chalkley & Powell, 1983; Curran, 1954; Gebhard, Gagnon, Pomeroy, & Christenson, 1965), the DSM-based core descriptive diagnostic criteria for Fetishism (Criterion A) have been essentially maintained for the past 30 years. In addition, this more circumscribed operational definition of Fetishism has been incorporated in the International Statistical Classification of Diseases and Related Health Problems-Tenth Edition (ICD-10), published by the World Health Organization (1992). Partialism is not specifically included in the diagnostic nomenclature of the ICD-10.

Partialism and Fetishism

Inasmuch as I will be discussing Partialism and whether it should retain its distinction as a separate and distinct psychiatric disorder from Fetishism in DSM-V, I will review the origin of this term. As best as I can ascertain, the term "partialism" originated in the writings of a German neurologist/sexologist, Albert Eulenberg (1840–1917), whose sexological publications (all in German language) were published in the very late nineteenth century and early twentieth century. Eulenberg is credited by Wilhelm Stekel (1886–1940) with developing the descriptive term partialism and Stekel's use of the term partialism described sexual attractions to body parts but, in contrast to fetishism, not of the sufficient intensity so as to impair sexual intercourse.

> The true fetish lover dispenses with a sexual partner and gratifies himself with a symbol. This symbol can be represented by a piece of clothing, a part of the partner's body (pubic hair, nails braid or pigtail) or any object used by the other person. (Stekel, 1952, pp. 12–13)

Stekel commented that "the most widespread form of partialism is preference for feet" (p. 169) and, although he presents an elaborated case of Calf Partialism, Sadism, and Kleptomania (pp. 133–168), he also presented an elaborated Analysis of a Foot Fetishist (pp. 225–275). Thus, for Stekel, an erotic preferences for part of the body can become a fetish when the body part is preferred to or replaces sexual intercourse.

This definition for Fetishism and its distinction from Partialism was further endorsed by Gebhard et al. (1965). Their sample included 888 predominantly incarcerated sexual offenders. Only 10 of these men, however, were adjudicated for fetish-motivated theft (0.011% of the sample). All of these men had stolen inanimate objects, typically women's undergarments, i.e., typical fetish nonliving objects. In discussing fetishism, I suggest: They comment in discussing fetishism

> To apply the term to a living part of the human body (hair excluded) at once makes the practical definition impossible, as one would appreciate after a little reflection. Would a man who cannot bring himself to have coitus with a woman who lacks breasts…be termed a "breast fetishist"? Or can all heterosexual males be said to have a fetish for females? In this way lies confusion. We prefer to limit fetishism to the inanimate, where it defines a clear-cut displacement phenomena. For exaggerated importance given to various parts or configurations of the human anatomy, we prefer to use another term—we suggest "partialism." Thus, some men may have a fetish for panties, hair, shoes or other inanimate objects which are intimately associated with the human body but which may be removed from it, and other men may have a fixation on such things as redheads, huge breasts, thinness or fatness. As with fetishism, partialism may become a sine qua non (as a man who is impotent with any female who is not red-headed), but, by definition cannot go further…. Whereas partialism is limited to the possible variations of the human body, virtually anything can be involved in fetishism. (pp. 415–416)

A contemporary literature review of Partialism reveals no empirical data under that search term but the diagnosis is mentioned in several texts (Cantor, Blanchard, & Barbaree, 2009; Davis, 1950a; Gebhard et al., 1965; McWilliams, 2006; Milner & Dopke, 1997; Milner, Dopke, & Crouch, 2008).

Is There New Empirical Information About Partialism and Fetishism Relevant to DSM-V?

Apart from single or very small sample case reports, before 1990, the only descriptive empirical articles or clinical samples that included more than 25 men with Fetishism were by Krafft-Ebing (1965), Stekel (1952), Gosselin and Wilson (1980), and Chalkley and Powell (1983). All of these investigators used the "broader" or an ambiguous definition of Fetishism.

