I read with interest the article by Sumathipala *et al* (2004) – an excellent review on *dhat* syndrome, a clinical entity highly prevalent in the Asian continent and not considered an entity in the Western world. This article is not free from publication bias. I wish to make the following observations based on our work in different parts of India over a period of 15 years.

Dhat syndrome, a concept developed from Sanskrit literature, is based on a cultural belief in people who live in the Indian subcontinent. The syndrome is highly prevalent not only in India but also in its neighbouring countries such as Pakistan, Nepal, Burma (Myanmar), Sri Lanka and others. It is more prevalent among men in early adulthood, starting in late adolescence. Patients present with multiple somatic and psychological symptoms in the background of loss of semen. Surprisingly, patients have their first contact with departments other than psychiatry, for example urology, dermatology and general medicine, and are then referred to psychiatry.

We presented our first observations from northern India on *dhat* syndrome from patients presenting with weakness, anxiety symptoms with sexual difficulties such as premature ejaculation and impotence (Behere & Nataraj, 1984). In further work by myself and others in the southern part of India, we were able to observe that the belief underlying *dhat* syndrome had a dimensional impact in clinical practice. While it was common to find anxiety and phobic symptoms, it was also extended to encompass hypochondriacal, obsessive and body dysmorphic symptoms. Affective symptoms were also common. Uncommonly, some patients presented with delusional beliefs. Thus, from a clinical perspective, the symptoms in *dhat* syndrome may cluster to give a spectrum of diagnostic possibilities ranging from anxiety to somatoform disorders, affective disorders and, rarely, psychosexual delusional disorder (further details available from the author on request).

This multiplicity of clinical presentation makes it difficult to classify *dhat* syndrome purely as neurotic. We question the validity of *dhat* syndrome being incorporated as a single neurotic disorder in ICD–10, where it is included under 'other specific neurotic disorders' (F48.8; World Health Organization, 1992). No single diagnosis encompasses the clinical presentation of *dhat* syndrome; the presentation of symptoms needs to be seen from a clinical perspective rather than viewing it as a neurotic disorder alone. This might help to formulate the management comprehensively on a biopsychosocial model depending upon its clinical presentation.

Behere, P. B. & Nataraj, G. S. (1984) Dhat syndrome: the phenomenology of a culture bound sex neurosis of the orient. *Indian Journal of Psychiatry*, **26**, 76–78.

Sumathipala, A., Siribaddana, S. H. & Bhugra, D. (2004) Culture-bound syndromes: the story of *dhat* syndrome. *British Journal of Psychiatry*, **184**, 200–209.

World Health Organization (1992) *International Classification of Diseases and Related Health Problems* (ICD–10). Geneva: WHO.

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I read Sumathipala *et al*'s (2004) review on *dhat* syndrome with interest. The authors' contention is that *dhat* syndrome is not culture-bound. My argument is although *dhat* is globally prevalent, the specificity of the culture (Ayurvedic concept) and certain psychosocial features being pathogenic in the development of *dhat* syndrome in the south Asian context cannot be ignored and the essence of the cultural perspective of 'semen loss anxiety' in different geographical areas has been misunderstood.

According to the traditional Indian Ayurvedic system of medicine, genital secretions are considered a highly purified form of *dhatu*, or bodily substance, and loss of this precious substance is thought to result in progressive weakness or even death. In south Asia, the complaint of loss of genital secretions is regarded with concern by both men and women. The cultural and biomedical meanings of the complaint of leucorrhoea in south Asian women (Karen, 2001) demonstrate that the complaint of vaginal discharge accompanied by a host of somatic symptoms could not fit a particular biomedical diagnostic category, and is understood within the ethno-medical context of Ayurveda.

As noted by Malhotra & Wig (1975), Asian culture condemns all types of orgasm because they involve semen loss and are therefore 'dangerous'. In contrast, the Judaeo-Christian cultures of the 18th and 19th centuries in Europe considered most types of sexual activities outside marriage to be 'sinful'.

