When Dhat Syndrome is Delusional: A Case Series

Когда синдром Дхат является проявлением бредового расстройства: серия клинических случаев

doi: 10.17816/CP15510

Case report

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ABSTRACT

The Dhat syndrome is a culture-bound syndrome associated with anxiety and somatic and mood symptoms related to semen loss. It sometimes occurs in women, in whom it comes with vaginal discharge. Only a single case has been reported whereby Dhat delusion was associated with schizophrenia. In this case report, we dwell on two individuals suffering from a somatic-type delusional disorder with Dhat-like symptoms who had initially presented classical symptoms of the Dhat syndrome. Further studies are needed to explore the intersections of Dhat syndrome and psychoses, as well as the risk factors involved in mutual predisposition.

АННОТАЦИЯ

Синдром Дхат относится к культурально-специфичным синдромам и характеризуется тревожными, соматическими и аффективными симптомами, связанными с потерей спермы. Иногда он встречается у женщин, и его связывают с вагинальными выделениями. В литературе встречается лишь единичное наблюдение пациента с синдромом Дхат с бредовыми идеями в рамках шизофрении. Представлено описание двух пациентов с соматическим подтипом бредового расстройства с симптоматикой, напоминающей синдром Дхат. В инициальном периоде болезни этих больных имели место типичные проявления синдрома Дхат. Необходимы дальнейшие исследования для изучения взаимоотношений между синдромом Дхат и психозами, а также для определения факторов риска, влияющих на возникновение обоих расстройств.

Keywords: *culture-bound syndrome; Dhat syndrome; delusional disorder; psychosis; obsessive-compulsive disorder*

Ключевые слова: *культурально-специфичный синдром; синдром Дхат; бредовое расстройство; психоз; обсессивно-компульсивное расстройство*

INTRODUCTION

The Dhat syndrome is characterized by a preoccupation with vaginal discharge/semen loss, accompanied with lethargy, appetite loss, weakness, difficulty to focus, and frequent loss of memory [1]. Sexual dysfunction and concomitant anxiety or depression are common in some patients and are typically secondary in Dhat syndrome [1]. Typically, patients attribute the passage of semen or a white discharge from the penis to all of their physical and psychological symptoms [1]. Dhat syndrome, in the past, has been linked to Koro syndrome, which likewise is a culture-bound syndrome. Distorted ideas regarding genital organs and their functioning are core to the psychopathology of these two ailments [2, 3]. In addition, these two syndromes have been linked to obsessive-compulsive disorder [2, 3]. Obsessions, obsessive ideas, and delusions can occur on a continuum, while ego-dsytonic obsessions can turn into obsessive ideas and then into ego-syntonic delusions [4]. Also, obsessive-compulsive symptoms can be prodromal manifestations of psychosis [4]. In the past, Dhat and

Koro-like symptoms have been described as consisting of a delusional core [5, 6]. To the best of our knowledge, only one case of Dhat delusion has been reported in the literature [5]. In this case series, we describe two individuals with Dhat syndrome manifesting itself as delusional disorder.

CASE SERIES

All patients, as described below, were diagnosed with delusional disorder of somatic type according to the Diagnostic and Statistical Manual, Fifth Edition (DSM-5)[1]. There was no significant family history or any history of mood, psychotic, or anxiety disorders, substance use, or a chronic medical illness in the past. In both cases, psychoeducation was conducted after the delusions had shown improvement and consisted of 3 sessions, each lasting around 30 minutes. The sessions consisted of physiological exercises involving semen production and vaginal discharge, accompanied with explanations that such acts are not deleterious to health, as well as the idea of mind-body connection and the associated genital changes. The patients reported a satisfactory improvement in their bio-psycho-social functioning. Written informed consent was obtained from the subjects for publication of their data.

Case A

Patient-specific information: 34-year-old single female.

