

Dhāt syndrome: a re-evaluation

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Clinical features

Dhāt syndrome (see Figure 1 for definition) was first described in 1960 (Wig, 1960). The condition is seen most frequently among young men (age range: 20–38 years), presenting at medical and psychiatric clinics in South Asian countries. Prevalence rates of 11.7% (India) to 30% (Pakistan), suggest the disorder is pervasive. Common symptoms include:

- weakness
- fatigue
- palpitations
- sleeplessness.

Most significantly, patients attribute these symptoms to a white discharge in their urine (which they claim is a ‘vital substance’ – semen). Losing such a vital substance thus generates anxiety and dysphoria. The condition has no known organic aetiology. Medical literature commonly refers to *dhāt* as a sex neurosis of the Indian subcontinent that is widely regarded as a culture-bound syndrome, and it continues to be extensively reported despite a prediction that the syndrome will ‘become less common with increasing literacy and progress in sex knowledge’.

Dhāt syndrome has been extended to include Indian women presenting with somatic symptoms associated with leucorrhoea, and explained as due to loss of a ‘vital fluid’. More recently, it has been reported among South Asian migrants to Europe. Randomized treatment trials suggest that the most effective clinical management of this condition includes a combination of anti-anxiety and antidepressant medication, together with counselling and cognitive-behavioural therapy.

Nosology

ICD-10 classifies *dhāt* syndrome as both a neurotic disorder (code F48.8) and a culture-specific disorder (Annex 2). The description under neurotic disorder states that it is caused by ‘undue concern about the debilitating effects of the passage of semen’. This section, based on advice from WHO experts, also cautions users of the ICD

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Defining *dhāt*

Ayurvedic medicine is a professionalized form of Asian medical knowledge, which has been popular in the Indian subcontinent from Vedic times, hence the term *Ayur-veda*. Rooted in Hindu religion and practised in empirical form, Ayurveda conceptualizes the healthy human body in the form of seven essential elements (*dhātus*) that are in harmony. These elements are:

- *rasa*, fluid from digested food
- *rakta*, blood
- *masma*, muscle
- *meda*, fat
- *ashti*, bone
- *majja*, marrow
- *śukra*, semen.

Additionally, an imbalance of any of the three bodily humours (or *dosas*: *vata*, *pitta* and *kapha*) can cause damage to the *dhātus*. The term *dhāt* is an English corruption of the Sanskrit word *dhātu*, and is erroneously equated with either ‘semen’ or ‘semen loss’ in the modern psychiatric literature.

1

manual: ‘The strong association of these syndromes with locally accepted cultural beliefs and patterns of behaviour indicates that they are probably best regarded as not delusional’.

Annex 2 of ICD-10, compiled by an American anthropologist, conflates several other local South and East Asian terms from India and China (*dhāt*, *jiryān*, *shen k’uei*, *shen-kui*). The section describes these disorders as characterized by ‘anxiety and somatic complaints such as fatigue and muscle pains, related to a fear of semen loss in men or women (also thought to secrete semen). Precursors are said to include excess coitus, urinary disorders, imbalance in bodily humours, and diet. The main symptom is a whitish discharge in urine, interpreted as semen loss. Traditional remedies focus on herbal tonics to restore semen or humoral balance’.

A cross-cultural misunderstanding

Defining *dhāt* as a culture-bound syndrome is based on several inaccurate and culturally fallacious premises (Figure 2).

Dhāt is an imprecise and misleading term – in Ayurvedic literature, *dhātu* is a generic term for seven bodily constituents, only one of which is semen or *śukra*. Disturbance or imbalance in bodily humours (*dosas*) can cause damage to any one of the seven *dhātus* (*Caraka Samhitā*, 2001). Although psychiatric reports justifying this syndrome inevitably cite portions of Ayurvedic texts, semen loss is not mentioned either as a contributory or causative factor in such traditional texts. Ayurveda does describe the semen-deficient state characterized by ‘weakness, dry mouth, pallor, lethargy, fatigue and impotence’ but does not technically view it as a ‘disease’. The emphasis in these treatises is more on balancing bodily fluids.

