Case report

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An elderly man presenting with symptoms suggestive of Dhat syndrome

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Abstract

Dhat syndrome is a culture-bound syndrome that has been reported among males in South Asian countries who are generally young, single or recently married, and this condition is known to be associated with prominent anxiety and depressive symptoms. We present an older male who presented with symptoms suggestive of Dhat syndrome with associated significant depressive symptomatology.

Keywords: Dhat syndrome, elderly, severe depression, culture-bound syndrome

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Introduction

Dhat syndrome or "semen-loss anxiety", is a culture-bound syndrome reported to arise from the cultural belief that semen is a precious and highly purified body fluid, and its loss may have harmful physical consequences (1-3). Patients with Dhat syndrome may present with anxiety and or depressive symptoms, sexual dysfunction, and vague somatic symptoms, which are attributed to the loss of semen, generally through nocturnal emissions or through urine, masturbation and sexual intercourse (2-6).

Dhat syndrome is mostly described in South Asian countries such as India, Sri Lanka, Nepal, Pakistan, and Bangladesh and its prevalence is reported to range from 11.7% to 30% (3,7). There are several case reports of patients with similar presentations from other parts of the world, including China, Russia and European countries (2,3). Dhat syndrome is generally reported among young males who are in their second or third decade of life and who are unmarried or recently married (3,5,8). They are also known to hold conservative beliefs about sexual activities and to hail from rural backgrounds (5,8). A considerable proportion of patients with this condition have been found to have associated comorbid sexual dysfunction, depression, and anxiety (3).

We present a patient, who developed symptoms suggestive of Dhat syndrome for the first time in his late sixties and subsequently developed a severe depressive episode with psychotic symptoms.

Case report

Mr T, is a 68-year-old married male, educated up to grade ten and the father of an adult daughter. He has been working abroad continuously for the last 32 years as a machine operator, until his sudden return to Sri Lanka two months ago. Prior to his return, he had visited his family in Sri Lanka at least three times a year during the last three decades and has been sexually active with his wife during these periods. He denied sexual relationships outside the marriage or any sexual dysfunction.

He had first started experiencing nocturnal emissions about four months ago while working overseas. These had occurred once or at times, twice a night and were not associated with any erotic dreams. He denies depressive, anxiety or psychotic symptoms before experiencing the nocturnal emissions.

Mr. T had become very anxious about the nocturnal emissions as he was worried that he was losing his virility as a man. About three months later, he had developed lack of energy, loss of weight and tremors of his hands, and these symptoms had further confirmed his worries about losing his virility. This had led him to return early to Sri Lanka much earlier before his contract concluded, and on return, he had avoided sexual contact with his wife and slept in a separate room. He had hidden his clothes and washed them on his own, and not disclosed his concerns to his wife or his friends as he was worried that they may think he had been sexually promiscuous while overseas. Even though the family noticed that his behavior was unusual they had not inquired about that

from him. He had subsequently started to believe that his neighbours were somehow aware of his issue, and he said that he could hear them talking to him in a derogatory manner for experiencing nocturnal emissions at his age. He had felt extremely guilty of ruining the reputation of his family and felt embarrassed to face the society. All these thoughts had made him feel very low in his mood. The above symptoms distressed him to such a degree that he had thoughts of ending his life on several occasions, however, he had not followed up with these thoughts. He was referred to mental health services after he finally confided his worries to a doctor known to him.

On mental state examination, he was observed to be anxious and restless. His speech was spontaneous but with long pauses. His mood was depressed. He had ideas of guilt about the possible reputational harm the nocturnal emissions may have caused his family. However, this did not amount to a delusion. He had an overvalued idea that he was losing his virility through semen loss and this did not amount to a hypochondriacal delusion. Whenever he saw his neighbours talking among themselves, he strongly believed that they were talking about him and his nocturnal emissions (delusion of reference). In addition, he felt worthless and had passive suicidal ideas. He had second person auditory hallucinations where he heard his neighbours talking to him in a derogatory manner.

He scored 28/30 and 19/30 in the Mini Mental State Examination (MMSE) and the Montreal Cognitive Assessment (MoCA) respectively (9, 10).

He was observed to have fine tremors in both upper limbs and bilateral cerebellar signs; including intentional tremors of both hands, dysdiadokokinesia, and ataxia. There was no nystagmus, dysarthria or pendular knee jerks. No other abnormality was found in his systems examination.

All hematological and biochemical investigations (including thyroid function test, fasting blood sugar, urine culture, etc) were normal except a markedly elevated serum creatinine level and reduced eGFR. The electroencephalogram (EEG) which was done in order to exclude nocturnal seizures was normal. Contrast-enhanced computerized tomography (CT) of the brain showed normal pressure hydrocephalus (NPH) and conservative management was recommended for this condition.

In our opinion, he developed symptoms suggestive of Dhat syndrome first and then went on to develop a severe depressive episode with psychotic symptoms. He was treated as an in-patient due to the degree of distress he was experiencing in the context of his symptoms and the severity of the depressive symptoms. He was commenced on venlafaxine 75mg daily and olanzapine 5 mg at night. He was also commenced on a short course of alprazolam 0.25mg daily to manage his distress. Psychoeducation was provided regarding the structure and function of the reproductive system and sexual myths. Mr. T showed some improvement of his symptoms 5 days after commencing treatment and was less distressed. He was discharged after 6 days of starting treatment. His alprazolam was tailed off upon discharge, and venlafaxine was increased to 112.5mg over the next two weeks. He was reviewed two weeks after discharge as an out-patient and showed a significant improvement of his depressive symptoms and he no longer had features of Dhat syndrome.

Discussion

The present case describes an unusual presentation of Dhat syndrome, as it involves an elderly male who had been, married for several decades, as opposed to the typical presentation described in literature (8,11). Further, this patient presented with a severe depressive episode with psychotic symptoms, with marked functional impairment, which is also not in keeping with the typical presentation of vague somatic symptoms, anxiety, and depressive symptoms (2, 4-6). Our patient did not have symptoms suggestive of depression or psychosis during the first three months when he only had worries regarding losing his virality.

We could not find any literature on Dhat syndrome being caused by organic pathologies. However, our patient had cerebellar signs and impaired cognitive functions in addition to the CT finding of NPH. In our opinion, NPH is likely to be unrelated to his initial symptoms.

Dhat syndrome is described to respond to psycho-education and counselling and also to anti-depressant or anti-anxiety medication (6). Cognitive behaviour therapy with sex education and resolving the sexual myths, corrections of cognitive errors, imaginal exposure with desensitization, as well as homework assignment in the form of masturbatory training have also been shown to be effective in reducing the symptoms (11).

This case is important as it highlights the need to consider culture-bound syndromes even in elderly patients, with atypical presentations.

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Declarations of interest

None.

Statement of contribution

PSA and CA were responsible for the clinical care, literature review and writing the initial draft. DLUA and YMR conducted the literature review and edited the draft. All authors approved the final draft.

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