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Translating culture and psychiatry across the Pacific: How koro became culture-bound

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Abstract
This article examines the development of koro's epistemic status as a paradigm for understanding culture-specific disorders in modern psychiatry. Koro entered the *DSM-IV* as a culture-bound syndrome in 1994, and it refers to a person's overpowering belief that his (or her) genitalia is retracting and even disappearing. I focus in particular on mental health professionals' competing views of koro in the 1960s—as an object of psychoanalysis, a Chinese disease, and a condition predisposed by culture. At that critical juncture, transcultural psychiatrists based outside of continental China—namely, Taiwan, Hong Kong, and Singapore—appropriated ideas from traditional Chinese culture to consolidate the clinical diagnosis of koro as culture-bound. This new global meaning of koro was made possible by a cohort of medical experts who encountered the phenomenon and its sufferers in Sinophone (Chinese-speaking) communities, but placed their contributions within the broader contours of the global reach of Anglophone psychiatric science.

Keywords
Koro, transcultural psychiatry, Sinophone, culture-bound syndrome, Asia

Introduction

The history of science has lately witnessed a major turn towards global analysis, with an emphasis on circulation and exchange.[1] Certainly, one of the most distinctive features of science is its geographical unrootedness. That is not to say that scientific practice and inquiry are not always intrinsically dependent on their local context, but rather that they

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are not *merely* local or regional in nature. Despite the growing momentum behind the global studies of science, technology and medicine, not all historians of science share the same optimism. In 2009, Warwick Anderson observed that 'in science and technology studies (STS), as elsewhere, euphoric accountings of globalisation rapidly are displacing anhedonic postcolonial genealogies, often to the detriment of critical thought'.[2] More recently, he added that 'on the way to the global we seem to have dropped the colonial' and that 'the global makes us comfortable with the multiplicity and ambiguity of its performative differences'.[3] Sarah Hodges has similarly cautioned against the recent 'global menace' in the history of medicine, whereby historians often tend to reproduce, rather than perform critical analytical work that accounts for, the uneven stumbles of globalization itself.[4] To quote Fa-ti Fan, a balanced global approach to the history of science must attend to 'the historical reasons and circumstances that fostered or hindered the movement of knowledge or material objects'.[5]

Building on these insights, this article uses 'Asia as method' and situates the history of East Asian medicine within a robust postcolonial framework.[6] I borrow the concept of the Sinophone from the literary scholar Shu-mei Shih to refer to Sinitic-language communities and cultures outside of China or on the margins of China and Chineseness.[7] Sinophone communities and cultures thus bear a historically contested and politically embedded relationship to China, similar to the relationships between the Anglophone world and Britain, the Francophone world and France, the Hispanophone world and Spain, the Lusophone world and Portugal, and so forth. By refocusing our attention away from 'the West' to the provincializing of China, Sinophone postcolonial studies broaches a *minor*, rhizomic form of transnationalism that is especially valuable for understanding the intercultural negotiation, standardization and comprehension of medical experience between the global and the regional, and on the epistemic and quotidian scales.[8]

In shedding light on the horizontal connections across Chinese-speaking postcolonial locations such as Taiwan, Hong Kong and Singapore, the Sinophone concept enables a historical perspective on transpacific medicine to emerge from outside the hegemonic parameters of the nation-state.[9] Specifically, this article explores the postwar development of transcultural psychiatry by focusing on the genealogy of a clinical diagnosis known as 'koro', or *suo yang* (縮陽) in Chinese. Koro was listed as a culture-bound syndrome in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*), and it referred to a person's overpowering belief that his (or her) genitalia is retracting and even disappearing.[10] This article examines mental health experts' competing views of koro in the 1960s. At that critical juncture, psychiatrists based outside of continental China – namely, Taiwan, Hong Kong and Singapore – appropriated ideas from traditional Chinese culture to consolidate the clinical diagnosis of koro as a *culture-bound* disorder. I will show that this new global meaning of koro was made possible by a cohort of medical experts who encountered the phenomenon and its sufferers in Sinophone communities, but placed their contributions within the broader contours of the universal reach of Anglophone psychiatric science.

In Cold War Asia, Sinophone psychiatrists strategically positioned themselves as experts on culture-specific mental illnesses with which their European and American counterparts were less familiar. Using local patient cases from the geocultural borders of the Sinosphere as the immediate grounds of comparison, they claimed for themselves an

unprecedented niche in Western biomedicine that defied the co-formations of Eurocentric and Sinocentric culturalism. The trajectory whereby koro became an object of psychoanalysis, a Chinese disease and a culture-specific disorder foregrounds the double marginality of Asian transcultural psychiatrists (and their patients), whose significance has been historically situated on the peripheries of both Western psychiatry and the meanings of China and Chineseness.

Koro as a psychoanalytic object

American psychiatrists were first exposed to Chinese cases of koro in 1963. In May that year, the Japanese Society of Psychiatry and Neurology and the American Psychiatric Association held a joint meeting in Tokyo. The Taiwan-based psychiatrist, Rin Hsien (林憲), delivered a paper on two koro patients.[11] Both patients had migrated to Taiwan from mainland China in the late 1940s, and both sought medical treatment at the Department of Neurology and Psychiatry at the National Taiwan University Hospital in the 1950s. Up to this point, cases of koro patients of Chinese descent had been reported only in Southeast Asia. Rin's patients were unique in that they represented the first sample of natives of mainland China diagnosed with this condition by the mental health profession.[12] Given the notable absence of koro cases in Taiwan during the Japanese colonial period (1895–1945), when Rin first encountered his Chinese koro patients in Taipei, he was determined to draw on his psychoanalytic training to treat their concomitant psychiatric illnesses, such as borderline personality disorder and schizophrenia.[13]

The first patient, 33-year-old T.H. Yang, visited the psychiatric clinic in August 1957. Originally from Hankow in Central China, Yang was the eldest of five sons brought up in a small town on the Yangtze River. His father passed away, due to an unknown illness, when Yang was only seven, shortly after his youngest brother was born. His mother subsequently remarried, but his stepfather frequently beat him. She then took Yang to live with her brother, who also mistreated him. Yang started to support himself at the age of 11, first working as a baker, then as a cook. However, he had difficulty in saving money after developing the habits of gambling and frequenting brothels. At one point he was concerned about his excessive masturbation, and he turned to Chinese herbal medicine (and even his urine) to 'cure' this problem. He enlisted in the army at the age of 22 and migrated to Taiwan with the Nationalist government in 1949. After arriving in Taiwan, he soon quit the army and found a job in a bakery. He redeveloped his habit of gambling and going to brothels. For an extended period he engaged in sexual intercourse on a daily basis.