The impact of such Ayurvedic doctrines declined with the colonial importation of allopathic medicine. But concepts from such doctrines have continued to be occasionally invoked in a piecemeal

Reasons for not regarding *dhāt* as a culture-bound syndrome

- *Dhāt* is an imprecise and misleading term
- *Dhāt* is a false theoretical premise based on exoticizing 'other' cultures
- Concerns about semen regulation are equally pervasive in Euro-American societies

2

fashion by local mental health professionals, to provide a context to explain the preoccupations of their *dhāt* patients. It should be noted that ideas about semen loss are certainly not 'false' beliefs, nor are they 'irrational' to the local population (Jadhav, 1992). In fact, Ayurvedic physicians continue to sanction ideas based on local physiology (including semen loss), and respond to patients' concerns with appropriate measures outlined in their traditional texts (Raguram *et al.*, 1994).

A false theoretical premise based on exoticizing 'other' cultures – soon after Indian independence in 1947, senior Indian psychiatrists, trained in Britain, energetically pursued the idea of national and local syndromes as a means of resisting imposed Western psychiatric disorders. *Dhāt* was the first of these local syndromes: the central explanation provided by patients (as loss of semen in their urine) was considered by Indian psychiatrists to be 'irrational' and a 'neurosis'. This fallacy of abstracting a local historical and culturally valid explanation to the level of a psychopathology suited both the general climate of post-independence India (emphasizing Gandhian self-reliance) and European transcultural psychiatrists who were busy mapping other cultures, and using their own societies as a baseline. Consequently, any cognitive deviation from the European psycho-physiological norm was viewed by Indian psychiatrists and their Western colleagues as 'psychopathology'.

Concerns about semen regulation are equally pervasive in Euro-American societies – there is evidence that moral and psychological concerns over losing or retaining semen prevailed in Euro-American societies. Both Galen and Aristotle drew attention to semen as a 'soul substance' (compare with Ayurvedic 'vital substance') and outlined the debilitating consequences of semen loss: 'Certain people have an abundant warm sperm which incessantly arouses the need of excretion: however, after its expulsion, people who are in this state experience a langour at the stomach orifice, exhaustion, weakness and dryness of the whole body. They become thin, their eyes grow hollow and they abstain from sexual relations. They feel discomfort in the head and at the stomach orifice along with nausea and they do not derive any significant advantage from their self-control' (Galen, 1963).

Galen also cited health problems consequent to the retention of semen: such men 'become dull and inactive without any reason and have a sad and hopeless expression on their faces like melancholics'.

Concerns about semen loss continued throughout the history of Western philosophy, religion and psychiatry. The literature that passionately argued for the debilitating consequences of semen loss included prominent figures such as Aretaeus, Celsius, Sinibaldi

and Tissot. Distinguished psychiatrists of the 20th century who reinforced and perpetuated the idea of mental illness specifically associated with semen loss included Edward Hare, Henry Maudsley and George Beard (Raguram *et al.*, 1994). In fact, this distress over losing a 'vital fluid' such as semen, continues to the present day in the popular press: 'According to devotees of restraint, the average teaspoonful of semen contains the nutritional equivalent of two pieces of steak, ten eggs, six oranges and two lemons. "Each time you orgasm," said one Los Angeles expert, "you lose a part of your vitality. Semen is a rarefaction of the whole body's energy."' (*The Sunday Times*, 1993).

It is evident that although explanations of local semen psychophysiology might differ across cultures, distress over semen loss or retention is neither specific nor unique to South Asia.

Anthropologists have long argued that it would be fallacious to operationalize the Indian *dhāt* symptoms into a checklist, administer this to North Americans or Europeans; show this constellation exists, and to then conclude that it is a universal syndrome (Obeyesekere, 1985). In a recent study, 48 white Britons of both sexes, living in London and suffering from dysthymia, were interviewed on their views about semen loss or retention and its link with depression. Over half the sample (58%) gave elaborate explanations that involved hydraulic and chemical mechanisms to explain the link between semen loss/retention and depression (Jadhav, 1999). More recently, concerns over semen being toxic (burning semen syndrome) to their partners and to themselves have been elicited from Gulf War veterans (Kilshaw, 2003; see also pages 17–20). While it could be argued that the veterans may well be expressing either psychological anxiety or a socio-somatic distress in a metaphorical manner, this is unlikely to be the case for the participants in the London study, because they were specifically asked if this concept was alien to them; only 10% of the sample thought so.

