Volume : 2 | Issue : 3 | March 2013 • ISSN No 2277 - 8160

Research Paper | Medical Science

A case report of Dhat syndrome with secondary depression in an adolescent boy: Imbibed from culture or induced by culture?

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ABSTRACT

Dhat syndrome is a culture bound syndrome of Indian subcontinent and depression is one of the frequently associated psychiatric co-morbidity with it. We present here the case of an adolescent boy who presented with major depressive disorder with Dhat syndrome who responded significantly to antidepressant and psychosocial intervention in a period of two weeks.

KEYWORDS: Dhat syndrome, Major depressive disorder, adolescent boy

Introduction

Dhat syndrome is a culture bound syndrome of the India, prevalent in many south East Asian countries with different names and is characterized by semen loss resulting in a range of anxio-somatic symptoms [1]. Loss of semen can be explained through masturbation, nocturnal emission, through urine and accompanying psychiatric symptoms are usually fatigability, weakness, anxiety, feelings of guilt, insomnia, loss of appetite, weight loss, anxiety and sexual dysfunction [1, 2]. Depressive symptoms, anxiety, somatization and sexual dysfunction are commonly associated with Dhat syndrome [3, 4]. Dhat (Semen) is believed to be a precious body fluid in many cultures and its loss can have harmful consequences to the body. This belief is carried forward over generations by different members of the society, which may be a key, authoritative elder member of the family or society or a traditional healer [5].

Case history

An adolescent boy of 16 years old, studying in standard 12th, belonging to a middle class, Hindu family presented with complaints of sadness of mood, reduced social interaction, poor appetite, disturbed sleep and death wishes for approximately 3 months. Family members reported that he remaining confined to his room most of the times and not going to school or participate in social activities. Since last three months, it was observed that he would avoid watching television, talking to friends over phone and listening music. When family members would ask him about his problems – he had expressed his wishes to die. He would also feel lethargy and frequently complained of headache, body-ache, fatigability, difficulty in concentrating in studies. He had no past history of similar or any other psychiatric illness or significant medical illness. Family history was not contributory, though his mother had committed suicide approximately 10 years back (seems to be an impulsive act). He was staying with his father, step mother and grandmother at home. Personal history was not contributory. Pre-morbidly, he was shy, introvert and was well adjusted to life. Physical and systemic examination did not reveal any abnormality. On mental status examination, there was poor eye to eye contact, reduced volume and flow of speech, impaired attention and concentration, depressed affect, hopelessness, pessimistic views about future, somatic preoccupation, ideas of guilt and death wishes. Laboratory investigations (routine hemogram, urine – routine and microscopic, renal function test, liver function test and thyroid function test) were with in normal limits.

With these complaints he was admitted in the psychiatric inpatients and diagnosis of Major depressive disorder was made. He was started with antidepressant Mirtazapine 15 mg/day and clonazepam 2mg/day. During the inpatient stay, patient had revealed that he was having some sexual problems and on detail exploration after reassurance, he told that he had done excessive masturbation following which his symptoms of weakness, fatigability, irritability and lack of concentration in study had been started. He would feel extreme sorry for his acts of masturbation and attributing all his symptoms to masturbation and semen loss due to it. He had also told that as his family members seen him masturbating at home and told him that it is a bad thing and can have several negative consequences. Family members (Father and grandmother) had focused on this issue and warned him about the harmful consequences of masturbation. His friends were teasing him in the class, as he used to sleep in the class in these days. He attributes his feelings of lethargy and sleepiness in the class to his masturbatory behavior and would feel guilt for it which resulted to hopelessness and frequent death wishes.

We shifted our focus of management and addressed the myths related to sexuality and semen loss. Supportive psychotherapy, relaxation exercises and activity scheduling were done. Family members were also involved in the psychotherapy and their myths related to sexuality and masturbation was also addressed. With these interventions, there was significant improvement in patient's subjective distress and depressive symptomatology in one week.

The diagnosis of the patient was revised and kept as "Major depressive disorder with Dhat syndrome". He was discharged after two weeks of hospitalization and was maintained well in follow ups.

Discussion

Depression is a frequent co-morbid association with Dhat syndrome and usually results from the guilt of culturally disapproved semen loss. Even though the presenting symptoms are either somatic or affective (depression and anxiety), the core features remain to be related to Dhat (Semen). In our case, the clinical presentation was depression with somatic symptoms, but on detailed evaluation the core features were masturbation related semen loss and guilt out of it. A shy, adolescent boy could not share his feelings towards sexuality in first contact and his guilt feelings associated with masturbation resisted him to discuss this issue openly with the doctor. But he disclosed his symptoms related to masturbation in subsequent interviews. Initially a diagnosis of "Major depressive disorder" was kept which after detailed exploration and evaluation, revised to "Major depressive disorder with Dhat syndrome". Where, "Dhat syndrome" was primary and "Major depressive disorder" is secondary to it.

Addressing the psychosexual issues, supportive psychotherapy, reassurance, and family intervention reduced the distress level of the patient and there was rapid improvement of the depressive symptoms over a period of two weeks which also suggests that the depression was reactionary or secondary. Usually antidepressants take 2 to 4 weeks' time for the onset of action in majority of the patients [6, 7] and we got significant response over a period

of 2 weeks which seems to be unlikely because of antidepressants and seems more logical in favor of psychosocial intervention. Though combined modality of treatment (pharmacotherapy and psychotherapy) is considered to be the best modality of treatment in resolving the Dhat syndrome as well as the associated co-morbidities [4], but we got significant response before the time of usual onset of action of antidepressants.

The patient was scolded by parents and his grandmother including other family member repeatedly attempted to make him realize that masturbation is a shameful act and could lead to many harmful consequences. It in due course of time led to feeling of guilt, anxiety and depressive symptoms. Teasing by classmates further added to his distress. He had stared all his symptoms to the acts of masturbation.

In our society, it is a common social and familial issue. It seems that the myths and misconceptions carried over generations in our society gets instilled to subsequent generations causing a lot of psychological stress and reactive depression.

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