Yang's first attack of breathlessness and palpitation came in July 1957. He also suffered from dizziness, weakness in limbs and muscular twitching. Although physical examination was unanimously negative, he recovered in two weeks after receiving doses of vitamin B injection. But he visited brothels again, and more attacks came on a more frequent and prolonged basis. He saw many herb doctors at the same time that he was given regular vitamin injections. One of them told him that he was suffering from *shenkui* [腎虧], a diagnosis of sexual defect in Chinese medicine that implied the loss of vitality (possibly leading to death) due to excessive sexual intercourses. He finally decided to quit his job to save his strength.

In August 1957, Yang was referred to the psychiatric department by a medical doctor. According to Rin Hsien, 'irresistible sexual desire seized [Yang] whenever he felt slightly better; yet he experienced strange "empty" feelings in his abdomen when he had sexual intercourse'. With these strange feelings of an 'empty' abdomen, Yang 'often found his penis shrinking into his abdomen, at which time he would become very anxious and hold on to his penis in terror'. At night, Yang would frequently find his penis shortened to less than one centimetre long. Consequently, he 'would pull it out' so as to be 'able to relax and go to sleep'. Sometimes Yang thought that his anus was withdrawing into his body, too.[14]

The second patient, T.H. Wang, was a 39-year-old married man from Jiangsu. He was admitted into the psychiatric division of the National Taiwan University Hospital in May 1959 with the diagnosis of paranoid state. Wang was the only son in a traditional family, raised in a small town situated in the lower reaches of the Yangtze River (the urban centre of Chinese culture throughout the late imperial period). While he remembered his father to be very kind and gentle, his recollection of his grandmother, who took over raising him from the age of six, was more strict and authoritative. His father died when he was 11. Given the resulting economic burden placed on his family, Wang had to leave home at the age of 16 to work in a bookstore in Shanghai. During the Sino-Japanese War (1937–1945), he obtained a good position in a government office, married a lady who was five years older than him, and raised a daughter. They moved first to Nanjing after the war, then to Taiwan in 1949. The next year, he secured a job as chief accountant in a college office.

Between summer 1958 and spring 1959, a series of events happened to him that made him feel increasingly insecure and paranoid about the people whom he knew. He was first blamed by the dean of his college for his careless supervision of a co-worker. In September, he was accused of illegal construction after trying to expand his house to make room for his daughter. His salary disappeared from his house in November, at which point he began to develop insomnia and overt paranoid ideas. He started to trust no one and avoided contacts with others. It got to a point where he even believed that someone was hiding in the ceiling to spray poison on him.

By May 1959, the severity of Wang's symptoms led to hospitalization. According to Rin Hsien, Wang was referred to the psychiatric department because 'he believed that his scrotal skin was so loose that *jing* (精, semen) was leaking out and making the surrounding skin gelatinous'. To relieve his anxiety (in part about his penis withdrawing into his abdomen), the doctors delivered a course of insulin shock treatment. Afterwards, he was gradually relieved from his various somatic symptoms. He increasingly felt that his skin, especially his scrotum, was tighter. Eventually, achieving therapeutic catharsis, he was able to confront the extraordinary measure of emotional stress he had been under in recent years.[15]

In commenting on these two cases, Rin Hsien used a model that combined Western psychodynamic theories with concepts rooted in traditional Chinese culture. Psychoanalysts had long considered the indirect association of orality with dependency as the psychological basis for the prevalence of opium-smoking and gambling in Southern China.[16] Because Chinese culture emphasized orality, Rin observed, the symptoms of his two koro patients demonstrated a form of sexual defect on account of their oral

deprivation. In the yin-yang principle of Chinese medicine, yin denotes cold, wetness and the feminine, whereas yang is correlated with heat, dryness and the masculine. A balance of yin and yang was crucial for an individual's health. Koro's Chinese name, *suo-yang*, literally means the 'retracting of yang'. Viewed in this light, the various medications consumed orally by the first patient, Yang, were likely herbs that curbed yin excess and replenished deficient yang. Since the meaning of *suo yang* resembled the ideas of *shen kui* (腎虧, vital defect), *xin kui* (心虧, heart defect) and *shen kui* (神虧, spiritual defect), Rin grouped all of these conditions under the general category of the 'deficiency of vitality'.[17]

These Chinese concepts of illness helped Rin to understand koro through a psychoanalytic lens. In 1956, the Stanford anthropologist, John H. Weakland, published an article in *Psychiatry* that aimed to enumerate the connection between orality and Chinese male genital sexuality.[18] Drawing on examples from Robert van Gulik's *Erotic Color Prints of the Ming Period* (1951),[19] Weakland argued that 'one very basic and powerful Chinese conception of sexual intercourse is an oral relationship of feeding and eating, like that of mother and infant, but reciprocal. *Both* male and female genitals may play *either* the giving, feeding, milk-secreting role of the breast or the eating, drinking, absorbing role of the mouth.'[20] To explain the experience of his two koro patients, Rin borrowed Weakland's insight and relayed that 'powerful castration threats in the genital phase may be experienced by the Chinese as oral deprivation'.[21] Rin speculated the psychodynamics of the two cases in the following way:

> Owing to castration fear, the first case visited prostitutes after he had lost in gambling. The second case drank heavily in response to his wife's domination and rejection; later he developed a fear of sexual defect. Lack of oral supplies and threat to dependency needs leads to a fear of castration and eventually to a fear of loss of vitality. At that time the patients felt forsaken, decompensation and distortion took place, and delusions regarding genitals and their function were manifested. Hypochondriacal trends and narcissistic behavior were clearly shown by the patients during their state of panic. The patients' statements that their 'penis shrinks' and that their 'testicles drop off' are in keeping with Chinese concepts of illness and morbid fears.[22]

Rin placed an emphasis on the two patients' troubled childhood, noting especially the absence of a strong father figure in both of their lives. This led to 'confusion and anxiety in achieving masculinity' and 'excessive masturbation, indulgence in prostitution, gambling, drinking, and seeking maternal partners in marriage in their adult lives'.[23]

