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Sushrut Jadhav
University College London
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Sushrut Jadhav

The uncritical application of western psychiatric concepts in non-western societies resulting in culturally invalid psychiatric syndromes, have been extensively documented. Such instances are considered 'category errors'. In contrast, 'reverse category errors' although theoretically postulated, have never been empirically demonstrated. Diagnostic criteria of an established South Asian culture specific neurosis, Dhāt syndrome, were deployed by a psychiatrist of South Asian origin, amongst 47 white Britons in London, UK, presenting for the first time with a clinic diagnosis of ICD-9 Depressive Neurosis (Dysthymic Disroder, ICD-11). The proceedure yielded a new disorder, Semen Retention Syndrome. Based on narrative accounts and quantitative scores on the Hamilton Depression Rating Scale, the evidence suggests that a significant subset of white British subjects diagnosed with Dysthymic Disorder, may in fact be expressing a psychological variation of a previously unknown local White British somatisation phenomena labelled Semen Retention Syndrome. Anxiety and depressive symptoms presented by this subset of subjects were primarily attributed to a core irrational belief and a cognitive error centered around misunderstood concepts of semen physiology. Consequently, the undue focus on mood idioms by both white British patients and their health professionals, leads to a mistaken diagnosis of Mood Disorder, and results in incorrect treatment. The implications of this ethnocentric mode of reasoning raises concerns about existing concepts in psychiatric phenomenology and for official international diagnostic classificatory systems. The paper concludes by arguing that category errors in both directions are instances of cultural iatrogenesis, and underscore the importance of a culturally valid psychiatry.

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The discipline of cross-cultural psychiatry has long argued that 'category errors' arise when psychiatric concepts developed in any one particular society are uncritically

Correspondence to: Sushrut Jadhav, Senior Lecturer in Cross-cultural Psychiatry, University College London Medical School, Charles Bell House, 67–73, Riding House Street, London, W1W 7EJ, UK. Tel.: 44-207-6799292. Fax: 44-207-6799028; Email: s.jadhav@ucl.ac.uk

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applied in a contrasting culture to yield psychiatric syndromes lacking in cultural validity (Kleinman 1987). Over the past three decades, numerous psychiatric disorders have been subject to such scrutiny (Nuckolls 1992; Young 1995; Jadhav 1996; Kirmayer 1996; Jacobson 2002; Littlewood 2002; Timimi & Taylor 2004). A comprehensive review of the DSM-IV classification from a cultural perspective was published a decade ago (Mezzich *et al.* 1996) and a cultural research agenda to inform the DSM-V in 2002 (Kupfer *et al.* 2002). More nuanced discussions on Somatisation and Expressed Emotion as concepts that embody western cultural values have been detailed (Jenkins & Karno 1992; Kirmayer & Young 1996). It is interesting to note that all reported category errors have been argued and demonstrated in relation to psychiatric research deploying western categories and concepts in non-western settings.

In contrast to this, the phenomenon of 'reverse category error' refers to instances whereby mental health concepts indegenous to non-western societies are uncritically applied to western societies. In a theoretical argument, Obeyesekere (1985) considered the concept of 'semen loss' applied in the reverse direction:

> Take the case of a South Asian male (or female) who has the following symptoms: drastic weight loss, sexual fantasies, and night emissions and urine decolouration. In South Asia the patient may be diagnosed as suffering from a disease, 'semen loss'. But on the operational level I can find this constellation of symptoms in every society, from China to Peru. If I were to say, however, that I know plenty of Americans suffering from the disease 'semen loss', I would be laughed out of the court even though I could 'prove' that this disease is universal. The trouble with my formulation is that while the symptoms exist at random everywhere, they have not been 'fused into a conception' (such as semen loss) in American society. Yet if I were to employ the methodological norms implicit in the several Diagnostic and Statistical manuals and apply them from a South Asian perspective to the rest of the world (as Western psychiatrists do for depression), then it is incontrovertible that 'semen loss' is a disease and is universally found in human populations. (pp. 136–137)

Taken together with increasingly large numbers of overseas Indian mental health professionals working in the UK, who may well be applying ethnocentric ideas in their clinical practice, the author of this paper deliberately chose to enquire about the presence of Dhāt syndrome amongst white Britons in London. Dhāt syndrome was particularly chosen in view of the debate over its culture specific status (Raguram *et al.* 1994; Jadhav 2004). A summary consideration of the syndrome that problematises its nosological status is necessary in order to contextualise the present study.

