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.

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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.

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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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