Yang and Wang's migration served to show that Chinese cases of koro would be difficult to interpret without the fundamental concepts of ill-health that originated from Chinese culture. Both came to feel greater personal and family insecurity as a result of the various employment and financial difficulties triggered by migration. What they brought to Taiwan with them, therefore, was not just their physical bodies, but a whole set of belief systems that stressed the significance of yin-yang balance and its underlying sexual and cultural connotations. The movement of Chinese-speaking peoples directed the centrifugal flow of ideas and worldviews from mainland Han Chinese culture, and this pattern of migration critically anchored the formation of Sinophone communities in post war Taiwan.[24]

More importantly, Rin Hsien drew on ideas from traditional Chinese culture and medicine not as an end in and of itself to understand koro, but as a means to unpack the psychodynamics of its Chinese sufferers. He did not deem the Chinese concepts themselves as sufficient. Rather, they were necessary for him to foreground psychoanalytic paradigms, especially Freudian ideas about the different stages of psychosexual development (oral, genital, etc.) and castration anxiety, and to subsume traditional notions of vital deficiency under the explanatory power of Western psychogenic theories. Unlike the transmission of psychiatric knowledge and practice to formal colonial contexts in Asia and Africa, native intellectual and medical elites played an agential role in introducing psychoanalytic concepts to Chinese and Sinophone communities.[25] Mirroring the epistemic tension between the Chinese background of the patient and the Western psychodynamic approaches of the physician, koro emerged as a clinical entity on the overlapping geocultural margins of Chineseness and Anglophone psychiatric medicine.

Koro as a Chinese disease

In Southeast Asia, Singapore stood at the forefront of koro research. Gwee Ah Leng (魏雅聆), a neurologist and founding editor of the *Singapore Medical Journal*, was the leading authority on the subject in the 1960s.[26] In the same year that Rin Hsien spoke at the Tokyo meeting, Gwee reported three cases of Chinese koro patients living in Singapore whom he had followed up for more than seven years.[27] The first patient ('C.C.H.') was an 8-year-old Chinese schoolboy whose penis was considered by his parents to have retracted after an insect bite. He then visited the hospital on multiple occasions starting on 28 July 1956, and his penis was often found to be clamped by various things (chopsticks, a loop of string, etc.). The second case ('H.H.F.') was a 34-year-old Chinese man who, on 24 March 1956, believed that his penis was getting shorter when he went to the loo during a cinema show. He held onto his penis with his right hand, felt cold in the limbs and was weak all over. About half an hour later the attacks abated and he was able to see a medical specialist to resolve the situation. The third case ('N.C.') was a 38-year-old Chinese man married with seven children. His attack came during intercourse with his wife, but he recovered after holding onto his penis for 20 minutes. In the two years prior to the attack he claimed to have been feeling very weak and every time he defecated he thought that his penis would retract (though it never did), which aroused great fear and distress.[28]

Interestingly, all three patients were Chinese, were aware of 'Shook Yong' (Singaporean Anglicization of *suo yang*) prior to their koro attacks and were eventually cured by vigorous assurance and talks about sexual anatomy from the doctor. The 8-year-old schoolboy was in many ways led to believe in koro by his parents; the 34-year-old man claimed to have heard from his friends of both ' Shook Yong' and fatalities during intercourse; and the married man conceded that his knowledge of 'Shook Yong' as a dangerous and fatal disease went way back to his school days.[29] Moreover, whereas Rin Hsien paid a great measure of attention to his patients' childhood and teenage experiences, the cases presented in Gwee's report were succinct capsules of events pertaining to the koro episodes under discussion. The psychosexual development of the patient's experience remained irrelevant in Gwee's interpretation of these events.

Rather than using basic concepts from traditional Chinese culture to fortify a psychoanalytic understanding of koro, Gwee situated the triggering of koro experience within Chinese culture itself. Gwee not only questioned koro etiological explanations on pure psychological grounds, but he also turned to long standing Chinese customs and beliefs as a fertile source of cultural stimulus:

> it is interesting to note that castration is practiced in China to create eunuchs for the Court, and also that in ordinary conversation, children are frequently threatened with castration for misdemeanor in micturition habits. Further, promiscuity is frowned upon by Chinese culture in spite of the public sanction of multiple wives, and literature abounds in exhortations to avoid illicit sexual relationships with all sorts of supposed ills that may arise as a result of such practices. Also, Chinese medicine, which has a wide appeal, attaches great importance to the spermatic fluid, stating that 10 grains of rice form a drop of blood, and 10 drops of blood form a drop of spermatic fluid, and that a Man's health can be seriously jeopardized if there is an excessive loss of spermatic fluid. […] The formation of spermatic fluid is supposed to be attributable to the kidneys, and round about the kidneys is situated a mysterious point referred to as the Gate of Life (命門). Hence it can be seen that as far as Chinese culture goes, the ground is adequate to give rise to the concept that sexual excess, apart from being a social and religious taboo, can literally through the loss of the spermatic fluid result in the loss of life.[30]

In light of the rich tradition of viewing sex as the essence of life in Chinese culture, Gwee explained men's false anxiety over penile shrinking by way of two key factors: 'the free play of imagination of a physician on top of a culture which links fatality with genital retraction and sexual activity with risk to life'.[31] In other words, koro 'delusion' was not only instigated by the popular appeal of Chinese medicine, but it was also a problem propagated by Western biomedical physicians who 'made up' its clinical existence.[32] For Gwee, koro as a construct operated on two different registers: a form of common knowledge for which medical professionals held pivotal responsibility in its popular dissemination, and a form of experience informed and conditioned by the patient's (Chinese) cultural background.

Pushing for the argument that koro was nothing but a culturally imprinted phenomenon, Gwee was the first psychiatrist to unearth in detail the discussions of koro in classical Chinese medical sources.[33] In an article that he published in the *Singapore Medical Journal*, 'Koro—Its Origin and Nature as a Disease Entity' (1968), Gwee brought to light five Chinese medical texts in which the retraction of penis was documented.[34] The first, oldest, example came from the *Linshu* part of the classic *Inner Cannon of the Yellow Emperor* (first century BCE):

> In the case of the liver, grief moves the innermost self and causes harm to the animus. When the animus is injured, the result is madness [狂], amnesia, and lack of sperm. Without sperm, a person will not be well, and the manifestation is one of *retraction of genitals* [陰縮] wish spasm of muscles, the bones of the chest are depressed, and the hair colour poor. Death usually occurs in Autumn.[35]

The second example came from *The Etiology and Symptomatology of Diseases* (*Zhubing yuanhoulun* 諸病源候論, 610) compiled by Chou Yuanfang (巢元方), a physician to the emperor of the Sui Dynasty (550–630):

> This disease arises in the case of man or woman just recovered from fever, and indulging in intercourse before being completely well. The illness resulting is called the transposition of symptoms of Yin and Yan[g] … The symptoms are feeling of heat rising up the chest, head too heavy to be lifted up, vision blurred, and all limbs are in spasm, the lower abdomen is painful, there is carpo-pedal spasm, and, *all will die instantly* […] If the patient indulges in intercourse, the result will be swelling of genitalia with *retraction into the abdomen* [令人陰腫縮入腹].[36]

In these classical sources, as well as most of the Chinese medical texts that appeared before the nineteenth century, the Chinese word for both male and female sex organs is Yin (陰).

