Original Article

Non Pharmacological Treatment of Dhat Syndrome

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Abstract : *Dhat comprises of vague somatic symptoms of fatigue, weakness, anxiety, loss of appetite, guilt and sexual dysfunction attributed by the patient to loss of semen in nocturnal emissions through urine and masturbation. In the individual psyche therefore semen starts to take on an over whelming importance, and these notions frighten the individual. The present study was planned to assess common misconception among patients attending marital and psychosexual clinic and to examine the impact of psycho education on these myths and misconceptions. 42 patients were included in the study i) Diagnosis of dhat syndrome, ii) Concern regarding masturbation as a presenting complaint and iii) Seeking treatment for noctural emission of semen. Patients with associated co morbid psychiatric, medical, surgical, substance abuse, neurological disorders and intellectual deficit were excluded. A structured psychosexual proforma which included information on knowledge and attitude about sexual functions and sex disorders, past sexual practices, current sexual functioning and reasons of presenting to clinic was used. The level of intervention was determined by Word PLISSIT. Three psycho education sessions were taken. The findings of the study reveal that misconception associated with sex and sexuality are very common. 71% patients reported improvement in attitude and knowledge. The findings of the study are quite encouraging as the earlier intervention techniques including drugs and counseling have shown limited efficacy.*

Keywords: Non Pharmacological Treatment, Dhat, Intervention

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INTRODUCTION

In Ayurvedic literature, 'Dhat' is a generic term for seven bodily constituents, only one of which is semen or sukra. First described in western psychiatric texts, dhat comprises of vague somatic symptoms of fatigue, weakness, anxiety, loss of appetite, guilt and sexual dysfunction attributed by the patient to loss of semen in nocturnal emissions through urine and masturbation.[1]

Ayurveda describes the semen deficient state characterized by weakness, dry mouth, pallor, lethargy, fatigue and impotence but does not technically view it as a disease. In the individual psyche, therefore, semen starts to take on an overwhelming importance, and these notions frighten the individual. There is a general perception that it takes 40 days for 40 drops of food to be converted to one drop of blood and for 40 drops of blood to become one drop of flesh.[2] In the individual's mind, semen becomes an important factor. These notions frighten the individual into developing a sense of doom if a single drop of semen is lost, which produces a series of somatic symptoms.[3]

Masturbation is normal sexual behavior practiced universally and the prevalence of masturbation is as high as 100% in males and 75% in females.[4] However, most societies encourage the myth that masturbation is abnormal

and it causes weakness, mental problems, thinning and bending of penis and decreased sexual potency. Loss of "virya" [semen] through sexual acts or imagery is thought to be harmful both physically and spiritually. Most significantly, patients attribute these symptoms to white discharge in their urine (which they claim as a' vital substance' semen) and losing such a vital substance is believed to cause anxiety and dysphoria. Dhat syndrome has been extended to include Indian women presenting with somatic symptoms associated with leucorrhoea.[5]

The condition Dhat has no organic etiology and medical literature commonly refers "Dhatas" 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.[6] In a study conducted at Chandigarh,[7] attitude towards semen loss , its causation and management was explored. A significant proportion of the respondents had agreed that semen loss was harmful and their reasons varied. In another study [8] it was observed that among patients presenting with sexual dysfunction, semen loss was given a major causative attribution by the men themselves. These men believed that excessive loss of semen led to sexual dysfunction and physical symptoms and thus was harmful. Authors of another study found that patients attributed their symptoms to loss of semen wherein half had somatic symptoms and a third had sexual deficiencies.[9] These ideas of semen loss and consequent anxiety are not confined to India alone but have been reported by some other parts of the continent as well.

The management of dhat syndrome needs serious attention. This syndrome has become the domain of traditional health providers that is quacks, ayurvedic or unani practioners. The understanding of this condition by the modern medicine fails to impress most patients and the explanation and reassurance offered prove to be of not much use. Recommended intervention includes empathic listening, a non confrontational approach, reassurance and correction of wrong beliefs, along with use of placebo, anti anxiety and antidepressant drugs, wherever required. Randomized treatment trials suggest that most efficatious clinical management of this condition includes a combination of anti anxiety and anti depressant medication, with counseling and cognitive behaviour therapy.[10]

The present study was planned to assess common misconception among patients attending marital and psychosexual clinic and to examine the impact of psycho education on these myths and misconceptions.

METHODOLOGY

It was a non-randomized, open label, retrospective study. Case records of 200 patients registered in the marital and psychosexual clinic being run by the department between Jan 2008 to Aug 2008 were reviewed and 42 patients fulfilling following criteria were included in the study: i) Diagnosis of dhat syndrome, ii) Concern regarding masturbation as a presenting complaint and iii) Seeking treatment for nocturnal emission of semen.

