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Case Report

Phenomenology and Functional Impact of Dhat Syndrome: A Case Report

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ABSTRACT

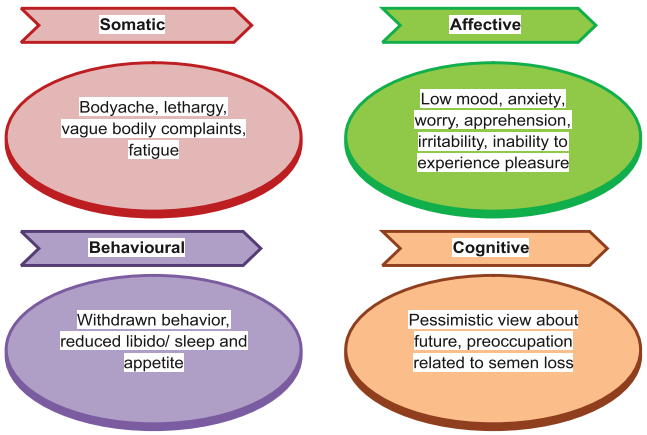
Dhat syndrome is culturally mediated condition related to semen loss and found commonly in natives of South Asian countries. The patient goes through extreme degree of tiredness, anxiety, clinical depression leading to fertility issues. All these symptoms are attributed to the contemporary myths in the society pertaining to semen loss. This is to report the case of a young male who initially suffered from repetitive semen loss in night-falls and via masturbation, causing extreme guilt and physical health symptoms which further aggravated into chronic depressive symptoms. Lack of insight, poor knowledge of sexual health and practices and inadequate treatment adherence added to the worsening of psycho pathology and precipitated obsessions and suicidal attempts in the patient. This discussion aims to explore the dynamics between socio-cultural aspects, personality, education and attitude towards psychological treatments in the community while treating Dhat Syndrome, and its resultant impact on the patient's occupational, social and emotional well-being.

KEYWORDS: Dhat, Depression, Obsession, Suicide

INTRODUCTION

An individual's demeanour develops because of the social-cultural background he lives in. India and other South Asian countries consider talking regarding sexual health a taboo. Thus, culture impacts one's concepts and conviction towards masturbation, nightfall or sexuality. The word *Dhat* originates from Sanskrit word *Dhatu* which means metal. Vedic literature says that *dhat* (semen) is an essential metal or element of one's body, important to be preserved.[1] Semen is considered precious because of the belief that it is formed by various steps of ultra-condensation of food that we consume in our daily lives, so men who are able to successfully preserve semen would have a balanced life, unlike the ones who lose semen by any means and risk facing serious health issues. [2]

CLINICAL MANIFESTATIONS OF DHAT SYNDROME[3]



A person can go through a range of polymorphic symptoms as mentioned in the figure above when Dhat Syndrome remains untreated. This case report is about a young male who didn't seek treatment initially due to lack of knowledge and over the time it progressed to developing suicidal ideation and behaviour along with obsessive preoccupation with genitalia dysmorphism and severe depression.

CASE PROFILE

A 23 years age young man, electrician by profession, from middle socioeconomic status, living in a nuclear family of rural background, presented with complaints of body ache, sad mood, not feeling any pleasure or interest in daily activities, decreased sleep and appetite, and self-harm ideation from last 4 years. These symptoms had been exacerbated since last 4 months during the pandemic-imposed lock down situation.

The apparent stressor at the onset of illness was episodes of night-falls experienced as an adolescence phenomenon by the patient. He disclosed that he had acne breakout at the time which did not resolve even after so many home remedies, so his friends suggested him to masturbate as a solution to his acne. He practiced the same thrice a week for a month without any response to the acne and he started having night-falls every week. He considered it as an un-natural event and found himself preoccupied with worry about the same. Due to lack of adequate knowledge about sexual and reproductive health vs illnesses, he was worried that if someone would get to know about it, he will be considered as 'less of a man' and he continued to keep it to himself. In addition, he was not vocal about his distress with his parents or friends as talking openly about sexual issues is generally considered inappropriate in his culture and a very private thing. As the year went by, he started feeling that no girl is going to marry him, as he considered night-falls a disability. He blamed masturbation to be the root cause of this problem, and started experiencing low energy levels, body aches, reduced confidence, low mood, problems in initiation and maintenance of sleep. Feeling incapable sexually, he felt worthless, hopeless, and helpless and tried to end his life by hanging himself, but the attempt was unsuccessful as he got scared of the potential pain. He was alone at home on the day of this attempt, and till date he has not shared about it with anyone in the family. However, this attempt made him realise that perhaps he needed help and address the guilt he felt about bringing on this disability in his life. When he first sought treatment from a Psychiatric OPD, he was offered Aripiprazole 10mg, Setraline 100 mg, Olanzapine 2.5mg and Clonazepam 0.5mg in divided doses per day. He complied with the medication for 2 months and reported improvement in his sleep, but not the other symptoms, especially night-falls. Lack of expected response made him non-compliant to the treatment.

When the sleep disturbances relapsed, he started feeling foreskin of his genitals is shrinking and size of genitalia is also reduced. This is the point of time when he had approached out OPD and thoroughly investigated for semen analysis, serum prolactin, serum testosterone levels, and thyroid function tests, sonogram of abdomen and routine blood investigations. Semen analysis showed pus cells, for which tablet Doxycycline 100 mg twice daily was offered for 5 days. Other medicines prescribed for the underlying symptoms were Paroxetine 12.5 mg, Mirtazapine 7.5 mg, Multivitamins and Clonazepam 0.25mg per day in divided doses. Also, He was assured of no physical anomalies found in the investigation reports and educated about psychological underpinnings of his symptoms. On follow-up, it was observed that the patient had high treatment expectations with immediate effect. When his expectations of complete and rapid improvement were not met, ideas of self-harm emerged again. He was educated about the nature of his illness, sexuality norms and cultural practices, nature of treatment response and need for psychosocial management.

