

## "GILAHARI (LIZARD) SYNDROME" IS IT A NEW CULTURE BOUND SYNDROME? - A CASE REPORT

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### ABSTRACT

*Culture bound syndromes are generally limited to specific societies or cultural areas and are localized. Authors report a case which seems to be a new culture bound syndrome, has atypical presentation and difficult to categories but could be diagnosed as somatoform NOS (F-45.9). This syndrome is commonly called Gilahari (Lizard) among local public and considered to be very serious and fatal illness prevalent in areas of west Rajasthan. According to public a small swelling climbs from the back reaches to neck leading to obstruction of airways and followed by death, though after examination and investigation patient did not revealed any physical illness so is seems to be a new culture bound syndrome.*

*Key words : Culture bound syndrome, Gilahari, somatoform disorder*

Cultures show great variety in all their aspects from their definitions of health and sickness to their relations with nature to their beliefs, cultural variables influence behaviour (Kaplan and Sadock, 1998). Culture bound syndrome are generally limited to specific societies or culture areas and are localized, folk diagnostic categories that frame coherent meaning for certain repetitive patterned and troubling sets of experience and observation (APA, 1994).

We report a case which has atypical presentation and difficult to categorize according to existing classification system though these type of cases are not uncommon in the area of west Rajasthan. It is commonly called "Gilahari" (lizard) among local public and considered to be a very serious fatal illness. People claim that death might had occurred but no one is able to tell about who has died because of "Gilahari". One of the author has talked to several people who had suffered from this "Gilahari" in the past. One such case consulted the casualty of PBM Hospital, Bikaner and from there, was referred

to the department of psychiatry and was admitted in female psychiatric ward.

### CASE REPORT

Mrs. K. aged twenty years, married illiterate females belongs to a lower class family was referred from casualty to the psychiatric OPD after assessment of physical condition. The patient was asymptomatic two days back then suddenly while working in the house, she started to complain that a swelling 4 cm x 3 cm called "Gilahari" was arising in her back, left sided lumbosacral region, moving gradually upwards with jerky moments and reached in the left side of the neck. Initially the patient tried to catch the swelling but was not able to hold it. She started shouting and became fearful thinking of "Gilahari" which would obstruct her air ways if not crushed in its path. The family members came and tried to hold it and later they crushed it by Chimta (fork) and by biting it. There were marks of bite on the neck of the patient (shown in photograph). The patient got relief for a while after crushing the

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swelling. According to the relatives, the swelling was crushed and blood spread out in the neck. They believe that this is a kind of illness in which a swelling occurs underneath the skin in the back, filled with dirty blood which climbs towards neck and if not crushed in between, it will obstruct the airways of the patients and will kill him or her. This whole episode took ten minutes. The patient started complaints of 'ghabrahat', palpitation and apprehension of getting again of "Gilahari" which will reappear again and will obstruct her air ways and she will die. This 'ghabrahat' followed by unconsciousness for three hours. There is no history of tonic-clonic movements, tongue bite or incontinence of urine and faeces, any abnormal body movements or any post ictal confusion. Patient regained her consciousness and has no recollection of the episode during the unconsciousness, though she says that she was perceiving some sensations during unconsciousness but she was not able to recall.

Patient was admitted in psychiatry ward and was given injection diazepam and other anti anxiety drugs. Patient showed some relief but later developed episode of short lasting unconsciousness in which she was having abnormal body movements, specially rolling movements of the body on the bed. In between, she was making some sounds. Patient and her family members were given assurance and were told not to worry about the nature of illness.

Patient was evaluated physically, she was

not having any organic pathology though she had complain of pain in neck at the site of the crush and was treated with local analgesics and antibiotics as advised by surgeon.

Patient was diagnosed according to ICD-10 (WHO, 1992) as somatoform NOS (F45.9) and treated in the ward for five days. During ward stay, multiple stresses were explored and reported i.e. (a) she has no issue two years after marriage (b) she has strained relationship with her mother in law (c) she has work load of whole family (d) her father was expected to come to see her condition at in-laws place. There was no acute and immediate stress. The patient was not having any past history of psychiatric or physical illness. She was second order child out of seven siblings (three males and four females). No history of any psychiatric illness in the family was present. There was cordial relationship among family members. She was full term normal home delivery, mile stones developed normally. She attained her menarche at the age of thirteen years, and having good sexual and emotional relationship with her husband. She was average intelligent lady with extroverted premorbid personality.

The patient witnessed the similar kind of "Gilahari" in her friend three months back at her parent's village. The "Gilahari" was crushed and the girl is alright at present. Patient remained in hospital for five days. She did not have this "Gilahari" again and her fits of unconsciousness and 'ghabrahat' was controlled after two days of hospital stay. Patient was discharged with anti-anxiety drugs and with assurance but the patient and her family members were not fully convinced about the nature of the illness.

### DISCUSSION

The patient was investigated thoroughly, not showing any obvious organic pathology. On the basis of clinical presentation she could be diagnosed as somatoform disorder NOS but the prevalence in a particular area of west Rajasthan and the belief among the public about the illness

that the "Gilahari" will climb to neck and will obstruct the air ways leading to death, create severe anxiety and associated maladaptive behaviour in the patient which can not be explained by another mental disorder. Though the patient responded to Antianxiety drugs and assurance but the authors were not able to even shake the idea that "Gilahari" can't obstruct the air ways. This cultural belief made the authors to think that this can be a culture or area specific syndrome. The authors met several physicians who have treated such kind of patients and they are of the opinion that this is a kind of psychiatric disorder. Similarly authors also met several people who have experienced "Gilahari" in past. They also describe about their fear of death and associated symptom of anxiety. This type of clinical syndrome fulfil the diagnostic criteria of culture bound syndrome. The term culture bound syndrome denotes recurrent, locality specific patterns of aberrant behaviour and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category. Many of these patterns are indigenously considered to be "illnesses", or at least afflictions, and most have local names (APA, 1994).

Simply by reporting one case and verbal reports of the physicians and public is not sufficient to denote a particular type of illness as a culture bound syndrome. The authors are of the opinion that they will see more cases and will evaluate them during regular follow ups before reaching some conclusion. The authors also seek help and information from the colleagues working at other places about this matter.

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