Gosselin and Wilson's sample ($n = 125$) was derived from volunteers in membership organizations such as The Mackintosh Society for rubber fetishists ($n = 87$ and the Atomage correspondence club for leather fetishists ($n = 38$). Chalkey and Powell's modestly sized clinical sample was derived from carefully culling over 20 years of discharge diagnoses from two major hospitals in London.

From these samples, the clinical cases described by Krafft-Ebing, Ellis, Hirschfeld, and Stekel and some additional contemporary data (Junginger, 1997; Scorolli, Ghirlanda, Enquist, Zattoni, & Jannini, 2007; Weinberg, Williams, & Calhan, 1994, 1995), several consistent clinical observations about Fetishism have emerged:

1. Many males who self-identify as fetishists in community or convenience samples do not necessarily report clinical

impairment in association with their fetish or fetish-associated behaviors (Chalkley & Powell, 1983; Gosselin & Wilson, 1980; Scorolli et al., 2007; Weinberg et al., 1994). Thus, many "fetishists" do not meet criteria for a psychiatric diagnosis of Fetishism that is associated with significant personal distress or psychosocial (including sexual) role impairment (Criterion B).
2. Fetishes, as with other paraphilic disorders, are almost exclusively male disorders. Clinically significant fetishes typically develop in childhood or early adolescence and are usually persistent sexual preferences.
3. Fetishes can co-occur with other paraphilic behaviors, especially "sadomasochism" (Brown, 1983; Buhrich, 1983; Gosselin & Wilson, 1980; Spengler, 1977; Weinberg et al., 1994) and transvestic fetishism (Blanchard, Racansky, & Steiner, 1986; Freund, Seto, & Kuban, 1996; Wilson & Gosselin, 1980) but are uncommon amongst sexual offender paraphiliacs (Abel & Osborn, 1992; Gebhard et al., 1965).
4. Men with clinically significant fetishes may steal and collect their fetishistic objects (Chalkley & Powell, 1983; Gebhard et al., 1965; Krafft-Ebing, 1965; Revitch, 1978; Stekel, 1952).
5. A male with a single fetish may have multiple fetishes, including preferential sexual arousal to both body parts and non-living objects (Chalkley & Powell, 1983; Scorolli et al., 2007; Weinberg et al., 1994).
6. Female undergarments, body parts especially feet, footwear including socks, shoes and boots, and leather objects are common fetishes in contemporary community or convenience samples of self-identified fetishists (Gosselin & Wilson, 1980; Junginger, 1997; Scorolli et al., 2007; Weinberg et al., 1994).
7. Fetishism is a multi-sensory sexual outlet as fetishists may smell, taste, touch, insert, rub or be visually aroused by their fetishistic object or body part (Chalkley & Powell, 1983; Gosselin & Wilson, 1980; Hirschfeld, 1956; Krafft-Ebing, 1965; Scorolli et al., 2007; Weinberg et al., 1994).

In the more recent reports, Fetishism and Partialism can co-occur, at least in community-based or convenience samples of males self-identified as fetishists (Scorolli et al., 2007; Weinberg et al., 1994).

The reports of Weinberg et al. (1994, 1995) and Scorolli et al. (2007) are particularly noteworthy because of their sample size ($n = 262$, and $n > 5{,}000$, respectively). In the "pre-Internet era," Weinberg et al., like Gosselin and Wilson (1980), gathered data from an organization of self-described fetishist practitioners. Weinberg et al. surveyed a predominantly homosexual/bisexual foot fetishist group called the "Foot Fraternity." In their data set, it was clear that their subjects did not make a specific distinction between body parts and non-living objects as they described their fetish objects and behaviors. Thus, Weinberg et al. concluded that male feet and footwear were the primary interests of the respondents. When asked more specifically what was most sexually arousing, their respondents listed clean feet (60%), boots (52%), shoes (49%), sneakers (47%), and smelly socks (45%). These percentages suggest significant overlap amongst these fetishistic objects and a body part (the foot). A total of 59 men (22.5%) considered their fetishistic interest and behavior was associated with significant emotional or sexual impairment as well as loneliness, low self-esteem, depressive affect, shame and guilt, sexual inadequacy, and problems associated with intimate relationships. Although diagnostic threshold criteria for clinically significant impairment were not specifically applied in this study, it would certainly appear that these men would meet the threshold for a DSM-IV-TR-based psychiatric diagnosis of Fetishism. This would be the largest contemporary sample of "clinical" fetishists or partialists to date.