Patients with associated co morbid psychiatric, medical, surgical, substance abuse, neurological disorders and intellectual deficit were excluded. As a routine, all the patient registered in the clinic are assessed in detail on a structured psychosexual proforma which includes information on knowledge and attitude about sexual functions and sex related disorders, past sexual practices, current sexual functioning and reasons for presenting to clinic. The level of intervention is determined by the Word PLISSIT (P= permission e.g. wife wants to know whether fellatio is safe, LI= Limited information e.g.

Table 1
Socio demographic Profile of Patients Attending Marital and Psychosexual Clinic (N=42)

Variable		Patients No. (%)
Age	10-15 years	1 (2.4)
	16-25 years	27 (64.28)
	>25 years	14 (33.33)
Marital status	Married	30 (71.42)
	Unmarried	12 (28.57)
Occupational status	Skilled/ Semiskilled	23 (54.76)
	Unemployed	19 (45.23)
Education	Illiterate	6 (14.28)
	Undermatric	10 (23.80)
	Graduate	26 (61.89)
Income	0-3500	25 (59.52)
	3500-7000	8 (19.64)
	>7000	9 (21.42)
Religion	Hindu	33 (78.57)
	Sikh	6 (14.28)
	Islam	3 (7.14)
Locality	Urban	22 (52.38)
	Rural	20 (47.61)
Referred from	Direct	19 (45.23)
	Medical/Surgical OPD	19 (45.23)
	Others	4 (9.60)

individual attributing physical symptoms to loss of semen in urine, SS= specific suggestion e.g. treatment [squeeze technique] for premature ejaculation and IT= intensive treatment e.g. in sexual dysfunction arising out of marital discord).

Limited intervention (LI) for persons presenting with dhat syndrome, masturbatory guilt, small size of penis and nocturnal discharge of semen was given in the form of three semi-structured sessions. The first session focused on anatomy of sexual organs using models and photographs of different sex organs. Information was provided on depth of vagina, normal size of penis, Cowper's glands and Bartholin's gland. The second session focused on physiology of sex organs, focusing on erogenous zones, orgasm, normal secretion related to sexual organs, refractory period, production of semen, its storage, discharge and its functions. The explanation was provided for the passage of whitish fluid in the urine. The third session was an open session.

Table 2
Clinical Profile of Patients Attending Marital and Psychosexual Clinic (N=42)

Diagnosis	Patients No. (%)
Dhat	18 (42.85)
Masturbation	2 (4.76)
Nocturnal Emission (NE)	12 (28.57)
Penis size	1 (2.4)
Dhat & NE	9 (21.42)
Oneset of Illness	
0-3 months	1 (2.4)
4-6 months	2 (7.2)
7-12 months	4 (9.5)
>12 months	35 (83.3)
Dhat	
Present	28 (66.66)
Absent	14 (33.34)
Consequences of Dhat	
Weakness	20 (47.61)
Weakness/anxiety	4 (2.4)
Weakness and loss of masculinity	1 (4.8)
Nil information	16 (38.09)
Consequences of masturbation	
Penis deformity	2 (4.76)
Thinness of semen	1 (2.4)
ED & weakness	7 (16.68)
Nil information	32 (76.19)
Nocturnal Emission	
Present	23 (54.76)
Absent	19 (45.23)
Consequences of NE	
Weakness & Erectile Dysfunction	18 (42.87)
Nil information	24 (57.14)

RESULTS

In our study, maximum number of patients (64.28%) were in the age group of 16-25 years, were married (71.42%) and unemployed (45.23%) (Table 1). 61.89% were graduate and 78.57 percent were Hindu. About half (45.23%) were referred from medical or surgical departments.

Dhat was the most common concern (66.66%) among male population. Another 21.42% of patients presented with dhat and nocturnal emission of semen (Table 2). In majority of the patients (83.33%), the duration of illness was more than 1 year. Significant number of patients (47.61%) felt that dhat led to physical

Table 3
Outcome of Patients (N=42)

		Patients No. (%)
Change after Psycho education	Yes	15 (71.1)
	No	6 (28.9)
Follow up Visits	One	21 (47.16)
	Two	9 (21.42)
	Three	5 (11.92)
	>Three	7 (16.72)

weakness, loss of masculinity, restlessness and anxiety. However, large number of patients (42.85%) reported concern for masturbation and 14.28% of patients thought that it led to physical weakness. 54.76% of the patients reported concern for nocturnal emission and 40.47% of the patients attributed sexual and physical weakness to nocturnal emission.

47.61% of the patients came for follow-up only once, 21.42% patients came for follow up twice and 28.64% patient came for three or more sessions.