Dhāt syndrome was first described by Narendra Wig in 1960, athough it appears that the idea originated from earlier clinic observations in India by a British psychiatrist anthropologist, Morris Carstairs (1956). The prevalence rates in medical and psychiatric clinics range from 11–30%, affecting men aged 20–38 years, although an analogous version amongst south Asian females has also been suggested (Chaturvedi *et al.* 1993). Common symptoms include weakness, fatigue, palpitations and sleepnessness. Most crucially, patients attribute their symptom to a white discharge (*Dhātu*) in their urine, which presumably generates anxiety and dysphoria.

Researchers have also reported the condition to afflict south Asian migrants to Europe (Creed 1987). Randomised treatment trials confirm a combination of anti-depressants and anxiolytics, together with cognitive behaviour therapy as effective therapeutic strategies (Bhatia & Malik 1991).

The International Classification of Diseases, 10th edition (ICD-10, WHO 1992) classifies Dhāt Syndrome as both a Neurotic Disorder (ICD-10 code F48.8) and a Culture-Specific Disorder (Annex 2, ICD-10, WHO 1992). The description under Neurotic Disorder states that it is caused by 'undue concern about the debilitating effects of the passage of semen'(p. 110).

This section, based on advice from WHO experts, also cautions users of the ICD manual: 'The strong association of these syndromes with locally accepted cultural beliefs and patterns of behaviour indicates that they are probably best regarded as not delusional'(p. 111).

Annex 2 of ICD-10, compiled by an American anthropologist, conflates several other local South and East Asian terms from India and China (*dhāt, jiryan, shen k'uei, shen-kui*). The section describes these disorders as characterized by

> . . . anxiety and somatic complaints such as fatigue and muscle pains, related to a fear of semen loss in men or women (also thought to secrete semen). Precursors are said to include excess coitus, urinary disorders, imbalance in bodily humours, and diet. The main symptom is a whitish discharge in urine, interpreted as semen loss. Traditional remedies focus on herbal tonics to restore semen or humoral balance. (p. 178)

The term 'Dhāt' itself is an English corruption of the Sanskrit dhātu, and is erroneously equated with either semen or semen loss. Moreover, concerns over semen regulation as causal to mental illness are equally pervasive in Euroamerican societies. Historically, Galen discussed semen as a soul substance, and its damaging mental consequence were detailed by Aristotle, Celsius, Sinnibaldi and Tissot. Modern 20th century psychiatrists including Edward Hare, Henry Maudsley and George Beard described the mental pathologies associated with semen loss (Raguram *et al.* 1994). Popular advertisements of the late 20th century in broadsheet British newspapers support the proposition that semen loss distress is not culture specific to South Asians:

> According to devotees of restraint, the average teaspoonful of semen contains the nutritional equivalent of two pieces of steak, ten eggs, six oranges and two lemons. 'Each time you orgasm,' said one Los Angeles expert, 'you lose a part of your vitality. Semen is a rarefaction of the whole body's energy.' (Nelson 1993).

Conserving semen in sports such as soccer is well known (Abbott 2001), and football coaches continue to advocate sex bans before major matches (Parker 2006). Indeed, the *Urban Dictionary* defines Semen Retention Syndrome as 'a male counterpart's mental state of edginess due to lack of sexual satisfaction and frequent ejaculation' (Urban Dictionary online).