Perhaps the most important source from the Qing dynasty (1644–1911) that commented on genital retraction is the *Golden Mirror of the Orthodox of Medical Lineage* (*Yizong jinjian* 醫宗金鑑, 1742), a project commissioned by the Qianlong Emperor. As Marta Hanson has shown, the *Golden Mirror* 'was one of multiple publishing projects in the first decade of the Qianlong reign [1735–1796] that represent the initial stage of the emperor's obsession with defining orthodoxy (*zheng* 正) in all realms of Chinese knowledge as a tool of Manchu control over both Chinese culture and the Chinese'.[37] Following the aim of defining orthodoxy, the *Golden Mirror* used male figures to depict the standard human body in the vast majority of its images, while visual illustrations of the female body only appeared sporadically in non-normative, special circumstances.[38] The *Golden Mirror* passage that mentioned genital retraction was concerned with the symptoms of fever: 'In fever, yin and yan[g] transposition is seen as feeling of heaviness, shortness of breath, discomfort in lower abdomen, may be *retraction of genitals with spasm* [陰中拘攣], heat rising up the chest, head too heavy to be lifted, visions blur, knees and calves are spastic, the powder of burnt, panties is of value.'[39]

The two remaining Chinese medical texts were published in the nineteenth century. The first was the *New Compilation of Tested Prescriptions* (*Yanfang xinbian* 驗方新編, 1846) by Bao Xiang'ao (鮑相璈). In *New Compilation*, the section on the 'Retraction of Penis' (陽物縮入) in Chapter 6 directs the reader to the section under the heading of 'Yin-Type of Fever' (陰症傷寒) in Chapter 14. Interestingly, this passage may be the earliest documentation of female koro in Chinese medicine:

> After an intercourse between the male and female, may be arising of exposure to wind and cold, or the ingestion of raw or cold food, the result is pain in the abdomen, *the scrotum in the male or the nipples in the female are retracted* [男子腎囊內縮，婦女乳頭內縮]. May be the limbs will be flexed and of a dark purplish hue, and when severe, there is trismus, and cessation of breathing. This is called Yin-type of fever.[40]

Finally, Gwee included an image of the acupuncture tract with which koro was associated in Chinese medicine (Figure 1), the middle female meridian of the feet (*zujue yinganjing* 足厥陰肝經), 'which ran a course on the inner side of the lower limb to the genitalia and then to the ipsilateral side of the abdomen up to the chest'.[41] Gwee came across this connection in the *Collection of Acupuncture and Moxibustion* (*Zhenjiu jicheng* 針灸集成, 1874) by Liao Runhong (廖潤鴻). The section 'The Middle Female Meridian of the Feet' states that its value lies in 'difficulty in movement, painful hernia, impotence and blackouts, muscle spasms, loss of spermatic fluid, retraction of the penis

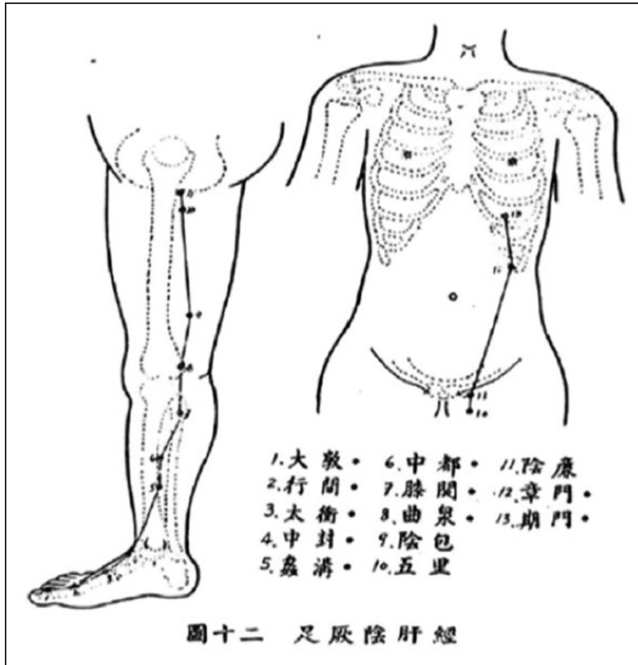

Figure 1. The middle female meridian of the feet. Source: Ah Leng Gwee, 'Koro; Its Origin and Nature as a Disease Entity', *Singapore Medical Journal* 9, no. 1 (1968): 3.

into the abdomen [陰縮入腹] … Nocturnal emissions, retraction of genitalia [夢洩遺精陰縮]'.[42] As Yi-Li Wu has shown, the flourishing publishing industry of the late Qing period helped to disseminate medical knowledge of various levels. Books such as the *New Compilation of Tested Prescriptions* and the *Collection of Acupuncture and Moxibustion* were likely to be popular medical handbooks, revised and edited by literati amateurs, that contained methods and remedies that aroused suspicion among scholar-physicians but were welcomed by lower-level literati families.[43]

In the autumn of 1967, a koro epidemic swept across Singapore (Figure 2). On the day of 3 November alone, as many as 97 male koro patients showed up at the emergency unit of the Singapore General Hospital.[44] Some appeared with their genitals clamped with restraint devices (Figure 3). In attempts to demystify this unprecedented event in Southeast Asia, Singaporean doctors clung to the idea that koro was merely a delusion suggested to the patient by his cultural background. The Chinese Physician Association of Singapore convened a seminar during the epidemic and arrived at the conclusion that 'the epidemic of Shook Yang was due to fear, rumour-mongering, climatic conditions, and imbalance between heart and kidneys, and was in no way similar to the classical entity of Shook Yin (縮陰)'.[45]

Gwee subsequently formed the Koro Study Team that conducted a comprehensive study of the epidemic between August and July 1968 (the late start was intended to avoid a second scare). Chaired by Gwee himself, the Koro Study Team involved Lee Yong