Scorolli et al. (2007) tried to estimate the relative frequency of fetishes in an international community sample by utilizing an Internet search through Yahoo! groups whose name or description included the word "fetish." From a list of 2,938 groups, they delimited their search to those whose title suggested most unambiguously a fetish as a "sexual preference." They reported on 381 groups with an estimated 150,000 members. Given that they were unable to ascertain how many members subscribed to more than one group, they very conservatively estimated that their data would include information from a minimum of about 5,000 individuals. The two most common fetish categories included objects associated with the body (33% of the sample) and body parts or features (30% of the sample). In the objects sub-group, the most common objects were objects worn on legs and buttocks, 33%; foot wear, 32%; and underwear, 12%. In the body parts or features sub-group, the most common body parts were feet and toes (47%). In reporting on combinations of categories, they reported that body parts and objects associated with the body were the most frequent combination. Scorolli et al. noted their survey's strengths (large sample, enhanced freedom of sexual self expression on the Internet, an observational survey, not an administered questionnaire) as well as their limitations (sampling bias, no control or comparison group, possible inaccurate reporting, higher socioeconomic and educational status of Internet subscribers). Scorolli et al. had no means to ascertain degrees of impairment from their sample.

These two reports are not specifically clinically-derived and each contains some inherent sample biases. Nonetheless, neither report empirically supports a clear distinction between fetishism and partialism. In fact, both surveys support both a significant continuum and overlap between Partialism and Fetishism.

Fetishism and Body Products

As was noted in DSM-III, body products, such as hair or fingernails, can become obligatory fetish objects. Other examples of

body products that have been described and categorized as fetishes include sweat, urine (urophilia, urolagnia: Davis, 1950b; Ellis, 1906) or undinism (Denson, 1982), blood, vampirism (Prins, 1985; Vanden Bergh & Kelly, 1964), necrophilia (Rosman & Resnick, 1989), and feces (coprophilia or coprolagnia; Ellis, 1906). There is insufficient extant clinical data, however, to definitively characterize these rare paraphilias as fetishes.

Recommendations for the DSM-V Diagnosis of Fetishism

I suggest, based on the aforementioned review of the available empirical literature, that the diagnostic criterion A for Fetishism as a paraphilic disorder be modified to reflect the reintegration of Partialism within the Criterion A operational definition for Fetishism and as a specifier of Fetishism (see Table 1).

Advantages and Disadvantages of Changing the DSM-V Diagnostic Criteria for Fetishistic Disorder

Advantages

Fetishism as a psychiatric diagnosis remains uncommon or, perhaps, under-reported because clinicians accumulate too few cases for publication. As is the case with many paraphiliacs, there may be many practitioners of variant sexual behaviors who do not meet the threshold for significant impairment in psychosocial or sexual functioning. Fetishism as a condition ascertained in community or convenience samples, however, strongly support a continuum of fetishistic behaviors across current categories (both non-living objects and body parts) as well as varying degrees of clinically significant distress or impairment in social, occupational or other important areas of functioning.

For approximately 100 years prior to the publication of DSM-III, the classical definitions for Fetishism included both non-living objects as well as exclusive focus on body parts as long as, in the latter case, there was significant impairment noted in interpersonal or especially heterosexual coital relations. The broader criteria for Fetishism, as historically defined, are consonant with the most recent data available (reviewed above) from fetishism practitioners, some of whom also report significant distress and psychosocial impairments in association with their fetish disorder.