Present Study

This research was part of a larger study enquiring into the cultural meaning and experience of depression amongst white Britons in inner London outpatient

clinics (Jadhav 1999). Findings detailing the range of illness meanings including presenting idioms of distress, perceived seriousness and outcome, experience of stigma, ideas of causation, and help seeking behaviour; and relationship with objective professional biomedical assessments have been reported elsewhere (Jadhav *et al*. 2001; Weiss *et al*. 2001). Preliminary fieldwork to develop a cultural adaptation of the original Indian EMIC (Weiss 1997) and other cultural considerations outlined earlier in this paper, strongly argued for including an enquiry into white British ideas about semen loss and retention and their causal link with depression and other psychological problems. The nature of the EMIC interview allows for both narrative description as well as pre-coded numerical categories of meanings associated with depression.

This paper focuses on subject's response to a key question on the EMIC subsection that specifically probed into the causal meaning of their reported pattern of distress with reference to semen regulation. A specific question within the British EMIC enquired whether subjects considered semen retention or loss was causal to their personal suffering and also in general if this might cause psychological problems.

Forty-seven white Britons (see Table 1 for demographic description) with a first episode diagnosis of Neurotic Depression (ICD-9) were interviewed on a culturally adapted British version of the EMIC. The subjects were subsequently rated on biomedical criteria by administering the Hamilton Depression Rating Scale (Hamilton 1960).

Results

All subjects were of white British origin and lived in the London borough of Camden and Islington at the time of interview. Almost two-thirds of the total sample had no confidants, and the majority (76.6%) did not discuss or share their problems with neighbours. Over half of the sample reported moderate to severe strain on their finances. Most (59.5%) felt their living conditions adversely affected their health, and a similar percentage did not get along with their neighbours.

Figure 1 is a bar chart showing percentage response to the emic question that enquired into links between semen loss and retention, and psychological problems. Note that responses elicited also allowed a categorical rating if the concept of semen loss-retention was unknown to the study subjects (10%) or they were uncertain about their views (22%). Less than half of the subjects (42%) responded with a categorical 'no'. Almost half the sample (48%) linked disturbed semen physiology with psychological problems. A quarter of the total sample elaborated in some detail, ways in which semen loss or retention or both caused psychological problems.

Table 2 is a narrative account of a select sample (two males and two females) highlighting the relationship between semen retention and psychological problems. Two significant metaphors emerge: hydraulic and chemical.

Figure 2 depicts subject scores on the 24 item Hamilton Depression Rating scale (mean 28.1), and indicates a moderate degree of symptom severity.

Table 1 Demographic Features of the Study Sample (%)

	Inpatient $n=27$	Outpatient $n=20$	Total $n=47$
Males	59.3	50.0	54.0
Females	40.7	50.0	46.0
Age (mean)	39.9 years	38.4 years	39 years
Duration of illness	12.2 months	13.8 months	
Ethnicity	English	70	
	Scottish	20	
	Irish	10	
Religion	Roman Catholics	40	
	Atheists	21	
	Protestants	17	
	Agnostics	20	
	Jewish	2	
Marital Status	Single	48	
	Married	12	
	Cohabiting	2	
	Separated	14	
	Divorced	24	
Mean Income	Outpatient	£593.46 month	
	Inatient	£549.09 month	
Education	Primary	45	
	Secondary	30	
	Diploma/Degree	25	
Occupation	Manual	30	
	Non-manual	70	
Employment	Unemployed	60	