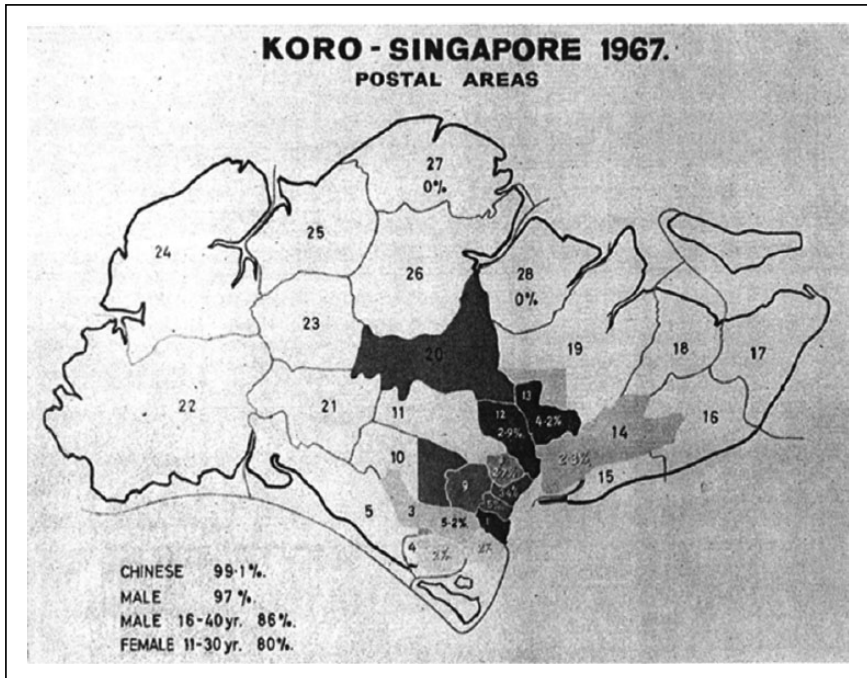

Figure 2. Breakdown of the incidence rates of the 1967 koro epidemic by postal areas. Source: The Koro Study Team, 'The Koro "Epidemic" in Singapore', *Singapore Medical Journal* 10, no. 4 (1969): 238.

Kiat, Tham Ngiap Boo, Chee Kim Hoe and William Chew from the Medical Unit III of the Outram Road General Hospital; P.W. Ngui, Wong Yip Chong, Lau Chi Who and Chee Kuan Tsee from the Woodbridge Hospital for mental diseases; and J.M. Colbourne from the Department of Social Medicine and Public Health at the University of Singapore.[46] The researchers sent a request letter to all doctors in Singapore, government emergency units and outpatient departments for details on all koro cases seen. The idea was that these details would provide the basis for follow-up studies. However, the group was disappointed by the low return rate from general practice. Furthermore, the few returned cases often contained insufficient information on date and address, and a significant portion of them refused to be followed up. In total, 469 cases were recorded, 80% of which came from the Emergency Unit of Outram Road General Hospital, but only 235 (52%) responded to the follow-up calls.[47]

Above all, the Koro Study Team used the data they collected to reaffirm Gwee's earlier view that koro was a condition produced by predisposition to Chinese culture. From the returns, they obtained the racial breakdown of 95% Chinese males and 2.2% of Malays and Indians combined. This distribution, the team argued, 'proved conclusively that in spite of the fact that the disease has a Malay name, *it is essentially a Chinese disease* and would seem to support the suggestion that the original pathogenetic concept was of Chinese origin'.[48] Since koro was a concept loaded with complex traditional and

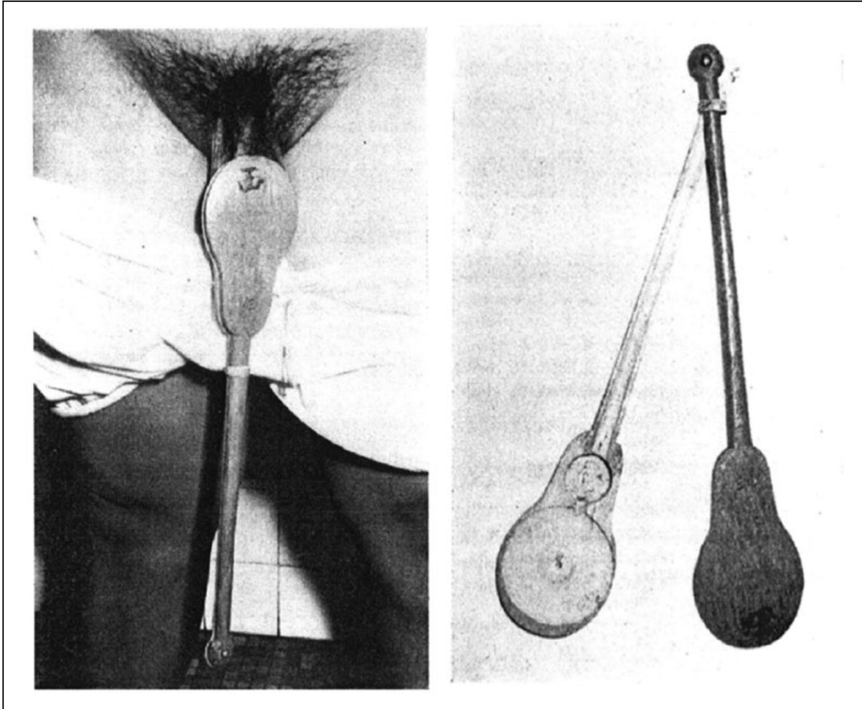

Figure 3. A restraint device used by a koro patient in Singapore. Source: The Koro Study Team, 'The Koro "Epidemic" in Singapore', *Singapore Medical Journal* 10, no. 4 (1969): 239–240.

cultural meanings, the researchers also associated prior knowledge of koro with higher educational attainment. Their results showed that of the 236 response cases, only 12 (5%) were uneducated, while 135 (57%) were Chinese educated and 84 (35%) were English educated. Hence, as 'expected', the rate of koro 'amongst educated persons [was] higher than the corresponding one amongst the uneducated'.[49] Moreover, the team came across six cases below the age of 6, which seemed to challenge the correlation they initially established between koro occurrence and the level of education. But the researchers explained that 'all these young children were literally "shanghaied" into the ranks of Koro patients by anxious parents who were only too ready to diagnose Koro'. Similar to the 8-year-old Chinese schoolboy whom Gwee discussed in his 1963 report, these young-age koro cases actually 'support the previous hypothesis that indoctrination had a great deal to do with the occurrence of the disease'.[50] Because 'every case has some idea of Koro either hearing about it previously or told about it at the "epidemic" before he was affected', the Koro Study Team conclusively called koro an *indoctrination* culture-bound syndrome.[51]