After a month of continuing same treatment albeit in inadequate doses, he was brought to the OPD by his father as he felt his son seemed low and became irritable without any significant provocation. In the interview patient mentioned that thoughts about his genitals were repetitive, also he has started feeling that he will never be alright, and he focused more on death related content in newspapers. He even tried to end his life by submerging his face in bucket full of water for 1 minute and tried to cut his wrist after that. Both the attempts were unsuccessful as he got scared of pain and now, he was looking for less painful measures for dying. He further mentioned that he was planning to consume poison for next attempt. He had not disclosed about his plans to anyone in the family. He was advised inpatient admission and care, but was not accepted by the patient at the moment. This time, supportive and family therapy sessions along with medication Amisulpiride 50 mg, Venlafaxine 75mg, Dosulepin25 mg and Clonazepam 0.5mg in divided doses per day were offered. On further review, the patient observed that he felt nearly 40% better on the prescribed medications, also he started working again. He expressed readiness for regular follow-up and cognitive behavioural therapy sessions along with strict relative attendance, supervised medication and relaxation techniques like meditation and pranayam.

DISCUSSION

Over the years Dhat syndrome has been reported to manifest with numerous clinical presentations. Many authors have studied the socio-demographic profile and symptoms in patients with Dhat syndrome, but there are very few cases reported suicidal attempts as one of its presentations. Dhikav and colleagues in their study on 30 patients with Dhat syndrome found that on an average this culture-bound syndrome has its onset at the age of 19 years, with the mean duration of symptoms being 11 months. Nearly two-thirds of the cases had clinically significant depression, as also evident in our case. One third cases had comorbid premature ejaculation, also seen in this reported case.[4] Bhatia and Malik studied 93 patients with Dhat syndrome and found that generalized physical weakness was the most common presenting complaint (70.8%), followed by symptoms like fatigue, insomnia, anhedonia and headache. These symptoms have also been reported in our patient. [5] Among the psychiatric problems in Dhat syndrome, neurotic depression has been the most commonly found, followed by mixed anxiety neurosis, major depression with psychotic features and obsessions about genitalia. Among the patients, 18.6% report to have suicidal thoughts, without definite suicidal attempts.[6]

The phenomenology of Dhat syndrome is conceptualized as a culture-bound neurosis, common to the Indian subcontinent. It usually runs a benign course, but sometimes worsens into anxiety, depression or sexual dysfunction like erectile dysfunction or premature ejaculation.[7, 8] In this case, we have reported a patient with severe untreated Dhat syndrome leading to severe depression with multiple suicidal attempts and sexual obsessions, which adversely impacted his social, occupational and interpersonal life. It was noticed that careful evaluation and adequate psycho education of these patients helps with better treatment response. We recommend that clinicians should spend significant amount time to impart scientific information to the patient as per his understanding about the illness and encourage role of combining various treatment modalities, including biological, psychological and social. Psychotherapists/counsellors should explore the expectations of patients from these treatment modalities and address them appropriately.[9]

CONCLUSION

Dhat syndrome is defined as a culture-bound syndrome of anxiety and vague psychological and physical symptoms in men, basically attributed to loss of semen. An untreated course of the same may lead to more psychiatric or sexual health problems. In this case, untreated Dhat syndrome led to severe depressive symptom manifestation and obsessions with the morphology of genitalia, as well as multiple suicidal attempts. Hence, clinicians should treat patients according to their cultures, beliefs, social or place of origin, to prevent prolonged untreated illness duration.

CONFLICTS OF INTEREST: None

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REFERENCES

1. Malhotra, H. K., & Wig, N. N. (1975). Dhat syndrome: A culture-bound sex neurosis of the orient. *Archives of Sexual Behavior*, *4*(5), 519-528.
2. Kar, S. K., & Sarkar, S. (2015). Dhat syndrome: Evolution of concept, current understanding, and need of an integrated approach. *Journal of human reproductive sciences*, *8*(3), 130.
3. Chadda, R. K., & Ahuja, N. (1990). Dhat Syndrome. *The British Journal of Psychiatry*, *156*(4), 577-579.
4. Dhikav, V., Aggarwal, N., Gupta, S., Jadhavi, R., & Singh, K. (2008). Depression in Dhat syndrome. *The journal of sexual medicine*, *5*(4), 841-844.
5. Bhatia, M. S., & Malik, S. C. (1991). Dhat syndrome–a useful diagnostic entity in Indian culture. *The British Journal of Psychiatry*, *159*(5), 691-695.
6. Prakash, O., & Kar, S. K. (2019). Dhat Syndrome: A Review and Update. *Journal of Psychosexual Health*, *1*(3–4), 241–245.
7. World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines*. World Health Organization.
8. Nakra, B. S., Wig, N. N., & Varma, V. K. (1977). A study of male potency disorders. *Indian Journal of Psychiatry*, *19*(3), 13.
9. Khan, N., Kausar, R., & Chaudhary, H. R. (2011). Demographic characteristics and implications of Dhat syndrome in Pakistan. *Indian Journal of Clinical Psychology*, *38*(1), 69-78.