It is noteworthy that Criterion B was absent in defining a diagnostic threshold for paraphilic disorders in DSM-III and DSM-III-R when Partialism was initially distinguished from Fetishism. As long as the threshold for personal distress or significant impairment of social or interpersonal functioning remains as a standard threshold for paraphilic disorders, the distinction between a non-sexual body part or an inanimate object associated with the human body produces an unnecessary division for research in fetishistic behaviors.

Disadvantages

During the past 30 years, the DSM-based operational definition for Fetishism as a psychiatric disorder has been remarkably consistent and clearly defined. The clinical significance qualifier (Criterion B) has been added as a major (and important) addition to the diagnostic criteria to determine a paraphilic disorder or diagnosis as opposed to an atypical sexual or behavioral proclivity. Inasmuch as Fetishism has remained relatively uncommon as a researched and clinically reported psychiatric diagnosis, returning the boundaries for this disorder to its historical precedent could lead to changes in research criteria of this condition and to its subsequent ascertainment in our community.

To suggest that the diagnostic criteria be altered primarily on the basis of four publications (Chalkley & Powell, 1983; Scorolli et al., 2007; Weinberg et al., 1994, 1995) may be premature. Reincorporating paraphilic expressions of Partialism as a specifier for Fetishism could lead to issues associated with indistinct boundaries for defining a fetish disorder or lead to false positive diagnoses or prevalence estimates because non-pathological expressions of fetishism are more likely to be found in larger population samples. This propensity, however, should be minimized or eliminated as long as diagnostic criteria include an enhanced delineation for significant personal distress or psychosocial functional impairment (Criterion B) as a necessary component for ascertaining and distinguishing a non- or preclinical condition from a true-positive DSM-V psychiatric diagnosis of Fetishism.

Table 1 Proposed DSM-V diagnostic criteria for Fetishism (302.81)

A. Over a period of at least 6 months, recurrent, intense, sexually arousing fantasies, sexual urges and behaviors involving either the use of non-living objects *and/or a highly specific focus on non-genital body part(s).*

B. The fantasies, sexual urges, and behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The fetish objects are not limited to articles of clothing used in cross-dressing (as in Transvestic Fetishism) or devices specifically designed for the purpose of tactile genital stimulation (e.g., vibrator).

Specify:

Body part(s):

Non-living object(s):

Other:

Note: The proposed changes are italicized

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References

Abel, G. G., & Osborn, C. (1992). The paraphilias: The extent and nature of sexually deviant and criminal behavior. *Psychiatric Clinics of North America, 15*, 675–687.

American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). Washington, DC: Author.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., revised). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Binet, A. (1887). Le fétichisme dans l'amor. *Revue Philosophique, 24*, 143–167, 252–274.

Blanchard, R., Racansky, I. G., & Steiner, B. W. (1986). Phallometric detection of fetishistic arousal in heterosexual male cross-dressers. *Journal of Sex Research, 22*, 452–462.

Brown, C. J. R. W. (1983). Sadomasochism, fetishism, transvestism and transsexuality. *British Journal of Psychiatry, 143*, 227–230.

Buhrich, N. (1983). The association of erotic piercing with homosexuality, sadomasochism, bondage, fetishism and tatoos. *Archives of Sexual Behavior, 12*, 167–171.

Cantor, J. M., Blanchard, R., & Barbaree, H. (2009). Sexual disorders. In P. H. Blaney & T. Millon (Eds.), *Oxford textbook of psychopathology* (2nd ed., pp. 527–550). New York: Oxford University Press.

Chalkley, A. J., & Powell, G. (1983). The clinical description of forty-eight cases of sexual fetishism. *British Journal of Psychiatry, 142*, 292–295.

Curran, D. (1954). Sexual perversions. *Practitioner, 172*, 440–445.

Davis, P. (1950a). Miscellaneous sexual perversions. In *Sex perversion and the law* (Vol. 2, pp. 53–60). New York: Banner Books.

Davis, P. (1950b). Urolagnia. In *Sex perversion and the law* (Vol. 2, pp. 5–18). New York: Banner Books.