However, this is what has happened with psychiatric classificatory systems, epidemiological research and the construction of culture-bound syndromes in low-income countries. The disarticulation of symptoms from cultural context might facilitate measurement and create categories, but the entities generated are devoid of meaning.

Re-evaluating *dhāt*

Dhāt syndrome can therefore be viewed as an iatrogenic syndrome through which Western-trained psychiatrists explain to themselves the exotic preoccupations of their patients – an accurate projection of their own discomfort in comprehending local meanings, onto their patients. The problem with *dhāt* syndrome is not to be viewed in isolation from the fundamental concerns at the very core of the theory and practice of psychiatry. Such category errors have significantly crippled advances and meaningful comparison of distress patterns across cultures. Although this contribution summarizes the conceptual problems associated with *dhāt* syndrome, these category fallacies demand an extensive re-evaluation of psychiatric theory and research methods in non-Western cultures. To proceed further entails the following.

- A study of lived experiences of everyday suffering and recourse to help, through local narratives and language that would identify key constructs and examine the cultural logic of constructing illness experience in both Western and non-Western settings. The

'semantic illness network' is one such approach that revealed local distress models for the Punjabi community in Britain and Shi'ite Muslims from Iran.

- Such local models would generate popular and locally meaningful patterns of distress to validate local experience on its own terms. These could then be operationalized and validated against Western phenomenology and psychopathology for congruence or goodness of fit in form, content and quality. It is likely that some patterns of distress may not fit with Western descriptions of psychopathology and disorders, and may therefore need separate and distinct class category representation. Alternatively, some patterns (mainly the psychoses) may well reveal common universals (but not necessarily the same configuration) that would further enrich the debate on cultural validity.
- Development of instruments, both quantitative and qualitative, that would measure such distress patterns and contribute towards the development of higher-order categories or syndromes. Only then can such categories be comparable with Western psychiatric concepts for cross-cultural equivalence and validity. For example, a study of life events contributing to mental health problems would require firstly a full picture of what a life event means to the population under study. What is their relative perceived threat to marriage, kinship ties and integrity of the community on the one hand versus economic risks or unemployment on the other? Should a life event questionnaire not be re-calibrated by local members of the population who might choose to rearrange the hierarchy of events? Similarly, how healthy, rather than pathological, are expressed emotions such as over-involvement in societies where extended kinship ties are valued and energetically pursued? Over-involvement in this context might well be the 'glue' that bonds families together.

Conclusion

Is *dhāt* syndrome then empty of meaning? Yes, because it is based on a cultural misunderstanding and a post-colonial paralysis of the Indian psyche's failure to examine its cultural and historical phenomenology. The only useful 'meaning' that this syndrome now offers is as a reminder of the dangers inherent in uncritical culture-blind importation of alien epistemologies, taken-for-granted methodologies and the consequent manufacture of dubious syndromes and clinical entities. To recapitulate: 'sickness is not just an isolated event, nor an unfortunate brush with nature. It is a form of communication through which nature, society and culture speak spontaneously. The individual body is the most immediate, proximate terrain where social truths and contradictions are played out' (Scheper-Hughes and Lock, 1987, quoted in Raguram *et al.*, 1994). Ideas about semen regulation offer a unique opportunity to explore this terrain. ◆

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Practice points

- Seemingly 'irrational' beliefs about suffering in any culture do not constitute a syndrome
- Abstracting local explanations of suffering to the level of a psychopathology constitutes 'cultural iatrogenesis'
- Uncritical import of Western epistemology by psychiatrists in non-Western cultures worsens existing alienation between psychiatrists and their patients
- Cultural validity of psychiatric disorders requires theory to be grounded in and shaped by local forms of suffering