Course of illness and clinical presentation: Gradual onset and continuous course. The patient initially presented herself to a gynecologist with complaints of worry and apprehension, occasional low mood, and fatigue for the previous 5 months, following failure in a college exam. According to her, all this was due to a recent increase in white discharge by the vagina. Upon clinical examination, no abnormality was detected. The patient's blood glucose, liver function test, kidney function test, thyroid function test, lipid profile, complete hemogram, serological tests for sexually transmitted diseases, microscopic examination and culture and odor of the urine and vaginal discharge were within normal boundaries. She was prescribed escitalopram (10 mg) and clonazepam (0.5 mg), which partially relieved her symptoms, and discontinued medication after 2 months. She later presented herself to an internal medicine physician with similar complaints and was prescribed venlafaxine, up to 150 mg, which also partially relieved her symptoms, before she discontinued the medication after 1 month. After a period of around 4 months, she presented herself to another internal medicine physician, with the added symptoms of verbal and physical aggression towards family members whenever a family member tried to reassure her that white vaginal discharge could not result in bodily symptoms and sleeplessness. She was prescribed olanzapine (10 mg), but she discontinued the medication after a week, citing fears of weight gain. When she arrived at our psychiatric outpatient department after around 3 months, she was secure in her belief that her body parts and the food she consumed were gradually "melting away" through the white discharge, which was resulting in a deterioration of her bodily functions, as well as a "drying up" and lumping into one mass of all of her internal organs. To her mind, the result was low mood, body pain, and sleeplessness. All her conversations with family members revolved around this topic. She further reduced her food and water intake believing that consuming food and water would consume energy and thereby increase the amount of white discharge, leading to further deterioration of her physical and mental health and increased aggression towards family members.

Management of the condition: She was diagnosed with delusion disorder (somatic type), and her symptoms significantly improved within 3 weeks with cariprazine (3 mg), and clonazepam (0.5 mg), together with psychoeducation. The patient was concerned about the side effects of many of the antipsychotic options offered, among them the chosen cariprazine. Clonazepam was discontinued after a week, and she held up well on cariprazine (3 mg), for 2 months until the last follow-up without any reported side effects.

Case B

Patient-specific information: 21-year-old single male.

Course of illness and clinical presentation: Gradual onset and continuous course.

Initial episodes of excessive worry, occasional sad mood, fatigue, and decreased attention span and concentration, which he linked to a loss of energy and vitality through semen following masturbation with a frequency of 1–2 times a day for 1 year. His blood glucose, liver function test,

[1] DSM Library [Internet]. Diagnostic and Statistical Manual of Mental Disorders; [cited 2023 Sep 1]. Available from: https://dsm.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425596

kidney function test, thyroid function test, lipid profile, and complete hemogram was within normal boundaries. He underwent psychoeducation and was prescribed fluoxetine (20 mg), but discontinued it after 1 week. Psychoeducation consisted of two brief sessions about building rapport, the physiology of semen production and discharge, and how the phenomenon is not pathological, mind-body link, and the associated changes in genitalia. He then presented himself after around 6 months with a firm belief that his brain and body were melting away along with the semen, which was leading to poor attention, concentration, and fatigue, which, in turn, he linked to his habit of watching sexually explicit videos and eating non-vegetarian food for 2 months. He would constantly seek assurance from his parents and friends about his beliefs and would often become aggressive towards them if they contradicted him. He stopped masturbating and consuming non-vegetarian food as advised by family members, but he continued to be consumed by the same belief during nocturnal ejections. He stopped going to college and would have multiple crying spells in a day.

Management of the condition: The patient was diagnosed with delusional disorder (somatic type), and his symptoms significantly improved within 4 weeks with risperidone (4 mg), along with psychoeducation. He held up well on risperidone (4 mg), for 1 year until the last follow-up, without any reported side effects.

DISCUSSION

In both cases, symptoms of Dhat syndrome existed in the initial period of the illness and the beliefs about vaginal discharge in case A and semen loss in case B were not delusional in nature. Compared to male Dhat syndrome, female Dhat syndrome is comparatively uncommon. Males typically report symptoms related to masturbatory guilt, whereas females typically express symptoms related to vaginal discharge [1].