Denson, R. (1982). Undinism: The fetishization of urine. *Canadian Journal of Psychiatry, 27*, 336–338.

Ellis, H. (1906). *Studies in the psychology of sex* (Vol. II). New York: Random House.

Freud, S. (1928). Fetishism. *International Journal of Psycho-Analysis, 9*, 161–166.

Freund, K., Seto, M. C., & Kuban, M. (1996). Two types of fetishism. *Behaviour Research and Therapy, 34*, 687–694.

Gebhard, P. H., Gagnon, J., Pomeroy, W., & Christenson, C. (1965). *Sex offenders: An analysis of types*. New York: Harper & Row.

Gosselin, C., & Wilson, G. (1980). *Sexual variations*. London: Faber & Faber.

Hirschfeld, M. (1956). *Sexual anomalies: The origins, nature and treatment of sexual disorders* (2nd ed.). New York: Emerson Books.

Junginger, J. (1997). Fetishism: Assessment and treatment. In D. R. Laws & W. O'Donohue (Eds.), *Sexual deviance: Theory, assessment, and treatment* (pp. 92–110). New York: Guilford Press.

Krafft-Ebing, R. (1965). *Psychopathia sxualis*. New York: G. P. Putnam's Sons. (Original work published 1886)

McWilliams, T. (2006). Partialism and the sex offender: The fascination with lactation. In E. W. Hickey (Ed.), *Sex crimes and paraphilia* (pp. 143–146). Upper Saddle River, NJ: Pearson/Prentice Hall.

Milner, J. S., & Dopke, C. A. (1997). Paraphilia not otherwise specified: Psychopathology and theory. In D. R. Laws & W. O'Donohue (Eds.), *Sexual deviance: Theory, assessment, and treatment* (pp. 393–423). New York: Guilford Press.

Milner, J. S., Dopke, C. A., & Crouch, J. L. (2008). Paraphilia not otherwise specified: Psychopathology and theory. In D. R. Laws & W. O'Donohue (Eds.), *Sexual deviance: Theory, assessment and treatment* (2nd ed., pp. 384–418). New York: Guilford Press.

Prins, H. (1985). Vampirism: A clinical condition. *British Journal of Psychiatry, 146*, 666–668.

Revitch, E. (1978). Sexually motivated burglaries. *Bulletin of the American Academy of Psychiatry and the Law, 6*, 277–283.

Rosman, J. P., & Resnick, R. J. (1989). Sexual attraction to corpses: A psychiatric review of necrophilia. *Bulletin of the American Academy of Psychiatry and the Law, 17*, 153–163.

Scorolli, C., Ghirlanda, S., Enquist, M., Zattoni, S., & Jannini, E. A. (2007). Relative prevalence of different fetishes. *International Journal of Impotence Research, 19*, 432–437.

Spengler, A. (1977). Manifest sadomasochism of males-results of an empirical study. *Archives of Sexual Behavior, 6*, 441–456.

Stekel, W. (1952). *Sexual aberrations: The phenomena of fetishism in relation to sex* (Vol. 1) (Trans., S. Parker). New York: Liveright Publishing Corporation.

Vanden Bergh, R. L., & Kelly, J. F. (1964). Vampirism: A review with new observations. *Archives of General Psychiatry, 11*, 543–547.

Weinberg, M. S., Williams, C. J., & Calhan, C. (1994). Homosexual foot fetishism. *Archives of Sexual Behavior, 23*, 611–626.

Weinberg, M. S., Williams, C. J., & Calhan, C. (1995). "If the shoe fits…": Exploring homosexual foot fetishism. *Journal of Sex Research, 32*, 7–27.

Wilson, G. D., & Gosselin, C. (1980). Personality characteristics of fetishists, transvestites and sadomasochists. *Personality and Individual Differences, 1*, 289–295.

World Health Organization. (1992). *International statistical classification of diseases and related health problems* (10th ed.). Geneva: Author.