Brit. J. Psychiat. (1963), **109**, 695–697

Correspondence

TREATMENT OF FETISHISM BY NEGATIVE CONDITIONING—A FURTHER NOTE

DEAR SIR,

In a recent paper, I reported (1963) the use of negative conditioning therapy on a persistent fetishist with initial apparent success. Raymond (1959) had also used this technique to useful effect but few, if any other, reports indicated a positive outcome to this type of treatment. Indeed in my own paper I commented on my misgivings about several points of method in discussion of the case, but initial success had clouded the importance of these. Now, it has been found that the patient has relapsed and that the success of treatment was only of a temporary nature, although at first follow-up the patient declared himself "completely cured".

At the time of writing the patient has not been seen again by me but, provided he has not been deconditioned by the treatment from hospital attendance, he will be interviewed again with a view to establishing the defect in the programme or the extraneous circumstances which led to his relapse. Further treatment may well be indicated in order to re-establish an aversive response to the stimulus objects, but in any case, this note seems necessary in order to set right the facts of the case, to qualify undue enthusiasm about the treatment, and to discuss the reasons for failure so that remedial action can be taken.

Because of early success with this patient I had called in question the theoretically and experimentally established importance of critically accurate timing of the CS/UCS interval. It now seems that this may have reflected unwonted temerity on my part and that, in fact, later failure might have been due to this looseness of timing. On the other hand, using the method of apomorphine as the UCS, accurate timing was not practically possible for reasons enunciated in the original paper. Further, the experimental evidence suggests that when the CS/UCS interval is wrong, conditioning does not occur and not that it occurs and extinguishes quickly as happened in this case.

A second possible explanation might be that the degree of negative conditioning achieved was allowed to become extinguished because of failure to follow up soon enough with additional treatment sessions—booster sessions—in the course of which the newly-learned aversion reaction could be over-learned. Again, there is real practical difficulty in arranging this. There is little way of judging in the individual case when the optimum interval for such boosters has passed. In this instance, the patient was asked to notify the writer as soon as he felt any tendency to revert to his fetishism, so that a booster treatment could be given. He failed to do so and, in fact, his wife reported his relapse.

The third theoretical point which arises in any explanation of failure has recently been discussed by Eysenck (1963) in an article most relevant to this very problem. He refers the reader to Hull (1943) and the principle of oscillation in biological systems. This principle states that from time to time the strength of inhibitory and excitatory potential in a given organism will vary in random fashion and that these variations may be sufficiently large in some instances to "swamp" the effects of a specific action potential recently elicited or near threshold. As Eysenck says, "Owing to the process of oscillation the effectiveness of aversion conditioning will be much weaker on certain occasions than on others, and if by accident the original stimuli are present at a time when the excitatory potential of the aversive conditioning is low, the individual will be liable to give way to temptation. If he does, then the extinction process phase of the aversive conditioning will have begun, because the conditioned stimulus has been presented without the (negative) reinforcement." This leads Eysenck to the prediction that relapse would be more likely to occur in cases of illnesses like fetishism or alcoholism rather than in illnesses of a dysthymic type, like phobias, compulsions and depressions. It is true that he adduces other arguments which would support the prediction, but the essential theoretical position has certainly been borne out by this case of temporary success followed by relapse.

The technique put forward by Eysenck to counter such effects is that of partial reinforcement, in which there is random reinforcement or non-reinforcement of conditioned stimuli. This has been shown to promote greater resistance to extinction of the CR and would, therefore, be the method of choice in such relapse-prone cases. Such a programme could be combined with booster treatments, spaced widely and reinforced as indicated above so that the necessary overlearning, which obviously did not occur in this instance, could be facilitated. It is pro-

posed to suggest this to the patient, but as is so often the case with such patients, the motivation to cure derives more from others, his wife, for example, than from himself and he may be unwilling to submit again to a relatively unpleasant regime in favour of a relatively, to him, pleasant fetishism.

Yours faithfully,

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AVERSION THERAPY OF SEXUAL PERVERSIONS

9 May, 1963.

DEAR SIR,

With reference to the paper by D. F. Clark in the *British Journal of Psychiatry* (May, 1963, **109**, pp. 404–407), I would regard the patient described as a transvestist rather than a fetishist in that he exhibited a morbid predilection to dress in female attire which Lukianowicz (4) sometimes associated with a wish to be regarded and socially accepted as a member of the opposite sex. Also, I would have thought that freedom from symptoms for a period of three months was insufficient time to evaluate the efficacy of treatment, bearing in mind that Raymond's (5) case required "booster treatments" following the original negative conditioning.

I was surprised to see that Dr. Clark omitted to refer to the recent work that has been done at Banstead Hospital on behaviour therapy for transvestism. This was reported by Lavin *et al.* (3) and the patient responded to treatment following the method previously used by Raymond, which was elaborated in great detail. This paper also summarized the literature on the various methods of treating sexual perversions from psychoanalysis to aversion therapy.

The disadvantages of the classical apomorphine/emetine method of deconditioning were reported by Barker *et al.* (1) in a letter to the *Lancet* in connection with the same case.

Following this another transvestist has recently been treated by electrical aversion. This patient was considered to be quite unsuitable for apomorphine treatment as he had previously suffered from a peptic ulcer. The technique was to stand the patient on an electrified grid at frequent intervals whilst he was dressed in female clothes, before a full-length mirror. It was much easier to operate, particularly from the point of view of measuring the time interval between the conditioned stimulus and response, which is of great importance in getting a good result from this type of therapy, and caused the patient far less discomfort than classical pharmacological aversion. The patient and the method used will shortly be described by Blakemore *et al.* (2) in a forthcoming communication in *Behaviour Research and Therapy*.

Yours faithfully,

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VASOMOTOR RHINORRHOEA

DEAR SIR,

I have just read an article in the January, 1963 issue of your Journal entitled "Psychogenic Factors in Vasomotor Rhinorrhoea" by George Fennell, **109**, 79–80. I feel this article calls for some comment.

I do not presume to criticize the method or conclusions of the drug trial described, as far as it