DHAT SYNDROME REVISITED
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SUMMARY

Fifty consecutive patients of male potency disorders were examined and classified as Dhat Syndrome, Impotence or Premature ejaculation depending on definition laid down for these. Dhat syndrome has been found predominantly in young adults. Thirty one patients (62%) complained of Dhat as a major symptom. Associated diagnosis was depression (48%) and anxiety neurosis (16%). No psychiatric disorder was noticed in 16 (32%) cases. The socio-demographic relationships are given and difficulty in handling such patients has been discussed.

The so-called 'Dhat syndrome' is a commonly recognized clinical entity in our culture both by lay people as well as clinicians in their general practice. However, very little scientific study has been made of the extent and manifestations of this semen-complex in the Indian society but it must be extremely common judging from the numerous sex therapists at street corners and advertisements in the newspapers.

In a survey conducted at Patiala (unpublished data) 48 per cent of rural and 23 per cent of college sample viewed masturbation and/or excessive sex as positively harmful and that it could lead to mental illness. Another 21 per cent of rural sample and 45 per cent of college sample agreed that it was physically debilitating but were not sure whether it could cause mental illness or not, only 32 per cent were positive that it was not harmful.

Nakra (1977) in a review of 150 consecutive patients of sexual dysfunction constituting 9.2 per cent of all patients seen at Chandigarh clinic reported that whereas 25 per cent complained of premature ejaculation and 35 per cent of impotence, the largest number 40 per cent complained of vague somatic symptoms (at times associated with impotence or P.M.E.) attributed to the belief that it was a direct consequence of their excessive indulgence in masturbation and/or sexual intercourse. It is commonly believed that 40 drops of butter produce 1 drop of blood and 40 drops of blood produce 1 drop of semen, hence the loss of semen leads to physical and mental weakness. We commonly refer to this as the 'Dhat syndrome' a term first used by Wig in 1960 (Dhat-semen). This belief is extremely widespread especially among the youth and whitish discharge with the urine is described as 'Dhat' by them. Over 2/3 of patients inquired, in the clinic viewed seminal loss as positively harmful and the percentage rose to 80 per cent among patients of Dhat syndrome.

'Dhat' is a Sanskrit word which literally can be translated as 'Dhatu' and refers to the basic or essential elements either of the body or of the universe considered to comprise of five elements-earth, water, air, fire and ether. At a differential level of conceptualization 'Dhat' is often used in the sense of 'to sustain'-or 'to retain' and at times refers to the supreme spirit of soul. Semen is referred in ancient Indian medical treatise as 'Virya'-which has been derived from the Sanskrit word meaning bravery, valour, strength, power or that which generates power and greatness. 'Shukra' is a term which more specifically refers to the sperm.
content of seminal fluid and is derived from the Sanskrit word 'Shuch'- the word 'Shucha' literally means the 'essence' or fire or shine or glow.

The dislike and fear of the loss of semen is far more vocal and intense in India than the west. The Shiva Samhita says 'the falling of seed leads towards death, the keeping of ones seed is life. Hence with all his power should a man hold his seed.' (quoted by Volin and Phelan, 1967). The idea of loss of semen and with it physical and mental power is often described as a fear-somewhat like the castration complex, but it is in fact, not a fear of attack by another person involving aggressive feelings towards the subject but primarily a loss of semen and a desire to retain the loved object. The belief that the semen is drawn from all parts of body and is the recreator of the self suggests an unusually strong cathexis on the semen which is practically identified with the ego.

It is thus evident that in our culture there is an intense libidinal cathexis of the semen as evident in Indian mythology. In view of this the 'loss' of semen like the loss of any other valued possession should theoretically produce a sense of grief and clinical depression. It was hypothesised that (a) the symptoms of the so-called Dhat syndrome should be similar to the symptoms of Depressive Neurosis rather than anxiety neurosis, and (b) that the patients would have high scores on the Amritsar Depressive Inventory (A.D.I.) (Singh et al 1974) - falling within the depressive range.

**Material and Methods**

Fifty consecutive patients of male potency disorders coming to the psychiatric outdoor department of Rajendra Hospital, Patiala, formed the basis of this study. These excluded the patients whose complaint of potency disorder was secondary to severe depression, schizophrenia, organic pathology or sexual perversion. Patients only with complaint of 'Dhat' were also included. For classificatory purpose the following definitions were used:

*Dhat syndrome*: A condition where a patient presents with primary complaint of loss of semen. Various physical and mental symptoms usually accompany the chief complaint. This includes loss of semen through night discharges and masturbation or through sexual intercourse. At times, patients complain of whitish discharge alone with or preceding passage of urine. This is usually related to presence of oxalate and/or phosphates in the urine but is believed to be semen by the subject.