DISCUSSION

The findings of the study reveal that misconceptions associated with sex and sexuality are very common. Large numbers of patients perceive even the natural physiological function as abnormal. The masturbation which is practiced world over by majority of males and significant number of females is perceived as unnatural and abnormal practice. Masturbation is perceived as detrimental to mental and physical health. The dhat syndrome is rampant among the Indian population and leads to large number of physical and psychological symptoms. Majority of these individuals visit self claimed sex specialists and traditional faith healers. The contact with these health providers not only strengthen their misconception and false beliefs, but also compel the patients to pay huge cost of investgations and drugs which are not only non-effective but also hazardous.

Large numbers of patients of Dhat syndrome are resistant to treatment. The treatment generally consists of pharmacotherapy (antidepressant and anti-anxiety) and counseling. However, the deep rooted misconceptions associated with anatomical and physiological aspects of sexuality are difficult to be corrected with pharmacotherapy and general counseling sessions. As such, no specific technique has been developed to handle these concerns.

Using the word PLISSIT for determining the level of intervention, we developed 3 session psycho education model keeping dhat syndrome under limited information (LI) level. The content of three sessions targeted cultural, anatomical, physiological and psychological aspects of sexuality. **The first session** focused on anatomy of sex organs using models and diagrams. The session explained the normal size of penis along with variation in different individuals, the normal depth of vagina, the location of Cowper's glands and Bartholin glands, the location of clitoris in females, location of hymen, glans penis, testis etc. Patients were explained that the size and shape of sex organs, like other body parts, does not change with physical activities. The aim of the session was to alleviate fears and apprehensions associated with masturbation and night emission. This session also addressed the concern regarding small size of penis. Some patients reporting to clinic perceived discharge from penile and Cowper's glands as premature discharge of semen. These beliefs were also rectified. **The second session** focused on the physiological aspect of sexuality. The session dealt with erogenous zones, production, and storage of semen. Specific emphasis was laid on the fact that urine and semen have separate sources of production and storage and thus passage of semen (Dhat) in urine is not possible. Patients were explained with diagram that the whitish material perceived as dhat is in fact dried up secretion from certain glands which are

associated with lubrication of sex organs which is mandatory for sexual activity. This session also focused on orgasm, both in males and females, the capacity of females to have multiple orgasms as well as inability to achieve orgasms on all the occasions. The refractory period in males after discharge was also discussed. **The third session** was an OPEN session where patients were encouraged to express their opinion regarding explanation provided in earlier two sessions. Patients were also asked to discuss any other concern which had not been discussed in earlier session. The concerns included fear of catching HIV and AIDS, fear of impotency, infections in urine etc.

In our study, out of 42 patients, fifty percent did not come after first contact and thus were treated as dropped out. Out of 21 patients who came after first contact, 9 patients attended only two sessions and rest attended three or more sessions. The reassessment at the end of treatment showed that 71% patients reported improvement. Improvement was taken as at least 50% reduction in symptoms from the baseline. Although no objective scale was used to document improvement, patients were asked to rate themselves on a 10 point scale, where 0 was no change and 10 was free of any symptoms. The findings of the study are quite encouraging as the earlier intervention techniques including drugs and counseling have shown limited efficacy. However, in view of large number of limitations including a small sample size, lack of control and absence of any tool to measure outcome, the findings are preliminary in nature and need to be studied further using stringent methodological design.

REFERENCES

1. Wig NN. Problems of the mental health in India. *J. of Clinical and Social Psychiatry*, 1960;17:48-53.
2. Bhugra D, Buchanan A. Impotence in ancient Indian texts. *Sexual Marital Ther*,1989; 4:87-92.
3. Chadha R, Ahuja N. Dhat syndrome. A sex neurosis of the Indian subcontinent. *Br J Psychiatry* 1990;156: 577 -79.
4. Kinsey A, Pomeroy W , Martin C.(Eds). Sexual Behavior in the Human Male. Philadelphia,1948; PA, WB, Saunders.
5. Kirmayer LJ, Young A. Culture and Somatization: clinical, epidemiological, and ethnographic perspectives. *Psychosom Med*, 1998; 60: 420-30.
6. Bhatia MS, Malik SC. Dhat syndrome. A useful diagnostic entity in Indian culture. *Br J Psychiatry*, 1991;159: 691 -95.
7. Malhotra HK, Wig NN. A culture bound sex neurosis in the Orient. *Arch Sex Behav* 1975; 4: 519-28.
8. De Silva P, Dissanayake SAW. The loss of semen syndrome in Sri Lanka. A clinical study. *Sexual Marital Ther* 1989; 4:195-04.
9. Dewaraja R, Sasaki Y. Semen loss syndrome. A comparison between Sri Lanka and Japan. *Am J Psychother* 1991; 45: 14-20.
10. Sumathipala A, Hewege S, Hanwella R et al (2000). Randomized controlled trial of cognitive behaviour therapy for repeated consultations for medically unexplained complaints: a feasibility study in Sri Lanka. *Psychol Med* 2000; 60:420-30.

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