Over the course of the illness, the beliefs related to semen loss and white discharge emerged as delusional. In both cases, the belief about semen loss and white vaginal discharge was held for more than a month, with strong conviction, effecting the patients' biological and social life. The belief was implausible and illogical nature-wise, and yet the patients remained preoccupied with the thoughts for days. The thoughts came with a sad mood, anxiety, and aggressivity towards family members and friends when contradicted regarding their firmly held beliefs. These characteristics are indication that these beliefs are delusional [7]. The delusions were related to bodily function, persisted for more than one month without any other symptoms of schizophrenia, and were therefore diagnosed as a delusional disorder of the somatic type 1. There is a dearth of data about what factors can play a role in the transition from culture-centered symptoms to delusions. Past research suggests that patients with an at-risk mental status and attenuated psychotic symptoms are susceptible to a transition from obsessions to overvalued ideas, and finally to delusions as part of schizophrenic symptoms, including negative symptoms and hallucinations. Such manifestations in the past have been termed schizo-obsessive disorder [4]. In our cases, the symptoms of Dhat syndrome may be the prodromal symptoms of the delusional disorder, which, along with schizophrenia, falls under the broader classification of non-affective psychotic disorders [8].

Our case differs from a single reported case of Dhat delusion where the patient presented themselves with catatonia, along with concern regarding semen loss and erection-causing weakness [2], whereas in our case, somatic delusions with Dhat syndrome-like content was present. This case also differs from a previously reported case series where classical koro-symptoms were absent before the development of koro-like somatic delusion [6], whereas in our case, classical Dhat syndrome was present before the development of Dhat delusions. What is more, in the previously reported case, the patient failed to improve with treatment and delusions emerged, whereas in our case the delusions emerged when the patient was not on any treatment. There is also a lack of data about the adequate duration of the treatment or dosage of the psychotropics used and about whether, if inadequately treated, the unhinged ideas related to semen loss or vaginal discharge devolved into delusional ideas.

CONCLUSION

Dhat delusion can be considered a distinct phenomenon compared to the Dhat syndrome, as delusional ideas have not been described traditionally in a culture-centered syndrome. Dhat syndrome, though classically described as a culture-rooted syndrome, may present itself as prodromal symptoms of a psychotic illness that needs to be explored further. What is more, future studies need to focus on the course of treatment regarding the adequate duration and dosage of treatment, and on which at-risk individuals

presenting Dhat syndrome symptoms or related culture-rooted syndromes should be followed up adequately and who may develop psychotic features in the future.

Article history

Submitted: 07.02.2024
Accepted: 26.02.2024
Published Online: 13.03.2024

Authors' contribution: All the authors made a significant contribution to the article.

Funding: The research was carried out without additional funding.

Conflict of interest: The authors declare no conflicts of interest.

For citation:
Bhattacharjee D, Banerjee D. When Dhat syndrome is delusional: a case series. *Consortium Psychiatricum.* 2024;5(1):CP15510. doi: 10.17816/CP15510

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References

1. Prakash O, Kar SK. Dhat Syndrome: A review and update. Journal of Psychosexual Health. 2019;1(3–4):241–5. doi: 10.1177/2631831819894769
2. Ghosh S, Chowdhury AN. A case of two culture-bound syndromes (Koro and Dhat syndrome) coexisting with obsessive–compulsive disorder. Indian J Psychiatry. 2020;62(2):221–2. doi: 10.4103/psychiatry.IndianJPsychiatry_298_19
3. Malik MFA, Najeeb B, Nizami AT. The association of symptoms of dhat syndrome with comorbid obsessive-compulsive disorder: A case report. Indian J Psychiatry. 2023;65(7):793–4. doi: 10.4103/indianjpsychiatry.indianjpsychiatry_437_22
4. Scotti-Muzzi E, Saide OL. Transition from obsession to delusion in Schizo-obsessive disorder. Innov Clin Neurosci. 2018;15(7–8):23–6.
5. Patra S, Sidana A, Gupta N. Delusion of dhat: The quandary of the form-content dichotomy! Ind Psychiatry J. 2014;23(2):171–2. doi: 10.4103/0972-6748.151708
6. Chakraborty A, Bhattacharjee D, Bandyopadhyay U. Secondary Koro presenting as delusional disorder: A case series. Journal of Psychosexual Health. 2022;4(4):260–2. doi: 10.1177/26318318221110188
7. Kiran C, Chaudhury S. Understanding delusions. Ind Psychiatry J. 2009;18(1):3–18. doi: 10.4103/0972-6748.57851
8. González-Rodríguez A, Seeman MV. Differences between delusional disorder and schizophrenia: A mini narrative review. World J Psychiatry. 2022;12(5):683–692. doi: 10.5498/wjp.v12.i5.683