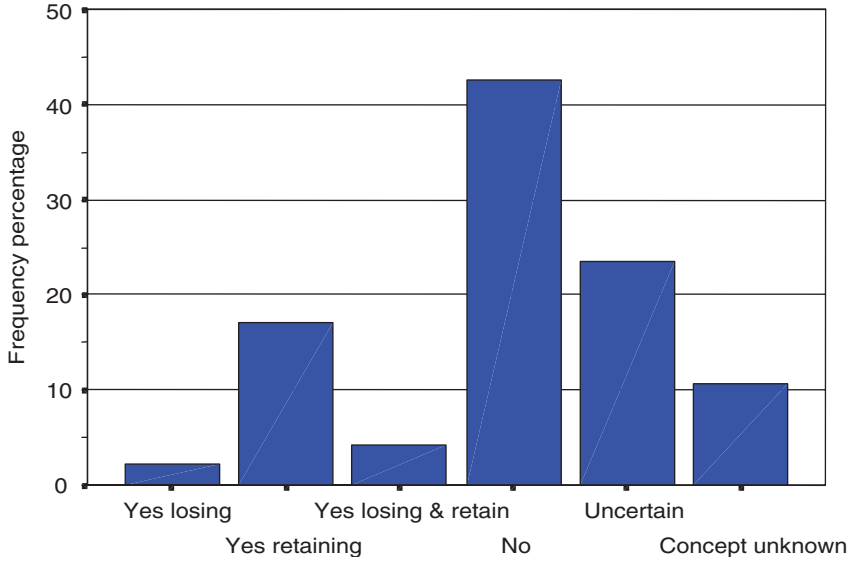

Figure 1 Responses of Forty-seven White Britons (18–65 yrs) with a First Time Clinic Diagnosis of Neurotic Depression to the question, 'Could losing or retaining semen cause depression or psychological problems?

Table 2 Narratives of White Britons: Semen Retention causing Psychological Problems

Male, age 50
I suppose it would. I mean it is not based on any factual evidence, um, but I suppose there is a build up of tension as a result (of retaining). I am not sure there is chemical evidence to say so, but, yeah . . . then the sexual appetite is not satisfied it can cause further problems . . . it might encourage release in ways that might not be useful.
Male, age 58
From the man's point of view, I think the regular build up and release of semen, part from all the physical sort of things release a lot of tension which as you can feel building up in yourself. (If retained) it will damn up the energy I think. (Where is that energy coming from?) Well it's given off improperly in the way I twitch (shows his muscles) but also one would be encouraged to build up tension again . . . rather like doing exercises on a bicycle . . . the easiest example I can give is my step brother-in-law . . . he has got mental illness . . . it has never worried me . . . I mean I have thought of having a vasectomy.
Female, age 29
Well if a man retains sperm then well every man has to procreate and if that is not fulfilled then it will become inwardly frustrating. If it is linked to the prostrate gland then that links a signal to the brain in need of fulfilment, a signal of death looming . . . then a man might become depressed . . . the body gets confused and the male's mind automatically becomes dead. (Wha about losing semen?) No. I think the more semen the man loses then the more it will regenerate itself. The body will say I need it more, more, more (that is just the opposite in India where losing semen causes concern) no, my theory is use it or lose it.
Female, age 45
I would have to say yeah. I should imagine it is like if you don't have periods you get bloated, you feel horrible and after the period is over it is like going . . . you know the loo, and having a poo every day . . . I feel clean after that and feel brand new . . . so if men carry too much semen wouldn't men not masturbate?

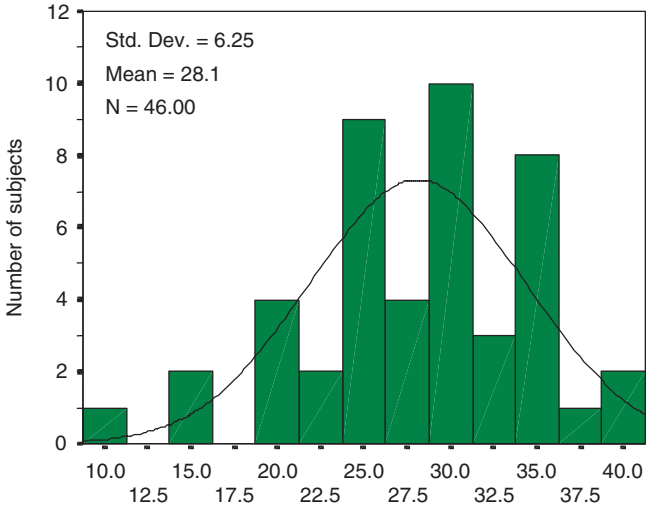

Figure 2 Subject Scores on the 24 Item Hamilton Depression Rating Scale

A content analysis of narratives from subjects is operationalised into a checklist as shown in Table 3. The list comprises extensive somatic symptomsin including loss of energy, diminished libido, muscular tension, twitching, bloating, anxiety and depression. Most crucially, subjects attributed their somatic and psychological

Table 3 Symptoms List for Semen Retention Syndrome Derived from Content Analysis of Narratives

Loss of energy
Diminished libido
Multiple somatic symptoms (tension, twitching, bloating)
Depression
Anxiety
Attributing symptoms to retention of semen

symptoms to retaining semen within their bodies. Although women did not explain their problems with respect to vaginal fluids, it is interesting to note that they endorsed ideas of semen retention causing mental distress amongst men.

