VENEREO PHOBIA
(A case report)

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Summary

A case of venereo-phobia who was treated successfully with drug-assisted systemic desensitisation and electro convulsive therapy (ECT) is reported. The patient was an old case of non-specific urethritis who developed fixated ideas to his genital organs in the form of worm-crawling sensation over his penis. The neurosis was associated with free-floating anxiety and masked depression.

Venereo - phobia, a well established entity, is a relatively uncommon condition in the clinics of sexually transmitted diseases (STD). The disability appears as a special form of fixated ideas to the genital system which is out of proportion to the demands of the situation[1]. Patients usually give history of sexual contacts or STDs within a short period of onset of their symptoms. They develop headache and pathological fear of venereal diseases. The unconscious conflicts of shame and guilt manifest as somatic complaints at the conscious level. Patients move from clinic to clinic with persistent complaints pointing to genitalia and become victims to various forms of treatment which lead neither to improvement nor cure. They are unable to get rid of their contents of unconscious conflicts or experience of subjective compulsion[2]. It is extremely important in such cases to exclude organic disability and to get proper psychiatric evaluation. A case of venereo phobia who was cured by psychiatric management is reported here.

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Case Report

A thirty years old Nigerian sailor was admitted to Command Hospital, Air Force, Bangalore on 8th May 79 with a feeling of "ants crawling" and itching sensation over penis of three years' duration. He also complained of moderate erection and swelling of penis since June '78. The symptoms used to disappear whenever he took some treatment.

The patient had got married in 1969 and divorced in 1974. He gave a history of repeated extra-marital contacts in the past. He was treated at this hospital during January '79 for non-specific urethrities with oxytetracycline 2 daily for seven days following a venereal exposure during Nov. '78. Examination showed a well built individual. General systemic and local examinations revealed no abnormality. He appeared to be tense, anxious and remained pre-occupied with his somatic complaint of crawling sensation over his penis. Insight,

judgement, intelligence, speech and memory were found to be normal. At times the patient was found depressed with morbid pre-occupation of his illness and his future marriage due in July '79.

The patient was fully investigated. Smear and culture examination for gonococci, candida, trichomonas vaginalis and blood serology were negative. Culture study for 'T' strain mycoplasma and chlamydia could not be undertaken for lack of facilities. Plain skiagram of abdomen and IV pyelogram were normal.

He was given a course of oxytetracycline 500 mg six hourly daily for seven days with only temporary benefit.

At this stage the opinion of the psychiatrist was sought and patient was diagnosed to have venereo - phobia with fixated ideas to the genital system. He was treated with drug assisted systemic desensitisation and ETC given on three occasions.

Systemic desensitisation was achieved by rousing anxiety and his subjective complaints and then he was asked to relax his penile muscle. The whole procedure took forty five minutes and diazepam (50 mg) was given as a muscle relaxant. Five such sittings were given in two weeks' time. The patient became completely symptoms - free after the above treatment and remained asymptomatic during the four months he could be kept under observation.

Discussion

All forms of sexual dysfunctions are known to produce true phobic states[3]. Phobia is regarded as a special form of fear which is out of proportion to the demands of situation and which can not be explained or reasoned out in any way. It is usually beyond voluntary control and may often be associated with depression and obsession in addition to free floating anxiety.

Venereo - phobia arises out of unconscious conflicts, shame and guilt in patients who had past illicit intercourse or venereal disease. It is known to appear for the first time during the course of a depressive illness and often runs a cyclic course[4].

Phobias are classified into three major groups namely specific phobia; morbid fear of specified object or a situation, social phobia ; fear of confronting strangers or making a fool of oneself in public and agora - phobia; fear of going alone. The latter is considered the most distressing one[5]. Venereo-phobia belongs to the group of specific phobias. Patients with this disease have persistent complaints referred to genital organs not based on any proper reason or organic disability. These patients need careful examination by the psychiatrist to detect any mental illness. One should judiciously explain to the patient the necessity for such examination to obviate hostility or resentment to referal to a psychiatrist. The patient under report had initially resented seeing a psychiatrist or being treated by him.

Systemic desensitisation is the commonest form of behaviour therapy for phobia disorders. The standard procedure is to provoke anxiety with a graded list of situations or suggestions and teaching a technique to obtain muscular relaxation[6,7]. Wolpe observed 90% cure rate[7] and Lazarus obtained 70% improvement in 408 patients suffering from phobias[8].

Accurate assessment of severity of phobia and response to the treatment is at times difficult due to non-availability of valid and reliable methods for grading the severity of symptoms. Self-rating or observer-rating scales have been used by different psychiatrists. It is extremely difficult to have adequate controls and samples.

Drug assisted systemic desensitisation is found to give the most satisfactory

result in the majority of cases[9,10]. Time of desensitisation is shorter with the aid of drugs than without. Short acting barbiturates are used to produce muscular relaxation. In our case diazepam was used with good result.

ECT is not the choice of treatment for phobic states. ECT was administered in this case as patient was found to be markedly depressed. There is no doubt that cases of sexual neurosis and venereo-phobia are encountered in STD clinics. This case report illustrates the importance in handling these patients. One should not be overenthusiastic to label patients as "psychiatric" cases before all investigations are done to rule out any organic disability.

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