The so-called culture-bound syndromes have been the focus of the debate between adherents of biopsychological universalism (universal human psychopathology) and adherents of an ethnological cultural relativism (typical aspects of a particular culture). Culture-bound syndrome is not always bound (Westermeyer & Janca, 1997) but heavily related to certain cultural traits or cultural factors that can be found in different geographical areas, or across ethnicity or cultural units or systems, which share the common cultural view, attitude or elements attributed to the formation of the specific syndromes. Based on this new understanding, the term should be changed to 'culture-related specific syndrome' to reflect its nature accurately (Tseng & McDermott, 1981).

Karen, T.-K. (2001) Cultural and biomedical meanings of the complaint of leukorrhea in South Asian women. *Tropical Medicine and International Health*, **6**, 260–266.

Malhotra, H. K. & Wig, N. N. (1975) Dhat syndrome: a culture-bound sex neurosis of the orient. *Archives of Sexual Behavior*, **4**, 519–528.

Sumathipala, A., Siribaddana, S. H. & Bhugra, D. (2004) Culture-bound syndromes: the story of *dhat* syndrome. *British Journal of Psychiatry*, **184**, 200–209.

Tseng, W. S. & McDermott, J. F., Jr (1981) *Culture, Mind and Therapy: An Introduction to Cultural Psychiatry.* New York: Brunner/Mazel.

Westermeyer, J. & Janca, A. (1997) Language, culture and psychopathology: conceptual and methodological issues. *Transcultural Psychiatry*, **34**, 291–311.

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Authors' reply: We are delighted to note the varying and huge response to our paper (Sumathipala *et al*, 2004). It is interesting to note that most of the comments are from the Indian subcontinent where the *dhat* syndrome is prevalent.

Drs Kuruppuarachchi & Wijeratne point out that semen loss anxiety is a form of communicating distress. We agree, but our conjecture is that male preoccupation with semen loss has been universal and we need to place the related depression and anxiety in the specific context. Our contention with which Kuruppuarachchi and Wijeratne agree is that ICD–10 and DSM–IV–TR are culturally influenced classificatory systems. Wig's (1994) suggestion that culture-bound syndromes should be integrated into existing rubrics of psychiatric classification is an appropriate one. Most of the correspondents feel that

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culture-bound syndromes should be separate, which is an assertion we disagree with.

Drs Painuly & Chakrabarti's suggestion that there are cases of 'pure' *dhat* also reflects the possibility that there are cases of 'pure' depression. To argue that treatments should reflect the diagnosis is putting the horse before the cart. It is not true to say that neurasthenia does not exist any more. Neurasthenia as a diagnosis exists not only in China but also in France, once again emphasising that idioms of distress do cross cultural boundaries.

Dr Gonjanur misses the point we were making. The semen loss anxiety which led to Kellogg and Graham marketing corn flakes and Graham crackers, respectively, as treatment (for semen loss) has disappeared from the West because of changes in the social, political and economic climate. Why have the symptoms that were widely prevalent and described in the UK, USA and Australia in the 19th century disappeared over time? Dr Shankar seems to argue that Ayurveda is a culture; it is a system of medicine developed at a specific time. It should be left to historians to discern whether Ayurveda reflects the culture or the culture is influenced by Ayurvedic concepts in exactly the same way as Western medical systems reflect or influence Western cultures. We believe that culture-bound syndrome as a nosological category is a colonial invention and deserves to be dumped in the bin of history. We agree that culture plays a key role in how symptoms are allowed and encouraged to be developed and expressed by individuals. However, the role of culture is essential for *all* our patients and not a few selected ones. Everyone has culture.

