Are culture-bound syndromes on the verge of extinction?

Mark Greener

Exotic and enigmatic they may be, but culture-bound syndromes could be disappearing from the medical lexicon, partly as a result of cultural boundaries becoming blurred by the march of the internet and mass media. Mark Greener explores some fascinating examples of culture-bound syndromes and reasons why the terms might be falling into disuse.

Culture-bound syndromes are among the most evocative, exotic and enigmatic conditions in psychiatry. Dhat, for example, describes extreme anxiety surrounding semen loss.1,2 People with koro fear that their genitals are disappearing into their abdomen.3 Yoruba people in Nigeria experiencing ode ori – literally ‘hunter of the head’ – report feeling as if an organism is crawling through their head and other parts of the body. They may hear boiling, hissing, humming or buzzing in their ears and experience dizziness, darkening or blurring of vision, headache, bodily pains and peppery sensations.4 However, some of these intriguing conditions may be on the verge of extinction.

The disappearing penis

Culture-bound syndromes have long fascinated psychiatrists. Koro, for example, begins with tingling in the feet and legs that spreads into the abdomen and other parts of the body. The traditional belief is that the symptoms arise as ‘bad air’ or ‘bad spirits’ enter the body through the toes and feet. A sudden intense anxiety grips patients that their genitalia – including the nipples in case of females with koro – will disappear into their body.3 Ghosts traditionally do not possess genitals.3 So, some sufferers worry that koro might prove fatal.3,5 A West Indian immigrant who presented with koro to a London hospital worried the retraction would end in him becoming female.3 Not surprisingly, koro sufferers also worry about genital dysfunction, impotency and the effect on their sex life.3

The typical koro patient is a young male. Of the 70 patients studied during an outbreak of koro in Assam in North East India, for example, 97% were male, 70% were unmarried and 62% were aged between 21 and 30 years. The episodes lasted from 10 minutes to five hours, with an average of 30 minutes. Koro usually occurs in epidemics, often fuelled by media reports.3 Koro patients go to great – and sometimes absurd – lengths to stop the retraction. Some tie strings around their genitalia. Others hold them tightly in their hands. Others ask family members and friends to grasp their genitalia firmly. Not surprisingly, injuries are common. During the Assam outbreak, some patients attended emergency departments sitting in a tub of water or with a wet cloth draped over their genitals. The traditional belief is that body heat causes the symptoms. So, they believe, keeping the genitals cool prevents retraction.3

Idioms of distress

Exotic though koro seems, culture-bound syndromes are essentially idioms of distress – and every culture has its own idioms. People worldwide commonly express emotional problems through physical symptoms – so-called somatisation.6 Dhat’s somatic symptoms include weakness, fatigue, appetite loss, guilt and sexual dysfunction.1,2 Koro’s somatic symptoms include palpitations, sweating, breathlessness, chest discomfort and restlessness. Of course, these are reminiscent of anxiety’s somatic symptoms. Indeed, some authors regard koro as a culturally-bound form of panic disorder, hysteria or sexual somatisation disorder and patients usually respond to anxiolytics and antidepressants.5

Medical anthropologist Andrew Russell notes that certain organs ‘may become the focus of anxiety’, which differ depending on the culture. In China, for example, somatisation may focus on the liver, spleen, kidney or heart. In Iran and the Punjab, the heart is a common focus for somatisation. People in the Anglophone world often focus on their bowels. ‘The expression of physical complaints in these organs is often a metaphorical and more socially acceptable way of indicating emotional distress,’ he comments.6

Similarly, when Japanese women reach the menopause they rarely experience the hot flushes and night sweats that are often associated with the end of menstruation in Western countries. Japanese does not even have a word for hot flush. According to medical anthropologist Margaret
Lock these differences in vasomotor symptoms may reflect, at least in part, the fact that female ageing is not associated with reduced status and worth in Japan, as it is in North America.7

Changing patterns
Culture-bound syndromes may reflect the dominance of western diagnostic and nosological classifications and, Ventriglio and colleagues comment, the ‘long-standing impact of colonialism’.2 For instance, dhat-like syndromes ascribed to semen loss though nocturnal emissions or masturbation have been experienced by men in the Americas, China, Europe and Russia at different points in history.2 In the west, the syndrome became a medical curiosity. In other parts of the world, it became a culture-bound syndrome.

At one point, for instance, the leading Victorian psychiatrist Henry Maudsley suggested that semen loss, especially through masturbation, caused serious psychiatric illnesses. In editorials and articles published between 1840 and 1843, The Lancet argued that seminal loss caused physical and mental impairment as well as moral degeneration.8 Similarly, brain fag’s ‘idiomatic and syndromic use’ (see below) became extinct in Britain in the 19th and 20th century, before a resurgence in Nigerian students, captured in a 1960 paper, and then in other African countries.9

In such cases, poor health literacy combined with local beliefs and attitudes transform a ‘universal condition’ into a culture-bound syndrome, such as turning the once widespread anxiety about semen loss into dhat. However, Balhara and Goel point out, just because a syndrome disappears because of improved treatment and literacy in one part of the world, that does not mean that the remaining manifestations should be labelled a culture-bound syndrome. ‘Better control of the infectious diseases in the western world would not mean relabelling … common infections in the Asian/African cultures as culture-bound,’ they note.5

