

CASE REPORT

A CASE REPORT OF *DHAT* AND *KORO*: A DOUBLE JEOPARDY

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Abstract

Objective: Culture-bound syndrome is a term used to describe syndromes unique to certain cultures. We need to understand the origins of cognitions related to these syndromes. **Methods:** We present the case report of a patient with *dhat* syndrome and *koro* with no other psychiatric disorder. **Results:** The cognitions related to these two distinct culture-bound syndromes in our patient seem to have their origins from different sources. While those related to *dhat* anxiety are peer-group induced, the one related to *koro*-like symptoms seem to have been affirmed by an alternative medical practitioner. **Conclusion:** Mental health professionals dealing with patients having culture-bound syndromes need to get to the core of origin of various cognitions and beliefs that such patients bring into the consultation rooms. *ASEAN Journal of Psychiatry, Vol. 13 (1): January – June 2012: XX XX.*

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Introduction

Culture-bound syndrome refers to recurrent and locality-specific patterns of aberrant behaviors and troubling experiences that may or may not be linked to a particular DSM-IV diagnostic category [1]. *Dhat* syndrome and *Koro* are the two culture-bound syndromes presenting with themes related to an individual's genitals and sexual life, reported from the Indian subcontinent. *Dhat* or semen-loss anxiety syndrome consists of somatic symptoms of fatigue, weakness, anxiety, loss of appetite, and symptoms of sexual dysfunction attributable to loss of semen following nocturnal emissions, masturbation or loss through urine [2]. *Koro* is a culture-bound syndrome characterized by intense anxiety and a belief that the genitals will retract into the abdomen and result in death [3].

Both these syndromes can occur independently in a patient or can present with other comorbid psychiatric disorders. We present a case report of a patient who presented with symptoms of both *dhat* syndrome and *koro* with no other psychiatric morbidity. A striking feature of this case was the reconfirmation of the *koro* beliefs in the patient by an alternative medical practitioner.

Case Report

A 32-year-old male patient, educated up to the 6th grade, married for 11 years, came to psychiatric outpatient department with complaints of feeling a stretching sensation at the base of penis for the past 5 years that had worsened over the past 3 years and a feeling that his penis is 'getting buried' into the abdomen for

the past one year. Five years before the patient first presented to us, he started complaining of an itching sensation around the base of his penis and a yellowish discoloration of the skin in the region. He first consulted a dermatologist within a fortnight of onset of these symptoms. Regular use of oral medications (details not available) and some local applications prescribed by the dermatologist did not provide relief to him after 2-3 months. The patient was then advised to undergo some procedure by the same doctor that involved piercing needles in the skin around the penis following which he perceived complete relief of both itching and discoloration. This improvement persisted for around 2-3 months following which he started experiencing some stretching and pulling sensation in his penis, the pulling force directed inwards towards his loins. Although these symptoms were continuous, they did not interfere with his sexual or other physical activities, as a result of which he neglected them.

During this period, patient migrated to Dubai for work in 2006, the symptoms still being persistent but neglected by him. In Dubai, he worked as a chauffeur that involved around 10-12 hours of driving within city limits; he said that he would get sufficient time to rest intermittently in his work hours. He returned to his family in 2008. During his stay with his wife, after 8-10 days of daily intercourse, he started perceiving that the strength of his erections and penile length had decreased slightly. Along with this the earlier stretching and pulling sensations had also increased. All these complaints were making him anxious and sad. Since he had to go back to Dubai again, he did not consult a professional and instead went back, only to return a year later. During his stay in Dubai, his concerns over the decreasing length of his penis were disturbing him although they did not affect his socio-occupational functioning to a large extent. On his return, his symptoms increased for which he consulted an alternative medical practitioner (*Ayurvedacharya*). He was started on some traditional treatment by this practitioner that comprised of daily visits to his clinic with local application of some medicine over the penis followed by wrapping it with a wet cloth and

some plant leaf for a few minutes. In addition to this, he was also advised local application of some oil over the penis twice a day.

During interview the patient revealed that at his first visit to the *Ayurvedacharya*, the practitioner claimed that if he had not consulted him on time, his penis would have shrunk, and completely retracted and disappeared into his abdomen. Patient had spent approximately Rs. 60,000/- on the treatments that this physician had advised but was happy that his symptoms had completely abated although his penis did not return to the earlier size.