One of the key factors that the correspondents have chosen not to discuss is the distinction between disease and illness. *Dhat* as a symptom and syndrome reflects illness in the broadest term. The clinicians are trying to place this in a disease category, thereby paying lip service to cultural influences only in the pathological diagnostic sense, not in a broader idiom of distress. Although some acknowledgement is made to the heterogeneity of the syndrome, we believe that cultures themselves are markedly heterogeneous and the clinicians must address not only the cultural values and identity of individuals but also those of the cultural groups to which the individual belongs, and place the expression of distress in its historical and social context. It would appear that our correspondents are arguing for exemption for a geographical syndrome. It is indeed a pity that Westermeyer & Janca's (1997) argument is not universally accepted in the classificatory and nosological systems as it deserves to be – the exact point we have striven to put across. Culture-bound syndromes have fascinated anthropologists and psychiatrists alike as accounts of strange syndromes, myths and symbols. We urge clinicians to place these symptoms in the context of cultural values and not simply medicalise and pathologise distress that can be dealt with using other models. Another question that deserves to be raised and answered is why *amok* in Malaysia is seen as a culture-bound syndrome but similar behaviour of random shootings and running 'amok' is not seen in this way in the USA? It is time that we gave up the ghost of colonialism and looked at culture-bound syndromes with a new eye. We acknowledge that culture is an important pathogenic and pathoplastic influence but our belief is that culture-bound syndromes are a historical anomaly. *Dhat* as symptom is important but the classification of *dhat* syndrome is problematic.

Sumathipala, A., Siribaddana, S. & Bhugra, D. (2004) Culture bound syndromes: the story of *dhat* syndrome. *British Journal of Psychiatry*, **184**, 200–209.

Westermeyer, J. & Janca, A. (1997) Language, culture and psychopathology: conceptual and methodological issues. *Transcultural Psychiatry*, **34**, 291–311.

Wig, N. N. (1994) An overview of cross-cultural and national issues in psychiatric classification. In *Psychiatric Diagnosis* (eds J. Mezzich, Y. Honda & M. Kastrup), pp. 3–10. New York: Springer.

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Disability after trauma

That post-traumatic stress disorder (PTSD) is not associated with disability and that its clinical importance 'may be questionable' are huge claims and somewhat counterintuitive. For Neal *et al* (2004) to come to such counterintuitive conclusions would require a very strong piece of research. Unfortunately, since their paper does not seem to offer a sound methodology or results, the force and the validity of their conclusions is debatable.

Six years (on average) after a traumatic event the armed services personnel they study report high levels of disability. From the paper it *appeared* that the authors thought that the association was not mediated via diagnoses of PTSD, depression or alcohol dependence on statistical grounds (although these disorders were all frequently present in the 70 armed services personnel referred to the PTSD unit). The presence of high scores on the Beck Depression Inventory (BDI) accounted for a 'high proportion of the variability'. In other words, diagnoses did not account for variability but 'depression consequent upon trauma' did. It is difficult to understand how the findings of relatively high disability 6 years (on average) after a trauma associated with depressive scores on the BDI cannot be linked to the diagnoses found at interview, as the conclusion of the abstract section clearly implies.

There are several problems with the study design. There is no control group. All the interviews were conducted by a single individual, a nurse, who was presumably not masked to the origin of the patients. The Structured Clinical Interview for DSM–IV (SCID) is not primarily intended as an instrument to detect PTSD. An easily administered alternative to the SCID might have been the Short Posttraumatic Stress Disorder Rating Interview (SPRINT) (Connor & Davidson, 2001) which has solid psychometric properties. There is perhaps an over-reliance otherwise on self-report questionnaires.

The study also fails to refer to relevant literature. A study published in 2001 by Tucker *et al* recruited 307 patients with PTSD and was both double-blind and placebo-controlled. This found a significant reduction in disability, as measured by the same Sheehan Disability Scale, after 12 weeks of treatment with paroxetine (Tucker *et al*, 2001).

At this point I must state my own interest in that I have written court reports on PTSD, but on joint solicitors' instructions or single solicitor's instructions for claimants or defendants. However, with regard to the authors – although one would like to believe in their independence – surely it is not credible for there to be no declaration of interest stated when all three authors are employed either directly or indirectly by the Ministry of Defence?

Declaration of interest

B.H.G. has written numerous personal injury and clinical negligence medico-legal reports and is Editor of Psychiatry On-Line.

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