Koro becomes culture-bound

But the Koro Study Team was not the first to distinguish koro as specifically bound to Chinese culture. From the early to mid-1960s, the vocabulary of *culture-bound syndrome*

was introduced in a series of articles published by a psychiatrist based in Hong Kong, Pow-Meng Yap. Yap was a senior specialist in psychiatry of the Hong Kong Government and the Head of the Psychiatric Division in the Department of Medicine at Hong Kong University.[52] It was within the broader context of his comparative studies on possession and exotic psychoses that Yap assigned koro the nosological label of 'culture-bound depersonalization syndrome'.[53] Over the course of 15 years, Yap gathered 19 cases of patients affected by koro in Hong Kong. Based on clinical observations, Yap considered patients of this particular disorder to be sufferers of 'a localized depersonalization of their penis'.[54] Yap explained that because the penis is 'toneless' and 'beyond voluntary control', its physical contours are largely 'dependent upon episodic emotional arousal'.[55] Whereas Gwee, in Singapore, argued that koro patients are delusional since 'in truth no anomaly has occurred', Yap maintained that they actually 'ha[ve] not lost touch with reality as far as the conviction of penile retraction goes, because this is based on partial depersonalization'.[56] According to Yap, the fear of penile shrinkage is 'reinforced by the existence of a folk belief in the *reality* of a possibly dangerous koro illness'.[57] He therefore chose the adjective 'culture-bound' to underscore koro's close connection to the Chinese cultural background of its subjects.

Although both Gwee and Yap attributed the cause of koro to an awareness of the Chinese cultural repertoire, they disagreed on its physical and psychogenic mechanisms. For Yap, the varying size of the penis falls within the normal realm of the organ's physiology, and this was *no less real* than the existence of the belief (and fear) of fatal genital retraction. On the contrary, a proponent of interpreting koro as a delusional state, Gwee maintained that 'this belief has no anatomical or physiological basis'. 'In other words,' Gwee explained, 'it is actually not so much a true depersonalization of an organ, which does not disappear in Koro, but even in the mind of the affected is very much present but in the wrong place, in other words a *translocation*'.[58] Whether it is a culture-bound depersonalization or translocation syndrome, by the late 1960s, koro had become a *distinctively mental* illness, no longer resembling a pure somatoform disorder as depicted in Chinese medical texts. The Western biomedicalization of koro recasts Chinese culture itself as a source of this pathology and an important arbiter for its contemporary psychologization and understanding.[59]

Starting in the 1970s, psychiatrists began to discover cases of koro more frequently outside Chinese East Asia. Reports of koro came from all over the world – Great Britain, France, Canada, the United States, India, Georgia, Yemen and Nigeria.[60] These findings pushed Western and non-Western psychiatrists alike to acknowledge the increasing need to engage with anthropological perspectives in order to fully understand the development of certain mental health problems in culturally saturated contexts.[61] Most recently, the genital-theft panic in Western African nations in the 1990s posed a significant challenge to the move to a universal set of genital retraction disorders, a tendency encouraged by the 'tightening up' of the *DSM*.[62] The desire for more standardized diagnostic criteria, more systematic clinical practices and fewer case histories compelled some mental health experts to elevate culture-bound syndromes to a more general family of psychiatric illness.[63] This reorganization culminated in 1990 when two faculties at Boston University, Ruth Bernstein and Albert Gaw, proposed a new classification scheme for the forthcoming *DSM-IV*.[64] According to Bernstein and Gaw, koro could 'provide a paradigm for

examining other culture-specific disorders'.[65] In 1994, Chinese koro officially entered the *DSM-IV* as the 'true' koro model for understanding other culture-bound syndromes in modern psychiatry.

Conclusion

In the existing scholarship on koro, the medical sociologist Robert Bartholomew distinguishes himself as an adamant critic of the clinical reality of koro, arguing that epidemic koro in particular is 'a non-Western example of a collective social delusion'.[66] More recently, historian Ivan Crozier has provided a Foucauldian perspective that depicts koro as 'transient' across time and 'not a stable reality; it is rather a series of specific practices that can only be understood against their local, historical context'.[67] However, Crozier's account tends to stress the roots of modern transcultural psychiatry in colonial psychiatry.[68] His narrative misses the crucial role and agency of non-Western doctors in shaping the emergent discourse of 'culture-bound syndrome' that significantly reoriented the relationship between culture and psychiatry in the 1960s and beyond.

This article has tried to balance this omission by examining the effort of those mental health practitioners who grappled with koro in Sinophone communities and yet were based mainly on the periphery of Anglophone psychiatry. From the start, psychiatrists in Chinese-speaking East Asia did not consider Western psychiatric theories sufficient for explaining koro.[69] All of them reached for ideas in traditional Chinese medicine and culture, which they considered to provide a more adequate basis for understanding why the phenomenon occurred. The Koro Study Team even went so far as to label koro a *Chinese* disease. The renaming of koro as a culture-bound syndrome was so widely accepted after the 1960s that even Rin Hsien, who did not refer to the concept initially, would later devote a whole chapter to it in his textbook on transcultural psychiatry.[70] In the process whereby koro was imported back into the American psychiatric mainstream with a culture-bound diagnostic status, mainland Han Chinese culture had been significantly appropriated and reworked in Sinophone locations outside of the People's Republic of China – in Taiwan, Hong Kong and Singapore. Yet, despite their technical disagreements, Asian psychiatrists presented cases of Chinese koro in English and repositioned long-standing Chinese cultural norms by bringing them into the core of global biomedical discourse. Therefore, this study suggests that in order to historicize culture-bound disorders and indeed the discipline of transcultural psychiatry itself, one must begin with not a stable ontology of the 'otherness' of non-Western culture, but the translational permeability, fluidity and porousness of culture as a moving target.[71]

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Literature and Transnational Cultural Studies of National Chung Hsing University; and the 8th International Congress on Traditional Asian Medicine. I thank participants at these events for their perceptive and pointed questions.

