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Case Series of Female Dhat Syndrome

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Abstract

Dhat syndrome is commonly seen in males. Female dhat syndrome is a rarely described clinical entity. Similar to males, females can also present with various physical and psychological symptoms that they attribute to the vaginal discharge. Here we report on two such female patients who presented to the psychiatric OPD with various somatic and psychological complaints that they attributed to the whitish vaginal discharge.

Keywords: Dhat Syndrome; Females; Vaginal Discharge.

INTRODUCTION

Culture bound syndromes were defined by Little wood and Lip sedge as episodic and dramatic reactions specific to a particular community.[1] Dhat syndrome is also a kind of culture bound syndrome that is commonly seen in India.[2] Several previous studies have emphasized dhat syndrome as a global phenomenon.[3] The term Dhat is derived from the Sanskrit word "Dhatus", which means elixir.[4] It is considered the most vital component of the body, and its preservation is essential for good health and longevity.[5] Ayurveda mentions the formation of semen by the process of purification and condensation in several steps. It believes that the food is first converted into blood, which is then converted to bone marrow, and that is then converted to semen. That it takes 40 drops of blood to create a drop of bone marrow, and 40 drops of bone marrow to create a drop of semen.[6] Hence, semen is considered a vital component. Dhat syndrome refers to the presentation of non specific symptoms attributed to a preoccupation with the loss of semen in urine, through masturbation or nocturnal emissions.[7] Professor N.N. Wig coined the term Dhat syndrome in 1960.[8] The International Classification of Diseases, 10th Revision (ICD-10) includes Dhat syndrome under 'Other specified neurotic disorders.[9] There is a female equivalent of dhat syndrome. It is considered by many women that the whitish vaginal discharge, which is called safed paani or swed pradhar, is a vital component of the body in women, similar to semen in men.[10] Chaturvedi, for the first time, equated the symptoms of vaginal discharge in females with dhat syndrome in men.[11] Females also present with various physical and psychological symptoms like weakness, back pain, headache, insomnia, low mood, fatiguability, irritability, etc., attributing them to a loss of genital secretions.[12] Very few case reports of female dhat syndrome is available in the literature.[13] Non-

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pharmacological interventions mainly focus on psycho education.[14] Pharmacological intervention has shown good results with SSRIs.[15]

CASE REPORTS

Case 1

27-year-old hindu female patient, educated up to BA, house wife, married and separated since 1 year, belonging to rural background, came with complaints of passage of vaginal discharge associated with the symptoms of pain in the abdomen, weakness, easy fatigability, inability to work, flatulence, body aches, and irritability for the last 3 years, causing significant socio-occupational dysfunction. These symptoms start after the passage of vaginal discharge and would last for 1-2 hours. Vaginal discharge was described as watery, transparent, and non-foul-smelling, with 2-4 drops and a feeling of light wetness in the vagina and occurring 2-3 times per day. Vaginal discharge is preceded most of the time by sexual desire. A history of increased vaginal discharge after consumption of certain foods that seems to produce heat and avoidance of the same is present. Patient believes that her symptoms are mainly due to vaginal discharge, as she has heard from her family members that vaginal fluid is vital for the body and loss of it can result in illness, and she has also noticed that during the days when there is no vaginal discharge, she feels more energetic, is able to manage her daily activities well, and has no somatic symptoms. Patients sleep is decreased. No other significant medical or psychiatric history is present. The menstrual cycle is regular. Her brother also holds the belief that her complaints are mainly due to vaginal discharge, and her personal history reveals that she was raised in the kind of family where talking about sex was discouraged. On MSE, the mood was irritable. The patient was evaluated for medical and gynecological examinations, which were normal. She was diagnosed as having Dhat syndrome (other specified neurotic disorders, F 48.8), was psychoeducated, and was started on tablet Sertraline 50mg OD, increased to 100 mg after 15 days, and tablet Clonazaepam 0.25 mg at night. Patient reported a 5–10% improvement in the symptoms after a month.

Case 2

A 24 year old hindu female patient, educated up to the 10th standard, a house wife, married for 1 year, from a rural background, presented with complaints of disturbed sleep, tiredness, the inability to do work, body pain, and low mood since 1 year. The patient claims that her symptoms started after her marriage, when she started engaging in sexual intimacy with her husband. The patient says her symptoms would begin after around an hour of physical intimacy with her husband. Patient would develop sleep disturbance and body pain after every sexual act at night, and the next morning she would feel tired, unable to get up from bed. Following this, the patient used to feel exhausted, with the feeling of energy being drained from her body, and hence it would become difficult for her to do daily household activities. The symptoms would remain for one or two days following the sexual act. As this progressed, the patient started developing a low mood. As a result, she started limiting her acts of sexual intercourse with her husband. The patient attributes her symptoms to the passage of a whitish vaginal discharge that followed every sexual act. Her vaginal discharge was non foulsmelling, noncopious. There is no history of fever, pain in the abdomen, or symptoms suggestive of any sexually transmitted diseases. There is a history suggestive of dhat syndrome in maternal uncle. Patient believes that, as vaginal fluid is an energy component, its loss is the reason for her symptoms, and some of her family members hold the same belief. No other significant psychiatric or medical history was elicited. Everything was normal during the medical and gynaecological examinations. On MSE, her mood was sad, and her thought content revealed a pre-occupation with the loss of vaginal fliud. A diagnosis of female dhat syndrome was made, and she was started on tablet sertraline 50mg and lorazepam 2mg at night and also psychoeducated. Patient showed up after a month and reported some 5% improvement, and sertraline was increased to 100mg a day, and slowly, lorazepam was tapered and stopped.

DISCUSSION

In the first case, the patient presented with multiple somatic and psychological symptoms attributable to the vaginal discharge, which seemed to be non pathological. There is a temporal relationship between vaginal discharge and the patient's symptoms. Consumption of foods that produce heat in the body was believed to be the reason for the increase in vaginal discharge, and avoiding such foods was seen as having a beneficial effect. Patient and her brother hold the belief that vaginal fluid is vital and loss of it can result in illness. A significant contribution from the family members attitudes towards sex and beliefs about vaginal discharge is present.

In the second case, the patient presented with various physical and psychological symptoms causing significant socio-occupational dysfunction. She believed her symptoms were mainly due to the passage of vaginal discharge after an act of inter course with her husband, which resulted in the avoidance or limitation of the same. The history of dhat syndrome in the maternal uncle explains the significant contribution from family members attitudes towards understanding sex or sexual acts.

In both cases, SSRIs and psychoeducation seemed to be helpful.

CONCLUSION

Females can also present with dhat syndrome similar to men. Cultural belief about vaginal discharge being vital fluid plays a significant role. This belief can result in various distressing physical, psychological, and cognitive symptoms in females, causing significant socio-occupational dysfunction. Both non-pharmacological and pharmacological management are useful. Non-pharmacological interventions involve mainly psycho education of the patient regarding the anatomy and physiology of the female reproductive system and the physiology of sexual act. In pharmacological interventions, SSRIs seemed to be helpful mainly in reducing somatic and mood symptoms, while benzodiazepines were helpful in the short term in controlling sleep disturbances.

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