It was further classified into: (a) Dhat syndrome with no other sexual complaints, (b) Dhat syndrome with impotency and/or P.M.E.

**Impotence**: A persistent inability to obtain an erection sufficient to allow orgasm and ejaculation to be satisfactorily concluded during heterosexual coitus (Hastings, 1963).

**Premature ejaculation (P.M.E)**: A condition wherein orgasm and ejaculation persistently occur before or immediately after penetration of the female introitus during heterosexual coitus (Schapiro, 1943).

The patients were subjected to routine psychiatric and medical check up. Detailed psychiatric history and mental state examination was done. Special emphasis was given on taking in detail the sexual history.
Results

The age range, marital status and literacy of the patients is given below Table 1.

| 1. Age (in yrs): | Range 18-45 | Mean 25.9 ± 5.8 |
|------------------|-------------|-----------------|
| 2. Age at onset  | Range 16-25 | Mean 21.8 ± 4.0 |
| 3. Marital Status| Married     | 35 70%          |
|                 | Single      | 15 30%          |
| 4. Literacy     | Illiterate  | 3 6%            |
|                 | Below 5th   | 4 8%            |
|                 | 5-10th Class| 20 40%          |
|                 | Above High school | 18 36% |
|                 | Postgraduate/Professional | 5 10% |

Diagnosis wise, twelve patients (24 per cent) suffered from impotence alone, seven (14 per cent) from premature ejaculation, eleven (22 per cent) from Dhat and impotence and twenty (40 per cent) complained of Dhat in urine (Dhat syndrome) with no complaint of either P.M.E. or impotence. In all, thirty-one patients (62 per cent) complained of Dhat as a major symptom.

Associated psychiatric diagnosis is given in Table 2.

| Associated diagnosis                     | N = 31 |
|-----------------------------------------|-------|
| Anxiety neurosis                        | 8 16% |
| Depressive reaction                     | 24 48%|
| Psychotic depressive reaction           | 2 4%  |
| N.P.D.                                  | 16 32%|

N.P.D. = No other psychiatric disorder.

Scoring was done on A.D.I, which is a self report instrument and has been found to correlate well with clinical diagnosis of depression and the Hamilton Rating Scale (Singh et al, 1951) to elicit the degree of depression. The scores ranged from 12-27 with a mean of 18.8 ± 4.6 which confirmed the presence of clinical depression in almost majority of cases.

Table 3 shows the symptoms, most commonly presented by patients of Dhat syndrome. Somatic symptoms (fatigue, muscular aches and pains, feelings of weakness) were present in 73.8 per cent of these patients. Tension headache was complained of by another 68.8 per cent. Depressed mood and anxiety were shown by another 62.5 per cent and 51.6 per cent of these patients. Thus, from the above table coupled with findings of A.D.I. scores of 18.8 ± 4.6, it is evident that majority of these patients suffer from underlying depression.

Discussion

The findings of the present study suggest that...
generally young adults, and the onset of symptoms in most cases is in late teens or early adulthood—mean age being 21.8 years. A majority were married (70 per cent) while only fifteen (20 per cent) were unmarried, this contrasts with findings of Nakra in whose series almost half were still unmarried. An important finding was that Dhat syndrome was more common among the literates e.g. 40% were educated between 5-10th class and another 36% with education level above high school. It is interesting to note that patients with low literacy levels constitute only 14 per cent of the total. These figures compare well with Nakra (1977).

A total of thirty-one out of 50 patients (62 per cent) came with the primary complaint of Dhat syndrome and of these eleven patients also complained of impotence and/or P.M.E. An additional psychiatric diagnosis was made in 68% of the total sample and in 50 per cent of these cases it was of depression and in fact two patients had psychotic depressive reaction. A.D.I. scores also show that these persons score high on depressive scale (mean of 18.8) (The recommended cut off point for depression on the scale is 14.0). Follow up of these patients is very poor, majority (64 per cent) did not come again after the first visit and hence the response to anti-depressant treatment could not be assessed. It is probably that these patients were not satisfied with our explanation that seminal loss was not harmful but that their symptoms were due to their excessive worrying about this for which we would prescribe them the treatment. On the contrary it seems extremely naive to believe that after telling a patient that he is not suffering from the illness for which he has come, we should expect him to take our treatment for an illness which he does not believe even exists. However, that is exactly what most of us have been doing and our results have been a dismal failure as compared to the roaring success of the so-called sex clinics.

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