Currently, for the past one year, he again started feeling that his penis including the scrotum is shrinking and reducing in size. Almost daily, he would measure the length of his erect penis with his palm (no tapes or rulers used); he never measured the penile girth, though on enquiry he reported that it had also reduced to some extent. He also accepted of sometimes applying a pulling-out pressure on his penis in order to prevent it from shrinking but this did not work and somehow made him even more anxious. At this time he also felt an increase in the pulling sensation around the genitals towards the loins. Patient reported of feeling anxious and depressed and was not able to concentrate on his work and life in general. He had never discussed this problem with anyone including his wife. He complained of occasionally having comparatively weaker erections, but did not report of totally failing to achieve or sustain erection for the duration of sexual intercourse. There was no history suggestive of any other sexual dysfunction, or urinary tract infection.

On asking if he was concerned about anything else, he complained of passing semen in urine and having night-falls since around the same time period. He complained of weakness, easy fatigability, body aches, and loss of power in his *penile blood vessels* due to loss of semen and was concerned that this may result in impotence. His anxiety had increased due to having so many problems related to his sexual organs, although this did not seem to affect his sexual life to a large extent. He did complain of not being able to satisfy his wife like before, as his wife was

complaining that he was not as actively performing as before and that his erections were also not as hard as before. Apart from this, his wife did not complain anything to him as far as his sexual performance or penile size was concerned. The patient denied resisting any of these thoughts unlike obsessions and also claimed that both these symptom of anxiety over shrinking genitals and anxiety over losing his *dhat*, although started around the same time, were not related to each other in any way and that they were independent. He denied of feeling that he was losing his genitals because of losing his semen over a time-period.

Though he gave history of feeling sad and being unable to concentrate on his work on occasions, he denied of having other depressive features. There was no history suggestive of any other psychiatric, medical or surgical illness in the patient. A dermatological evaluation did not reveal any local infection. His mental state examination revealed intense anxiety over his reduced penile size and a fear that he will lose his masculinity once this happened completely. There was also an overvalued idea of losing his vigor and vitality due to semen loss in urine or night-falls (nocturnal emissions or wet dreams).

He was given the diagnosis of *koro* and *dhat* syndrome. He was given low dose clonazepam (0.25 mg BID) to tide over his anxiety and was taught relaxation exercises. He was subsequently followed up over several sessions that included educating him about the impossibility of the genitals shrinking and retracting into the abdomen. He was told about the benign nature of his symptoms and reassured. He was told how anxiety related to sexual matters could be reinforcing leading to further increase of his problems. Informing him that his symptoms of *koro* could best be explained as anxiety based beliefs that are modeled and communicated among vulnerable men also helped tide over his problems [4]. After the patient was satisfied with the explanation about his *koro*-like symptoms, his misconception about semen-loss was cleared over subsequent sessions that included psycho-education along with educating him about anatomical and physiological aspects. He is still following up with us on a regular basis over the last 6 months and is showing sustained

improvement in all his symptoms. His clonazepam was tapered off and stopped completely as he reported improvement in anxiety symptoms.

Discussion

This case clearly presents with two clinically distinct culture-bound syndromes that have similar underlying themes related to sexual organs and present as anxiety related to loss of sexual capacity as a result of both. *Koro* may be *primary* (either sporadic/epidemic form), in which genital shrinking is the only presenting complaint, and *secondary*, in which the presentation is comorbid with another psychiatric disorder (anxiety disorder, schizophrenia, depression), diseases of the central nervous system such as brain tumors and epilepsy [3,5], chronic abuse of amphetamine [6], cannabis [7], and alcohol [8]. With all secondary causes ruled out, our case appeared to be that of primary *koro* with co-morbid *dhat* syndrome. *Koro*-like symptoms have been documented in marital conflicts [9]; in our case there were no marital conflicts reported though it is worthwhile to note that he was a migrant worker and was frequently staying away from his family. There was no history of extramarital intercourse or any venereal disease in him, though these may be found commonly in *koro* patients [10].

Although our patient started feeling that his genitals were shrinking long before, his beliefs seem to have been further strengthened by the *Ayurvedacharya* and his wife who complained of reduced sexual satisfaction with him. Khubalkar and Gupta (1984) [11] suggested that *koro* is a learned phenomenon, which results in an insecure person by occasional exposure of such ideas by reading, hearing, or witnessing a case. In our case *Koro*-like symptoms appeared earlier but were asserted by the *Ayurvedacharya*, which led him to really believe that his genitals were shrinking.