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Notes

1. See, for example, Lissa Roberts, 'Situating Science in Global History: Local Exchanges and Networks of Circulation', *Itinerario*, 33, 2009, pp. 9–30; Sujit Sivasundaram, 'Sciences and the Global: On Methods, Questions and Theory', *Isis*, 101, 2010, pp. 146–158; Fa-ti Fan, 'The Global Turn in the History of Science', *East Asian Science, Technology and Society: An International Journal*, 6(2), 2012, pp. 249–258.
2. Warwick Anderson, 'From Subjugated Knowledge to Conjugated Subjects: Science and Globalisation, or Postcolonial Studies of Science', *Postcolonial Studies*, 12(4), 2009, pp. 389–400.
3. Warwick Anderson, 'Making Global Health History: The Postcolonial Worldliness of Biomedicine', *Social History of Medicine*, 27(2), 2014, pp. 372–384, on pp. 380, 383.
4. Sarah Hodges, 'The Global Menace', *Social History of Medicine*, 25(3), 2012, pp. 719–728.
5. Fan, 'The Global Turn in the History of Science', p. 253.
6. Warwick Anderson, 'Where is the Postcolonial History of Medicine?', *Bulletin of the History of Medicine*, 72(3), 1998, pp. 522–530; Kuan-Hsing Chen, *Asia as Method: Toward Deimperialization* (Durham: Duke University Press, 2010); Warwick Anderson, 'Asia as Method in Science and Technology Studies', *East Asian Science, Technology and Society: An International Journal*, 6, 2012, pp. 445–451.
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8. On minor transnationalism, see Françoise Lionnet and Shu-mei Shih (eds.), *Minor Transnationalism* (Durham: Duke University Press, 2005).
9. On 'transpacific' as a useful frame for historical analysis, see Chih-ming Wang, *Transpacific Articulations: Student Migration and the Remaking of Asian America* (Honolulu: University of Hawaii Press, 2013); Janet Hoskins and Viet Thanh Nguyen (eds.), *Transpacific Studies: Framing an Emerging Field* (Honolulu: University of Hawaii Press, 2014).
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of Koro in Respect to the Chinese Concept of Illness', *International Journal of Social Psychiatry*, 11, 1965, pp. 7–13.
12. Rin, 'A Study', p. 13.
13. Personal interview with Rin Hsien on 9 December 2013.
14. Rin, 'A Study', pp. 7–9.
15. Rin, 'A Study', pp. 9–11.
16. Warner Muensterberger, 'Orality and Dependence: Characteristics of Southern Chinese', *Psychoanalysis and the Social Sciences*, 3, 1951, pp. 37–69. Cf. Tsung Yi Lin, 'A Study of Mental Disorder in Chinese and Other Cultures', *Psychiatry*, 16(4), 1953, pp. 313–336.
17. Rin, 'A Study', p. 12. Rin also compared koro to frigophobia (畏寒症), a parallel culture-bound vital deficiency syndrome found in Chinese patients who suffered from a 'morbid fear of cold'. See Hsien Rin, 'Two Forms of Vital Deficiency Syndrome among Chinese Male Mental Patients', *Transcultural Psychiatric Research*, 3(1), 1966, pp. 19–21.
18. John H. Weakland, 'Orality in Chinese Conceptions of Male Genital Sexuality', *Psychiatry*, 19(3), 1956, pp. 237–247.
19. Robert Hans van Gulik, *Erotic Color Prints of the Ming Period: With an Essay on Chinese Sex Life from the Han to the Ch'ing Dynasty, 206 BC–AD1644* (Leiden: Brill, 2004 [1951]). This book was originally published privately by van Gulik himself in a 50-copies print run. In 2003 and 2004, Brill republished this book and his more well-known book, *Sexual Life in Ancient China* (Leiden: Brill, 1961). For an assessment of van Gulik's 'return' as signalled by these re-publications, see Charlotte Furth, 'Rethinking van Gulik', *Nan nü: Men, Women, and Gender in China*, 7(1), 2005, pp. 71–78, and Paul R. Goldin, 'Introduction', in Robert Hans van Gulik, *Sexual Life in Ancient China: A Preliminary Survey of Chinese Sex and Society from c. 1500BC till AD1644* (Leiden: Brill, 2003 [1961]), pp.xiii–xxx.
20. Weakland, 'Orality,' p. 244 (emphasis original).
21. Rin, 'A Study', p. 12.
22. Rin, 'A Study', pp. 12–13.
23. Rin, 'A Study', p. 12.
24. The Han group is the ethnic majority in the People's Republic of China. The popular rendition of 'Chinese' typically implies this particular ethnonational group and elides the other 55 'official' ethnic minorities. See, for example, Thomas Mullaney, James Leibold and Eric Vanden Bussche (eds.), *Critical Han Studies: The History, Representation, and Identity of China's Majority* (Berkeley, CA: University of California Press, 2012). Although there was already a large population of Han Chinese in Taiwan before 1945, their presence never imposed a form of colonial hegemony in the way Chiang Kai-shek's Nationalist regime did. On the role of Taiwan in the shaping of Qing colonial imaginary, see Emma Jinhua Tang, *Taiwan's Imagined Geography: Chinese Colonial Travel Writing and Pictures, 1683–1895* (Cambridge: Harvard University Asia Center, 2004). I thank Jia-hsin Chen for suggesting that what contributed to the koro symptomatology of Rin's patients was not Han Chinese culture per se, but the migration experience that differentiated them from the earlier Chinese settlers. In my view, the colonial hegemony of the Nationalist regime likely played a significant role in differentiating the migration experience of Rin's patients from that of the earlier Han settlers.
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Littlewood (eds.), *Colonialism and Psychiatry* (Oxford: Oxford University Press, 2001); Sloan Mahone, 'The Psychology of Rebellion: Colonial Medical Responses to Dissent in British East Africa', *Journal of African History*, 47, 2006, pp. 241–258; Hans Pols, 'The Development of Psychiatry in Indonesia: From Colonial to Modern Times', *International Review of Psychiatry*, 18(4), 2006, pp. 363–70; Richard Keller, *Colonial Madness: Psychiatry in French North Africa* (Chicago: University of Chicago Press, 2007); Sloan Mahone and Megan Vaughan (eds.), *Psychiatry and Empire* (Basingstoke: Palgrave Macmillan, 2007); Waltraud Ernst and Thomas Muller (eds.), *Transnational Psychiatries: Social and Cultural Histories of Psychiatry in Comparative Perspectives, c. 1800–2000* (Newcastle: Cambridge Scholars Publishing, 2010); Warwick Anderson, Deborah Jenson and Richard C. Keller (eds.), *Unconscious Dominions: Psychoanalysis, Colonial Trauma, and Global Sovereignties* (Durham: Duke University Press, 2011); Jonathan Saha, 'Madness and the Making of Colonial Order in Burma', *Modern Asian Studies*, 47(2), 2013, pp. 406–435; Matthew Heaton, *Black Skins, White Coats: Nigerian Psychiatrists, Decolonization, and the Globalization of Psychiatry* (Athens, Ohio: Ohio University Press, 2013); and Waltraud Ernst, *Colonialism and Transnational Psychiatry: The Development of an Indian Mental Hospital in British India, c. 1925–1940* (London: Anthem Press, 2013). On psychoanalysis in China see Jingyuan Zhang, *Psychoanalysis in China: Literary Transformations, 1919–1949* (Ithaca: Cornell University Press, 1992); Haiyan Lee, *Revolution of the Heart: A Genealogy of Love in China, 1900–1950* (Stanford: Stanford University Press, 2007); Wendy Larson, *From Ah Q to Lei Feng: Freud and Revolutionary Spirit in Twentieth-Century China* (Stanford: Stanford University Press, 2009); Howard Chiang, 'Epistemic Modernity and the Emergence of Homosexuality in China', *Gender and History*, 22(3), 2010, pp. 629–657; Tao Jiang and Philip J. Ivanhoe (eds.), *The Reception and Rendition of Freud in China: China's Freudian Slip* (New York: Routledge, 2012); and Howard Chiang (ed.), *Psychiatry and Chinese History* (London: Pickering & Chatto, 2014).