On the way out?
Over the last few years, barriers between cultures have become more porous, encouraged by the internet and other media,1 which might change the patterns of many so-called culture-bound syndromes. For instance, brain fag syndrome has several distinctive emotional and somatic symptoms, including: intellectual and sensory (usually visual) impairment; pain or a sensation of burning in the head and neck; sad and tense facial expressions, and ‘a characteristic gesture of passing the hand over the surface of the scalp or rubbing the vertex of the skull’.9 Typically, brain fag emerges at times of intensive study, such as just before exams. Patients typically ascribe the symptoms to mental exhaustion following excessive ‘brain work’.9

Against this background, a recent survey of 102 psychiatrists in Nigeria found that 98% recognised the term ‘brain fag syndrome’. But only 22% diagnosed brain fag syndrome in their practice. Most preferred diagnoses of anxiety, affective and somatic disorders.7 They treated brain fag using psychological therapies (46.5%), pharmacotherapy (42.8%) and lifestyle changes such as changing study methods and sleep hygiene (4.8%). Interestingly, psychiatrists who had practised for more than five years diagnosed brain fag significantly more often than those practising for five years or less (59% and 41%). Registrars were 90% (odds ratio 0.1) less likely to diagnosis brain fag than the consultants. If the trends continue the authors predict the ‘decline and possible extinction in the use of this diagnosis among Nigerian psychiatrists, critically within the society in which this culture-bound syndrome was originally described’.9

The reasons for a fall in brain fag’s diagnostic popularity – such as any contribution made by the change from postcolonial to contemporary medical training – are not clear. But the decline parallels wider cultural changes. Brain fag was ‘a familiar idiom of distress’ when some senior clinicians were being educated. In today’s Nigerian society, brain fag is ‘no longer common cultural parlance’. Indeed, the authors of the paper, who are of Nigerian ancestry and work in mental health services in the country, ‘have rarely’ heard the term used ‘outside academic circles’.9 This raises the prospect that culturally-bound diagnostic categories could perpetuate culture-bound syndromes after the term and syndrome has fallen into disuse elsewhere in society.

Two-way traffic
Cultural influences, however, go both ways. Migration can contribute to the spread of some culture-bound syndromes. Initially, psychiatrists believed koro was confined to people of South China and Yangtze valley, where it is called suo-yang. Koro also emerged in migrant Chinese workers in South-East Asia. Later studies identified koro in India, Western Africa, America and Britain.5 Cases of koro in the UK have been reported in, for instance, European Cauca-
sians and West Indian immigrants. In some cases, koro can be a manifestation of affective or schizophrenic psychosis. In other words, koro – in many ways the archetypal culture-bound syndrome – may not be a specific diagnosis.5
More recently, the hikikomori syndrome is recognised increasingly outside Japan. A person with the hikikomori syndrome – typically an adolescent male – completely withdraws from society for at least six months. The lifetime prevalence in young adults in Japan is around 1%. Typical hikikomori cases and hikikomori-like phenomena have also occurred in, for example, Oman, Spain, India, Iran, Korea, Bangladesh, Australia and the USA. The hikikomori syndrome appears to be especially common in urban settings.10

While psychiatrists from diverse cultures recognise the hikikomori syndrome, management differs and there is little agreement about the underlying aetiology. Hikikomori-like phenomena are ‘somewhat accepted’ in Japanese society and psychiatrists tend to suggest psychotherapy, especially for teenage patients. Psychiatrists in Bangladesh, Iran and Korea tend to suggest pharmacotherapy.10 The extent to which the variations in management are ‘true’ cultural differences rather than reflecting, for instance, access to services awaits further study.

Against this background, the future of the culture-bound syndromes as a diagnostic category seems uncertain. On the one hand, the lowering of cultural barriers means that constellations of symptoms will become culturally influenced rather than bound:1 a trend that, as we have seen, already seems to be underway.

In addition, diagnostic criteria may need to expand as studies suggest that constellations of symptoms once regarded as culture-bound are found outside the region in which they were identified first. For instance, further epidemiological and psychopathological studies need to characterise ‘primary’ (not an expression of another psychiatric disorder) and ‘secondary’ hikikomori (caused by an established disorder such as Asperger’s syndrome, personality disorder or social phobia). If primary hikikomori exists, Kato et al. believe that the condition should be added to the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems (ICD).10

On the other hand, the Chinese and some other countries may move to a more culture-specific classification of mental health.1 Ventriglio and colleagues suggest that psychiatrists need to urgently debate the merits of a universalist versus relativistic classification. Potentially, however, they suggest that ‘better understanding across cultures will lead to more balanced and nuanced approaches to diagnostic categories’.1 Indeed, better understanding of culture-bound syndromes will help uncover the multitude of factors that contribute to idioms of distress from Tokyo to Tallahassee to Tewksbury, and thereby aid management. Perhaps the extinction of culture-bound syndromes might not be before time.

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References
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