Our patient had anxiety over both loss of semen through nocturnal emissions and also his shrinking genitals, but was more concerned and disturbed about the latter, since losing the

genitals was more frightening for him. It was interesting to know that our patient had discussed the issue of semen-loss with his peer-groups earlier and knew of other friends who complained of loss of vigor and vitality due to semen-loss; however he did not know of any other individual who shared his complaints of shrinking genitals, nor had he discussed this with anyone else. His 'strange' complaint of shrinking genitals prevented him from talking about it to anyone thus making it more secretive and almost chronic, lasting for around three years.

During psychotherapy sessions with him, his anxiety over shrinking genitals was targeted before his anxiety over semen-loss as the former was more worrying to the patient and hence warranted immediate attention. Dutta (1983) [12] has reported that *koro* can be cured by suggestion; the *koro* epidemic of Assam in 1982 was helped by focused public education by mass media [13]. His semen-loss anxiety was later dealt, by educating him about the physiological aspects of sexual organs and semen production. It has been shown that psycho-education and removing misconceptions about semen-loss help to effectively deal with *dhat* syndrome [14]. Both his symptoms abated following psycho-education over several sessions. Since it was observed that the patient only sought treatment for his problems while he was away from work (i.e. in India), he was advised to seek treatment for his problems as and when they arise and not let them become a chronic problem for him.

Conclusion

This case presents an interesting confluence of two distinct culture-bound syndromes related to sexual organs in a single patient. The patient presented primarily with an intense anxiety about the shrinking of his genitals and also loss of vital energy due to semen-loss during nocturnal emissions. His semen-loss anxiety seems to have been borne out of the belief system shared with his peer group; on the other hand, his belief about shrinking genitals seems to have been furthered by the alternative medical practitioner who confirmed his pre-existing belief of the possibility of genitals shrinking and

retracting into the abdomen. This case highlights the importance of psycho-educating the practitioners of alternative medicine as they form an important part of the pathways to care in various cultures before the individual seeks formal care. This case also highlights the implications of treatment in migrants as it was seen that the patient sought treatment only when he was away from work. It is always preferable to probe into the origins of various beliefs that the patient brings into consultation to gain a deeper insight into their etiology. In such cases it is advisable to target the symptoms that are most disturbing to the patient such as *koro*-like symptoms in our patient. Following-up with the patient regularly along with psycho-education and removing misconceptions seems to give good results.

References

1. Guarnaccia PJ, Rogler LH. Research on Culture-Bound Syndromes: new directions. *Am J Psychiatry* 1999 156:1322-7.
2. Bhugra D, Sumathipala A, Siribaddana S. Culture-bound syndromes: a re-evaluation. In: Bhugra D, Bhui K. (eds). *Textbook of cultural psychiatry*. 1st edition, New York: Cambridge University Press. 2007 141-56.
3. Bernstein RL, Gaw AC. Koro: proposed classification for DSM-IV. *Am J Psychiatry* 1990. 147:1670-4.
4. Mather C. Accusations of genital theft: a case from Northern Ghana. *Cult Med Psychiatry*. 2005 29:33-52.
5. Kar N. Chronic koro-like symptoms- two case reports. *BMC Psychiatry*. 2005 5:34.
6. Bloor RN. Whizz-dick: Side effect, urban myth or amphetamine-related koro-like syndrome? *Int J Clin Pract*. 2004 58:717-9.

7. Kalaitzi CK, Kalantzis A. Cannabis-induced koro-like syndrome. A case report and mini review. Urol Int. 2006 76:278-80.
8. Al-Sinawi H, Al-Adawi S, Al-Guenedi A. Ramadan fasting triggering koro-like symptoms during acute alcohol withdrawal: a case report from Oman. Transcult Psychiatry. 2008 45:695-704.
9. Adityanjee Zain AM, Subramaniam M. Sporadic Koro and marital disharmony. Psychopathology. 1991 24:49-52.
10. Chowdhury AN. Biomedical potential for symptom choice in koro. Int J Soc Psychiatry. 1989 35:329-32.
11. Khubalkar R, Gupta OP. Psychodynamics of koro. Indian J Psychiatry. 1984 26:180-1.
12. Dutta D. Koro epidemic in Assam. Br J Psychiatry. 1983 143:309-10.
13. Jagadisha, Kar N. Sexuality and Psychopathology. In: Kar N., Kar G.C. (eds). Comprehensive Textbook of Sexual Medicine. 1st edition, New Delhi, Jaypee Brothers Publishers. 2005: 429-438.
14. Malhotra HK, Wig NN. Dhat syndrome: a culture-bound sex neurosis of the orient. Arch Sex Behav. 1975 4:519-28.

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