26. For more biographical information on Gwee see Robert C.K. Loh, 'Dr. Gwee Ah Leng', *Singapore Medical Journal*, 47(5), 2006, pp. 447–449, and Robert C.K. Loh, 'Gwee Ah Leng (1920–2006)', *Annals Academy of Medicine*, 35(6), 2006, pp. 443–444.
27. Ah Leng Gwee, 'Koro—A Cultural Disease', *Singapore Medical Journal*, 4(3), 1963, pp. 119–122.
28. Gwee, 'Koro—A Cultural Disease', pp. 119–120.
29. Gwee, 'Koro—A Cultural Disease', pp. 119–120.
30. Gwee, 'Koro—A Cultural Disease', p. 121.
31. Gwee, 'Koro—A Cultural Disease', p. 121.
32. Ivan Crozier, 'Making Up Koro: Multiplicity, Culture, Psychiatry, and Penis-Shrinking Anxieties', *Journal of the History of Medicine and Allied Sciences*, 67(1), 2011, pp. 36–70. Crozier's analysis builds on the philosophical work of Ian Hacking, 'Making up People', in Thomas C. Heller (ed.), *Reconstructing Individualism: Autonomy, Individuality and the Self in Western Thought* (Stanford: Stanford University Press, 1986), pp. 222–236.
33. More recently the following examples have been supplemented by Ben Yeong Ng and Ee Heok Kua, 'Koro in Ancient Chinese History', *History of Psychiatry*, 7, 1996, pp. 563–570.
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35. 'Lin-Chi on Basic Animus', trans. by Gwee in 'Koro—Its Origin and Nature', p. 6 (emphasis added).
36. 'Chapter 10—Fever, transposition of Yin and Yan symptoms', trans. by Gwee in 'Koro—Its Origin and Nature', p. 6 (emphasis original).
37. Marta Hanson, 'The *Golden Mirror* of the Imperial Court of the Qianlong Emperor, 1739–1742', *Early Science and Medicine*, 8(2), 2003, pp. 111–147, on p. 112.

38. Yi-Li Wu, 'The Gendered Medical Iconography of the *Golden Mirror* (*Yuzuan yizong jinjian*御纂醫宗金鑑, 1742)', *Asian Medicine*, 4, 2008, pp. 452–491.
39. 'Annotated Book of Fevers: Relapse of Fevers as a Result of Work, Food, and Yin and Yan Transposition', trans. by Gwee in 'Koro—Its Origin and Nature', p. 6 (emphasis added).
40. 'Yin-type of Fever', trans. by Gwee in 'Koro—Its Origin and Nature', p. 5 (emphasis added).
41. Gwee, 'Koro—Its Origin and Nature', p. 3.
42. 'The Middle Female Meridian of the Feet', trans. by Gwee in 'Koro—Its Origin and Nature', p. 6.
43. Yi-Li Wu, *Reproducing Women: Medicine, Metaphor, and Childbirth in Late Imperial China* (Berkeley, CA: University of California Press, 2010), pp. 54–83.
44. The Koro Study Team [Gwee et al.], 'The Koro "Epidemic" in Singapore', *Singapore Medical Journal*, 10(4), 1969, pp. 234–242, on p. 234. On the 1967 koro epidemic in Singapore, see P.W. Ngui, 'The Koro Epidemic in Singapore', *Australian and New Zealand Journal of Psychiatry* (special issue on studies of anxiety) II, 3(3a), 1969, pp. 263–266; and Scott D. Mendelson, *The Great Singapore Penis Panic and the Future of American Mass Hysteria* (USA: Author, 2010).
45. Gwee, 'Koro—Its Origins and Nature', p. 4.
46. The Koro Study Team, 'The Koro "Epidemic" in Singapore', p. 234.
47. The Koro Study Team, 'The Koro "Epidemic" in Singapore', pp. 235–236.
48. The Koro Study Team, 'The Koro "Epidemic" in Singapore', p. 236 (emphasis added).
49. The Koro Study Team, 'The Koro "Epidemic" in Singapore', p. 237.
50. The Koro Study Team, 'The Koro "Epidemic" in Singapore', p. 237.
51. The Koro Study Team, 'The Koro "Epidemic" in Singapore', p. 240.
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55. Yap, 'Koro—A Cultural-Bound Depersonalization Syndrome', p. 48.
56. Gwee, 'Koro—Its Origin and Nature', p. 4; Yap, 'Koro—A Cultural-Bound Depersonalization Syndrome', p. 48.
57. Yap, 'Koro—A Cultural-Bound Depersonalization Syndrome', p. 48 (emphasis added).
58. Gwee, 'Koro—Its Origin and Nature', p. 4 (emphasis added).
59. On the analytic frame of 'biomedicalization', see Adele E. Clarke, Laura Mamo, Jennifer Ruth Fosket, Jennifer R. Fishman, and Janet K. Shim (eds.), *Biomedicalization: Technoscience, Health, and Illness in the U.S.* (Durham: Duke University Press, 2010).

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66. Robert E. Bartholomew, *Exotic Deviance: Medicalizing Cultural Idioms—From Strangeness to Illness* (Boulder: University Press of Colorado, 2000), p. 91.
67. Crozier, 'Making Up Koro', p. 41.
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