The data presented suggests that a previously unreported somatic constellation of symptoms attributed to Semen Retention and camouflaged as Depression, has been uncovered amongst a subset of white Britons in London. Depression then is a mere epiphenomena of a primary irrational beleif about semen physiology. To rephrase the ICD-10 description, the features of Semen Retention in the present British sample are similiar to Dhāt Syndrome except that the *undue concern is about the debilitating effects of the retention of semen*.

Discussion

Is Semen Retention a Syndrome?

For a syndrome to be confirmed, further such clinical research needs to be reproduced. This requires a larger sample size although there is no agreed cut off for a mimimum number needed to firmly establish a syndromal status. The Oxford English Dictionary defines a syndrome as 'a set of several symptoms that run together' (OED 1997). No criteria for the number, extent and severity of symptoms is specified in the medical literature. More interestingly, since the mid-20th century, the term syndrome has also been used for 'a characteristic combination of opinions, behaviour, etc.; frequently preceded by a qualifying word' (OED 1997). The qualifying word is not a necessary criteria although examples provided by the OED cite a range of demographic variables (gender, profession, sub-culture) and factors that are considered aetiological to the syndrome.

Clinicians subscribing to the Kraepelinian form-content dichotomy are likely to find the symptoms of Semen Retention fairly unambiguous to elicit, quantify and attribute to a consensual discrete cause. Reproducibility (and running together of symptoms) could be demonstrated by developing a symptom rating inventory from the checklist (Table 3), increasing the sample size, and administering across diverse settings: genitor-urinary and psychosexual clinics, and general practice surgeries. This would allow calculation of prevalence rates, establish the unique configuration of symptoms, confirm the stated aetiology of the condition, and elicit further narratives to determine the cultural logic of this condition. Indeed, special clinics patterned along the lines of both professional and folk psycho-sexual clinics in South Asia (and similar to Allergy and Tourette disorder clinics in the UK); staffed by

established South Asian clinician researchers would ensure recruitment of study subjects, offer screening for detection of the condition, and provide counselling and cognitive behavioural intervention to correct these irrational beliefs (Jadhav & Littlewood 1994).

Further legitimacy for the malady could be gained though establishing of social and medical links with 'User' groups who desire health professionals acknowledging their suffering; such as the Gulf War veterans who complain of the 'Burning Semen Syndrome' (see Kilshaw, this issue). This would ensure popular cultural support and encourage such 'User' groups to demand that the mental health profession acknowledge their suffering. The essential characteristics of Semen Retention Syndrome could then pave the way for pharmacological trials to ameliorate the distressing symptoms. South Asian migrants in Europe are likely to enthusiastically report more semen-related concerns if their distress is less viewed as 'exotic' by their European physicians. A shift of ethnic representation amongst senior health bureaucrats at international health institutions such as the World Health Organisation (WHO) from Euro-American domination to South Asian might facilitate this change in future editions of international nomenclatures for mental disorders. In short, D(T)hat would turn into D(T)his: the exotic out there into the ordinary local here.

If such a syndrome exists amongst White Britons, why don't people report and seek treatment for this condition? If one follows Obeyesekere's (1985) argument, that the condition is not 'fused into a conception', the evidence presented both from the reviewed literature and the present study challenges this thesis. When a popular healing system in any society generates illness categories, these diffuse into the wider culture and generate a demand. The field of cultural construction of psychiatric knowledge systems has over the past two decades, demonstrated evidence for this phenomenon (Gaines 1992; Young 1995; Helman 2001; Kirmayer 2005; Skultans 2007). For a more specific example within the South Asian context, see Jadhav 1994. Patients and doctors engage through a shared idiom that could be initiated from either party (Martinez-Hernaez 2000). It is common clinical experience that many subjects who present at hospital clinics do not necessarily report a textbook description of a syndrome. It is often the physician's task to elicit (and uncover hidden) symptoms, diagnose the condition and offer treatment. Often the physician might challenge patient formulation and include health information to re-educate patients about their condition.

From the data obtained in this study, it could also be hypothesised that British psychiatrists currently focus on mood symptoms to the exclusion of somatic features detailed in the symptom list generated from this study. It follows that British doctors might need training to make a correct diagnosis of Semen Retention Syndrome. Further support for this hypothesis comes from findings comparing this London sample with a similar study conducted at Bangalore using an Indian adaptation of the EMIC. This study, showing the tendency of British patients to report psychological symptoms but acknowledge somatic symptoms on probing, is matched by the tendency of Indian patients to report somatic symptoms spontaneously, but acknowledge psychological symptoms on probing (Figure 3).

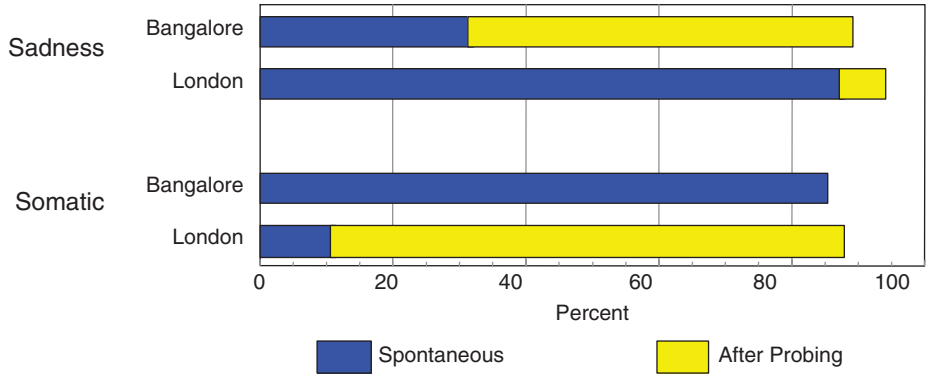

Figure 3 Reports of Sadness and Somatic Symptoms of Depression in Bangalore ($N = 80$) and London ($N = 47$). Reprinted with permission from Jadhav *et al.*, 2001, p. 60

This comparison between reported patterns of distress amongst London and Bangalore subjects challenges the clinical notion that 'depression' is primarily a psychological universal illness, somatic features being secondary 'cultural' artefacts. Such a stark difference in reporting style of subjects could well result in incorrect diagnosis and wrong treatment. Thus British patients with Semen Retention Syndrome would be misdiagnosed as Depression and remain untreated for their primary pathology, and compare this with South Asian patients suffering from Depression, but erroneously diagnosed and treated for Somatisation Disorders.

Conclusions

From an interpretive anthropological and cultural psychiatric perspective, the data presented, the methods deployed, and inferences drawn in this paper could well be considered as ethnocentric research. Indeed, the disarticulation of symptoms from cultural context might facilitate measurement and create categories, but the entities generated are devoid of meaning. What then of the reverse for a range of mental disorders and culture bound syndromes in low income nations identified as category errors?

The author argues that a blatant demonstration of 'reverse category errors' closer to the 'homes' of Euro-American psychiatry, would serve to highlight the serious consequences of existing flawed concepts embedded within Euro-American psychiatric phenomenology and official international diagnostic classificatory systems, just as the use of the ICD diagnostic category of 'Psychosis Not Otherwise Specified' allows clinicians to accumulate evidence demonstrating cultural variations and difficulties in accepting universal criteria for psychoses (Kleinman 1987). Similarly, it could be hypothesised that there are significant advantages and serious implications for reframing 'category errors' in either direction as instances of 'cultural iatrogenesis'. If further examples such as those detailed in the present study are allowed official coding within the DSM and ICD, they are more likely to highlight

the moral and ethical consequences of ethnocentric classificatory systems, and further the argument for a culturally valid psychiatry.

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